NEW YORK STATE | Department of Health | Medicaid Redesign Team

Behavioral Health

(Depression & Anxiety, Trauma & Stressor and Schizophrenia)

Clinical Advisory Group #5

Meeting Date: June 23, 2016

Tentative Meeting Schedule & Agenda

Depending on the number of issues address during each meeting, the meeting agenda for each CAG meeting will consist of the following:

Meeting 1

- Clinical Advisory Group - Roles and Responsibilities
- Introduction to Value Based Payment
- HARP Population Definition and Analysis
- Introduction to Outcome Measures

Meeting 2

- Recap First Meeting
- HARP Population Quality Measures

Meeting 3

- Episodes - Understanding the Approach
  - Depression Episode
  - Bipolar Disorder Episode
- Introduction to Bipolar Disorder Outcome Measures

Meeting 4

- Behavioral Health CAG – Status Recap and Scope Refinement
- CVG Behavioral Health Episode Restructuring Process
- Behavioral Health Episodes and the Big Picture
- Understanding the Approach – Introduction to HCI3
- Depression & Anxiety (D&A) – Trauma & Stressor (T&S) Episode Definition
- Introduction to D&A – T&S Outcome Measures

Meeting 5

- Reconvening the CVG
- Depression & Anxiety and Trauma & Stressor Quality Measure – Recap and Finalization
- Behavioral Health Scope Refinement
- Understanding the Approach – Introduction to HCI3
- Proposed BH Additional Episode Review:
  - Schizophrenia Episode Definition
  - Schizophrenia Quality Measures

Content

Introductions & Tentative Meeting Schedule and Agenda:

A. Reconvening the CVG
B. Wrapping Up Depression & Anxiety and Trauma & Stressor
   - Criteria for Selecting Measures
   - Depression Quality Measure Selection Recap
   - Anxiety Quality Measure Review and Selection
   - Episode Recap – Trauma & Stressor
   - Trauma & Stressor Quality Measure Review and Selection
C. Behavioral Health Scope Refinement – Incorporation of Schizophrenia
D. Understanding the Approach – Introduction to HCI3
E. Schizophrenia Episode Definition
F. Introduction to Schizophrenia Outcome Measures

Appendices

Reconvening the Clinical Validation Group (CVG)

- The CVG, led by Dr. Amita Rastogi (HCI3), met over six times from September-November 2016 and reviewed 4,000+ lines of ICD-9 Codes to develop and enhance five separate episodes
    1. Depression & Anxiety
    2. Trauma & Stressor
    3. Bipolar Disorder
    4. Substance Use Disorder
    5. Schizophrenia
- The CVG will reconvene for one session to
    1. Perform a more in depth review of episode data
        - Actual & Expected Costs for Each Episode
    2. Discuss & evaluate Potentially Avoidable Complications (PACs) associated with each episode
        - Role of inpatient admission (e.g. Substance Use Disorder [SUD] episode may often begin with an inpatient admission for detox – may not always be a PAC)
        - Suicidal Ideation - a state of a disease vs. PAC

B. Criteria for Selecting Quality Measures

Depression & Anxiety, Trauma & Stressor and Schizophrenia

Remember: Criteria for Selecting Quality Measures

CLINICAL RELEVANCE

- **Focused on key outcomes of integrated care process**

  I.e. outcome measures are preferred over process measures; outcomes of the total care process are preferred over outcomes of a single component of the care process (i.e. the quality of one type of professional's care).

- **For process measures: crucial evidence-based steps in integrated care process that may not be reflected in the patient outcome measures**

- **Existing variability in performance and/or possibility for improvement**

RELIABILITY AND VALIDITY

- **Measure is well established by reputable organization**

  By focusing on established measures (owned by e.g. NYS Office of Quality and Patient Safety (OQPS), endorsed by the National Quality Forum (NQF), HEDIS measures and/or measures owned by organizations such as the Joint Commission, the validity and reliability of measures can be assumed to be acceptable.

- **Outcome measures are adequately risk-adjusted**

  Measures without adequate risk adjustment make it impossible to compare outcomes between providers.

Remember: Criteria for Selecting Quality Measures

FEASIBILITY

- **Claims-based measures are preferred over non-claims based measures (clinical data, surveys)**
- **When clinical data or surveys are required, existing sources must be available**

  I.e. the link between the Medicaid claims data and this clinical registry is already established.

- **Preferably, data sources be patient-level data**

  This allows drill-down to patient level and/or adequate risk-adjustment. The exception here is measures using samples from a patient panel or records. When such a measure is deemed crucial, and the infrastructure exists to gather the data, these measures could be accepted.

- **Data sources must be available without significant delay**

  I.e. data sources should not have a lag longer than the claims-based measures (which have a lag of six months).

KEY VALUES

- **Behavioral health transformation focus**

  i.e., measures are person-centered, recovery-oriented, integrated, data-driven and evidence-based

Measure Review Process

Similar process as was used in that last meeting: decide on measures by theme.

- Assessment and Screening
- Monitoring and Education
- Medication and Treatment Management
- Outcomes of care

After reviewing the list, assign measures to a categorization “bucket.”

Categorizing and Prioritizing Measures by Category (or 'Buckets')

CATEGORY 1
Approved quality measures that are felt to be both clinically relevant, reliable and valid, and feasible.

CATEGORY 2
Measures that are clinically relevant, valid and probably reliable, but where the feasibility could be problematic. These measures should be investigated during the 2016 or 2017 pilot.

CATEGORY 3
Measures that are insufficiently relevant, valid, reliable and/or feasible.

B. Depression Quality Measures

- Selection Recap

Depression Quality Measure – **Selection Recap**

Depression

During the previous BH CAG meeting, members expressed satisfaction with the following quality measure elements for Depression Disorder:

IMPACT Model

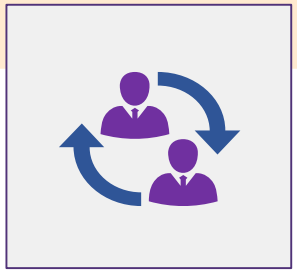
- Specific interest in:
  - Depression screening and diagnosis with the PHQ-9
  - Initiation and adjustment of treatment
  - Symptom reduction

Suicide Risk Assessment

- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
  - Members expressed the importance of suicide risk assessments remaining separate and distinct from the PHQ-9

Follow-up Feedback Mechanisms

- Discussed the current lack of safeguards to evaluate/ensure that a recommended Mental Health service was actually conducted
- Suggested focus on development of a feedback loop/mechanism between the provision of physical and mental health services



Depression

Follow-up Feedback Mechanisms

In regards to follow-up quality measures and how they might be used as a starting point to develop more robust feedback mechanisms between Physical and Behavioral Health services, the CAG highlighted:

- Follow-up after hospitalization for mental illness within both 7 and 30 days

- Follow-up after discharge from the emergency department for mental health, alcohol and other drug dependence

- Re-evaluation of depression symptom frequency and intensity using the PHQ-9

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Depression Quality Measure – **Selection Recap**

Depression

Category 1	Category 2	Category 3	Uncategorized
Depression Screening, Diagnosis and Monitoring with PHQ-9 (IMPACT Model)	Measurement of Treatment Outcomes (IMPACT Model)	Depression Response at Twelve Months – Progress Towards Remission	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
Diagnosis (IMPACT Model)		Depression Remission at Six Months	Major Depressive Disorder (MDD): Diagnostic Evaluation
Initiation of Treatment (IMPACT Model)		Depression Remission at Twelve Months	Preventive Care and Screening for Clinical Depression and Follow-up Plan
Adjustment of Treatment Based on Outcomes (IMPACT Model)		Timely filling of appropriate medication prescriptions post discharge (30 days and 100 days)	(Screening, Brief Intervention, and Referral to Treatment) SBIRT screening
Symptom Reduction (IMPACT Model)		Potentially preventable ED visits (for persons with BH diagnosis)	Multidimensional Mental Health Screening Assessment
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment		Potential preventable readmission for SNF (skilled nursing facilities) patients	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
Follow-Up After Hospitalization for Mental Illness within 7 Days		Percent of Long Stay Residents who have Depressive Symptoms	Antidepressant Medication Management
Follow-Up After Hospitalization for Mental Illness within 30 Days		Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	
Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence			
Readmission to mental health inpatient care within 30 days of discharge			
PAC % Cost*			
Antidepressant Medication Management			

*Please note that the PAC % Cost would be for Depression and Anxiety together.

B. Anxiety Quality Measures

Review and Selection

Anxiety

Anxiety Quality Measure – **Review and Selection**

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NBQF (SAMSHA)	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Screening and Assessment	1	Generalized Anxiety Disorder 7-item (GAD 7) Scale	Process			X				No	Yes	
	2	Acute Stress Disorder Interview (ASDI) [1]	Process							No	Yes	
	3	Acute Stress Disorder Scale (ASDS) [1]	Process							No	Yes	
	4	Social Phobia Inventory (SPIN) [2]	Process							No	Yes	
	5	Mobility Inventory for Agoraphobia (MIA) [2]	Process							No	Yes	
	6	Panic Disorder Severity Scale (PDSS-SR) [2]	Process							No	Yes	
	7	Obsessive-Compulsive Inventory (OCI-R) [2]	Process							No	Yes	
	8	Recommended to track via the World Health Organization Disability Assessment 2.0 (WHODAS 2.0) [2]	Process							No	Yes	
	9	PAC % Cost*	Outcome							Yes	No	

[1] Quality Measures recommended by the National Center for PTSD for assessing Acute Stress Disorder (ASD). More information found at: http://www.ptsd.va.gov/professional/treatment/early/acute-stress-disorder.asp

[2] Additional Quality Measures recommended in the International Consortium for Health Outcomes Measurement (ICHOM) – Depression & Anxiety Standard Set. More information found at: http://www.ichom.org/medical-conditions/depression-anxiety/

*Please note that the PAC % Cost would be for Depression and Anxiety together.

