Department of Health | Medicaid Redesign Team

Behavioral Health (BH) Clinical Advisory Group (CAG) Meeting

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

Lindsay Cogan | Office of Quality and Patient Safety

Pat Lincourt | Office of Alcoholism and Substance Abuse Services

Tom Smith, MD | Office of Mental Health

April 13, 2018

Agenda

1. Introduction 20 min
    - Roll Call
    - Introduction of Bureau of Social Determinants of Health
    - Future of VBP in New York State
    - CAG Timeline & Expectations for 2018
    - VBP Measure Integration Timeline

2. NYS Core Outcome Measure Strategy 15 min
    - Update on Quality Measure Consolidation

3. Implementation Timeline and Strategy for New Measurement Year (MY) 2017 BH Measures 60 min
    - Cascade on Gaps in Care
    - Update on New Measure Development

4. National Quality Measurement Updates 5 min
    - Mental Health and Substance Use

5. MY 2018 Priority Clinical and Care Delivery Goals 20 min
    - Identification of Gap Areas

Section 1: Introduction

Roll Call
Introduction of Bureau of Social Determinants of Health
Future of VBP in New York State
CAG Timeline & Expectations for 2018
VBP Measure Integration Timeline

Introduction of Bureau of Social Determinants of Health

Bureau of SDH: 2018 Goals

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

Standard: Implementation of SDH Intervention

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

Description:

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

Guideline: SDH Intervention Selection

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

Description:

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

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

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

Standard: Inclusion of Tier 1 CBOs

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

Description:

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

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

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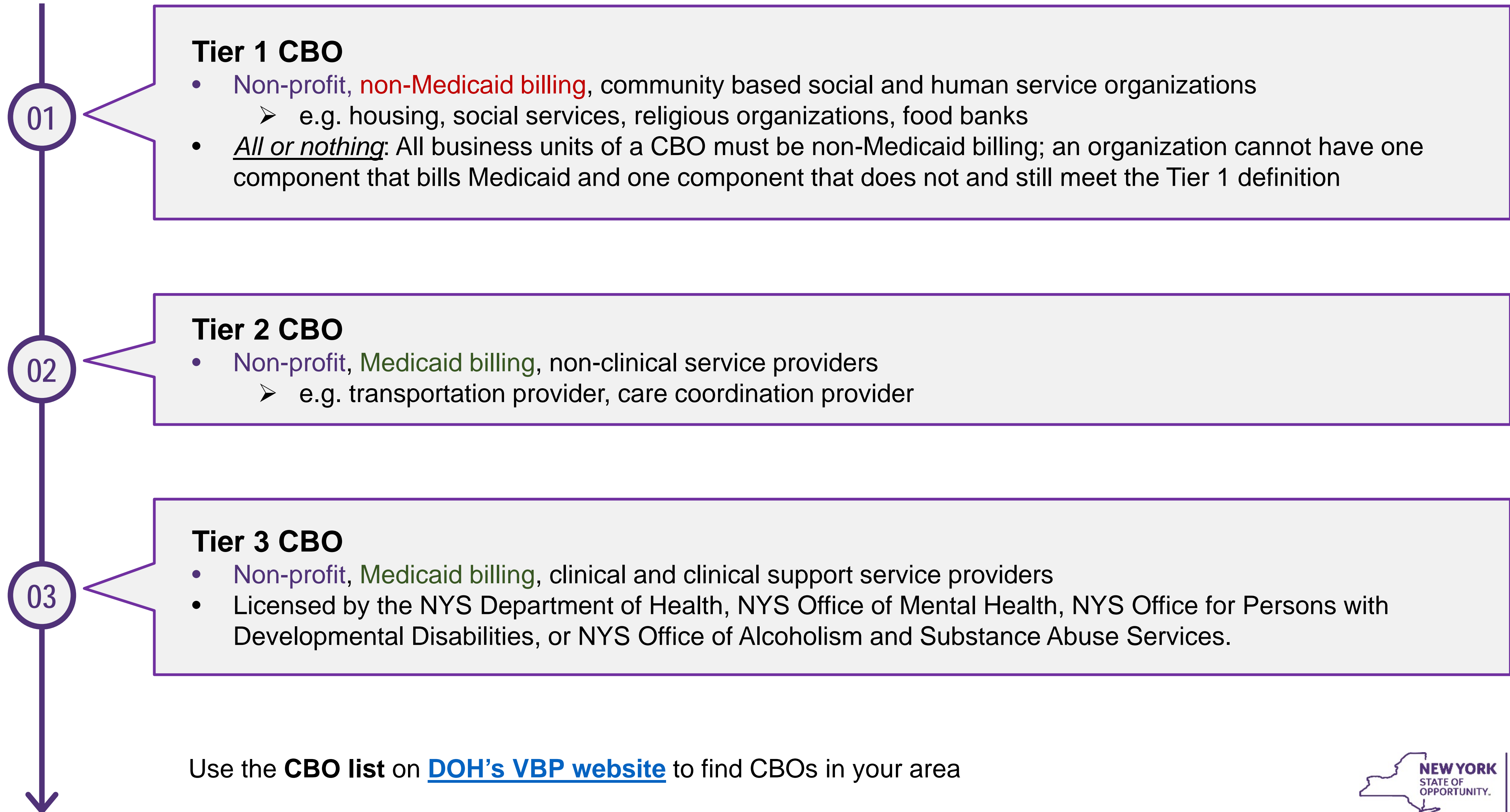
Tier 1, Tier 2, and Tier 3 CBO Definitions



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The Future of VBP in New York State

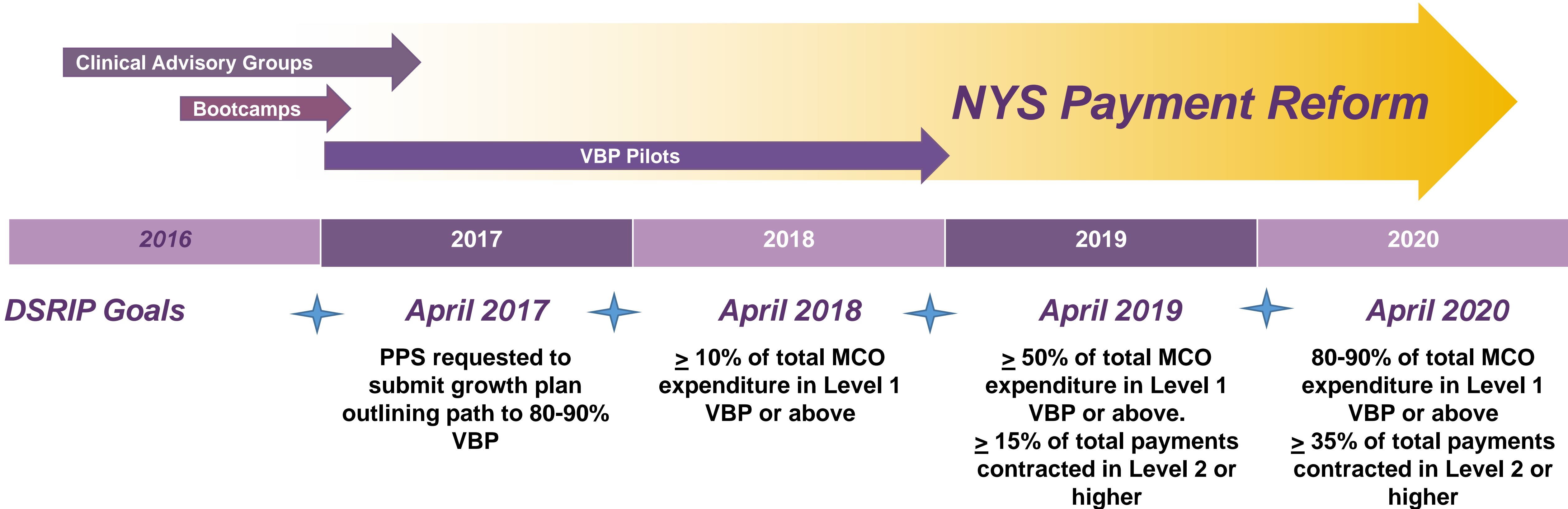
The Future of Value Based Payment Programs

- NYS DOH 1115 Waiver renewed in December 2016 for 5 years (until 2021) and the Delivery System Reform Incentive Payment (DSRIP) program goes through March 31, 2020
- VBP is the sustainability limb of DSRIP
- NYS' Centers for Medicare and Medicaid Services-approved VBP Roadmap commits that 80% of managed care organization (MCO) payments to providers are to be in a value-based arrangement (Level 1, 2, or 3) by April 1, 2020
  - https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/
- New Medicaid Director, Donna Frescatore, our new Champion of VBP, has vast experience with NYS Medicaid
- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the bipartisan legislation signed into law on April 16, 2015, is pursuing *Advanced* Alternative Payment Models (APMs)
  - These programs are part of CMS' larger quality strategy to reform how health care is delivered and paid

Timelines and Expectations

VBP Transformation: Overall Goals and Timeline

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



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

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CAG Timeline & Expectations for 2018

2018 CAG Goals

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

Timeline

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

VBP Quality Measure Integration Timeline

Summary of 2017 Measure Readiness by VBP Measure Set

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

TCGP/IPC Measure Set (40 Total Measures)

- **5** measures are unique to the TCGP/IPC Arrangements
- **35** measures are shared with at least one of the other measure sets.

HARP Measure Set (41 Total Measures)

- **9** measures unique to the HARP Arrangement
- **32** measures that are also included in the TCGP/IPC Arrangement

HIV/AIDS Measure Set (44 Total Measures)

- **10** measures unique to the HIV/AIDs Arrangement
- **34** measures that are also included in the TCGP/IPC Arrangement

Maternity Care Measure Set (18 Total Measures)

- **17** measures unique to the Maternity Care Arrangement
- **1** measure that is also included in the TCGP/IPC Arrangement

Of the **76** unique quality measures, **44** measures have been identified as not ready for implementation based on technical specification requirements or feasibility concerns and will not be included in as reportable in the 2017 VBP Arrangement Measure Sets. Over the course of future program years, these measures will undergo development work to refine specifications and address technical capabilities supporting quality measure data collection and reporting processes.

2017 HARP VBP Arrangement Summary

2017 HARP VBP Quality Measure Set	2017 Measure Feasibility Review				Anticipated Integration			
	Feasible in 2017		Not Feasible in 2017					
Measure Set Total*	**All Measures**	**Unique to HARP**	**All Measures**	**Unique to HARP**	**2018**	**2019**	**2020**	**Integration Date Unknown**
41	**26/41**	6/9	**15/41**	3/9	+ 3 *(1 unique)*	+ 5 *(1 unique)*	+ 4 *(1 unique)*	3
Category 1								
P4P	**16/18**	3/3	**2/18**	0/3	2	0	0	0
P4R	**7/14**	3/5	**7/14**	2/5	1	2	4	0
Category 2								
	3/9	0/1	**6/9**	1/1	0	3	0	3

*9 measures are unique to the HARP Measure Set

See Appendix A for further detail on anticipated integration.

