NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Health Home Performance

February 21, 2018

Agenda

- Health Home Quality and Utilization Report
- Health Home Measure Specification and Reporting Manual
- Performance Goals (PG)
- Annual Improvement Targets (AIT)
- Draft Performance Report Card
- Reporting Schedule
- Data charts/tools and Performance Improvement Support
- Data distribution
- Next Steps

Health Home Quality and Utilization Report

- HHSA lead Health Homes and Managed Care Plans received measures rates in report
  - Rates provided for calendar years 2013 – 2016
- HHSC will receive a 7-month Health Home Quality and Utilization Report in March/April
  - Rates provided for December-June 2017
  - 41 measures included within six domains
    - HHSC Measure set
  - Rates developed using HEDIS or NYS measure specifications
  - Measure name and descriptions included
  - Rates will then be updated quarterly

Measure Domains

Preventive Care (10)

Care for Chronic Conditions (7)

Mental Health (12)

Substance Use Disorders (4)

Utilization (6)

Avoidable Utilization (2)

Health Home Quality and Utilization Report

- Eligible Population
  - Comprised of all enrolled members attributed to the most recently enrolled Health Home
    - Attributed to the Health Home as of the measurement time frame, such as end of the measurement year. Member eligibility information is evaluated for the measurement window, such as 12 months irrespective of Health Home attribution
  - Results are member-centric, evaluating each member for meeting criteria for the measure
  - Excludes outreach members
  - Members who are dually eligible (Medicare and Medicaid) will not be included in Health Home measure results

Health Home – Subpopulations

Subpopulation	HHSA, HHSC, Both	Data Source
Chronic-asthma	Both	HHSC: modified HEDIS; HHSA: HEDIS (MMA)
Chronic-diabetes	Both	HHSC: modified HEDIS; HHSA: HEDIS (CDC)
HIV	Both	HEDIS (Comp Care)
SUD	Both	HHSC & HHSA: HEDIS (IAD)
SMI	HHSA	SAMHSA definition
AOT	HHSA	Billing questionnaire
HH+	HHSA	Billing questionnaire
AH+	HHSA	Billing questionnaire
HARP	HHSA	Billing questionnaire
Chronic-overweight	HHSC	Billing questionnaire
Complex Trauma	HHSC	Billing questionnaire
Foster Care	HHSC	billing questionnaire
Early Intervention	HHSC	Need to define
SED	HHSC	Need to define - working with HHSC Team

Identification of Alcohol and Other Drug Services (IAD)

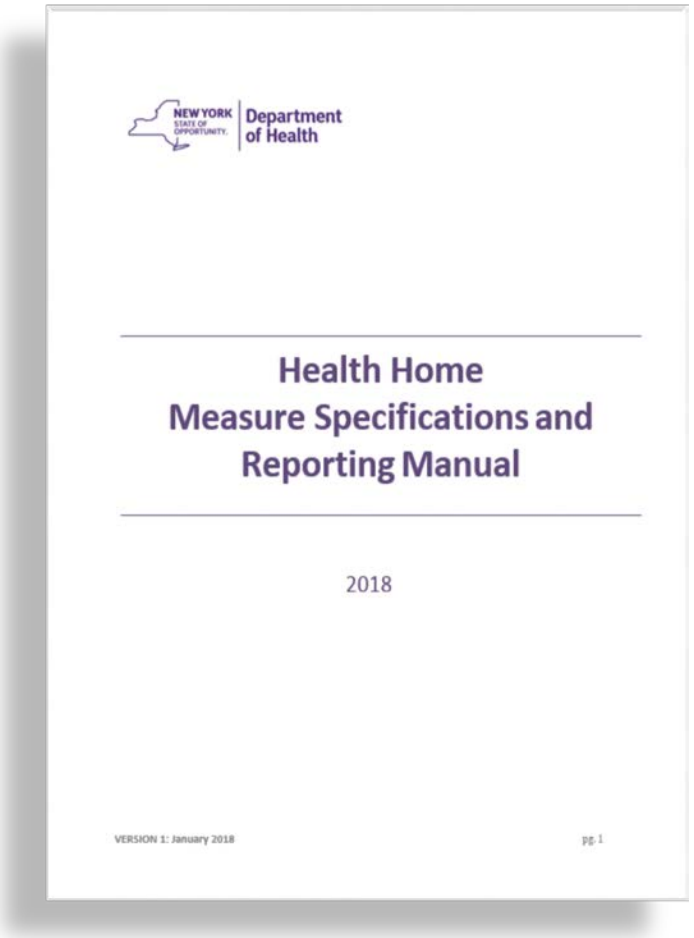
This measure summarizes the number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year:

