HEALTH HOMES FOR CHILDREN: OUTCOMES AND QUALITY ASSURANCE

Presented to the Voluntary Foster Care Agencies

June 23, 2015

NYCCP

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OVERVIEW

- The children's healthcare landscape is changing

- New York State, working with IPRO, has commissioned the New York Care Coordination Program to provide a series of Health Home trainings to assist Voluntary Foster Care Agencies in fulfilling their role as a downstream Health Home care managers for children in Foster Care

- Today's session is the second in the Administrative Track of a series of training sessions addressing both administrative and care management topics.

INTRODUCTIONS AND TODAY'S PRESENTERS

- Adele Gorges, Executive Director, New York Care Coordination Program, Inc.

- John Lee, Director, New York Care Coordination Program, Inc.

- Christine Mangione, Clinical Director, New York Care Coordination Program, Inc.

TODAY'S LEARNING OBJECTIVES

- Understand expected outcomes resulting from the work of Health Homes within a fee for service environment through 12/31/16, and a managed care environment beginning 1/1/17

- Understand how Health Home metrics will be tracked and reported

- Understand the key elements of a successful Health Home Quality Assurance Program both within a fee for service and a managed care environment

- Understand the types of reports needed to monitor performance

- Understand how to use audit tools to support quality assurance and outcomes

- Understand the timing - what to do now, through October 1st, between October 1st and January 1st 2017, and beyond

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PREPARING FOR CHANGE

NOW

- Review existing Performance Assessment/Quality Assurance-Improvement operations and expand to account for Health Home and MCO interaction.
- Become familiar with expected Health Home outcomes for children, and with associated quality measures.
- Identify your agency's IT needs.

By October 1, 2015

- Establish internal policies and procedures to monitor delivery of HH care management services, and to demonstrate outcomes.
- Become familiar with MAPP and with the MAPP dashboards by attending State trainings.
- Define internal pathways and procedures for reporting to Health Homes.
- Attend all trainings offered by DOH and the Health Home(s) you are contracted with.
- VFCA CMs discuss reporting obligations with Health Homes, learn Health Home policies concerning collective review of data and HH QA/QI initiatives.

From October 1, 2015 - January 1, 2017 (NYC/LI) and July 1, 2017 (ROS)

- Understand MCO requirements for Performance Assessment/Quality Assurance-Improvement and have internal QA-QI prepared to initiate internal processes while responding effectively to MCO policies regarding Health Home Care Management for their members

FIRST, SOME FUNDAMENTALS…

- **Quality Assurance** (QA) is identifying and correcting mistakes; collecting data during QA activities can inform strategizes to prevent mistakes and avoid problems in the future.

- **Quality Improvement** (QI) is making changes that will lead to better patient outcomes (health), better system performance (care), and better professional development (learning); QI activities can determine which resource investments make a difference and which do not.

- **Outcomes Management** applies *Continuous Quality Improvement* (CQI) techniques to health care, assessing both the effectiveness of products and services and the quality with which they are provided. Linking the structure and process of care to the outcome is critical to success.

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WHY FOCUS ON OUTCOMES AND QUALITY?

- The Affordable Care Act provides an opportunity to build a person-centered care delivery model that focuses on improving outcomes and disease management for beneficiaries with chronic conditions and obtain better value for state Medicaid programs.

- Health Home Care Management Agencies will be required to report information about outcomes.

- The recommended Health Home core quality measures are an integral part of a larger payment and health care delivery system reform effort that focuses on quality outcomes for beneficiaries.

- The following chart describes the process flow for organizations interested in Health Home outcomes and quality

WHY FOCUS ON QUALITY AND OUTCOMES?

OVERSIGHT FLOW DOWNSTREAM
-Designate entities to provide specific Health Home functions
-Set standards and requirements by function
-Set Quality Measures-Clinical Outcomes, Experience of Care, Quality of Care

REPORT BACK FLOW UPSTREAM
-Use systems, join learning sessions, and provide information as required
-Collect and report data on compliance with standards and requirements
-Collect and report quality measure data required by oversight entity