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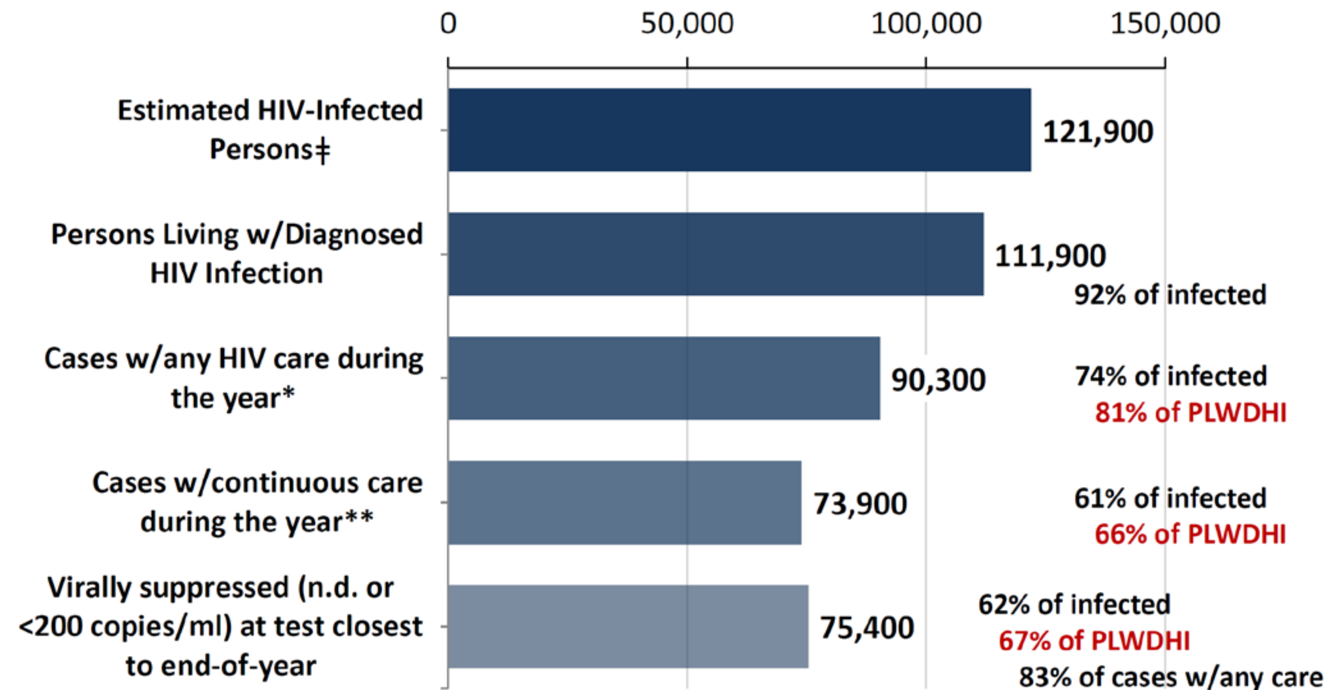
HARP VBP Arrangement Anticipated Measure Integration

	Anticipated Measure Integration			
	2018	**2019**	**2020**	**Integration Date Unknown**
Total New Measures	**+ 3** *(1 unique)*	**+ 5** *(1 unique)*	**+ 4** *(1 unique)*	**3**
Category 1 Measures				
P4P	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	-	-	-
P4P	Controlling High Blood Pressure	-	-	-
P4R	*Percentage Enrollment in Health Home*	Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence	Comprehensive Diabetes Care: Foot Exam	-
P4R	-	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow – Up Plan	*Percentage of HARP Enrolled Members Who Received Personalized Recovery Oriented Services (PROS) or Home and Community Based Services (HCBS)*	-
P4R	-	-	Preventive Care and Screening: Influenza Immunization	-
P4R	-	-	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	-
Category 2 Measures				
	-	Continuing Engagement in Treatment (CET) Alcohol and other Drug Dependence	-	Asthma: Assessment of Asthma Control – Ambulatory Care Setting
	-	*Mental Health Engagement in Care 30 Days*	-	Lung Function/Spirometry Evaluation (Asthma)
	-	Use of Opioid Dependence Pharmacotherapy	-	Patient Self–Management and Action Plan (Asthma)

Introduction to Care Cascade Concept

HIV Care Cascade



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

Section 2: NYS Core Outcome Measure Strategy

Update on Quality Measure Consolidation

Quality Measure Consolidation: Goals for MY 2018

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

CMS Meaningful Measures Framework

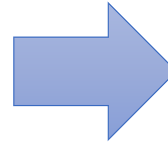
Focus everyone's effort on the same quality areas:

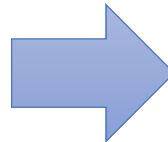
- Address high-impact measure areas
- Patient-centered and meaningful to patients
- Outcome-based where possible
- Relevant and meaningful to providers
- Minimize level of burden for providers
  - Remove measures where performance is already very high
- Significant opportunity for improvement
- Address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

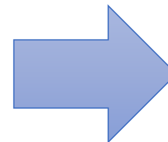
NYS Focus on Meaningful Measures Objectives

Focus Areas:

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







State Efforts:

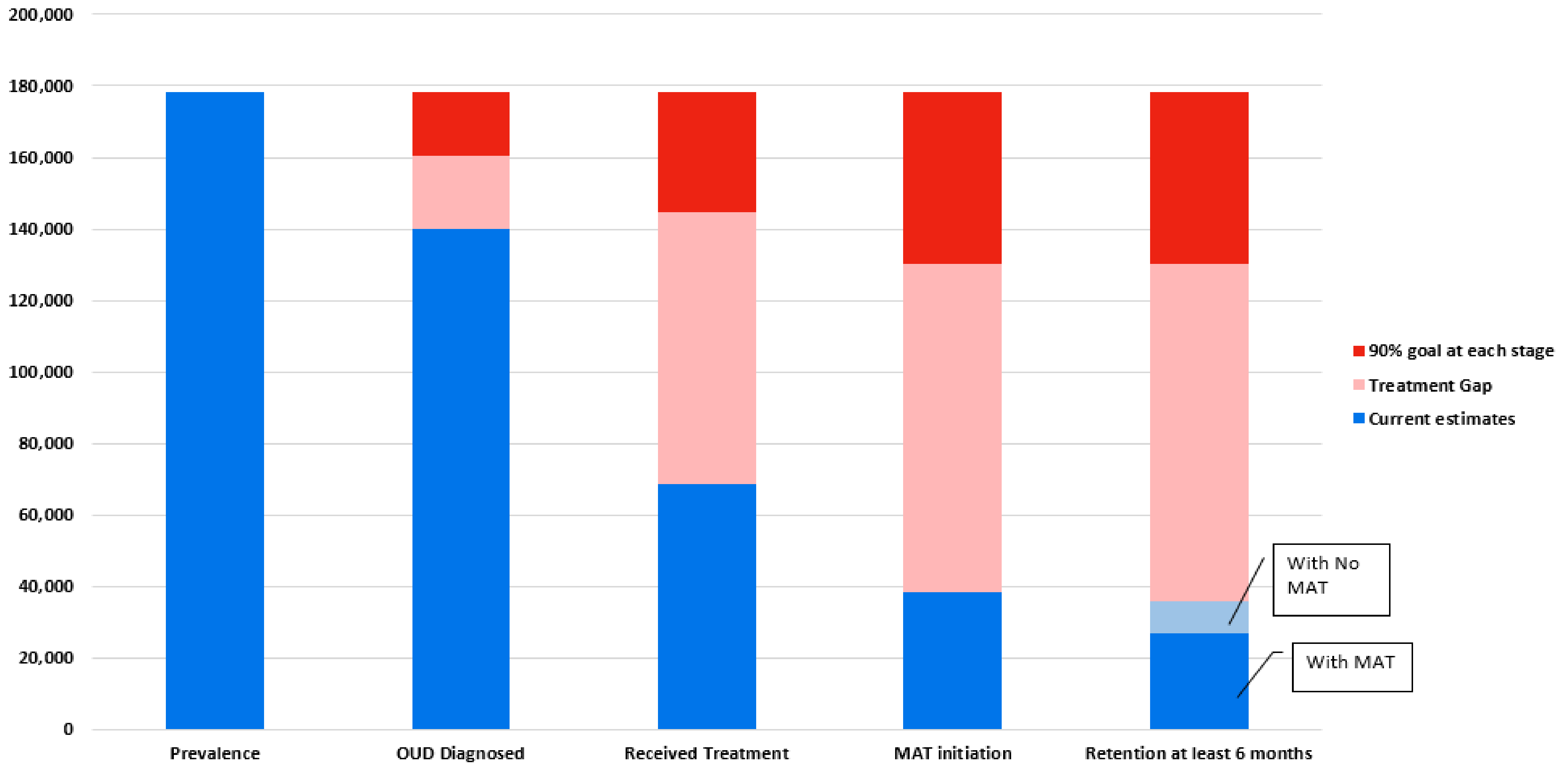
- Medicaid Involvement in Advanced Primary Care (APC) Initiative
- Reevaluate Quality Measure Sets (Clinical Advisory Groups, Measure Support Task Force, VBP Workgroup)
- VBP Pilot Measure Testing (Controlling High Blood Pressure)

Section 3: Implementation Timeline and Strategy for New MY 2017 BH Measures

Cascade on Gaps in Care
Update on New Measure Development

Cascade on Gaps in Care

Pat Lincourt | Office of Alcoholism and Substance Abuse Services



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

Measure Overview for Alcohol and Substance Abuse or Dependence

Overview of Measures

Measure	Description
Continuity of Care from Inpatient Detox to Lower Level of Care	The percentage of inpatient detox discharges for members between 21 and 64 years of age* with a diagnosis of alcohol and other drug (AOD) dependence, who had a follow-up lower level visit for AOD within 14 days of the discharge date.
Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care	The percentage of inpatient discharges for members between 21 and 64 years of age* for alcohol and other drug abuse or dependence treatment (AOD), who had a follow-up lower level AOD visit within 14 days of the discharge date.
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence	The percentage of individuals who initiate pharmacotherapy with at least 1 prescription or visit for opioid treatment medication within 30 days following an index visit with a diagnosis of opioid abuse or dependence.
Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence	The percentage of individuals who initiate pharmacotherapy with at least 1 prescription for alcohol treatment medication within 30 days following an index visit with a diagnosis of alcohol abuse or dependence.
Utilization of Pharmacotherapy upon New Episode of Opioid Dependence	The percentage of individuals with any encounter associated with opioid dependence, with at least 1 prescription or visit for appropriate pharmacotherapy at any time during the measurement year
Utilization of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence	The percentage of individuals with any encounter associated with alcohol use or dependence, with at least 1 prescription for appropriate pharmacotherapy at any time during the measurement year.