- **Inpatient**
- **Intensive outpatient or partial hospitalization**
- **Outpatient or an ambulatory MAT dispensing event**
- **ED**
- **Telehealth**
- **Any service**

Measure Specifications and Reporting Manual

Manual provides an overview of the:

- Methodology for Establishing Performance Goals and Annual Improvement Targets
- Performance Report Card
- Performance Reporting Schedule
- Reporting Submission Process
- Technical Assistance Resources and Performance Improvement Support
- Measure Calculation and Modifications Process
- Performance Measures



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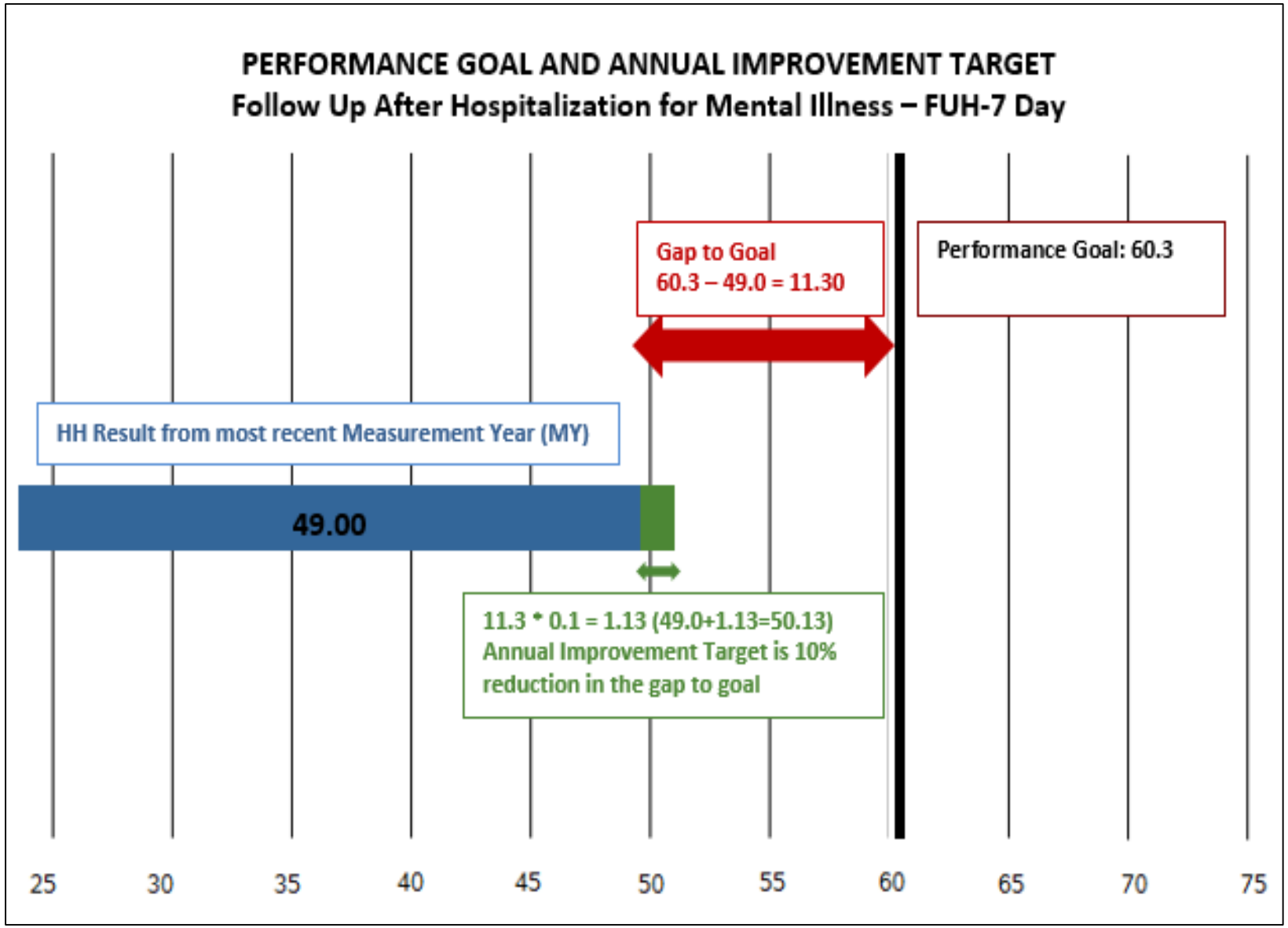
Establishing Performance Goals (PG)