CMS → NYS DOH → FFS Now to 1/1/17 → Health Home → CMA (VFCA)
MCO 1/1/17 Forward
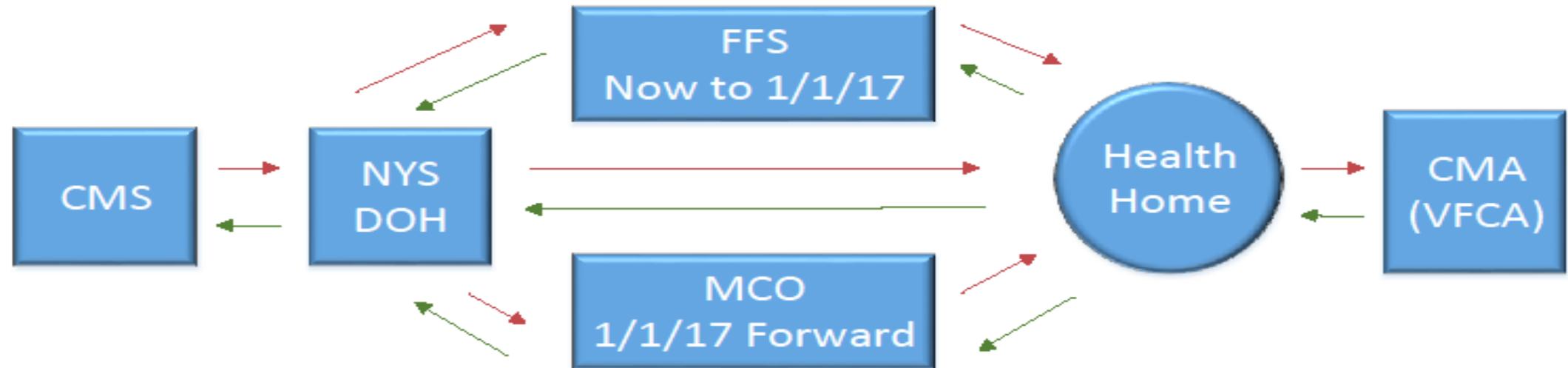
DOING THE WORK : Provide direct care, administrative and oversight services for functional level ▷ Comply with standards and requirements for functional level ▷
Achieve quality measures as required by each oversight entity

CMS HEALTH HOME QUALITY MEASURES

CMS Core Set of Quality Measures:

1. Adult Body Mass Index (BMI) Assessment,

2. Ambulatory Care - Sensitive Condition Admission,

3. Care Transition – Transition Record Transmitted to Health care Professional,

4. Follow-up After Hospitalization for Mental Illness,

5. Plan- All Cause Readmission,

6. Screening for Clinical Depression and Follow-up Plan,

7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment,

8. Controlling High Blood Pressure

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/smd-13-001-hh-qm.pdf

NYS PLAN QUALITY MEASURES

State Plan Quality Measures:

Goal-based Quality Measures

- Goal 1: Reduce utilization associated with avoidable (preventable) inpatient stays
- Goal 2: Reduce utilization associated with avoidable (preventable) emergency room visits
- Goal 3: Improve Outcomes for persons with Mental Illness and/or Substance Use Disorders
- Goal 4: Improve Disease-Related Care for Chronic Conditions
- Goal 5: Improve Preventive Care

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/statewide_hh_quality_measures.pdf

WHAT ARE THE DESIRED OUTCOMES FOR HEALTH HOMES SERVING CHILDREN?

WHY HEALTH HOMES?

- Improve health care and health outcomes
- Lower Medicaid costs (over time for children)
- Reduce preventable hospitalizations and ER visits
- Avoid unnecessary care for Medicaid members
  - Right service at the right time
  - Avoid the escalation of services and costs from unmet needs

WHY HEALTH HOMES FOR CHILDREN IN FOSTER CARE?

- Provide remediation of deficiencies in early childhood or pre-foster care.
- Begin immediate and continuing trauma-informed intervention.
- Set in motion a general improvement in health care status that will telescope out through adulthood, reducing health care costs and improving personal functioning over decades.
- Create continuity of care that will continue during and after foster care.
- Strengthen families in their roles as children's natural care managers.
- Systematically upgrade primary health care accessibility and provision.
- Incorporate behavioral health services as a core part of health care for children.