* For this presentation only. Per NYS Quality Assurance Reporting Requirements specifications, the eligible age group is 13 years of age and older.

2016 Measure Results – Alcohol and Substance Abuse or Dependence

Continuity of Care from Inpatient Detox to Lower Level of Care (COD)

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

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

Continuity of Care from Inpatient Rehabilitation to Lower Level of Care (COR)

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

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

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

Initiation of Pharmacotherapy upon New Episode of Opioid Dependence

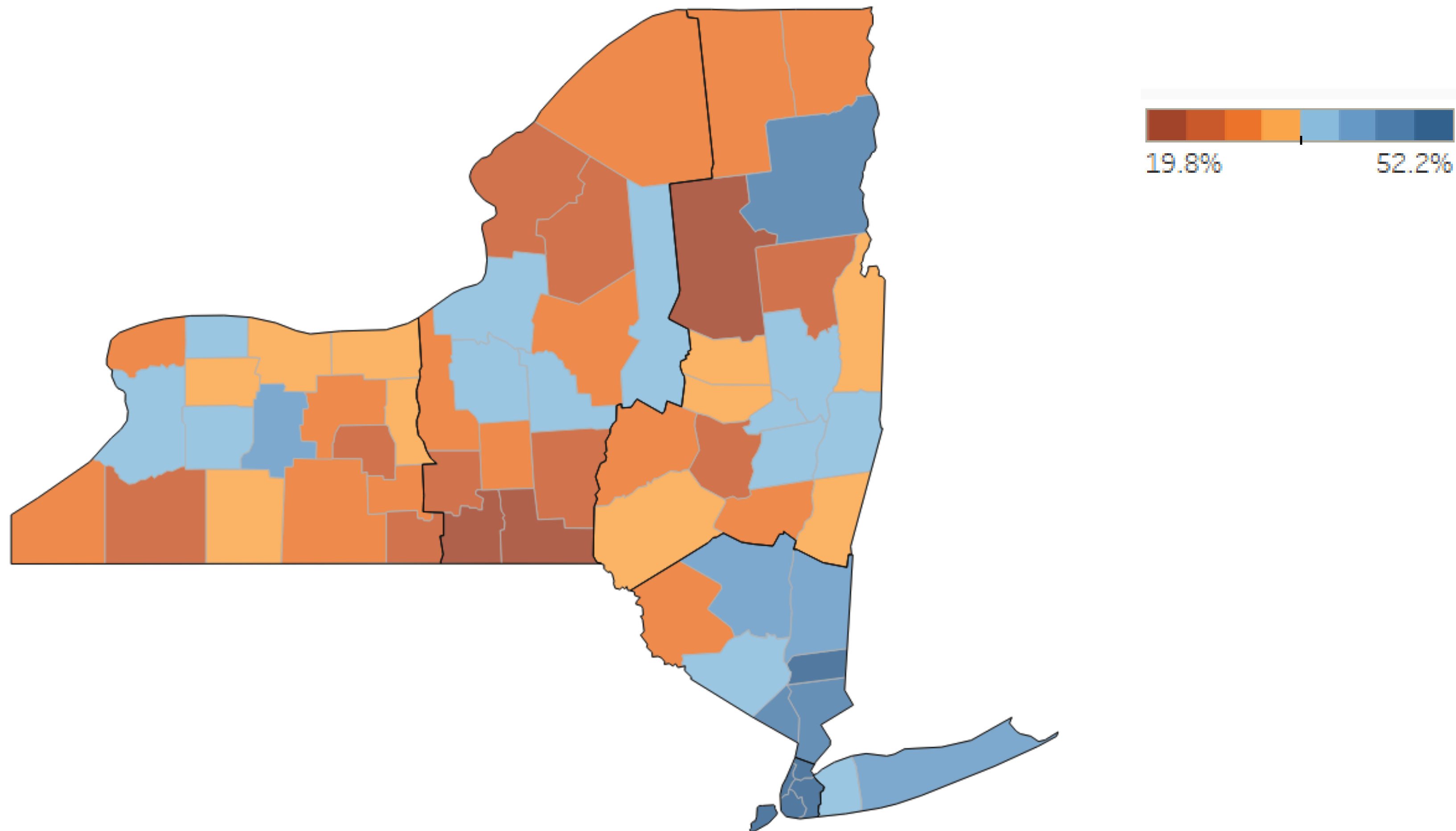
Among Members Ages 13+ in HMO/PHSP, HARP, or HIV SNP plans, By Region, 2016

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

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

Initiation of Pharmacotherapy upon New Episode of Opioid Dependence

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



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Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence

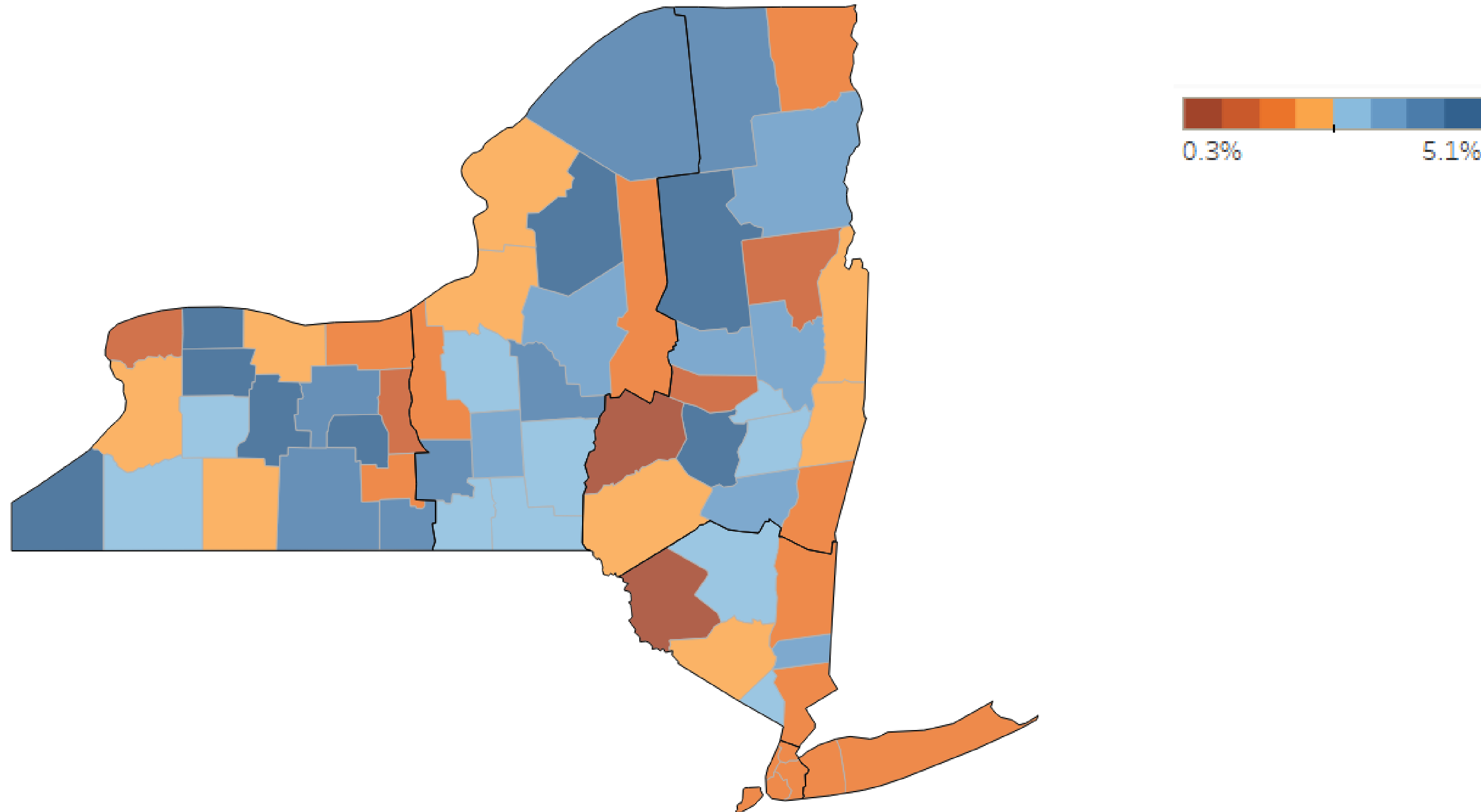
Among Members Ages 13+ in HMO/PHSP, HARP, or HIV SNP plans, By Region, 2016

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

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

Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence

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



Utilization of Pharmacotherapy upon New Episode of Opioid Dependence

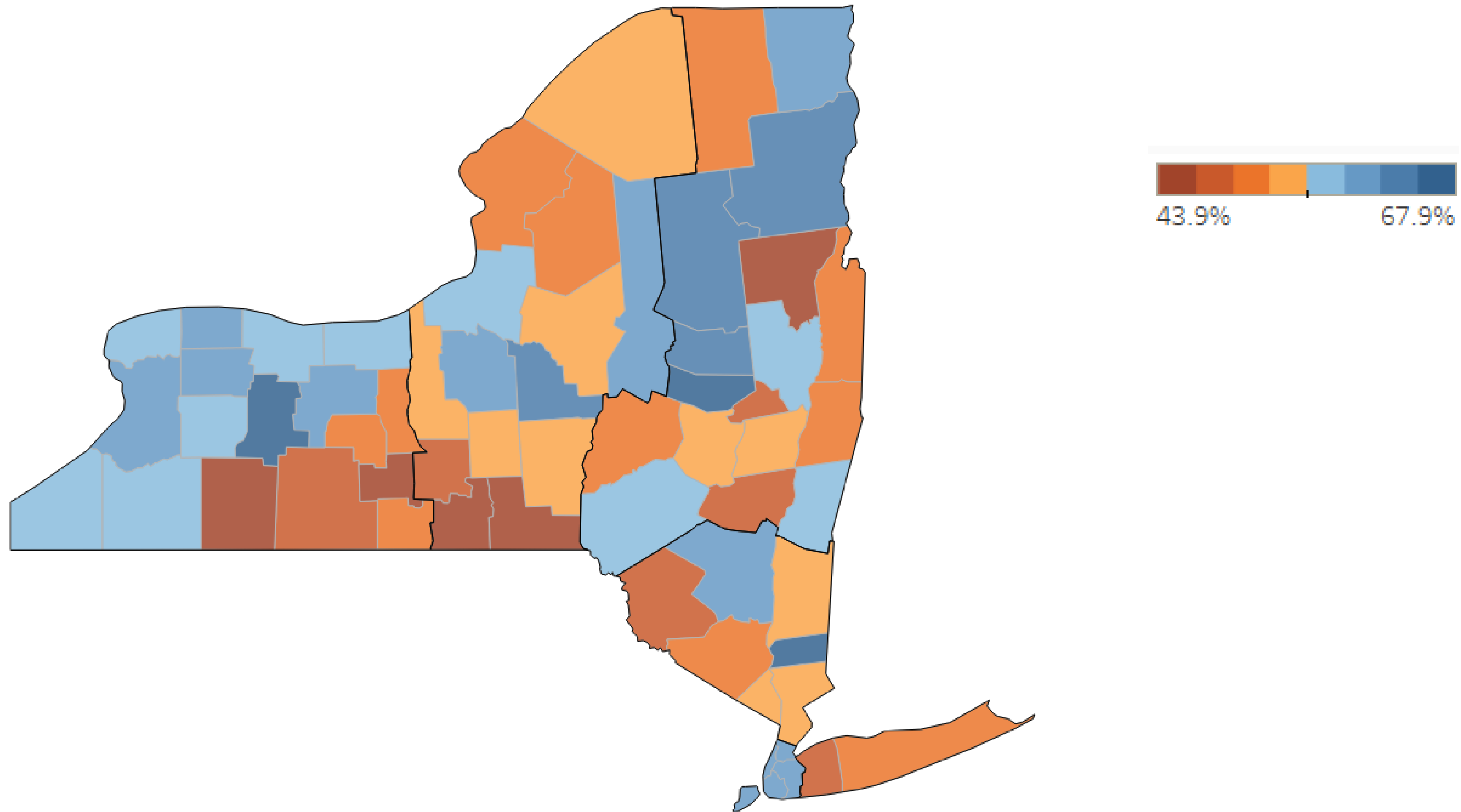
Among Members Ages 13+ in HMO/PHSP, HARP, or HIV SNP plans, By Region, 2016