- Performance Goals
  - Reflect best performance expected in New York State
  - Currently, the HHSA PG is consistently applied to all Health Homes each year and will not be changed for a two-year period (until 2020), when the goal will be re-evaluated. A determination will be made about the HHSC PG once established
  - Will determine which year to use Health Home performance data to calculate performance goals for each performance measure (HHSA used 2015 data)
  - For measures where the goal is to increase the occurrence and a higher result is desirable, the 90th percentile is used, and for measures where the goal is to reduce an outcome or occurrence and a lower result is desirable, the 10th percentile is used

Establishing Annual Improvement Targets (AIT)

- Annual Improvement Targets (AIT)
  - Established using the methodology of reducing the gap to the goal by 10%
  - Most current HH measurement year (MY) result will be used to determine the gap between the Health Home result and the measure's performance goal, and then 10% of that gap is added to the most current Health Home result to set the annual improvement target for the current MY
  - Each subsequent year will continue to be set with an improvement target using the most recent year's result
  - If a Health Home result for a MY meets or exceeds the performance goal, then the annual improvement target for the next MY will equal the Health Home's most recent result

Establishing AIT example



NYSDOH-HH PG and AIT Example

MSR_ID	Domain	Measure Title	16 Rate	'18 NYS HH AIT	NYS HHPG
ABA	Preventive Care	Adult Body Mass Index (BMI) Assessment	81.16	82.63	95.80
AMB ED	Utilization	ED Utilization	N/A	N/A	N/A
AMM ACUTE	Mental Health	Antidepressant medication management (Acute Phase)	53.69	54.40	60.80
AMM CONT	Mental Health	Antidepressant medication management (Continuation Phase)	40.80	41.44	47.20
BMS	Mental Health	Adherence to mood stabilizers for individuals with bipolar I disorder	52.82	53.90	63.60
CBP	Care for Chronic	Controlling High Blood Pressure (hybrid)	53.99	55.26	66.70
CDC HG	Care for Chronic	Comprehensive diabetes care (HbA1c test)	84.80	85.06	87.40
CHL	Preventive Care	Chlamydia Screening in Women	70.14	70.58	74.50
COL	Preventive Care	Colorectal Cancer Screening	52.82	53.17	56.30
FUA 30 DAYS	Substance Abuse	Follow-Up After ED Visit for Alcohol and Other Drug Dependence-30 day	37.83	39.24	51.87
FUA 7 DAYS	Substance Abuse	Follow-Up After ED Visit for Alcohol and Other Drug Dependence-7 day	28.96	30.38	43.23
FUH 30 DAYS	Mental Health	Follow Up After Hospitalization for Mental Illness within 30 days	67.20	68.20	77.20
FUH 7 DAYS	Mental Health	Follow Up After Hospitalization for Mental Illness within 7 days	49.03	50.16	60.30
FUM 30 DAYS	Mental Health	Follow-up After ED Visit for Mental Illness - 30 day	76.48	77.61	87.83
FUM 7 DAYS	Mental Health	Follow-up After ED Visit for Mental Illness - 7 day	59.48	61.05	75.13
HIV ENGAGED	Care for Chronic	HIV/AIDS-Engaged in Care	93.71	93.88	95.40
HIV LOAD MON	Care for Chronic	HIV/AIDS-Viral Load Test	61.55	63.18	77.80
HIV SYPH	Care for Chronic	HIV/AIDS-Syphilis screening	71.96	72.27	75.00
IET ENGMT	Substance Abuse	Engagement of Alcohol and Other Drug Dependence Treatment	19.50	19.94	23.90
IET INITIATION	Substance Abuse	Initiation and Eng. of Alcohol and Other Drug Dependence Treatment	51.39	51.87	56.20
IPU DSCH	Utilization	Inpatient Utilization – General hospital/Acute Care	N/A	N/A	N/A
MMA 50	Care for Chronic	Medication management for people with asthma - 50%	69.58	69.94	73.20
MMA 75	Care for Chronic	Medication management for people with asthma - 75%	45.03	45.64	51.10
MPT	Utilization	Mental health utilization	N/A	N/A	N/A
NFU	Utilization	Skilled Nursing Home Admission	N/A	N/A	N/A
PBH	Care for Chronic	Persistence of beta-blocker treatment after heart attack	45.53	46.38	54.00
PCP	Utilization	Primary Care	411.14	417.99	479.63
PCR	Utilization	Plan All-Cause Readmission Rate	29.75	29.44	26.64
PPR	Avoidable Utiliz.	Potentially Preventable Readmissions	6014.63	5841.06	4278.90
PPV	Avoidable Utiliz.	Potentially Preventable Emergency Room Visits	105.12	101.87	72.54
PQI 92	Utilization	Chronic Condition Hospital Admission Composite:Prev. Quality Indicator	6086.06	5715.55	2381.00
SAA	Mental Health	Adherence to antipsychotics for individuals with schizophrenia	59.76	60.26	64.70