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NEW QUALITY MEASURES SPECIFICALLY FOR CHILDREN

(Source: NYS Health Home for Children Application)

- Appropriate Treatment for Children with Upper Respiratory Infection

- Appropriate Treatment for Children with Pharyngitis

- Childhood Immunization Status

- Immunization for Adolescents (Combination 1)

- Annual Dental Visit

- Well-Child Visits in the First 15 Months of Life

- Well-Child Visits in the 3rd, 4th, 5th & 6th Year

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NEW QUALITY MEASURES SPECIFICALLY FOR CHILDREN

(CONTINUED)

- Adolescent Well-Care Visits and Preventative Care

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index

- Follow-up After Hospitalization for Psychiatric Reasons

- Medication Management for Asthma 75% (ages 5 – 18)

- Asthma Medication Ratio (ages 5 – 18)

NEW QUALITY MEASURES SPECIFICALLY FOR CHILDREN
(CONTINUED)

- Follow Up Care for children Prescribed ADHD Medication: Initiation and Continuation

- Use of Multiple Concurrent Antipsychotics in Children and Adolescents

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

- Metabolic Monitoring for Children and Adolescents on Antipsychotics

- Lead Testing

DEVELOPING A QUALITY PROGRAM FOR YOUR HEALTH HOME FOR CHILDREN CARE MANAGEMENT SERVICES

DEVELOPING A QUALITY PROGRAM

1. Program Structure
   - Identify how HH QI/QA activities will be integrated into your agency's existing quality activities
   - Identify the point person for HH QI/QA activities
2. Resources
   - Assess your agency's ability to collect and analyze data
   - Identify the other oversight entities that will provide you with information and feedback about your performance, and the manner in which you will receive that feedback
3. Communication
   - Define organizationally how your agency QI/QA administrator will ensure that information about performance is shared up (with the Board of Directors), and down (to the Care Managers)

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DEVELOPING A QUALITY PROGRAM(CONTINUED)

4. Process
   – Train staff on the requirements, and develop policies/procedures for standardization
   – Create methods for collecting information to assess the quality of services
   – Appoint a quality review committee, made up of both clinical and administrative staff, to review both internal audit findings and performance reports from other oversight entities
   – Develop plan of correction to address deficiencies, and monitor implementation
   – Hold regular meetings to keep staff informed of agency performance

DEVELOPING A QUALITY PROGRAM(CONTINUED)

5.   Other Steps

- Participate in quality improvement activities offered by the Health Home: learning communities, work groups

- Be aware of and participate in *all* training programs offered by the Health Homes and the State:
  - DOH: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes
  - List Serve for DOH: LISTSERV@LISTSERV.HEALTH.STATE.NY.US
  - MCTAC: http://mctac.org/page/provider-readiness

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ASSESSING PERFORMANCE

ASSESSING PERFORMANCE

EVERYONE will be monitoring performance to ensure quality and make sure that outcomes are met! Here are some EXAMPLES of what that might look like on every level:

- **Voluntary Foster Care Agency** level
    - The next slides suggest methods for collecting information about performance

- **Health Home** level care management data analysis tool

- **Managed Care Organization** level outcomes reports

- **State** level reports generated from MAPP, collecting information from all of the above

METHODS FOR COLLECTING INFORMATION ABOUT PERFORMANCE

- Satisfaction surveys
- Critical incident reviews
- Learning collaboratives with other agencies
- Supervision
- Creation of an inter-agency QA team
- Chart audit tool
- Audits from the Health Home on completion of mandated reporting fields
- Reports from the oversight entities; including the Health Home, Managed Care Plans, and the State

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AGENCY LEVEL – CHART AUDIT TOOL

- Uses:
  - Compare agency outcomes against State requirements
  - Compare Health Home Care Manager outcomes within the agency
  - Compare current performance against previous performance
- Following are <u>examples from a current adult Health Home </u>of the types of items included in their Chart Audit Tool
- Going forward, comparable tools will need to be developed for the Children's Health Homes

AGENCY LEVEL – CHART AUDIT TOOL

- **Elements for a Voluntary Foster Care Agency audit tool may be derived from the following:**
  - NYS Health Homes Model for Children, as structured for Voluntary Foster Care Agencies
  - NYS DOH Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations - DRAFT - 6/12/2015:
    - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/mco_cm_standards_6_12_15.pdf
  - NYS DOH Administrative Health Home Services Agreement - DRAFT - 6/12/15:
    - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/mco_asa_template.pdf
  - How the VFCA contracted Health Home(s) plan to tailor and deliver each of the Six Core Health Home requirements to meet the complex needs of children eligible for Health Home
  - How those requirements are implemented within the HIT systems of the Health Home(s) with which a VFCA contracts
  - How the requirements are implemented in MAPP