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

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

Utilization of Pharmacotherapy upon New Episode of Opioid Dependence

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



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Utilization of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence

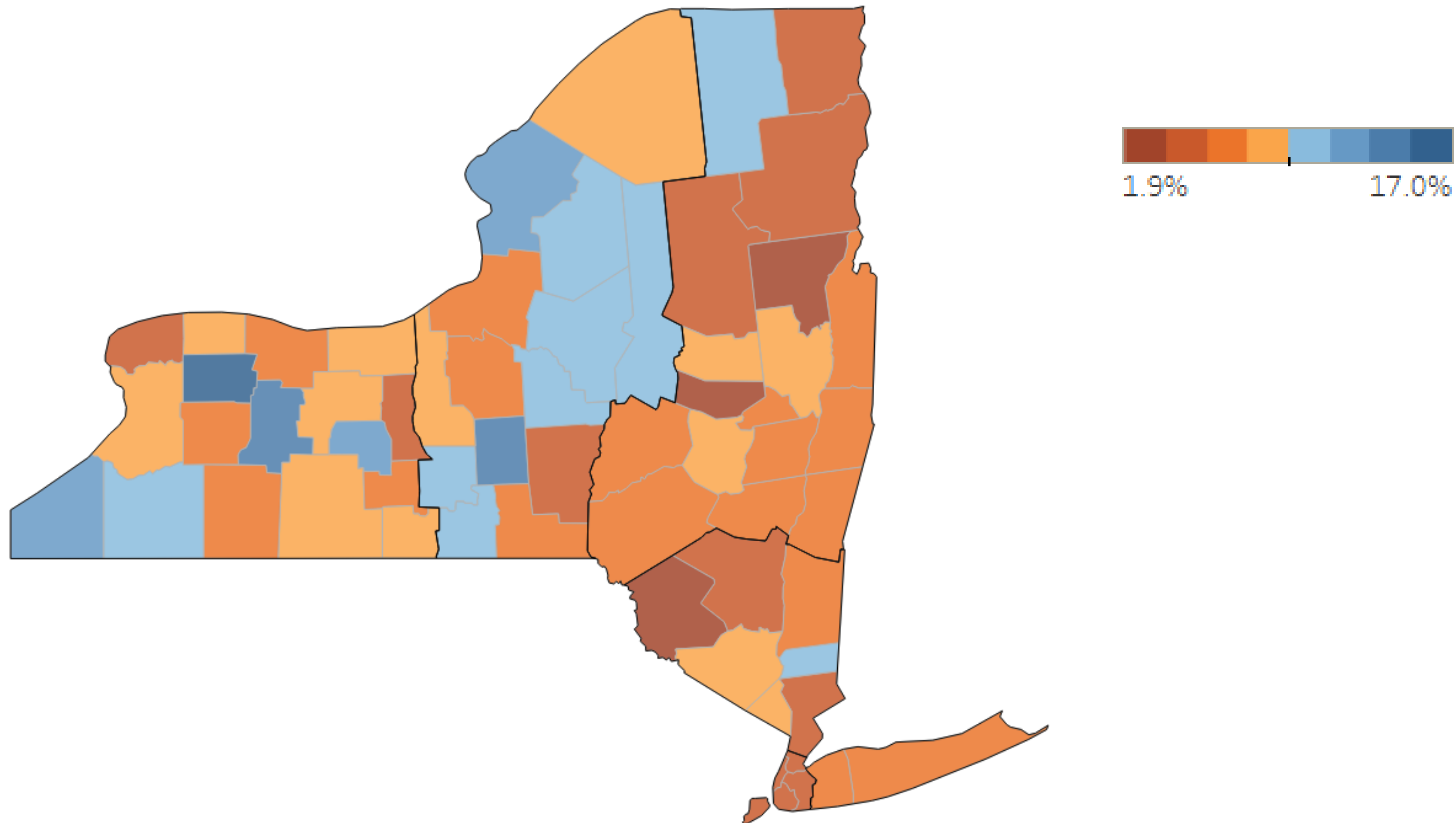
Among Members Ages 13+ in HMO/PHSP, HARP, or HIV SNP plans, By Region, 2016

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

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

Utilization of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence

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



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Work Under Development

- Continuing Engagement in Treatment (CET)
- Outcome Measures

Continuing Engagement in Treatment (CET)

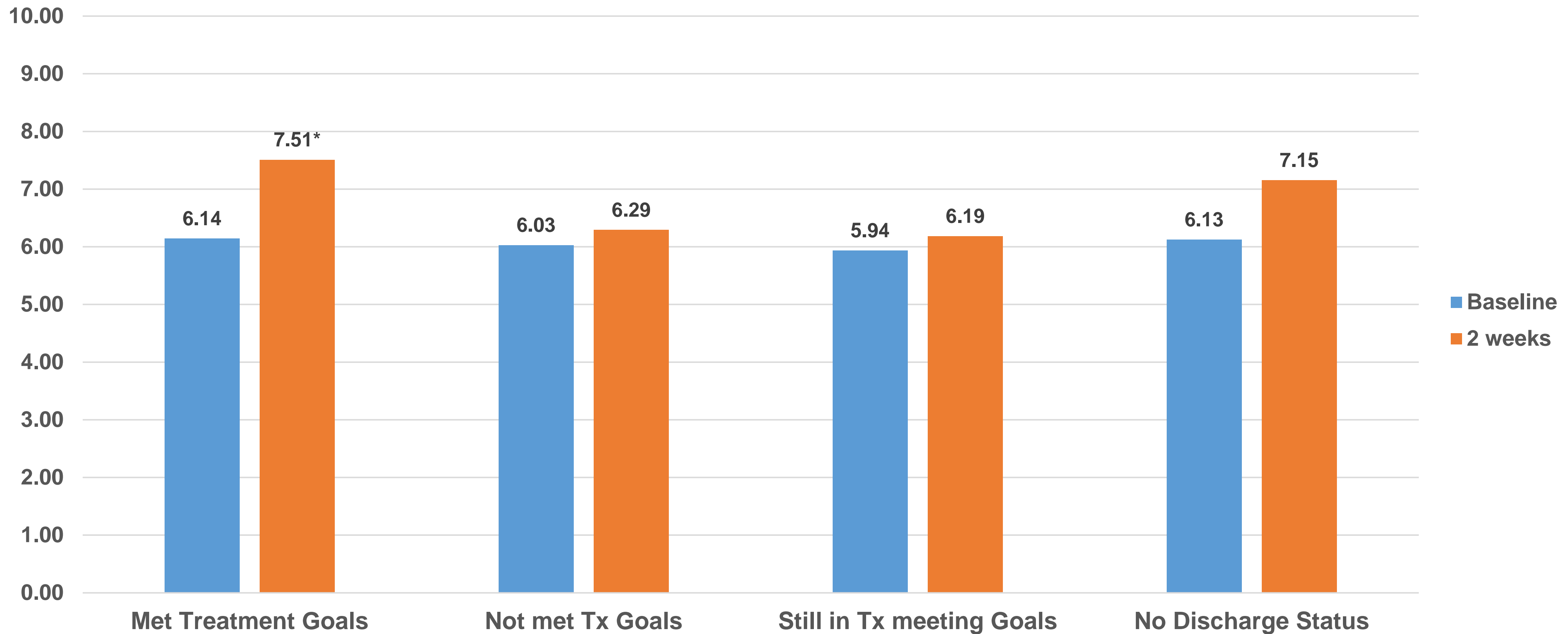
- **Description:** Percentage of individuals with at least one Alcohol and/or Other Drug dependence (AOD) treatment* within the intake period and at least one subsequent AOD treatment every 30 days thereafter for a total of 180 days from the date of the initial AOD treatment

- * AOD treatment is defined as treatment received in an AOD Inpatient Rehabilitation, AOD residential, AOD outpatient or AOD opioid treatment program.

Outcome Measures for Opioid and Substance Abuse or Dependence

Average Treatment Effectiveness Assessment* (TEA) Scores

By Discharge Completion at Baseline and 2 Weeks



* Ling W, Farabee D, Liepa D, Wu L-T. The Treatment Effectiveness Assessment (TEA): An efficient, patient-centered instrument for evaluating progress in recovery from addiction. *Substance Abuse and Rehabilitation*. 2012;3:129-136. doi:10.2147/SAR.S38902.

Source Data: The data presented here are results from a pilot study conducted from January 2017 to June 2017. Seven (7) Substance Use Disorder (SUD) providers pilot tested the TEA and TPA in their clinics.