Four utilization measures do not have Performance Goals

ED Utilization

Inpatient Utilization

Mental Health Utilization

Skilled Nursing Home Admission

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Draft Health Home Performance Report Card

Current HHSA Performance Report Card consists of the following data:

- Enrollment
- HARP Conversion Rate
- Member Medicaid Cost (PMPM)
- Change in Preventable Cost PMPM (from prior year)
- Retention (for at least six months)
- Avoidable Utilization Composite Score
- Quality Composite Score
- Structural Measures

- A weighting factor is applied to all elements to develop a Summary Score

HHSC Performance Report Card will probably look different

Draft Health Home Performance Report Card

HH Information	Enrollment		Cost		Retention	Performance Measure Composite Score		Structural Measures			Score
Weighting Factor (%)	0%	15%	0%	0%	15%	15%	25%	5%	15%	10%	100%
Health Home	Number of Enrolled Members	HARP Conversion Rate	Medicaid Cost (PMPM)	Change in Preventable Utilization Cost (PMPM)	Retention Rate	Preventable Utilization-Composite Score (PPV and PPR)	Quality-Composite Score	RD Site visit level	Timely Billing	HHDF Use	Summary Score
Adirondack Health Institute											
Bronx Accountable											
Bronx Lebanon											
Capital Region Health Connections											
Care Central											
Central New York Health Home											
Community Care Management Partners											
Community Healthcare Network											
Coordinated Behavioral Care											
Encompass											
Greater Buffalo United IPA											
Greater Rochester Health Home Network											
Health Home Partners of Western NY											
HHUNY Central (Circare)											
HHUNY Finger Lakes (Huther-Doyle)											
HHUNY Southern Tier (Chautaugua County)											
HHUNY Western (Lake Shore)											
Hudson River HealthCare											
Hudson Valley Care Coalition											
Institute for Family Health											
Mary Imogene Bassett Community Health Navigation											
New York City Health and Hospitals Corporation											
New York Presbyterian											
Niagara Falls											
Northwell Health											
Queens Coordinated Care Partners											
Southwest Brooklyn Health Home											
St. Joseph's Care Coordination Network											
St. Luke's											
St. Mary's Healthcare											
United Health Services											

Performance Reporting Schedule

- Each measurement period will encompass six months, from January 1 - June 30 and July 1 – December 31
  - The reason for using a mid-year time period is to allow for a claim lag of six months so data will be as complete as possible when Health Home performance is calculated for the measurement year
- The measurement year will encompass a twelve-month calendar year
- Health Homes will be able to access performance data on a quarterly basis (twelve-month rolling calendar) and monthly in the near future
- NYSDOH-HH will check-in on performance bi-annually
  - Health Homes receiving technical assistance will have more frequent monitoring
- Performance Report Card distributed on an annual basis