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CREATING A CHART AUDIT TOOL

Initial Documentation Maintained in Record	Yes	No	Partial	N/A
Demographic Information completed				
CANS-NY completed				
Consents completed				
Initial Care Plan completed				
Timeframes Documented				
Comprehensive Assessment completed within 30 days of Enrollment				
Annual Comprehensive Assessment completed timely				
Initial Care Plan developed upon Enrollment				
Care Manager Notes are entered within 5 days of the activity				
Quality of Services Documented				
Comprehensive Assessment addresses: physical health, mental health, academic, vocational, family relationships, community supports				
Care Plan is representative of identified needs/priorities from Comprehensive Assessment				
Care Plan is person-centered and reflects input of the enrollee				

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SAMPLE HEALTH HOME CHART AUDIT TOOL (Source: HHUNY)

Quality	Yes	No	Partial	N/A
CareManager notes demonstrate the Care Manger's efforts in obtaining needed services				
CareManager notes show evidence of the Care Manager working with other service providers				
CareManager notes shows evidence that the Care Manager shared the Care Plan with other service providers and/or social supports				
Appropriate justification for discharging the client is evident				
Problems are referred to Providers				
Social Support Contacts are documented				
Medicaid CIN is accurate and active				
Total # of Questions:				**50**
Total # of Questions Applicable:				**50**
Score:				**0.00%**
Comments:				

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HEALTH HOME LEVEL:
CARE MANAGEMENT DATA ANALYSIS TOOL

- Uses:
  - Collect standardized care management data for members assigned to Health Homes
  - Compare agency outcomes against State requirements
  - Evaluate the volume and type of interventions
  - Assess the impact care management services have on outcomes for health home enrollees

HEALTH HOME LEVEL - SAMPLE CARE MANAGEMENT DATA ANALYSIS TOOL (SOURCE: CMART)

Health Home CMART Frequencies			
Total Intervention Frequencies (As Labeled) Engaged CM = Yes			
Title	**Reported Values**	**N Counts**	**Percentage of Total**
Total Intervention - Mail, Phone, Person	Value	N	%
0		167	3.5
1		508	10.64
2		502	10.51
3		1144	23.96
4		715	14.97
5		426	8.92
6		310	6.49
7		205	4.29
8		165	3.46
9		122	2.55
10		99	2.07
11		84	1.76
12		59	1.24
13		56	1.17
Total		4775	100

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HEALTH HOME LEVEL - SAMPLE CARE MANAGEMENT DATA ANALYSIS TOOL (SOURCE: CMART)

Health Home CMART Frequencies: Frequency Counts of information as submitted.			
Title	**Reported Values**	**N Counts**	**Percentage of Total**
Care Manage, Engaged CM = Yes *	Value	N	%
	0	696	14.58
	1	926	19.39
	2	790	16.54
	3	833	17.45
	4	464	9.72
	Total	4775	100
Comm Social, Engaged CM = Yes *	Value	N	%
	0	3624	75.9
	1	540	11.31
	2	289	6.05
	3	144	3.02
	Total	4775	100

Coming in 2017
MANAGED CARE PLAN LEVEL - OUTCOMES REPORT

- Uses:
  - Compare agency outcomes against State requirements (six core functions)
  - Compare health home performance against each other
- Practices regarding outcomes reports vary among MCOs
- Following example is an excerpt from the reports of one MCO that typically brings reports to monthly meetings with Health Homes; reports are then shared by with the contracted Care Management Agencies

MANAGED CARE PLAN LEVEL - SAMPLE OUTCOMES REPORT

Health Home Services	Process Goal	Outcome Goal	HEADLIGHTS MONITORING	TAIL LIGHTS REPORTING
Care Management	90% have patients assigned to Health Home have a comprehensive screening completed within 30 days of enrollment	Identify needs and increase patient activation levels	Eligibility and date completed	Assessment date and score
Care Transitions	90% of patients discharged from Emergency Department see a clinician for follow-up within 7 days of discharge	Reduction in Emergency Visits	Hospital alerts on ER discharge	Follow-up visit complete date at member level
Referral Management	90% of patients referred by PCP/BH to specialists or to community resources are seen and PCP follow-up w/in 30 days end to end	Reduction in Adverse Events (any admission to ER or IP stays)	Patients w/ specialist visit scheduled or referral to community resources	Referral management outcomes report
Individual Support	90% of patients have a face to face encounter with their assigned care coordinator in the last 30 days are assessed for depression and have active care plan goals.	CMS Outcome 6: Screening for Clinical Depression and Follow-Up Plan	Patients w/ no Care Coordinator face o face visit in last 90 days	Documentation in care plan of screening and follow-up action step

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STATE LEVEL - REPORTS

MAPP HEALTH HOME PERFORMANCE DASHBOARDS

- Dashboards developed to help the Health Home Provider Community – Managed Care Plans, Health Homes, and associated Care Management Agencies – track progress and take actions to improve performance.