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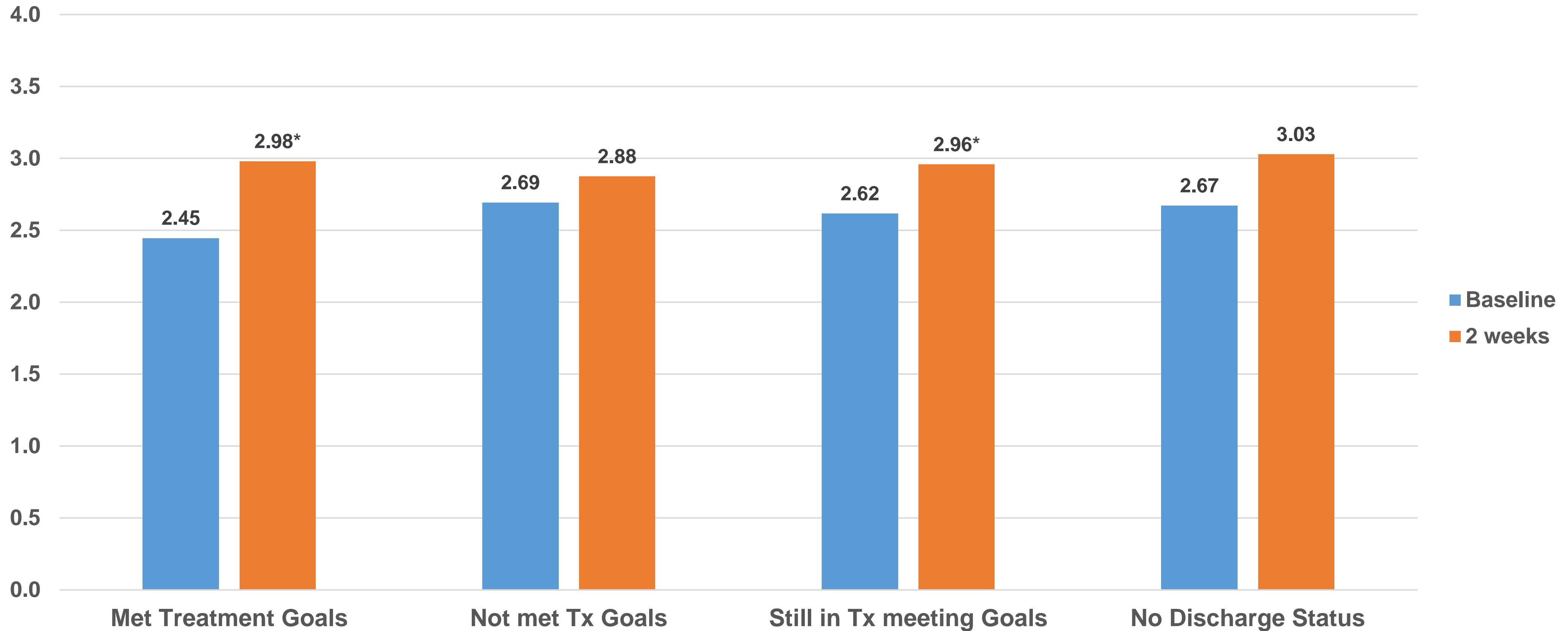
Average Treatment Progress Assessment -8 (TPA-8) Scores

By Discharge Completion at Baseline and 2 week

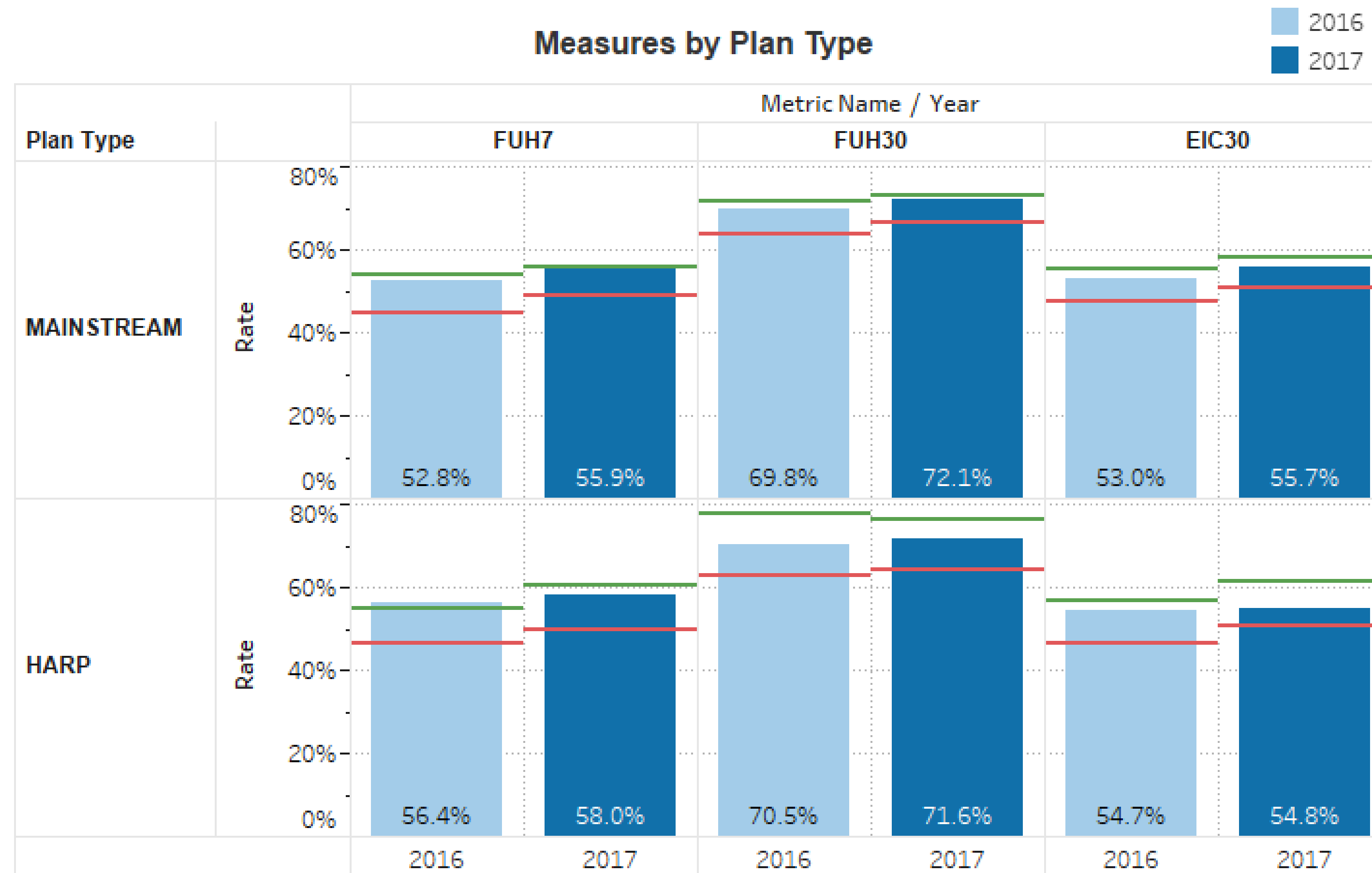


Source Data: The data presented here are results from a pilot study conducted from January 2017 to June 2017. Seven (7) Substance Use Disorder (SUD) providers pilot tested the TEA and TPA in their clinics.

Community Mental Health Measures Update

Tom Smith, MD | Office of Mental Health

Behavioral Health Measures by Plan Type



Note:

1. Red reference line represents the specific plan rate corresponding to 25th percentile of all plan rates using the nearest-rank method and green reference line represents that to 75th percentile.
2. Data was updated as of Feb, 2018 by OPME. Measures of 2017 are computed with discharges of the first two quarters only to avoid influence on rates due to Medicaid data lag.

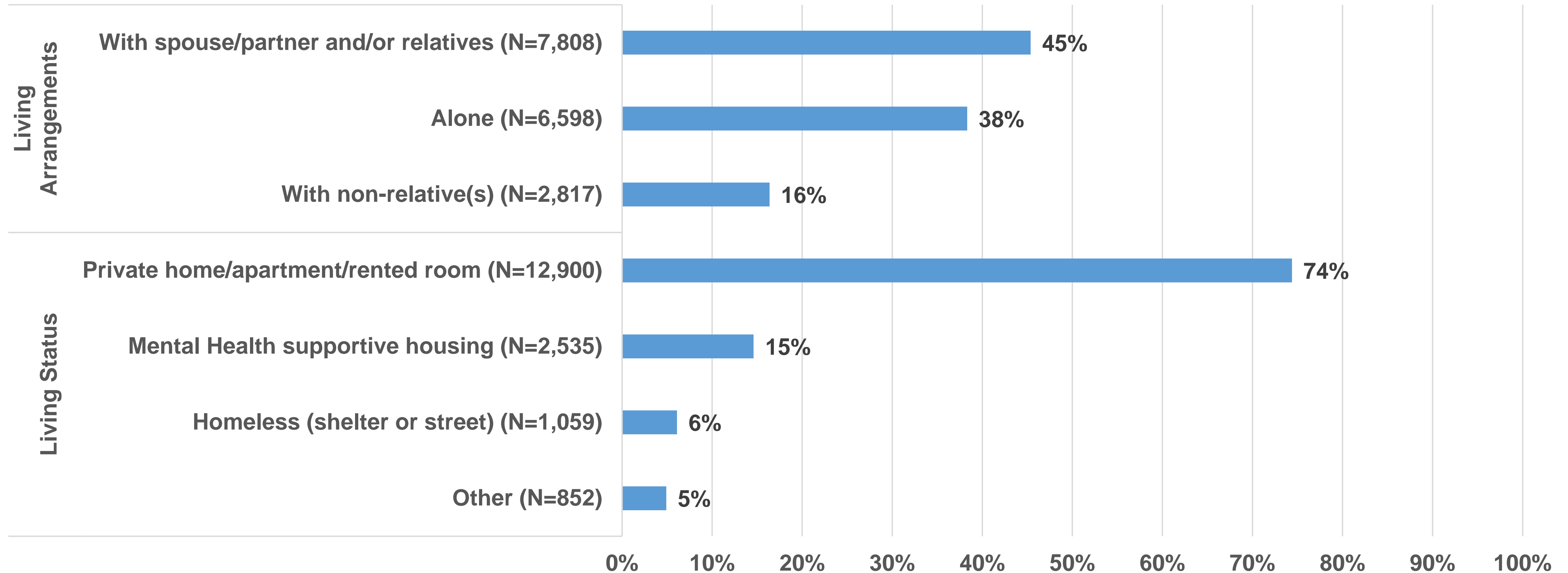
FUH7 (7-Day MH Follow-up)
FUH30 (30-Day MH Follow-up)
EIC30 (30-Day MH Engagement in Care)

New York State Community Mental Health Screening

- This analysis includes:
  - Only those who were enrolled in a HARP or HIV SNP at the time of the Community Mental Health (CMH) screen
  - If an individual had multiple screens, only data from the first complete screen was included.
  - 16,121 individuals
  - Screens completed from October 2015 – December 2017

- The Patient Characteristics Survey (PCS), conducted every two years by OMH, provides an additional source of data
  - Collects demographic, clinical, and service-related information for each person who receives a public mental health service during a specified one-week period
  - All programs licensed or funded by OMH are required to complete the survey (~4,000 mental health programs, ~180,000 patients)
  - Only OMH data source that describes all the public mental health programs in NY State
  - https://my.omh.ny.gov/analytics/saw.dll?Dashboard&PortalPath=%2Fshared%2FPCS%2F_portal%2FPatient%20Characteristics%20Survey&Page=Clients%20Served%20By%20Program%20By%20Homelessness