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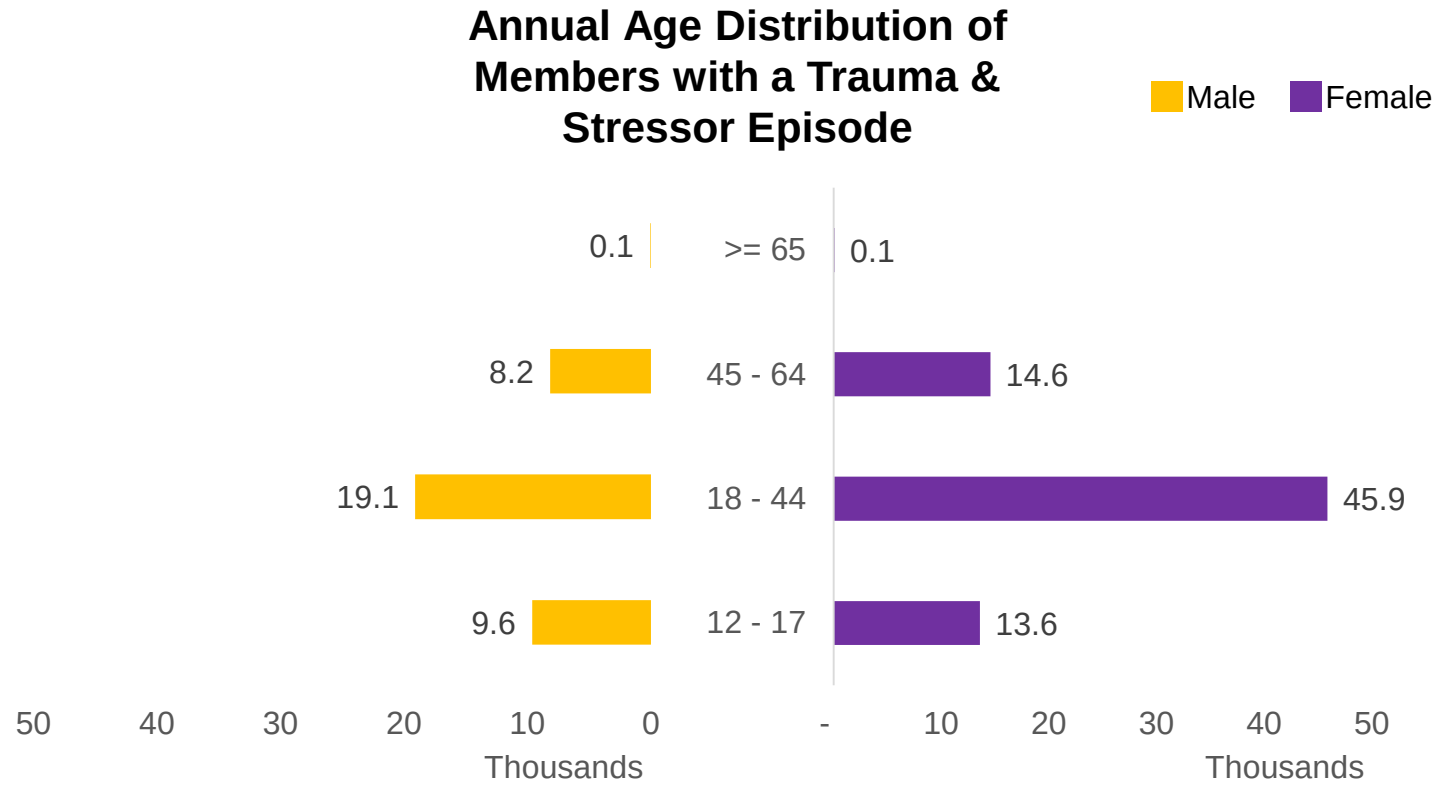
B. Episode Review

Trauma & Stressor

Trauma & Stressor episodes account for nearly $73M in Annual Medicaid Spend

Total Annual Cost of Trauma & Stressor (to the State)
$73M

Average Costs per Episode for Members with a Trauma & Stressor Episode
$662



Costs Included:
- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.

Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

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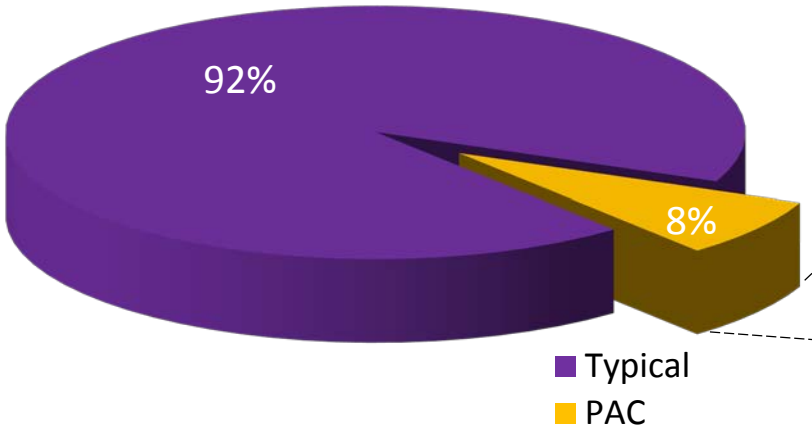
PAC Costs Represent $5.5M of All Trauma & Stressor Costs

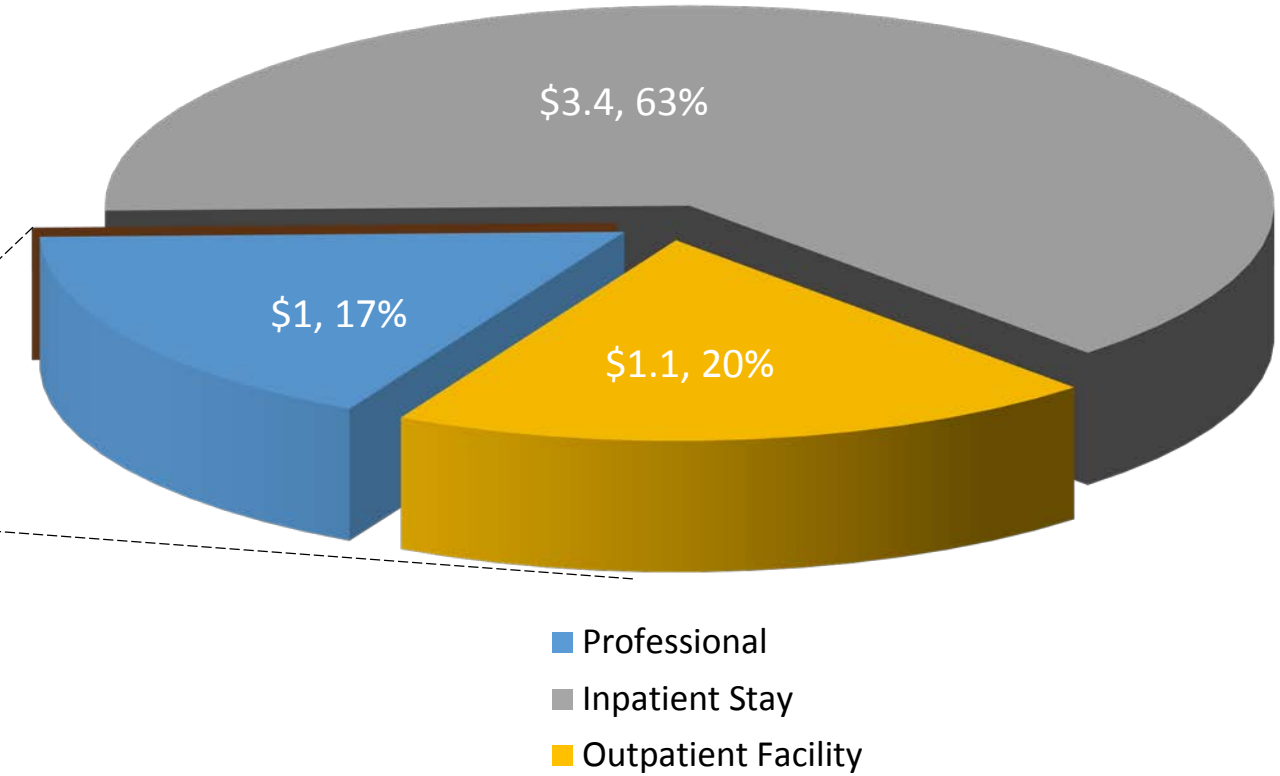
Dollar Allocation of Typical Costs and PAC costs

Total Amount Spent on Trauma & Stressor: $73M



Dollar Allocation for PAC Services (in Millions)

Total Amount of PAC Services: $5.5M



Costs Included:

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- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.

Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

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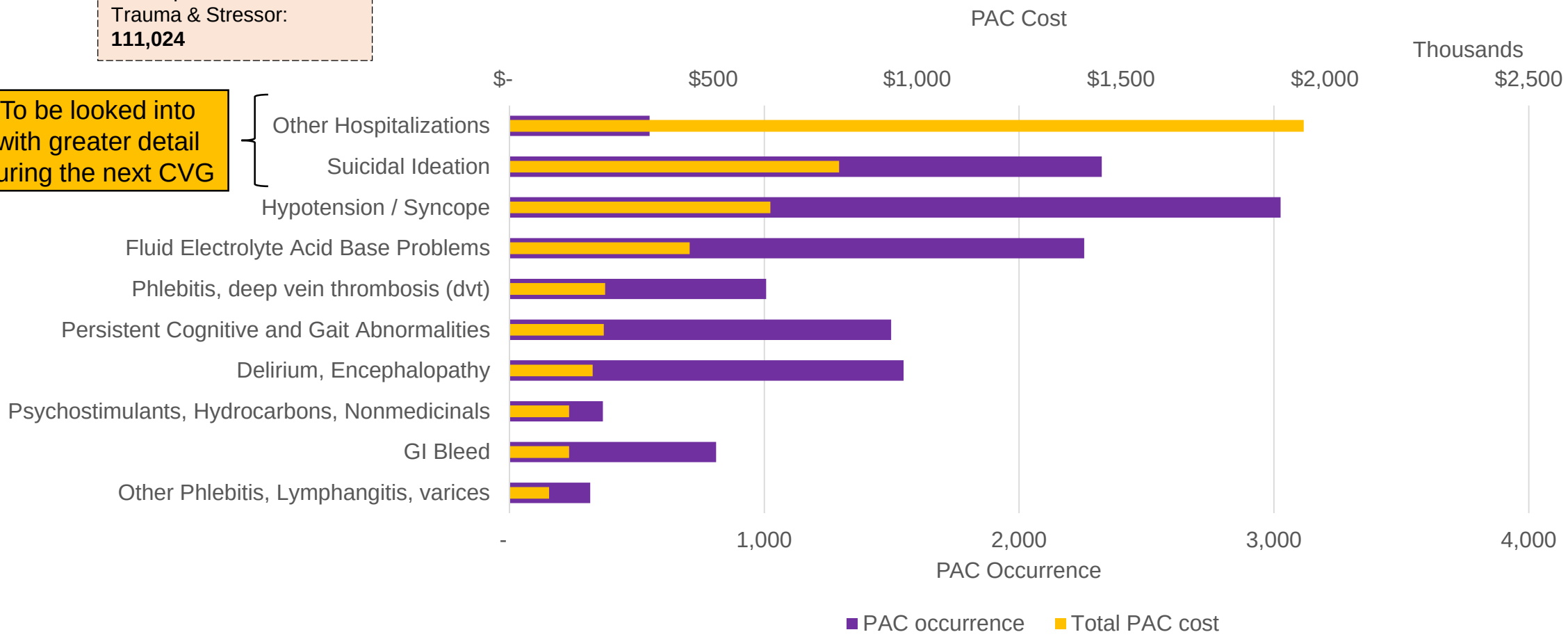
Top 10 Trauma & Stressor PACs Represent 90% of the Total Cost of Trauma & Stressor PACs

Total episodes in Trauma & Stressor:
111,024

To be looked into with greater detail during the next CVG



Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

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B. Trauma & Stressor Quality Measures

Review and Selection

Recommended Trauma & Stressor Screening and Assessment Tools – **PC-PTSD**

Trauma & Stressor

Definition

- **Primary Care–Post-Traumatic Stress Disorder (PC-PTSD) Screening –** is a **4-item screen** that was designed for use in primary care and other medical settings

Delivery

- Can be conducted in most medical waiting rooms. The screening is conducted as follows:

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:	
Have had nightmares about it or thought about it when you did not want to?	YES/NO
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	YES/NO
Were constantly on guard, watchful, or easily startled?	YES/NO
Felt numb or detached from others, activities, or your surroundings?	YES/NO

Scoring

- Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items

Recommended Trauma & Stressor Screening and Assessment Tools – **PCL-5**

Trauma & Stressor

Definition

- If preliminary screening for PTSD with PC-PTSD is positive, it is recommended that a follow-up comprehensive assessment is conducted with the **PTSD Checklist for DSM-5 (PCL-5) –** a **20-question**, self-report measure that aligns with the 20 symptoms of PTSD

Delivery

- Is designed for delivery in primary/other medical care settings
  - Can be used to screen and diagnosis PTSD as well as monitor PTSD symptom change during and after treatment

Scaling and Scoring

- The rating scale is 0-4 for each symptom, enabling a total possible score of 80 and a positive score of ≥ 33
  - Each symptom with a rating of ≥ 2 is considered a *symptom endorsed*, with positive diagnosis of PTSD requiring the following symptom endorsed breakdown:

≥ 1 B item	≥ 1 C B item	≥ 2 D items	≥ 2 E items
Questions 1-5	Questions 6-7	Questions 8-14	Questions 15-20

Recommended Trauma & Stressor Screening and Assessment Tools – **CAPS-5**

Trauma & Stressor

Definition

- **The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)** is recognized at the ***gold standard*** for assessing PTSD. It is a 30-item questionnaire corresponding to the DSM-5 diagnosis for PTSD

Delivery

- The CAPS-5 is a **30-item structured interview** that can be used to:
  - Make a current (past month) or lifetime diagnosis of PTSD as well as assess the onset, duration, and impact (intensity) of PTSD symptoms

Scaling and Scoring

- The CAPS-5 symptom severity ratings are based on symptom frequency and intensity on a scale of 0-4
  - Scoring methodology and positive PTSD screening criteria are similar to the PCL-5, but also provide insight into both symptom presence and severity

Trauma & Stressor Quality Measure – **Review and Selection**

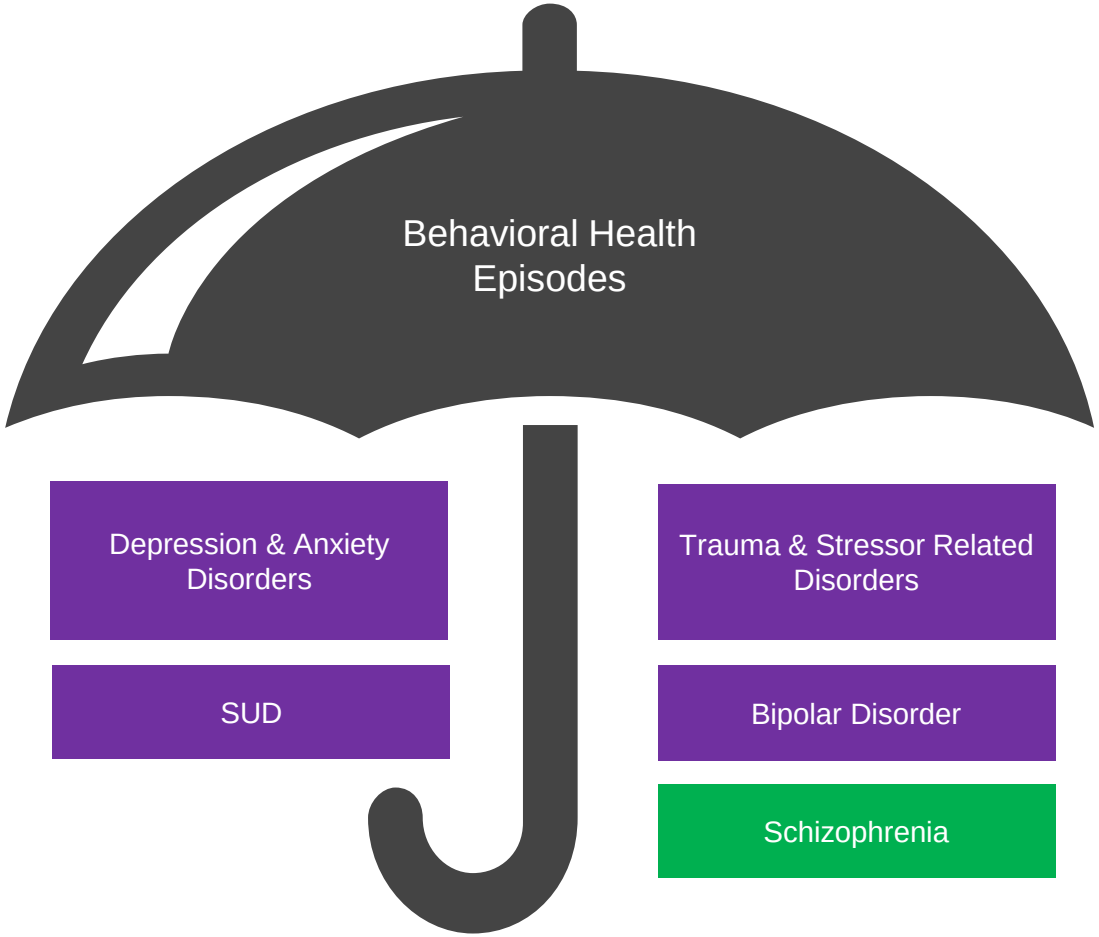
Trauma & Stressor

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NBQF (SAMSHA)	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Screening and Assessment	1	Primary Care PTSD Screen (PC-PTSD)	Process			X				No	Yes	
	2	PTSD Checklist for DSM-5 (PCL-5)	Process			X				No	Yes	
	3	Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)	Process							No	Yes	
	4	PAC % Cost	Outcome							Yes	No	

C. Behavioral Health Scope Refinement

Incorporating Schizophrenia

Behavioral Health Scope Refinement



- After CVG enhancement and creation of BH episodes, four episodes were chosen to be further analyzed for VBP contracting purposes
- A fifth episode, Schizophrenia was identified and to be analyzed for analytical purposes only
  - Further evaluation, however, demonstrated that ~43% of total Schizophrenia costs are due to Potentially Avoidable Complications (PACs)
  - Furthermore, the single largest episode *outside* of HARP that has not yet been captured in VBP is Schizophrenia.

Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

D. Understanding the Approach

Introduction to HCI3

Why HCI3? – **Recap**

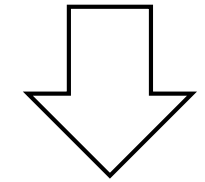
- One of two nationally used bundled payment programs
- Specifically built for use in value based payment
- Not-for-profit and independent
- Open source
- Clinically validated
- National standard which evolves based on new guidelines as well as lessons learned

Source: HCI3 Homepage, available at – http://www.hci3.org/

Evidence Informed Case Rates (ECRs) – **Recap**

- Evidence Informed Case Rates (ECRs) are the HCI3 episode definitions
- ECRs are patient centered, time-limited, episodes of treatment
- Include all covered services related to the specific condition
  - E.g.: surgery, procedures, management, ancillary, lab, pharmacy services
- Distinguish between “typical” services from “potentially avoidable” complications
- Are based on clinical logic: Clinically vetted and developed based on evidence-informed practice guidelines or expert opinions

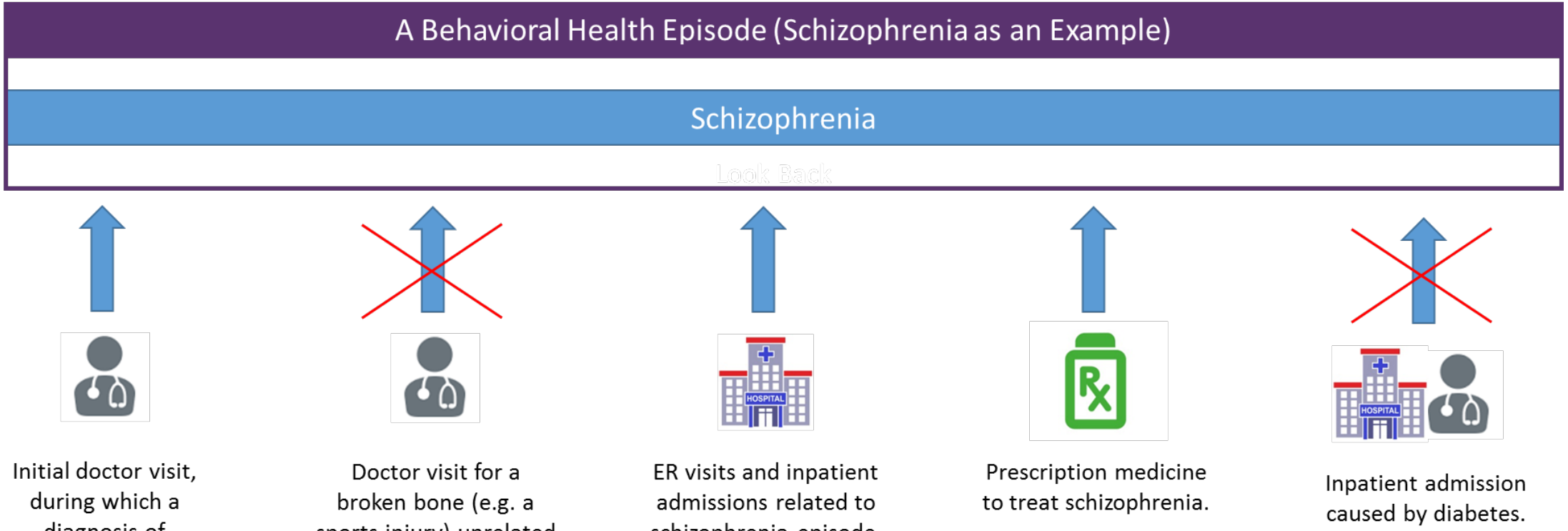
All patient services related to a single condition



Sum of services (based on encounter data the State receives from MCOs).

Source: HCI3 Presentation, available at – http://216.70.89.98/onlinecourses/Module201prt1.htm

Clinical Logic – **Recap**



Source: HCI3 Presentation, available at – http://216.70.89.98/onlinecourses/Module201prt1.htm

Episode Component: Triggers – **Recap**

A trigger signals the opening of an episode, e.g.:

- Inpatient Facility Claim
- Outpatient Facility Claim
- Professional Claim

More than one trigger can be used for an episode

- A confirming claim is used to reduce false positives

Triggers for Schizophrenia:

1. Inpatient claim with a schizophrenia diagnosis as the principal diagnosis code

2. Outpatient claim with a schizophrenia diagnosis in any position accompanied by an Evaluation & Management (E&M) procedure code on the same claim

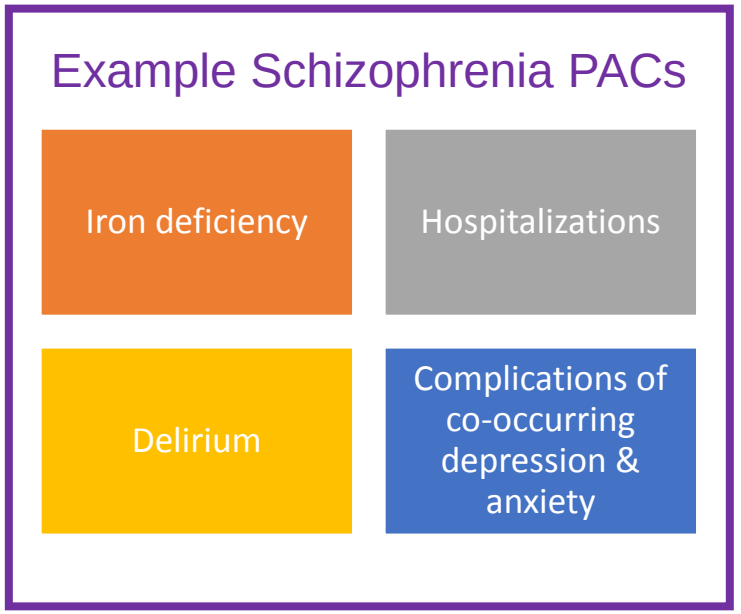
3. Professional service claim with a schizophrenia diagnosis in any position accompanied by an E&M procedure code on the same claim *with a confirming claim*, which…

- Must occur within a certain time period following the initial professional claim
- Can be an inpatient, outpatient, or professional claim which meet the criteria described above

Source: http://www.hci3.org/content/hci3s-measures-improve-quality-and-outcome-care-patients-endorsed-nqf