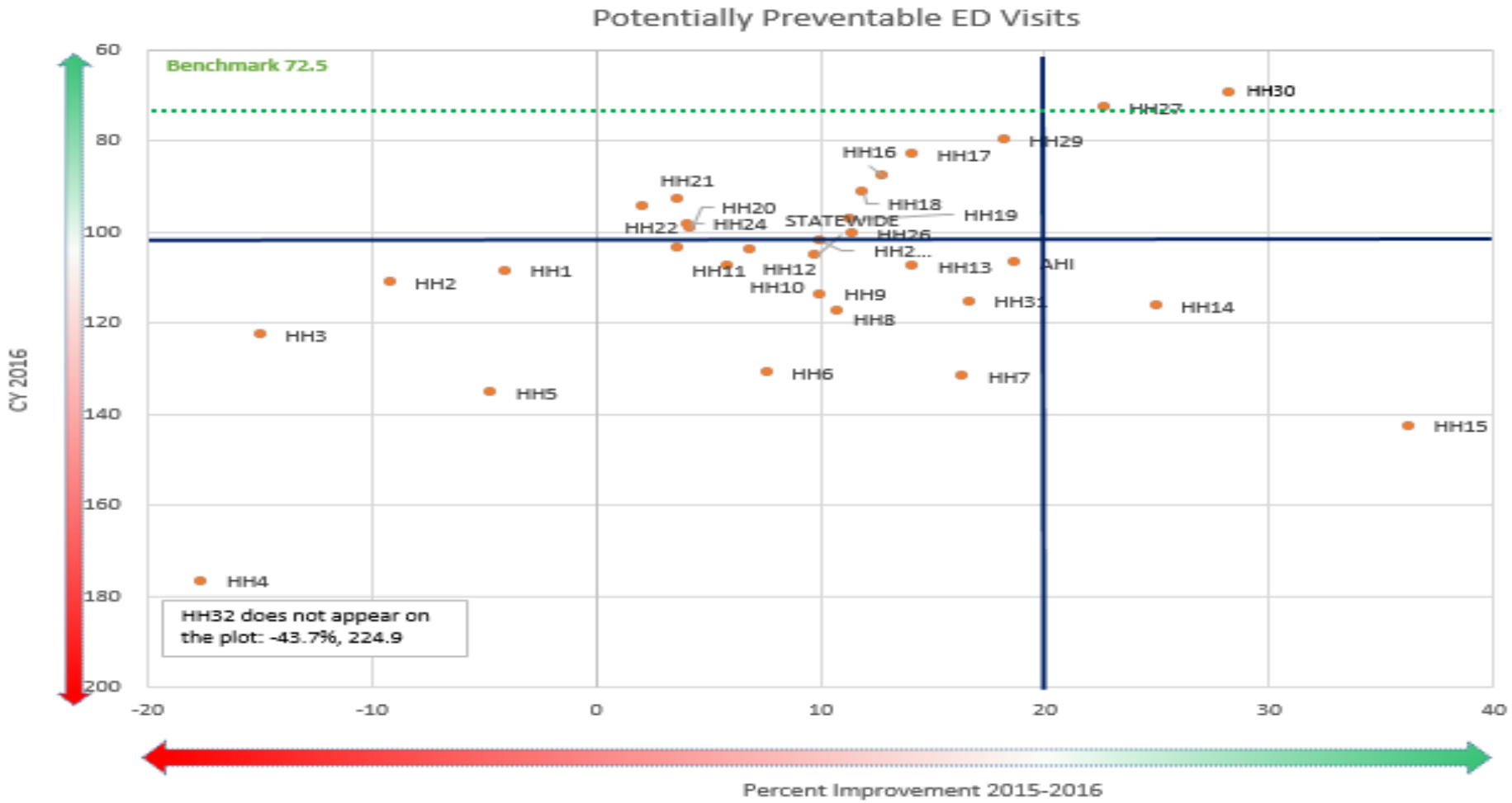
Performance Reporting Schedule

Annual Measurement Year Cycle	Time Frame
December 2016- June 2017 HH Performance rates released to HHs	March/April 2018
July - December 2017 HH Performance rates released to HHs	June 2018
Health Home Performance Report Card released to HHs	August 2018
Performance Goals and Annual Improvement Targets for 2019 calculated and released to HHs	September 2018

Performance Improvement Support

- NYSDOH-HH will analyze data using Tableau:
  - Scatterplot
    - One Plot per Measure
      - CY2016 performance is on the y-axis (high performance at the top), and percent improvement over 2015 is on the x-axis (high improvement to right)
      - Small sample size: the measure must have a denominator of 30 or greater in both 2015 and 2016 for the HH performance to appear on the scatterplot
    - Data Labels and Outliers
      - Extreme outliers are not plotted; the outlier data is shown in a box located in the quadrant in which the data point would appear if the axis were re-scaled
  - Bubble Charts/Dot Plots
    - Easily identifies Statewide and HH improvement from 2014 through 2016