CMH Living Arrangements and Living Status



* Data were not available for 140 individuals

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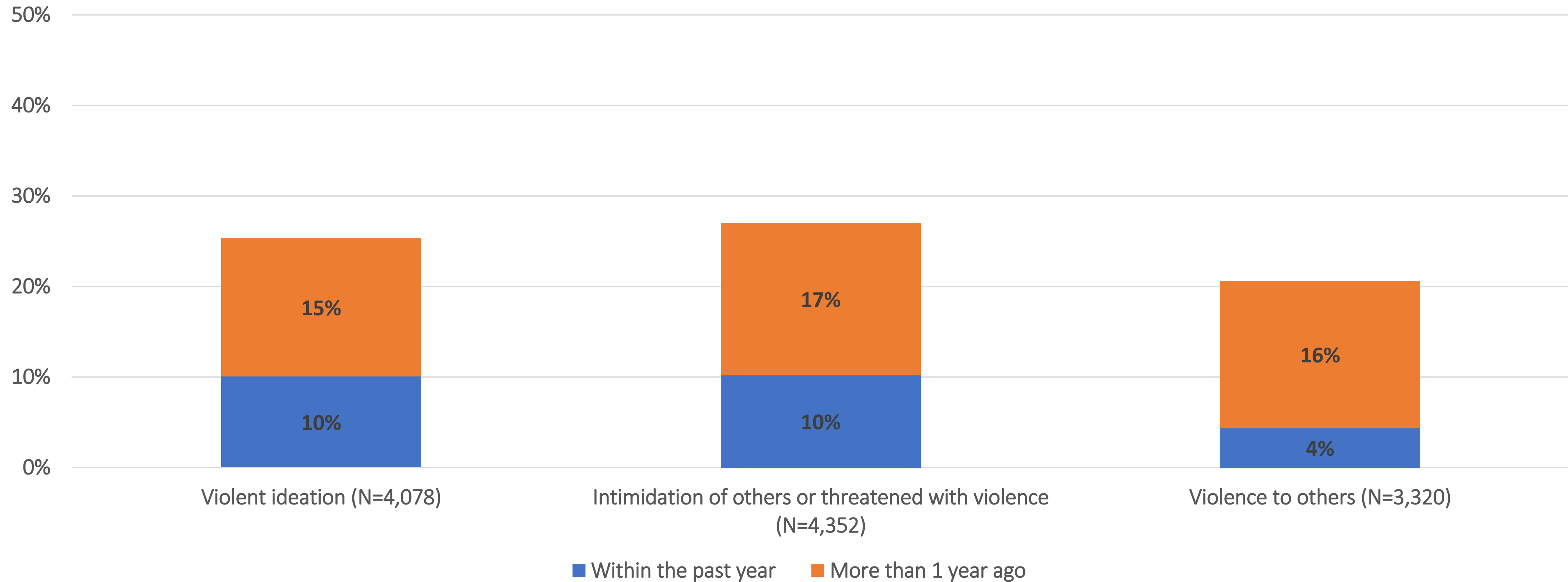
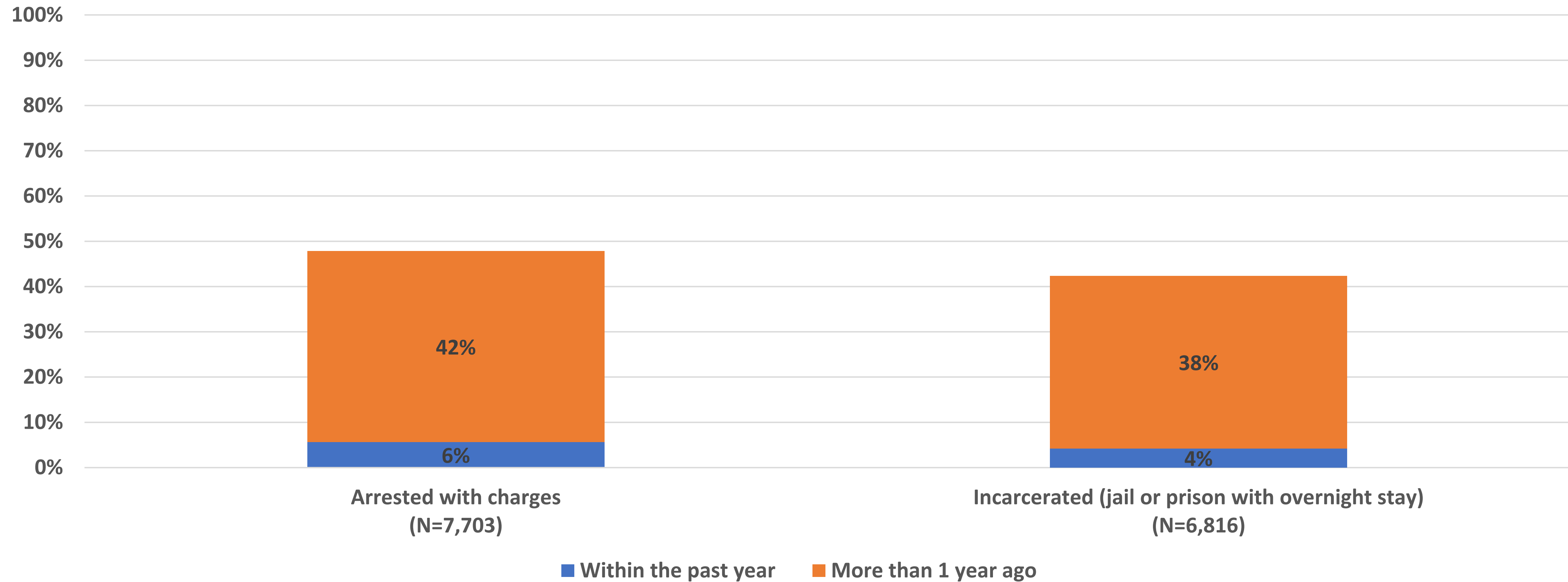
CMH Violence Indicators



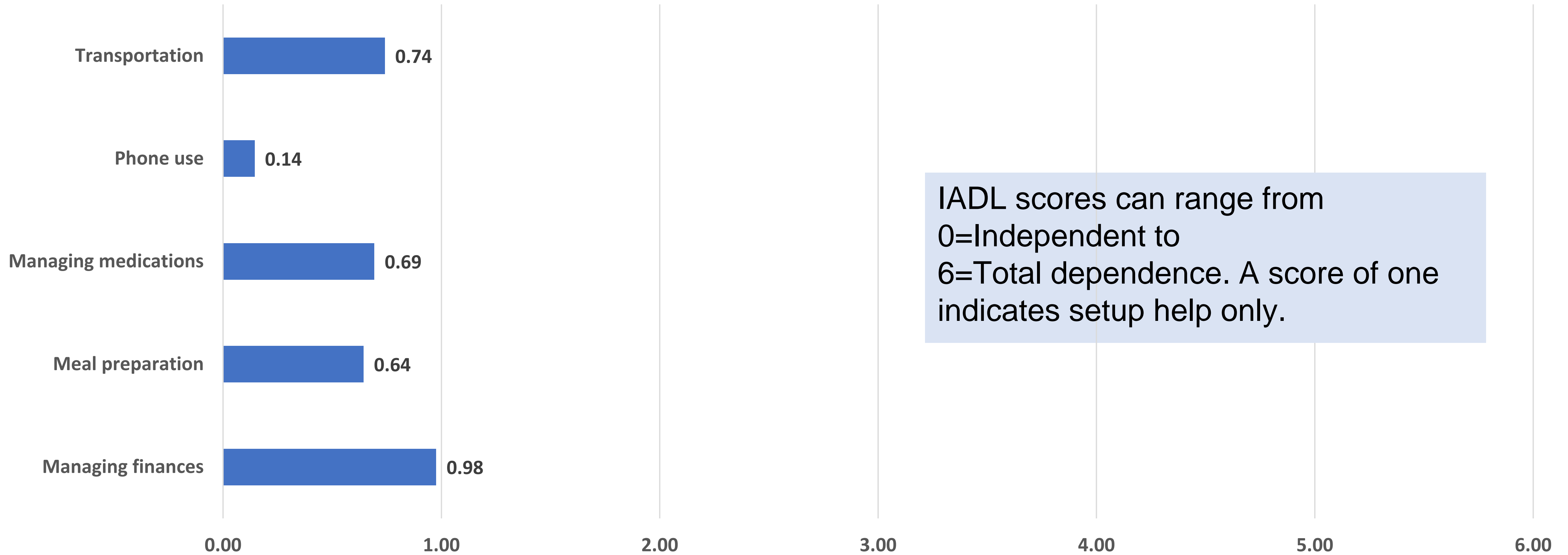
* Data were not available for 17 individuals

Select CMH Criminal Justice Indicators



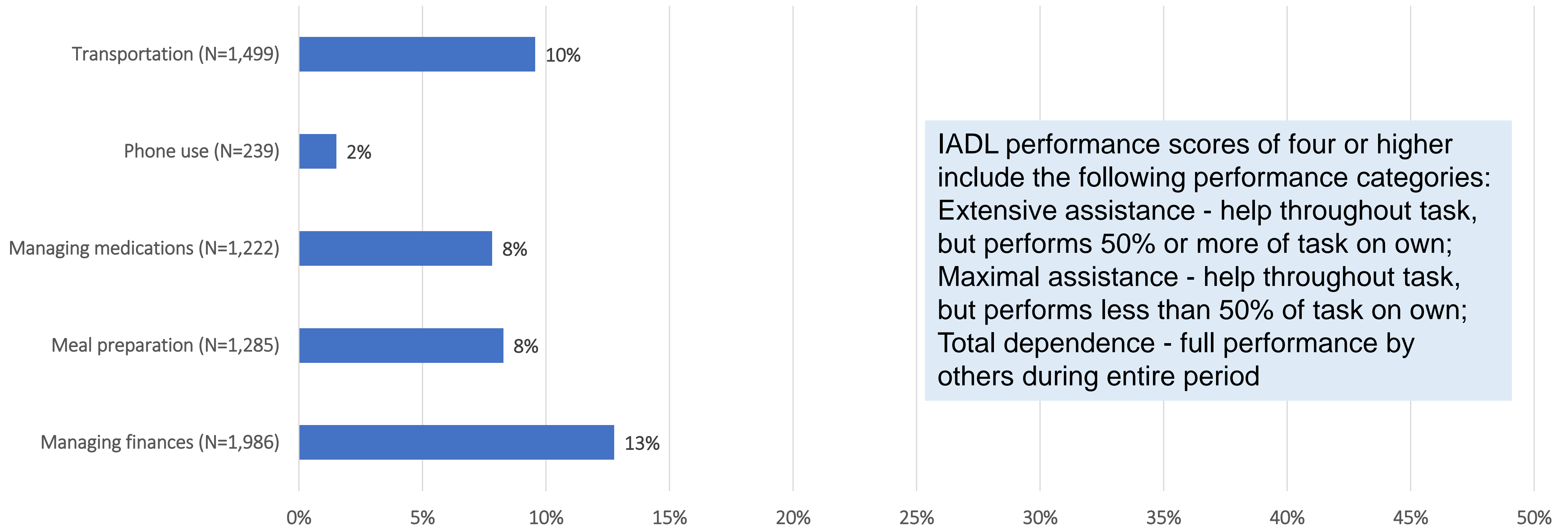
* Data were not available for 14 individuals