Episode Components: PACs – **Recap**

- Costs are separated for “typical” care, from costs associated with care for Potentially Avoidable Complications (PACs)
- PACs can stem from care avoidance, poor coordination, failure to implement evidence-based practices or from medical error
- As all aspects of the episode definitions, PACs are established as a national standard by clinical expert groups, and constantly evolve on the basis of feedback and validation work
- Risk-adjusted expected costs of PACs are built in as an incentive towards a shared savings
- Only events that are generally considered to be (potentially) avoidable by the caregivers that manage and co-manage the patient are labeled as ‘PACs’ by clinical expert groups
- Examples of PACs: exacerbations, ambulatory-care sensitive admissions, and inpatient-based patient safety features

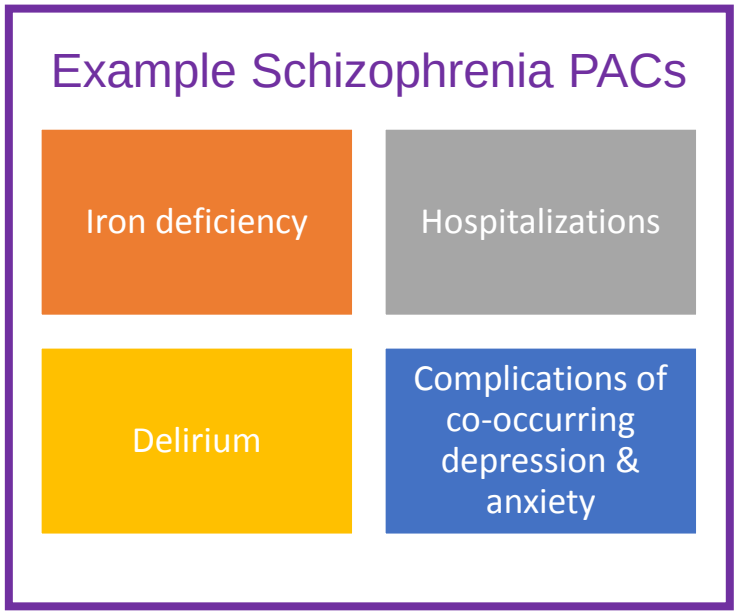


Source: http://www.hci3.org/content/hci3s-measures-improve-quality-and-outcome-care-patients-endorsed-nqf

Episode Components: PACs – **Recap**

Two uses of PACs:

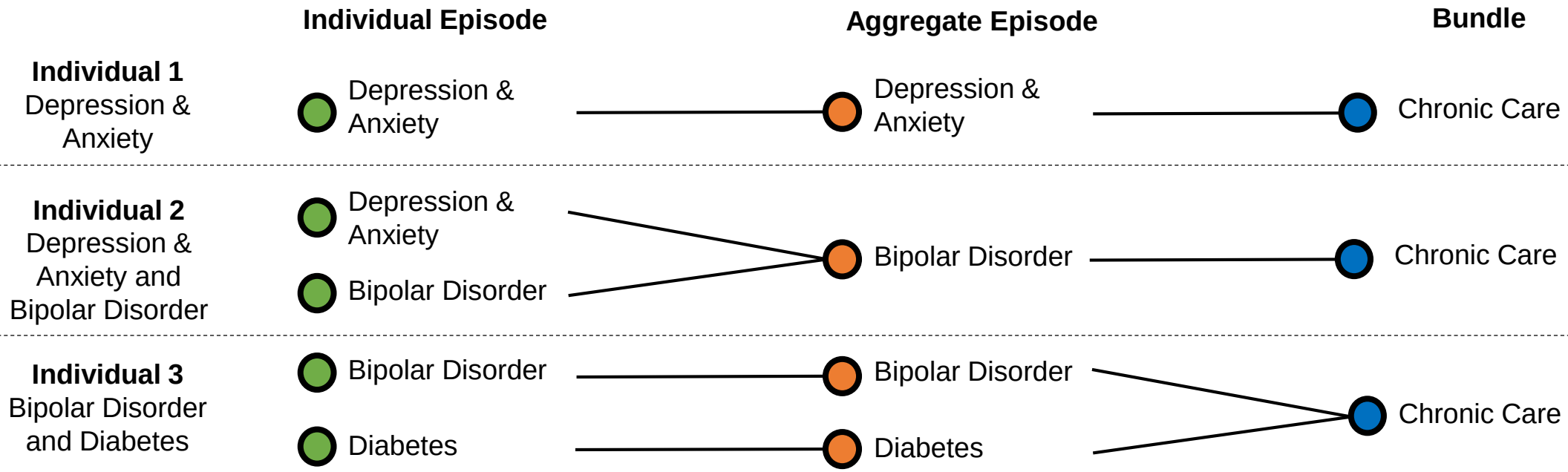
- **% of episode costs that are PACs**: indication for improvement opportunity
- **% of episodes with a PAC:** endorsed by NQF for several physical chronic episodes. Validation of use as *overall* outcome measure for chronic episodes and the Chronic Bundle is ongoing
- *All risk-adjusted measures*



Source: http://www.hci3.org/content/hci3s-measures-improve-quality-and-outcome-care-patients-endorsed-nqf

Episode Components: Leveling Example – **Recap**

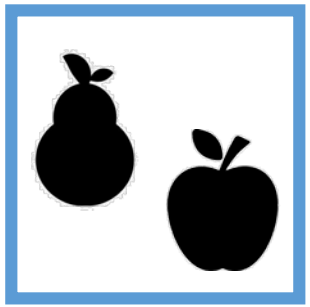
The grouper uses the concept of leveling (individual episode, aggregate episode and bundle), in which individual associated episodes may get grouped together to reflect a primary diagnosis as you move higher in the levels



As you move higher up in levels, associated episodes get grouped together to reflect a primary diagnosis

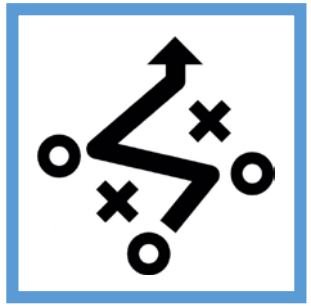
Source: More information can be found at: : http://www.hci3.org/programs-efforts/prometheus-payment/ecr-analytics

Risk Adjustment for Episodes – **Recap**



Make “apples-to-apples” comparisons between providers by accounting for differences in their patient populations

Takes the patient factors (co-morbidity, severity of condition at outset, etc.) out of the equation



Separate risk adjustment models are created for ‘typical’ services and for ‘potentially avoidable complications’

Source: More information can be found at: http://www.hci3.org/programs-efforts/prometheus-payment/ecr-analytics

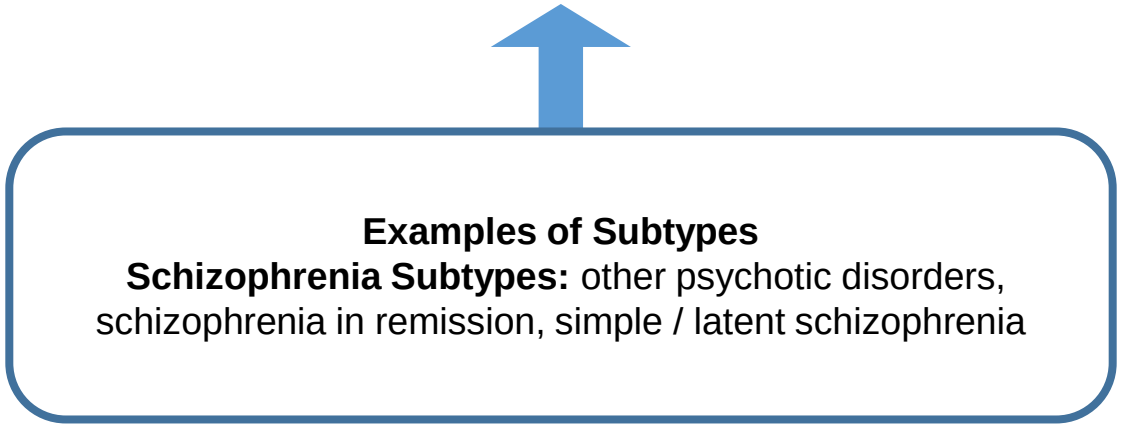
Inclusion and Identification of Risk Factors – **Recap**

The CVG helped re-define the parameters of age and developed sub-types for Schizophrenia

- **Risk Factors**
  - Patient demographics – Age, gender, etc.
  - Risk factors - Co-morbidities
  - Subtypes - Markers of clinical severity within an episode

Patient related risk factors

Episode related risk factors



- **Identification Risk Factors**
  - Risk factors come from historic claims (prior to start of an episode) and same list is applied across all episode types
  - Subtypes identified from claims at start of the episode and specific to episode type

Four Important Costs Drivers for Episodes are Price, Volume, PACs and Service Mix – **Recap**

Cost Drivers

Price

The price of a service can vary based on providers' own costs (e.g. wages). In NYS, we will in the beginning only use price-standardized ('proxy-priced') data for comparative purposes.

Volume

The volume of services rendered (e.g. doing 1 psychiatric evaluation vs. 3 in the first 2 months).

PACs

Potentially avoidable complications (e.g. acute situation).

Service Mix

The mix of services and intensity of care received during the episode (e.g. inpatient vs. outpatient point of care).

E. Schizophrenia Episode Definition

Schizophrenia Episode

Trigger

- One or more claims that carry a diagnosis code for schizophrenia and meet the trigger criteria that is specified for this episode

Confirming trigger

- Another trigger as stated above at least 30 days after the first trigger (for a Professional Billing E&M service *only*).

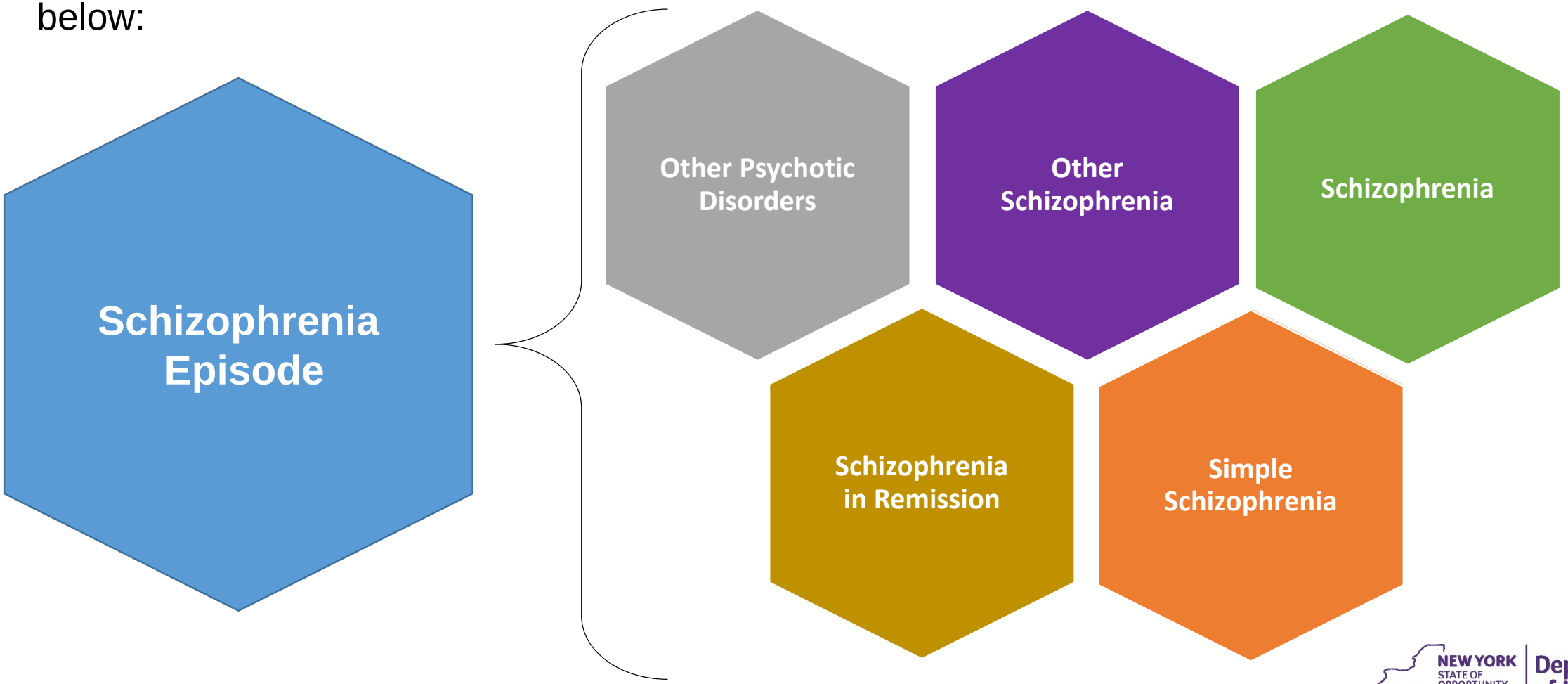
Included in episode:

- All typical and complication costs for schizophrenia during the duration of the episode

- In addition to hospitalizations, complications include, but are not limited to:
  - Suicidal ideation
  - Delirium
  - Complications of co-occurring depression & anxiety
  - Iron deficiency and other anemia's

Scope of Schizophrenia Episode

- An example of some of the Schizophrenia subtypes captured within the episode are listed below:



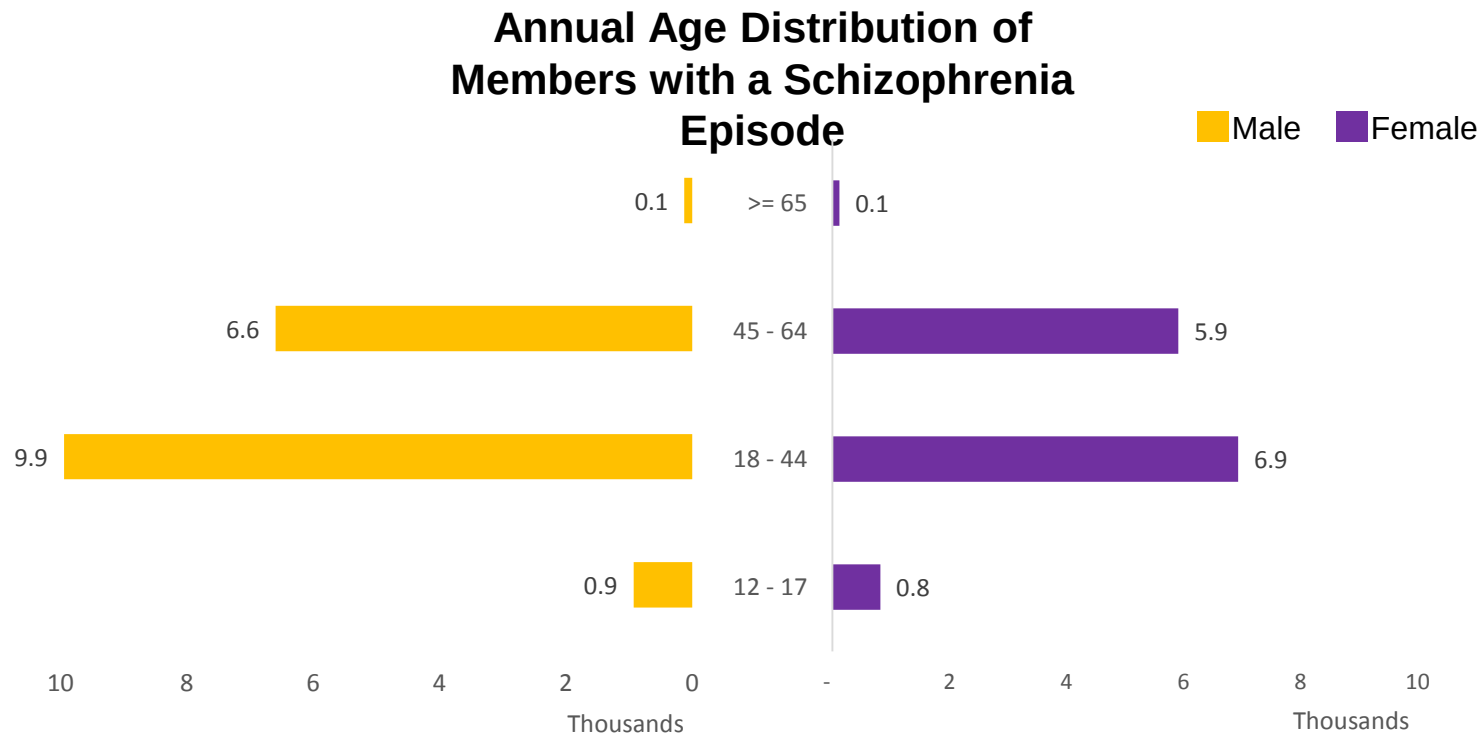
Schizophrenia episodes account for approximately $221M in Annual Medicaid Spend

Total Annual Cost of Schizophrenia (to the State)

$221M

Average Costs per Episode for Members with a Schizophrenia

$7,044



Costs Included:

- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.

Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

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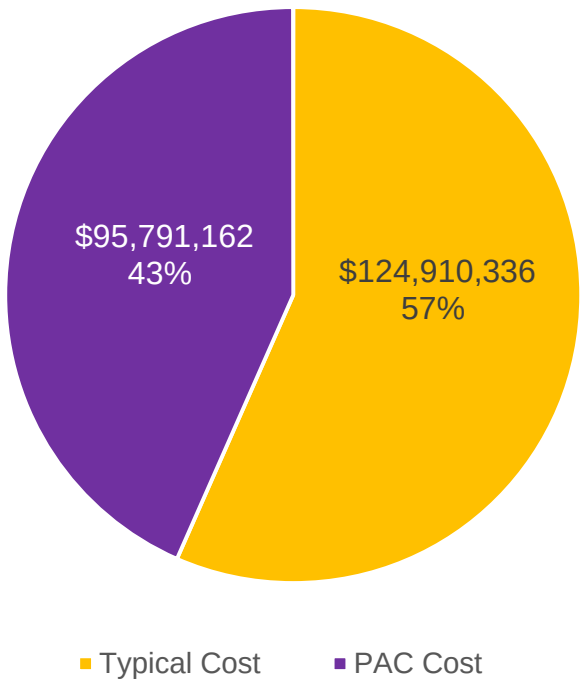
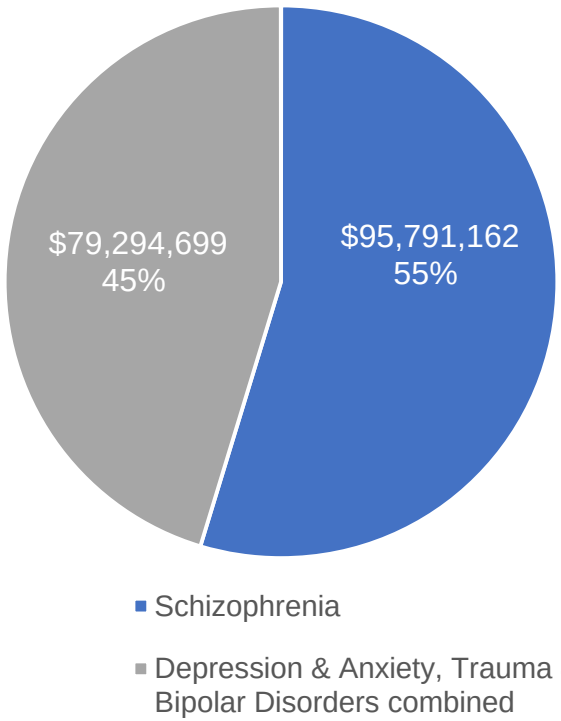
PAC Costs Represent $95.8M of All Schizophrenia Annual Costs

- While Schizophrenia PAC costs are just below 50% of total costs, its PAC costs are 10% *higher* than the remaining mental health episodes (bipolar, depression & anxiety, and trauma & stressors) PAC costs combined.

SCHIZO Dollar Allocation of Typical Costs and PAC Costs (CY2014)



PAC Cost Comparison - SCHIZO vs. Remaining Mental Health Episodes (CY2014)

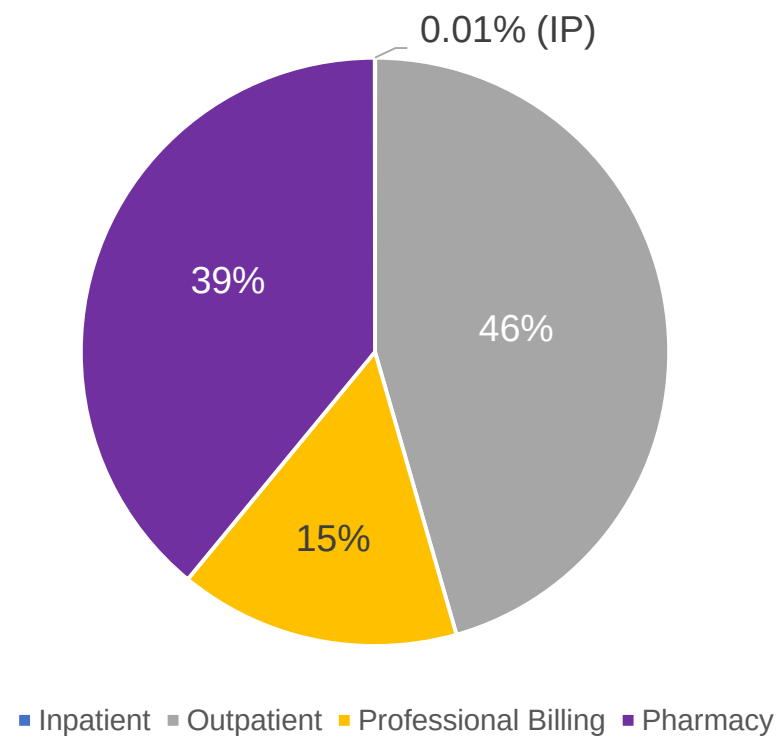


Costs Included:
- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.