Performance Improvement Support



Support is focused on Health Homes in the LL quadrant

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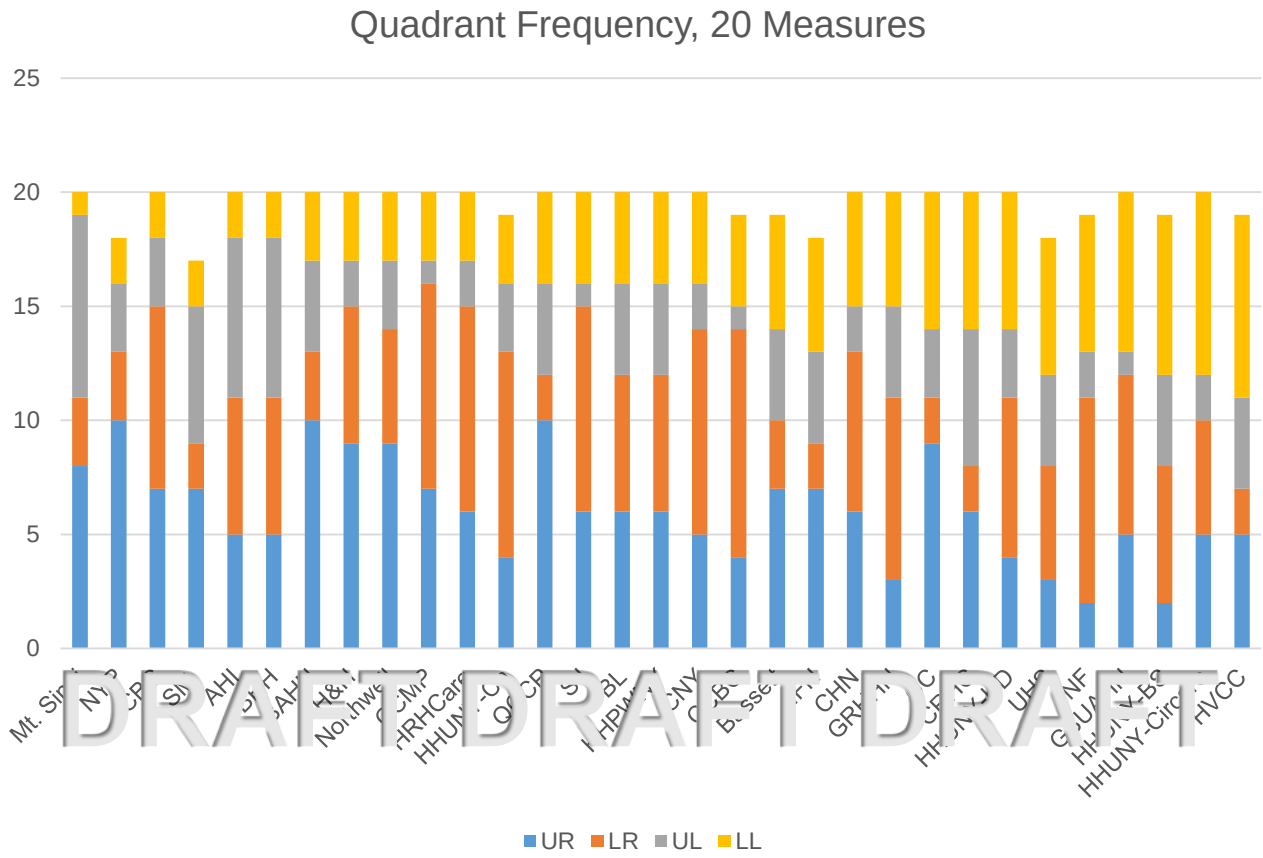
Performance Improvement Support

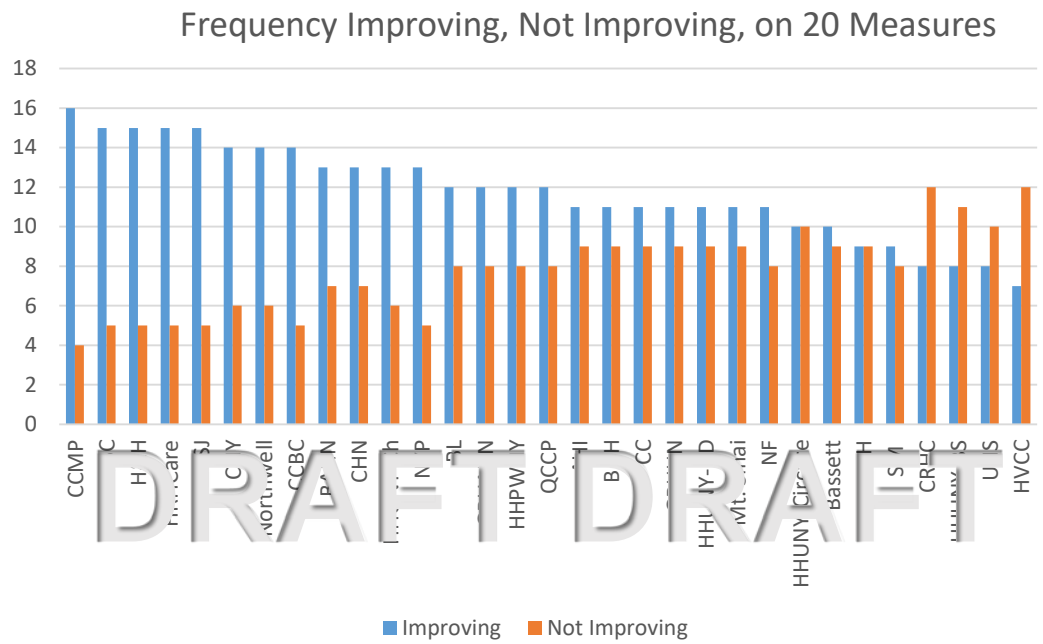
- Used to identify the number of times the Health Home is in a specific quadrant