CMH Performance of Independent Living Skills



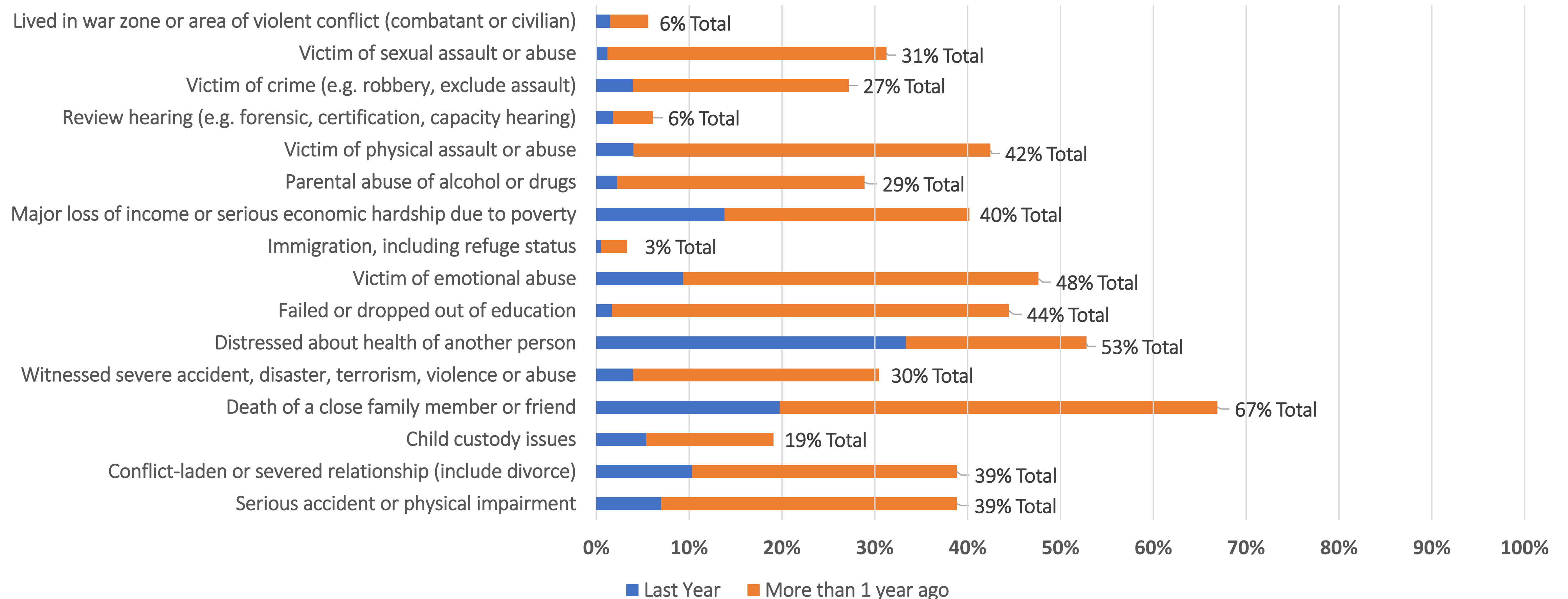
* Data were not available for 17 individuals and 562 were excluded for not performing skills within the assessment period.

CMH Performance of Independent Living Skills



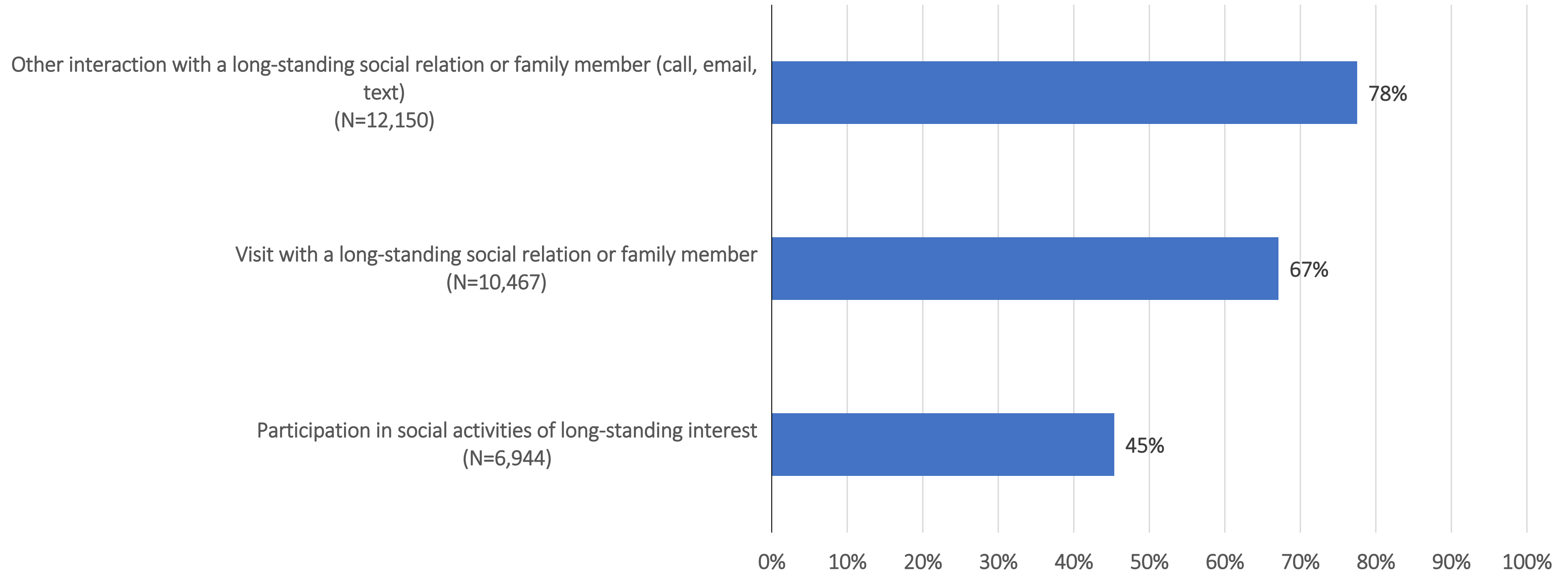
* Data were not available for 17 individuals and 562 were excluded for not performing skills within the assessment period.

CMH Life Events



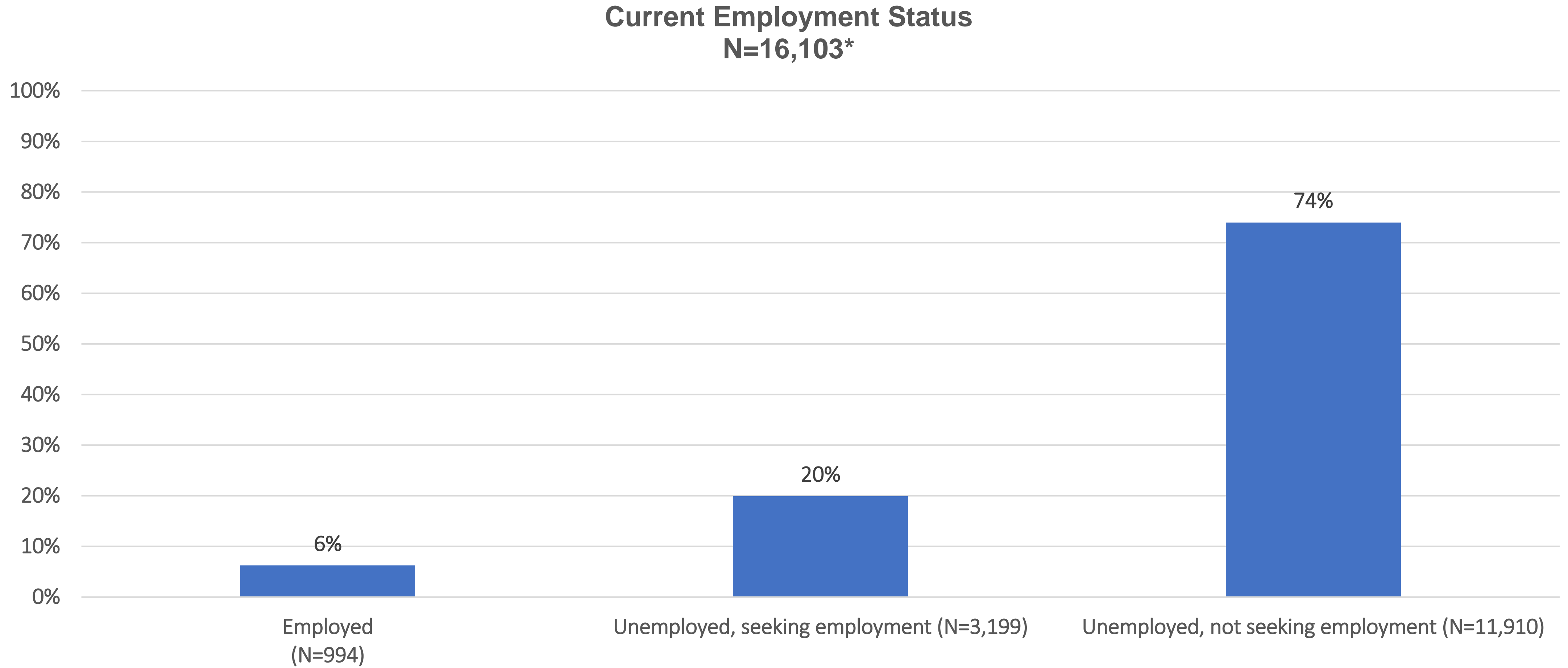
* Data were not available for 24 individuals