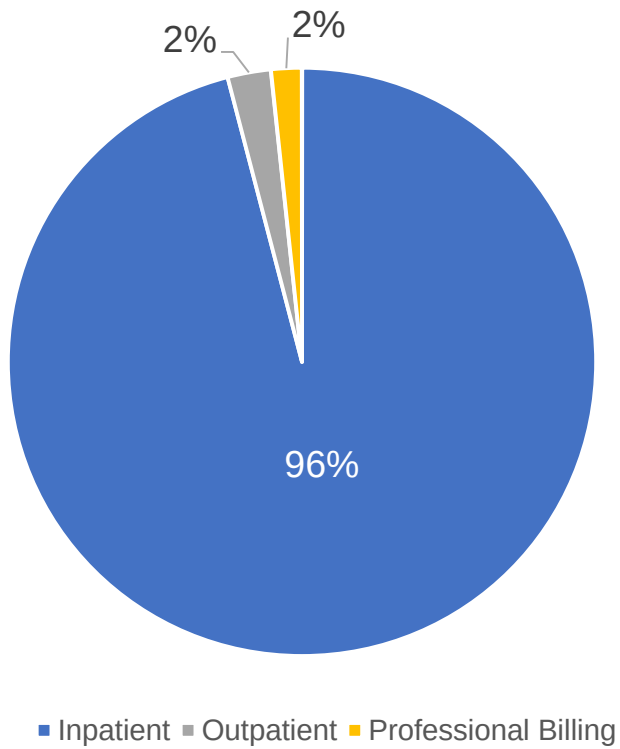
Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

Category of Service Breakdown – Schizophrenia Typical vs. PAC Cost

Typical Costs Dollar Allocation, by Category of Service (CY2014)



PAC Costs Dollar Allocation, by Category of Service (CY2014)



Costs Included:

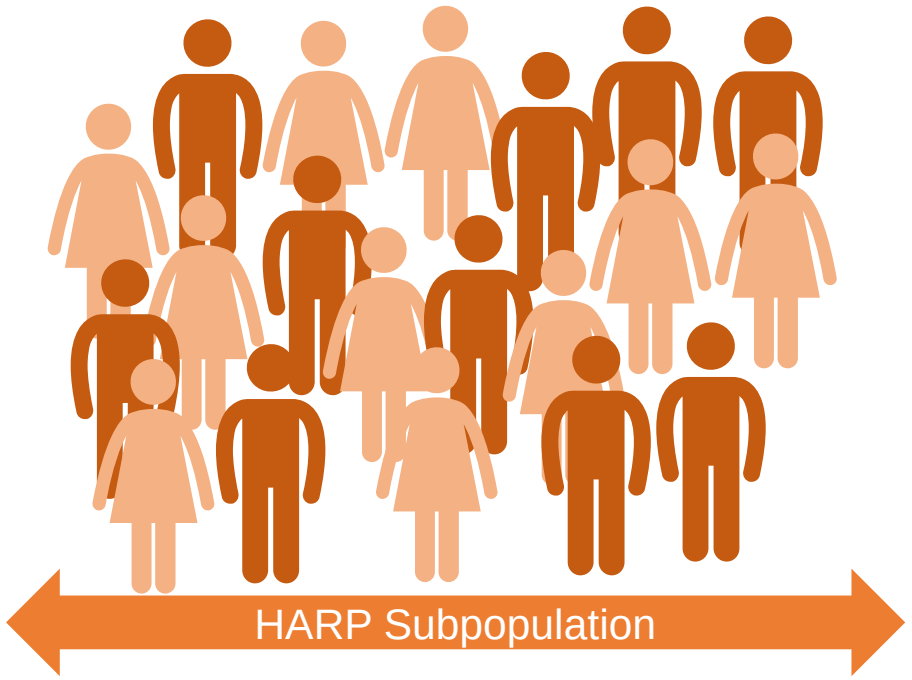
- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.

Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

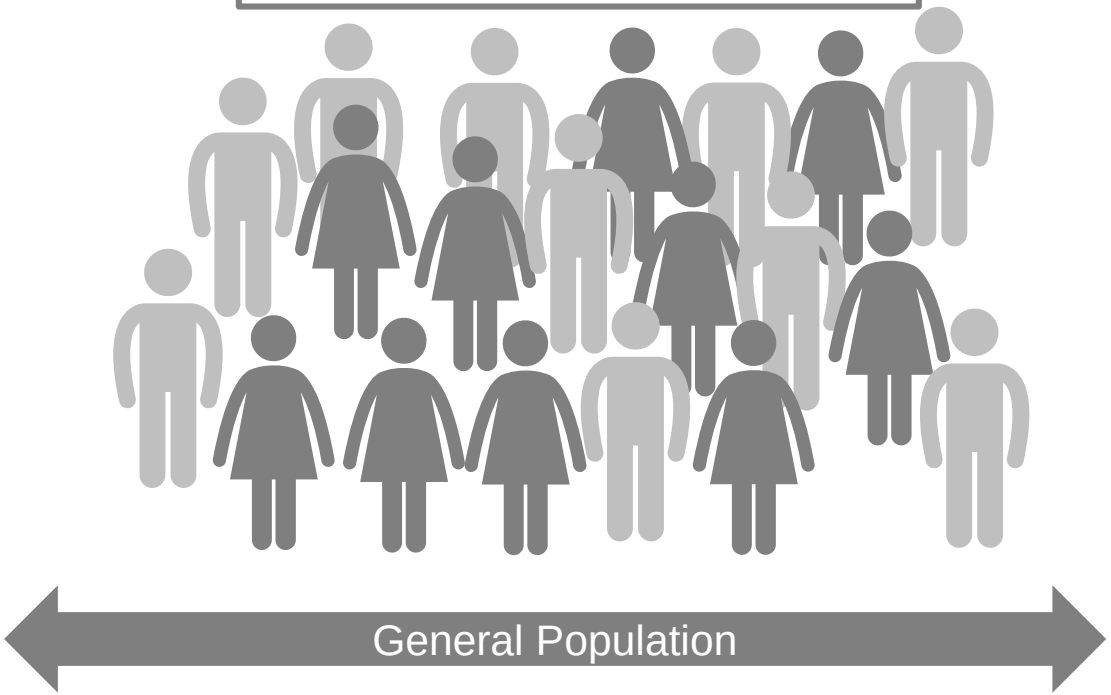
Distribution of Schizophrenia in the Medicaid Population

- Almost half of the schizophrenic population is in HARP, and their per episode average cost is 60% more than the general population.

Schizophrenia Episodes in HARP:
29,425
Total Cost: **$339,479,380**
Per Episode Cost: **$11,545**



Schizophrenia Episodes outside of HARP:
31,375
Total Cost: **$220,701,498**
Per Episode Cost: **$7,004**



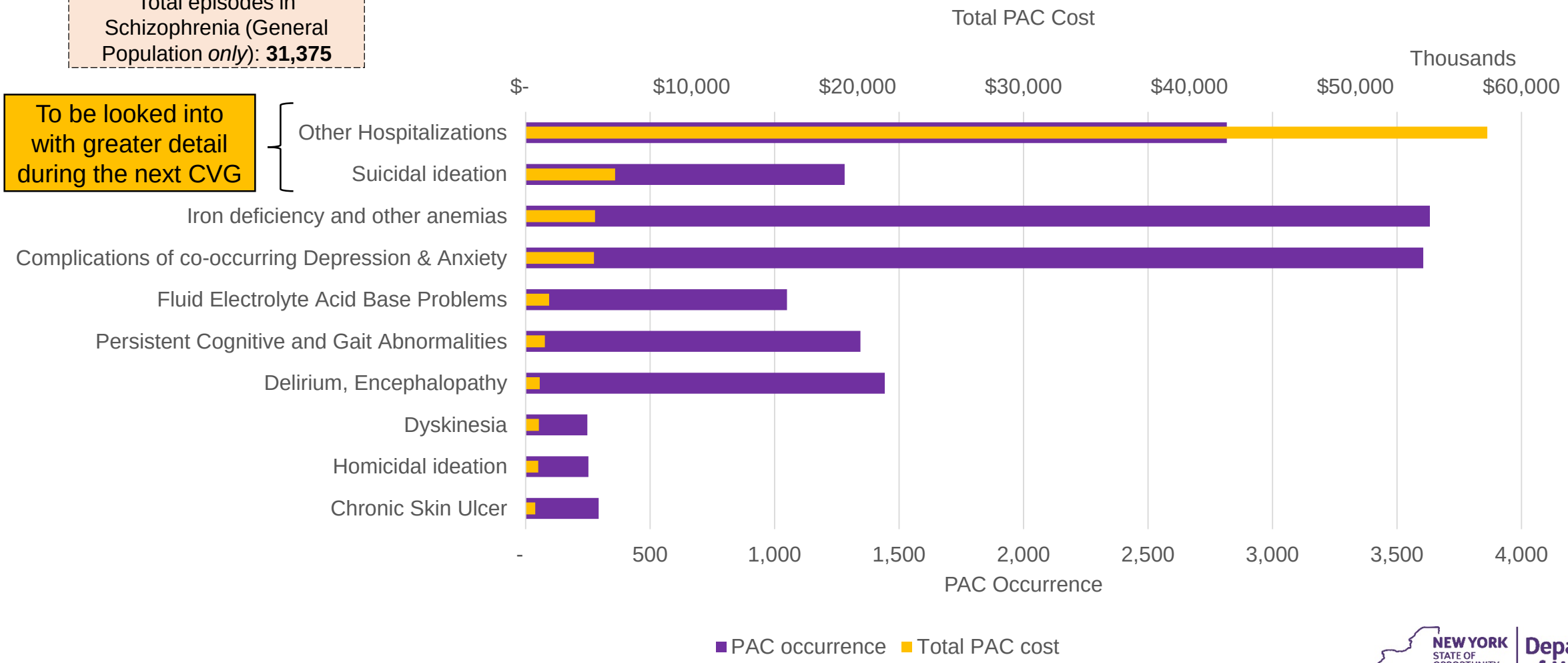
Costs Included:
- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.

Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population *and* HARP Population

Top 10 Schizophrenia PACs Represent 96% of the Total Cost of Schizophrenia PACs in the General Population

Total episodes in Schizophrenia (General Population *only*): **31,375**

To be looked into with greater detail during the next CVG



Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

NEW YORK STATE OF OPPORTUNITY. Department of Health

F. Quality Measures

Schizophrenia

Schizophrenia Quality Measure – **Review and Selection**

Schizophrenia

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NBQF (SAMSHA)	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Screening/Assessment and Monitoring	1	Alcohol Screening and Follow-up for People with Serious Mental Illness	Process					X		Yes	Yes	
	2	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Process					X		Yes	Yes	
	3	Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	Process					X		Yes	Yes	
	4	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness	Process					X		Yes	Yes	
	5	Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	Process					X		Yes	Yes	
	6	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	Process					X		Yes	Yes	

Schizophrenia Quality Measure – **Review and Selection**

Schizophrenia

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NBQF (SAMSHA)	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Treatment and Outcome	7	Schizophrenia: percent of patients with severe symptoms or side effects and no recent medication treatment change to address these problems	Process							Yes	Yes	
	8	Schizophrenia: percent of patients with family members or caregivers who have had no contact with clinic providers during the past year	Process							Yes	Yes	
	9	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Process				X		X	Yes	Yes	
	10	Controlling High Blood Pressure for People with Serious Mental Illness	Outcome						X	Yes	Yes	
	11	Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)	Process						X	Yes	No	
	12	PAC % Cost	Outcome							Yes	No	

BH CAG #5 (SUD) will be:

Friday - July 8, 2016

KPMG NYC Office

1350 6th Ave (10th Floor - Conference Room 10M07H)

New York, NY 10019

9 am – 12 pm

Appendix

- Quality Measure Definitions
- HARP Measures
- HARP Episode Analysis

2016 Depression Quality Measures – Category 1

Quality Measure	Measure Steward	Data Source	Description
Depression Screening (IMPACT Model)	University of Washington	Claims Data	% of patients with documentation of annual screening for depression with the PHQ-2 or similar screening measure.
Diagnosis (IMPACT Model)	University of Washington	Claims Data	% of patients with a positive screen who receive a structured depression assessment (e.g. PHQ-9) to help confirm a diagnosis of depression within 4 weeks of screening.
Initiation of Treatment (IMPACT Model)	University of Washington	Claims Data	% of primary care patients diagnosed with depression who initiated treatment (antidepressant medication, psychotherapy, or ECT) or attended a mental health specialty visit within 4 weeks of initial diagnosis.
Adjustment of Treatment Based on Outcomes (IMPACT Model)	University of Washington	Claims Data	% of primary care patients treated for depression with a PHQ-9 score of >= 10 at follow up who receive an adjustment to their depression treatment (e.g. change in antidepressant medication or psychotherapy) or attend a mental health specialty consult within 8-12 weeks of initiating treatment.
Symptom Reduction (IMPACT Model)	University of Washington	Claims Data	% of patients treated for depression who have a decrease > 50% in depression symptom levels from baseline as measured by the PHQ-9 or similar quantifiable measure and a PHQ-9 score < 10 within 6 months of initiating treatment.
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	Claims Data	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.
Follow-Up After Hospitalization for Mental Illness within 7 Days	HEDIS	Claims / Clinical Data	This measure is used to assess the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.
Follow-Up After Hospitalization for Mental Illness within 30 Days	HEDIS	Claims / Clinical Data	This measure is used to assess the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge.