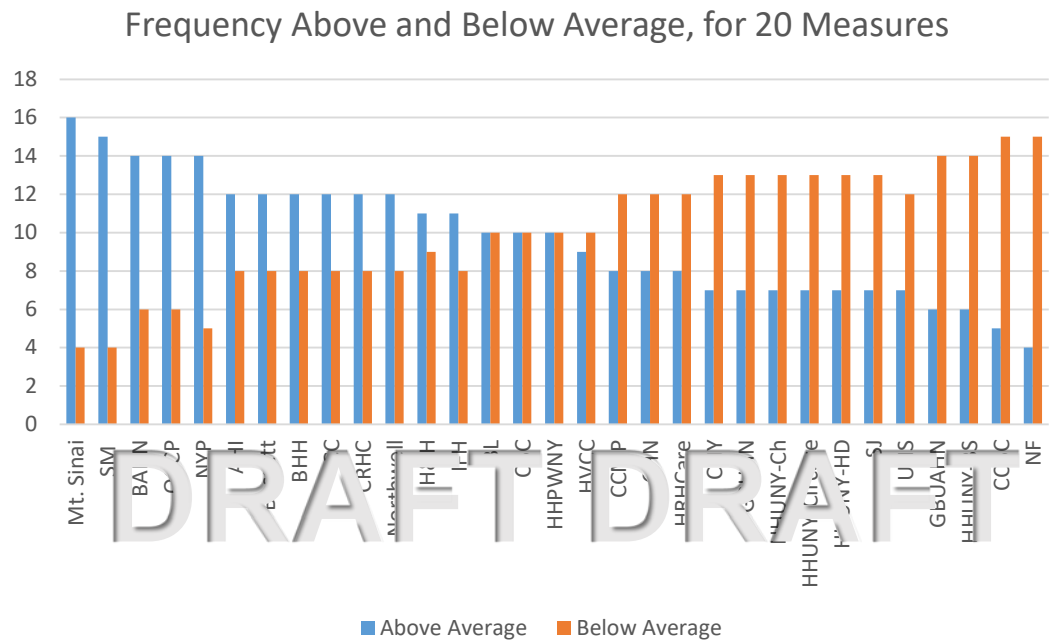
UR	above average and improved
LR	below average but improved
UL	above average but did not improve
LL	below average and did not improve



Performance Improvement Support

- Used to identify the number of measures a Health Home is above/below the statewide average and improving/not improving