- Each dashboard is an interactive, customizable view.

- Use these dashboards to view your agency's performance over time and in comparison to others, and drill in to gain insight about the population you serve and the performance of your associated providers.

MAPP HEALTH HOME PERFORMANCE DASHBOARDS

- **Scheduled for August 17, 2015 Release**
  - Health Home Program Enrollment
  - Managed Care Plan Assignment Work Flow
  - Health Home Assignment Work Flow
  - Care Management Agency Enrollment Performance
  - Dollars Paid for Members Not in Tracking System
  - Emergency Room Utilization for Health Home Members
  - Inpatient Utilization for Health Home Members
  - Primary Care Utilization for Health Home Members
- **New dashboards will be added as new data becomes available and new needs are identified**

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WHAT, WHEN, HOW…..

Introduction to MAPP Health Home Performance Dashboards
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_mapp.htm
[May 5, MAPP Health Home Bi-weekly Webinar wmv, 74MB]

Release Timeline
- August 17, 2015 release for current Health Homes / populations
- October 1, 2015 release with updates for Children's Health Homes

Access
- Through MAPP
- Available to your QI/QA staff if they have access to MAPP

Training
- Will be available from DOH
- Date for new Children's Health Homes providers TBD
- Tutorial available in the application

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Health Home Performance Dashboards

Tutorial

These dashboards were developed to help the Health Home Provider Community - Managed Care Plans, Health Homes, and associated Care Managers - track progress and take actions to improve performance.

Each dashboard is an interactive, customizable view. Use these dashboards to view your agency's performance over time and in comparison to others, and drill in to gain insight about the population you serve and the performance of your associated providers. To make the most of these dashboards, please take some time to click through the Dashboard Tutorial and explore the other resources available to you on this page.

The initial dashboards focus on enrollment management, expenditures made for people who were not entered into the Tracking System at the time of payment, and utilization of Emergency Room, Inpatient, and Primary Care services.

New dashboards will be added to this page as new data becomes available and new needs are identified, so please check back often!

Take the TUTORIAL!

Click the above icon to launch an interactive, step-by-step tutorial for using these dashboards.

Data Facts

The source of data for these dashboards is the NYS Salient Medicaid Enterprise System; Health Home Module. The data on these dashboards include:

- Health Home Assignment and Enrollment Data starting 1/2012
- Medicaid Claims and Managed Care Encounters

All dashboards contain statewide views to allow you to compare providers, regions, and more. No member-specific information is displayed.

Resources

Glossary of Terms

This glossary includes definitions for all of the terms used in the Health Home dashboards.

About the Data

Read more about the data included on the Health Home dashboards.

Change Log

Record of changes made to the Health Home Performance Dashboards page, resources, and dashboards.

Enrollment Management Dashboards

View and compare information about Assignment, Outreach, and Enrollment.

Health Home Program Enrollment

MCP Assignment Work Flow

Health Home Assignment Work Flow

CMA Enrollment Performance

Dollars Paid for Members Not in Tracking System

EXAMPLE: QUALITY IMPROVEMENT INITIATIVE FOR HEALTH HOME CARE MANAGEMENT AGENCY

Example of a Health Home Quality Initiative

- Identify the problem
  - Audit identifies lack of engagement of care teams in plans of care
- Collect information
  - Survey Health Home Care Manager Supervisors about their experience related to engagement of care teams in plans of care
- Analyze the data
  - What is the extent of the problem
  - What are the barriers
  - What might help
- Identify possible solutions
  - Working collaboratively, group formulates a plan
- Implement the plan
- Re-assess during the next audit – did you remediate the problem?

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IN SUMMARY: Recommended Actions to VFCAs

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Questions and Answers

NOW: Please submit questions via the chat box on the webinar screen

AFTER THE WEBINAR: Submit any questions/comments on Health Homes Serving Children to hhsc@health.ny.gov . All submitted comments should include "Your Organization Name" and "Partner Network/Downstream Care Management Agency " in the subject line.