2016 Depression Quality Measures – Category 1

Quality Measure	Measure Steward	Data Source	Description
Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	NCQA	Claims Data	The % of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge. Four rates are reported: -The % of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge. -The % of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge. -The % of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge. -The % of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.
Readmission to mental health inpatient care within 30 days of discharge	IPRO	Clinical Data	Suggested by OHM/OASAS Members who were readmitted to inpatient mental health care within 30 days of the previous discharge.
Antidepressant Medication Management	NCQA	Claims / Clinical Data	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).

2016 Depression Quality Measures – Category 2

Quality Measure	Measure Steward	Data Source	Description
Measurement of Treatment Outcomes (IMPACT Model)	University of Washington	Claims Data	% of primary care patients treated for depression who receive a structured clinical assessment (i.e., PHQ-9) of depression severity at: **Baseline:** within 2 weeks prior or subsequent to treatment. initiation **Follow-up:** within 8 to 12 weeks following treatment initiation. **Continuation:** within 3 to 6 months following treatment initiation.

2016 Depression Quality Measures – Category 3

Quality Measure	Measure Steward	Data Source	Description
Depression Response at Twelve Months – Progress Towards Remission	MN Community Measurement	Claims / Clinical Data	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate a response to treatment at twelve months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. This measure applies to both patients with newly diagnosed and existing depression identified during the defined measurement period whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.
Depression Remission at Six Months	MN Community Measurement	Claims Data	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at six months (+/- 30 days) are also included in the denominator.
Depression Remission at Twelve Months	MN Community Measurement	Claims Data	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.
Timely filling of appropriate medication prescriptions post discharge (30 days and 100 days) - Psychotropic Medication - Antipsychotic Medication - Mood Stabilizer/Antidepressant Anti-Addiction Medication - Mood-Disorder	BHO I	OMH/ OASAS	Please see: Section VII and VIII https://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/bho-reference.pdf

2016 Depression Quality Measures – Category 3

Quality Measure	Measure Steward	Data Source	Description
Potentially preventable ED visits (for persons with BH diagnosis)	3M	Claims Data	Emergency department visits with a principal diagnosis related to mental health
Potentially preventable readmission for SNF (skilled nursing facilities) patients	3M	Claims Data	This outcome measure assesses the risk-standardized rate of unplanned, potentially preventable readmissions (PPRs) for Medicare fee-for-service (FFS) Skilled Nursing Facility (SNF) patients within 30 days of discharge from a prior proximal hospitalization. A prior proximal hospitalization is defined as an admission to an inpatient prospective payment system (IPPS) hospital, critical access hospital (CAH), or psychiatric hospital.
Percent of Long Stay Residents who have Depressive Symptoms	CMS	Claims Data	This measure is used to assess the percent of long-stay residents who have had symptoms of depression during the 2-week period preceding the Minimum Data Set (MDS) 3.0 target assessment date.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA	Claims Data	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. - Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. - Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

2016 Depression Quality Measures – Uncategorized

Quality Measure	Measure Steward	Data Source	Description
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	Claims Data	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.
Major Depressive Disorder (MDD): Diagnostic Evaluation	AMA-PCPI NQF - 0103	Claims Data	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with evidence that they met the DSM-IV-TR criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified.
Preventive Care and Screening for Clinical Depression and Follow-up Plan	CMS NQF 0418 (adult)	Claims Data	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.
(Screening, Brief Intervention, and Referral to Treatment) SBIRT screening	MASBIRT	Clinical Data	Screening, Brief Intervention and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach for early identification and intervention with patients whose patterns of alcohol and/or drug use put their health at risk. http://www.integration.samhsa.gov/clinical-practice/SBIRT
Multidimensional Mental Health Screening Assessment	M3 Information LLC	Clinical Data	This is a process measure indicating the percent of patients who have had this assessment completed in a period of time. Specifically, adult patients age 18 and older in an ambulatory care practice setting who have a Multidimensional Mental Health Screening Assessment administered at least once during the twelve month measurement period (e.g., once during the calendar year) when staff-assisted care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. "Staff-assisted care supports" refers to clinical staff that assist the primary care clinician by providing some direct care and/or coordination, case management, or mental health treatment. A Multidimensional Mental Health Screening Assessment is defined as a validated screening tool that screens for the presence or risk of having the more common psychiatric conditions, which for this measure include major depression, bipolar disorder, post-traumatic stress disorder (PTSD), one or more anxiety disorders (specifically, panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, and/or social phobia), and substance abuse.
Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Center for Quality Assessment and Improvement in Mental Health	Claims Data	Percentage of patients 18 years of age or older with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.

2016 Depression Quality Measures – Uncategorized

Quality Measure	Measure Steward	Data Source	Description
Antidepressant Medication Management	NCQA	Claims Data / Clinical Data	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).

2016 Anxiety Quality Measures – Uncategorized

Quality Measure	Measure Steward	Data Source	Description
Generalized Anxiety Disorder 7-item (GAD 7) Scale	Substance Abuse and Mental Health Services Administration	Clinical Data	Choose the one description for each item that best describes how many days you have been bothered by each of the following over the past 2 weeks: -Feeling nervous, anxious, or on edge -Unable to stop worrying -Worrying too much about different things -Problems relaxing -Feeling restless or unable to sit still -Feeling irritable or easily annoyed -Being afraid that something awful might happen
Acute Stress Disorder Interview (ASDI) 1	PTSD: National Center for PTSD	Clinical Data	Is the only structured clinical interview that has been validated against DSM-IV criteria for ASD. It appears to meet standard criteria for internal consistency, test-retest reliability, and construct validity. The interview was validated by comparing it with independent diagnostic decisions made by clinicians with experience in diagnosing both ASD and PTSD.
Acute Stress Disorder Scale (ASDS) 1	PTSD: National Center for PTSD	Clinical Data	Is a self-report measure of ASD symptoms that correlates highly with symptom clusters on the ASDI. It has good internal consistency, test-retest reliability, and construct validity.
Social Phobia Inventory (SPIN) 2	ICHOM	Clinical Data	Is a questionnaire developed for screening and measuring severity of social anxiety disorder. This self-reported assessment scale consists of 17 items, which cover the main spectrum of social phobia such as fear, avoidance, and physiological symptoms. The statements of the SPIN items indicate the particular signs of social phobia. Answering the statements a person should indicate how much each statement applies to him or her. Each statement of SPIN can be measured by a choice of five answers based on a scale of intensity of social phobia singes ranging from "Not at all" to "Extremely". Each answer is then assigned a number value ranging from least intense to most intense. Overall assessment is done by total score, and the total score higher than 19 indicates on likelihood of social anxiety disorder.
Mobility Inventory for Agoraphobia (MIA) 2	ICHOM	Clinical Data	Is a 27-item inventory for the measurement of self-reported agoraphobic avoidance behavior and frequency of panic attacks, is described. On this instrument, 26 situations are rated for avoidance both when clients are accompanied and when they are alone.

2016 Anxiety Quality Measures – Uncategorized

Quality Measure	Measure Steward	Data Source	Description
Panic Disorder Severity Scale (PDSS-SR) 2	ICHOM	Clinical Data	Is a questionnaire developed for measuring the severity of panic disorder. The clinician-administered PDSS is intended to assess severity and considered a reliable tool for monitoring of treatment outcome. The PDSS consists of seven items, each rated on a 5-point scale, which ranges from 0 to 4. The overall assessment is made by a total score, which is calculated by summing the scores for all seven items. The total scores range from 0 to 28. The PDSS-SR is used for screening and the scores 9 and above suggest the need for a formal diagnostic assessment.
Obsessive-Compulsive Inventory (OCI-R) 2	ICHOM	Clinical Data	Is a comprehensive self-report measure for assessing symptoms of obsessive-compulsive disorder (OCD). It contains 42 items rated on two 5-point Likert-type scales: one measuring the frequency of symptoms and the other evaluating the distress caused by the symptoms. The 42 items form several subscales: Checking, Washing, Obsessing, Mental Neutralizing, Ordering, Hoarding and Doubting.
Recommended to track via the World Health Organization Disability Assessment 2.0 (WHODAS 2.0) 2	ICHOM	Clinical Data	Is a 36-item, generic instrument for assessing health status and disability across different cultures and settings. Includes 6 domains of functioning: Cognition, Mobility, Self-care, Getting along, Life activities (household and work), and participation. The average scores are comparable to the WHODAS 5-point scale, which allows the clinician to think of the individual's disability in terms of none (1), mild (2), moderate (3), severe (4), or extreme (5) in each domain and generally.

2016 Trauma & Stressor Quality Measures – Uncategorized

Quality Measure	Measure Steward	Data Source	Description
Primary Care PTSD Screen (PC-PTSD)	National Center for PTSD	Clinical Data	The Primary Care PTSD Screen (PC-PTSD) is a 4-item screen that was designed for use in primary care and other medical settings, and is currently used to screen for PTSD in Veterans using VA health care. The screen includes an introductory sentence to cue respondents to traumatic events. The screen does not include a list of potentially traumatic events.
PTSD Checklist for DSM-5 (PCL-5)	National Center for PTSD	Clinical Data	The PCL-5 is a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD. The PCL-5 has a variety of purposes, including: - Monitoring symptom change during and after treatment. - Screening individuals for PTSD. - Making a provisional PTSD diagnosis. The gold standard for diagnosing PTSD is a structured clinical interview such as the Clinician-Administered PTSD Scale (CAPS-5). When necessary, the PCL-5 can be scored to provide a provisional PTSD diagnosis.
Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)	National Center for PTSD	Clinical Data	The CAPS is the gold standard in PTSD assessment. The CAPS-5 is a 30-item structured interview that can be used to: - Make current (past month) diagnosis of PTSD. - Make lifetime diagnosis of PTSD. - Assess PTSD symptoms over the past week. In addition to assessing the 20 DSM-5 PTSD symptoms, questions target the onset and duration of symptoms, subjective distress, impact of symptoms on social and occupational functioning, improvement in symptoms since a previous CAPS administration, overall response validity, overall PTSD severity, and specifications for the dissociative subtype (depersonalization and derealization).