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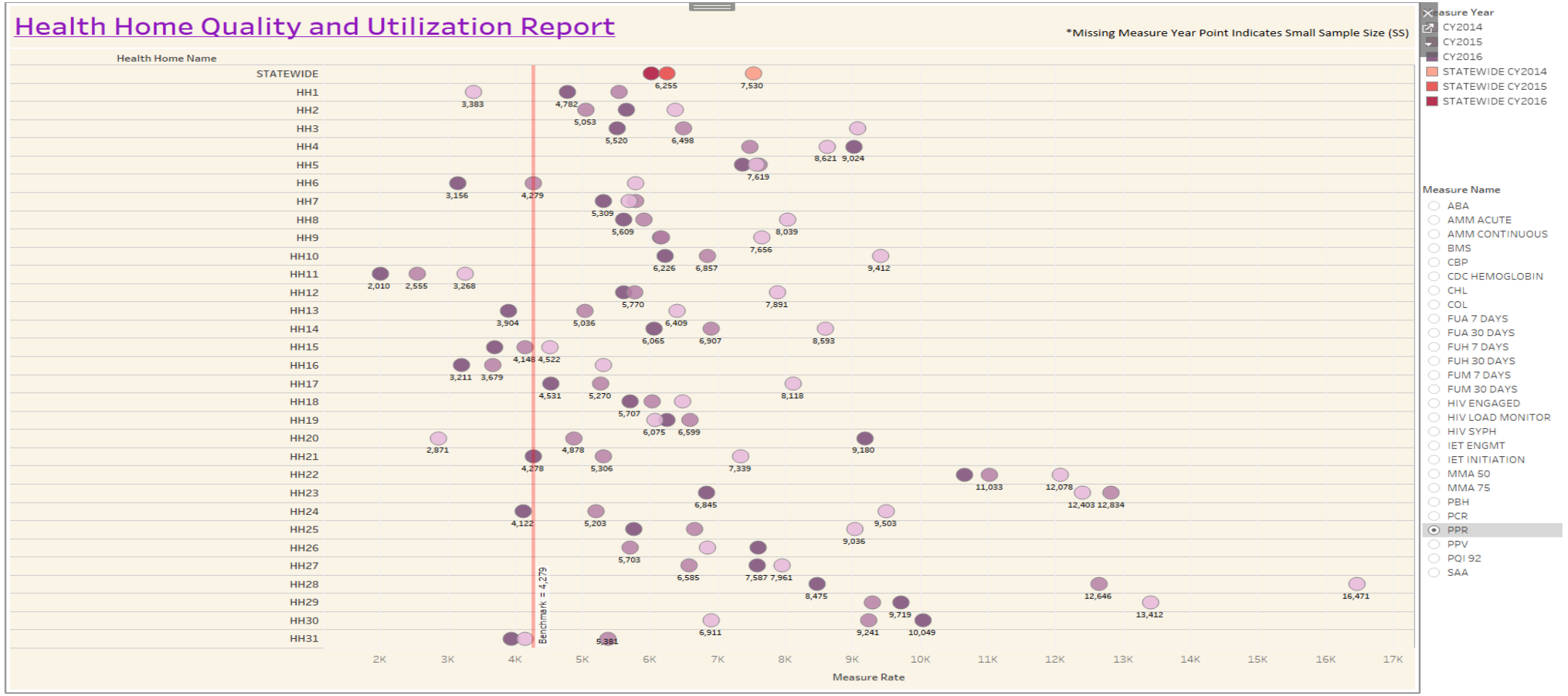
Performance Improvement Support



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Performance Improvement Support

- The scatterplots/dot plots show us if performance is above or below the statewide average, if performance changed over the prior year, and in what direction: *they do NOT tell us why*

- The scatterplots and dot plots provide a starting point to explore performance, to ask questions, to dive deeper

Performance Improvement Support

- Performance Management Team will initially meet with each Health Home to:
  - Review HH specific PG and AIT per measure and answer any questions
  - Discuss measures that the HH is performing below the statewide average
- Health Homes falling into the “low performer in current year and performance did not improve from prior year” category will be prioritized for technical assistance
  - Identify root cause of poor performance and develop plan for improving performance
  - Identify additional data reports that would support performance improvement
- Health Homes not falling in the LL quadrant can also request Performance Improvement Support
- DOH State Agency Partners are used as resources and are actively involved in the process, as appropriate

Accessing Performance Data

- A “Space” has been created for Health Home Performance within a web-based platform known as Atrium. This application is within HCS already
  - Atrium allows for provisioned access to specific users; similar to SharePoint
  - Within the Health Home Performance Space, a separate folder has been created for each Health Home In addition to the HH-specific folders, a “Statewide Reports” folder has been created and is accessible by every Health Home

- Atrium is presently an application that can be added to your “My Applications” list after you login to HCS
  - No separate login information needs to be created since it is self-contained within HCS.
  - This will allow for easier distribution of reports and other documents to and from DOH.

- Salient Dashboard will be enhanced with an additional dashboard with 14 measures (Phase 1)

Next steps

- Provide HHSC Performance Data using Atrium
- Move forward with creating interactive Tableau visualizations
- Report on HHSC measures and subpopulations
- Develop HHSC Performance Report Card
- Post performance data on HH Performance Management webpage and in Atrium
- Continue progress on Salient Performance Measure Dashboard Requirements Gathering and HH access to DSRIP Dashboards
- Finalize data analysis and begin performance improvement support

Questions ???

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