2016 Schizophrenia Quality Measures – Uncategorized

Quality Measure	Measure Steward	Data Source	Description
Alcohol Screening and Follow-up for People with Serious Mental Illness	NCQA	Admin. Claims / Paper Medical Records / E. Clinical Data	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user.
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	NCQA	Admin. Claims / E. Clinical Data: Laboratory and Pharmacy	The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	NCQA	Admin. Claims / Paper Medical Record / E. Clinical Data	The percentage of patients 18 – 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.
Body Mass Index Screening and Follow-Up for People with Serious Mental Illness	NCQA	Admin. Claims / Paper Medical Records / E. Clinical Data	The percentage of patients 18 years and older with a serious mental illness who received a screening for body mass index and follow-up for those people who were identified as obese (a body mass index greater than or equal to 30 kg/m2). Currently used by the Physician Quality Reporting System.
Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	NCQA	Admin. Claims / E. Clinical Data / E. Clinical Data: Pharmacy	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	NCQA	Admin. Claims / E. Clinical Data / E. Clinical Data: Laboratory	The percentage of patients 18 – 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

2016 Schizophrenia Quality Measures – Uncategorized

Quality Measure	Measure Steward	Data Source	Description
Schizophrenia: percent of patients with severe symptoms or side effects and no recent medication treatment change to address these problems	AHRQ	Paper Medical Records / Patient Survey / Pharmacy Records	This measure is used to assess the percent of patients who have severe symptoms or side effects and no change in medication treatment change to address these problems.
Schizophrenia: percent of patients with family members or caregivers who have had no contact with clinic providers during the past year	AHRQ	Admin. Clinical Data / Paper Medical Records / Patient Survey	This measure is used to assess the percent of patients with family members or caregivers (with whom they have contact at least twice a week) who have had no contact with clinical providers during the past year.
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	CMS	Admin. Claims / Clinical Data / Pharmacy Records	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).
Controlling High Blood Pressure for People with Serious Mental Illness	NCQA	Admin. Claims / Paper Medical Records / E. Clinical Data,	The percentage of patients 18-85 years of age with serious mental illness who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year.
Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)	NQCA	Admin. Claims	The percentage of discharges for individuals 18 – 64 years of age who were hospitalized for treatment of schizophrenia and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: • The percentage of individuals who received follow-up within 30 days of discharge • The percentage of individuals who received follow-up within 7 days of discharge

2016 PAC Quality Measures – Uncategorized

Quality Measure	Measure Steward	Data Source	Description
PAC Rate		Medical Claims	PAC Rate is = total number of episodes with PAC occurrence (occurrence = 1 or 0) / total number of episodes.
PAC % Cost		Medical Claims	PAC % Cost is = total PAC costs of all episodes / total costs of all episodes.

HARP Measures

Category 1 and 2 Selections by the BH CAG

Selection of Measures – IMPACT Measures

Depression

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NBQF (SAMSHA)	Availability		CAG Categorization & Comments
										Medicaid Claims Data	Clinical Data	
Assessment, Treatment and Follow-up	1	Depression Screening, Diagnosis and Monitoring with PHQ-9 (IMPACT Model)	Process	X						No	Yes	**Category 1** CAG members are in strong support of the IMPACT mode. There were 6,000 people in the demonstration using the IMPACT model with the progress of individuals with reassessment.
	2	Diagnosis (IMPACT Model)	Process	X						No	Yes	**Category 1** May want to Combine this with the first one into one measure.
	3	Initiation of Treatment (IMPACT Model)	Outcome	X						No	No	**Category 1**
	4	Measurement of Treatment Outcomes (IMPACT Model)	Outcome	X						No	No	**Category 2**
	5	Adjustment of Treatment Based on Outcomes (IMPACT Model)	Outcome	X						No	No	**Category 1** This is important. Indicative that you are tracking treatment outcomes and if you are achieving effects based on treatment.
	6	Symptom Reduction (IMPACT Model)	Outcome	X						No	No	**Category 1**

Additional Measures for Consideration – Assessment and Screening

Depression

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NBQF (SAMSHA)	Availability		CAG Categorization & Comments
										Medicaid Claims Data	Clinical Data	
Assessment and Screening	1	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Process						X	Yes	No	**Category 1** • Conditional, if they screen and diagnosed with major depressive disorder.
	2	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Process						X	Yes	No	**Category 2 or 3?**
	3	Major Depressive Disorder (MDD): Diagnostic Evaluation	Process						X	Yes	No	**Category 2 or 3?**
	4	Preventive Care and Screening for Clinical Depression and Follow-up Plan	Process	X			X		X	Yes	Yes	**Category 2 or 3?**
	5	(Screening, Brief Intervention, and Referral to Treatment) SBIRT screening	Process			X				Yes	Yes	**Category 2 or 3?**
	6	Multidimensional Mental Health Screening Assessment	Process					X		No	Yes	**Category 2 or 3?**
	7	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Process						X	Yes	No	**Category 2 or 3?**

Additional Measures for Consideration – Treatment and Follow-up (pre- 30 days)

Depression

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NBQF (SAMSHA)	Availability		CAG Categorization & Comments
										Medicaid Claims Data	Clinical Data	
Treatment and Follow-up (pre- 30 days)	1	Follow-Up After Hospitalization for Mental Illness within 7 Days	Process	X	X		X	X		Yes	Yes	**Category 1**
	2	Follow-Up After Hospitalization for Mental Illness within 30 Days	Process	X	X		X	X		Yes	Yes	**Category 1**
	3	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Process					X		Yes	No	**Category 1**
	4	Readmission to mental health inpatient care within 30 days of discharge	Outcome			X				Yes	Yes	**Category 1**

Depression

Follow-up (post- 30 days)

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NBQF (SAMSHA)	Availability		CAG Categorization & Comments
										Medicaid Claims Data	Clinical Data	
Follow-up (post- 30 days)	1	Depression Response at Twelve Months – Progress Towards Remission	Outcome					X		Yes	Yes	**Category 3** • All captured by the PHQ-9
	2	Depression Remission at Six Months	Outcome					X	X	No	Yes	**Category 3** • All captured by the PHQ-9
	3	Depression Remission at Twelve Months	Outcome					X	X	No	Yes	**Category 3** • All captured by the PHQ-9
	4	Timely filling of appropriate medication prescriptions post discharge (30 days and 100 days)	Outcome			X				No	No	**Category 3** • This seems like a reach, for VBP phase 2 or 3? Close to a QARR measure
	5	Antidepressant Medication Management	Process	X	X		X			Yes	Yes	**Category 3** • Included in APC scorecard

Depression

Follow-up (post- 30 days)

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NBQF (SAMSHA)	Availability		CAG Categorization & Comments
										Medicaid Claims Data	Clinical Data	
Follow-up (post- 30 days)	6	Potentially preventable ED visits (for persons with BH diagnosis)	Outcome	X						Yes	No	**Category 3**
	7	Potential preventable readmission for SNF (skilled nursing facilities) patients	Outcome	X						Yes	No	**Category 3**
	8	Percent of Long Stay Residents who have Depressive Symptoms	Outcome				X			Yes	Yes	**Category 3**
	9	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Process	X	X					Yes	No	**Category 3** • Will be in SUD episode

Depression

Additional Measures for Consideration

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NBQF (SAMSHA)	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
	10	PAC % Cost	Outcome							Yes	No	

Category 1 HARP Measures

#	Measure Description
1	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence*
2	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
3	Diabetes Monitoring for People With Diabetes and Schizophrenia
4	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing*
5	Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy*
6	Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)*
7	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*
8	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)*
9	Diabetes Care for People with Serious Mental Illness: Eye Exam*
10	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
11	Controlling High Blood Pressure for People with Serious Mental Illness*

#	Measure Description
12	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness*
13	Antidepressant Medication Management
14	Adherence to Antipsychotic Medications for Individuals With Schizophrenia
15	SUD pharmacotherapy for alcohol and opioid dependence
16	Follow-up After Hospitalizations for Mental Illnesses (within 7 and 30 days)*
17	Percentage of patients within the HARP subpopulation that have a potentially avoidable complication during a calendar year.
18	Identification of Alcohol and Other Drug Services[X]
19	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment[X]
20	HH assigned/referred members in outreach or enrollment[X]
21	HH members in outreach/enrollment who were enrolled in measurement year[X]

[X] Measures were added after the CAG to reflect initiatives underway in BHO I and DSRIP

As of April 2016

Category 2 HARP Measures

#	Measure Description
22	% enrollment in HH (specified by ethnicity and potential other subpopulations)
23	SBIRT Screening
24	Depression Utilization of the PHQ-9 Tool*
25	Multidimensional Mental Health Screening Assessment*
26	Major Depressive Disorder (MDD): Diagnostic Evaluation
27	Major Depressive Disorder (MDD): Suicide Risk Assessment
28	Substance Use Screening and Intervention Composite*
29	Alcohol Screening and Follow-up for People with Serious Mental Illness*
30	Medical Assistance With Smoking and Tobacco Use Cessation
31	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
32	Potentially preventable ED visits (PPV) (for persons with BH diagnosis)
33	Readmission to mental health inpatient care within 30 days of discharge
34	Mental Health Utilization
35	Outpatient Engagement
36	Timely filling of appropriate medication prescriptions post discharge
37	Percentage of SUD Detox Discharges Followed by a Lower Level SUD Service within 14 Days

#	Measure Description
38	Percentage of SUD Rehabilitation Discharges Followed by a Lower Level SUD Service within 14 Days
39	Percentage of SUD Detox or Rehabilitation Discharges where a Prescription for an Anti-Addiction Medication was Filled within 30 Days
40	% of members with case conference
41	HH Disenrollment
42	Depression Remission (at Twelve or Six Months)*
43	The % of members currently employed
44	The % of members employed at least 35 hours per week in the past month
45	The % of members employed at or above the minimum wage
46	The % of members currently enrolled in a formal education program
47	The % of members who are homeless
48	The % of members with residential instability in the past two years
49	The % of members who were arrested within the past 30 days
50	The % of members who were arrested within the past year
51	The % of members who were incarcerated within the past 30 days
52	The % of members who were incarcerated within the past year
53	The % of members with social interaction in the past week
54	The % of members with one or more social strengths
55	The % of members who attended a self-help or peer group in the past 30 days

As of April 2016

Episode Summary for HARP Population (CY2014)

Disclaimer: Attribution for HARP is undergoing updates. Data is not yet finalized.

Episode Description	Volume in HARP	Per Episode Cost	Total Cost	% of Total (all) HARP Costs	Total PAC Costs %
Schizophrenia	29,425	$11,545	$339,479,380	22.2%	35.5%
Substance use disorder	38,682	$5,852	$226,181,270	14.8%	43.3%
Bipolar Disorder	26,190	$7,778	$203,469,357	13.3%	21.3%
Diabetes	17,710	$5,020	$88,859,400	5.8%	25.2%
Depression & Anxiety	29,462	$2,926	$86,131,979	5.6%	9.7%
Hypertension	36,474	$1,396	$50,869,814	3.3%	40.0%
Osteoarthritis	10,748	$4,168	$44,731,838	2.9%	16.9%
Asthma	22,455	$1,969	$44,170,316	2.9%	39.7%
Chronic Obstructive Pulmonary Disease	11,848	$2,760	$32,652,809	2.1%	31.9%
Low Back Pain	24,881	$1,189	$29,560,277	1.9%	25.7%
Trauma & Stressors Disorders	16,771	$1,289	$21,580,669	1.4%	7.2%
Heart Failure	2,755	$5,846	$16,100,690	1.1%	37.5%
Gastro-Esophageal Reflux Disease	19,213	$838	$16,077,108	1.1%	20.5%
Coronary Artery Disease	5,809	$2,495	$14,465,775	0.9%	43.4%
Arrythmia/Heart Block/Condn Dis	4,170	$3,141	$13,089,697	0.9%	44.0%
Allergic Rhinitis/Chronic Sinusitis	13,954	$804	$11,207,266	0.7%	18.1%
Glaucoma	5,133	$452	$2,317,106	0.2%	13.0%
Diverticulitis	1,310	$1,765	$2,312,138	0.2%	35.1%
Crohn's Disease	325	$6,411	$2,083,457	0.1%	27.3%
Ulcerative Colitis	277	$4,932	$1,366,224	0.1%	32.2%
Totals	**317,592**	**$72,576**	**$1,246,706,570**	**81.6%**	

Costs Included:

- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.
- % of Total HARP Costs is based off *all* costs within the HARP population (not only chronic episodes).

Source: CY2014 Medicaid claims, Real Pricing, Level 5, Chronic Bundle, HARP Population

NEW YORK STATE OF OPPORTUNITY. Department of Health