CMH Social Connectedness Indicators



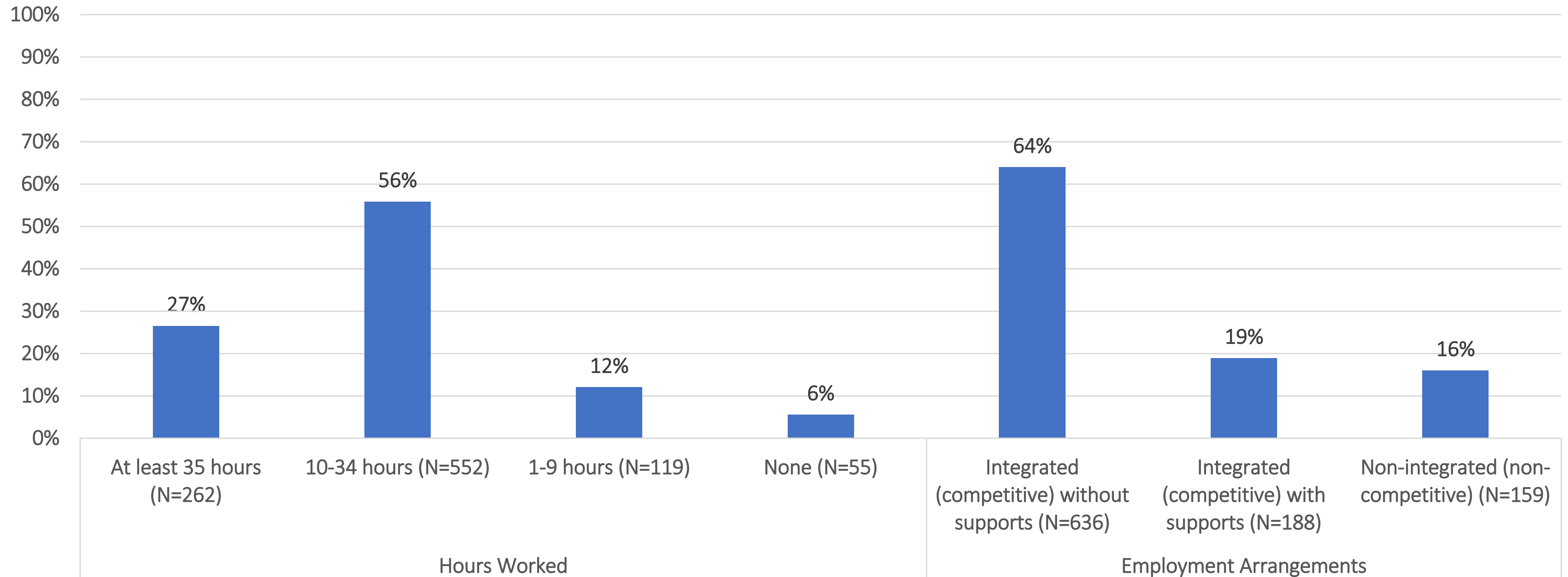
* Data were not available for 808 individuals

CMH Current Employment Status



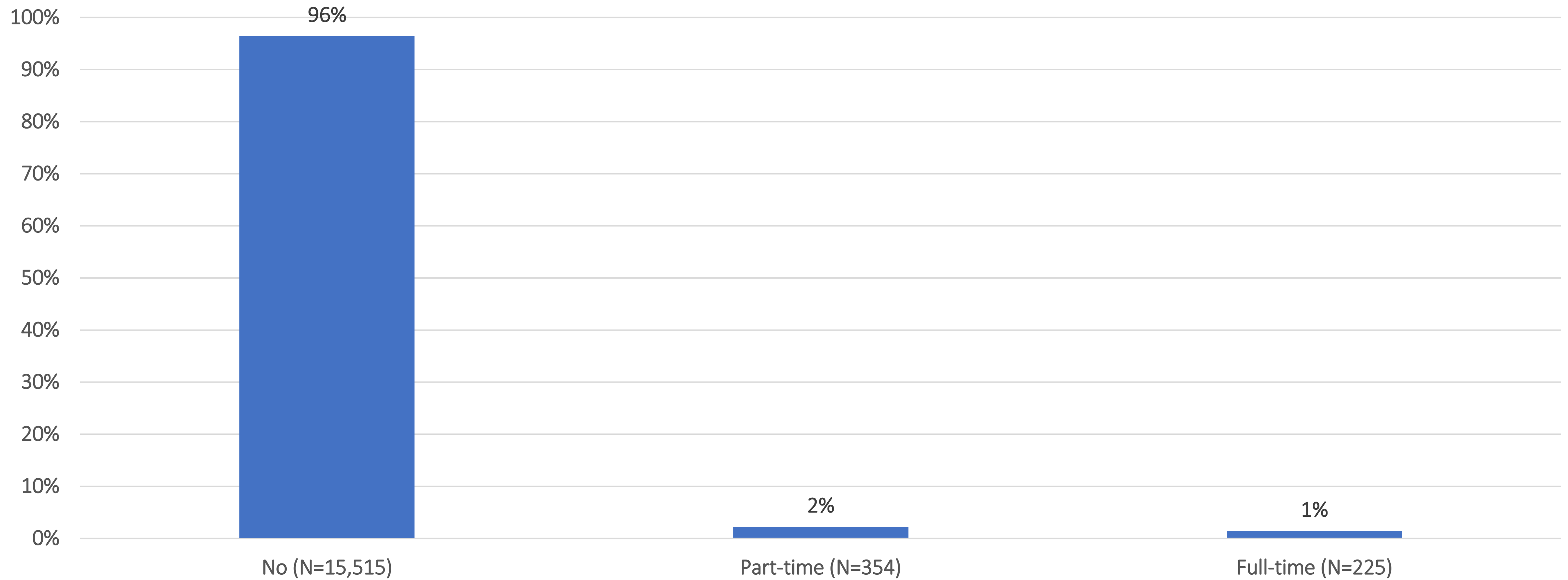
* Data were not available for 18 individuals

CMH Employment Characteristics



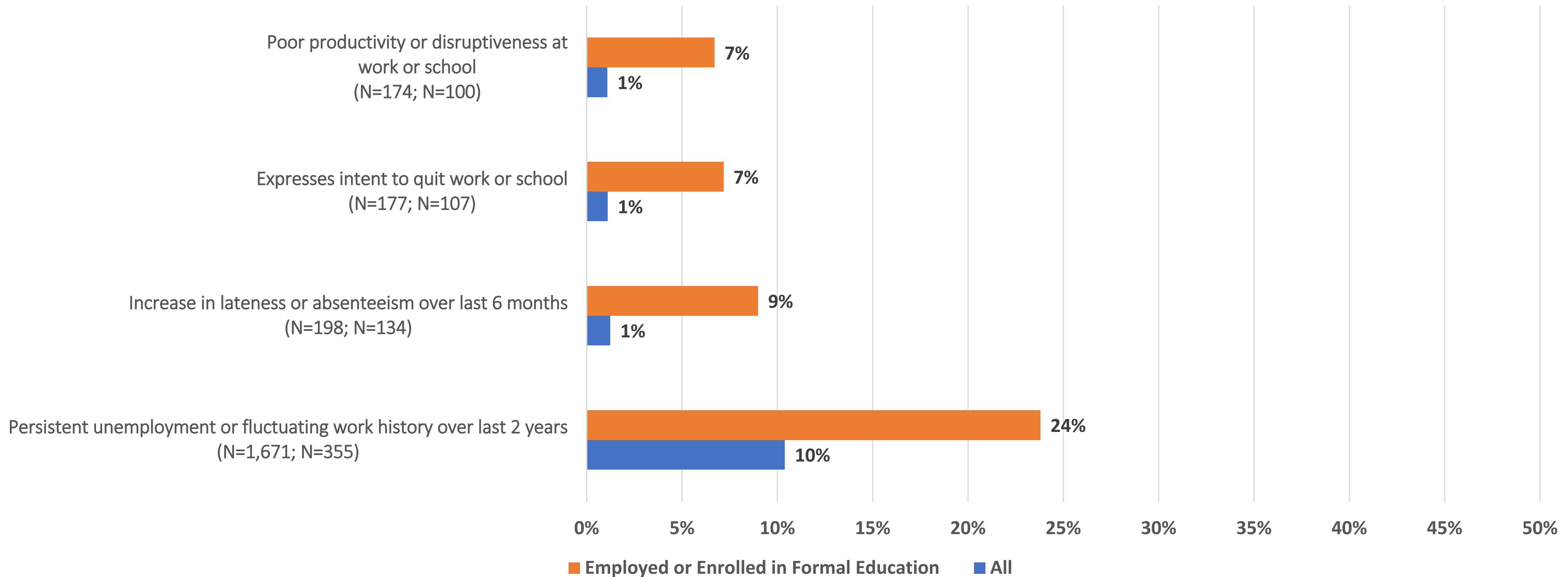
* Data were not available for 6 individuals and 15,109 individuals who were not employed were excluded

CMH Enrollment in Formal Education



* Data were not available for 27 individuals

CMH Risk of Unemployment or Disrupted Education



* Data were not available for 25 individuals

Section 4: National Quality Measurement Updates

Mental Health and Substance Use

National Quality Measurement Updates

Mental Health

<u>HEDIS 2019 public comment</u>

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

Substance Use

<u>HEDIS 2019 public comment</u>

- New Measure- Risk of Chronic Opioid Use

<u>NQF Endorsement</u>

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

Section 5: MY 2018 Priority Clinical and Care Delivery Goals

Identification of Gap Areas

Confirm and Expand Priority Clinical and Care Delivery Goals

- The initial set of Priority Clinical and Care Delivery Goals for the Total Care for the General Population (TCGP) and Integrated Primary Care (IPC) Arrangements are based on review of the BH CAG meeting materials and Measure Set recommendations.
  - Measures were associated with a clinical or care delivery goal focus area and targeted phase of care based on the measure detail and the purpose or intent for use.
- Goal setting will establish clear clinical and care delivery targets and will provide strategic direction for the State to consider in the development of a multi-year strategy and plan for the development and implementation of a high-value and responsive measure set for the TCGP and IPC arrangements.
- The following slides present an initial set of Priority Clinical and Care Delivery Goals. Clinical and Care Delivery Goals are broad-based aims for the promotion of optimal patient outcomes through the delivery of safe, effective, and efficient evidence-based care delivery for the following episodes of care:
  - Depression and Anxiety Disorders
  - Bipolar Disorder
  - Substance Use Disorder
  - Trauma and Stressors Disorders

1) Depression and Anxiety Disorders Episode

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	***Comments*** *(modifications, additional goals/ subgoals)*
1) Population at Risk	Systematic screening for Depression and Anxiety Disorders		
	Additional Goals?	– *Subgoals?*	

2) Diagnosis, Initiation and Engagement in Treatment	Care Coordination	– Use of shared care plans among primary care and behavioral health providers	
	Early Identification and Diagnosis	– Mental health consultation and diagnostic support for difficult cases – Use of standardized scale (e.g., Patient Health Questionnaire (PHQ) 2 and PQH-9 or the Generalized Anxiety Disorder Survey (GADS) 7 to facilitate diagnosis	
	Initiation of Therapy	– Patient chooses treatment in consultation with provider(s)	
	Systematic Measurement of Disease Activity and Classification Using a Standardized Scale to Facilitate Decision Making		
	Additional Goals?	– *Subgoals?*	

1) Depression and Anxiety Disorders Episode *(continued)*

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	***Comments*** *(modifications, additional goals/ subgoals)*
3) Evaluation and Ongoing Management	Enhance Patient Self-Management	– Patient education – Self-management support	
	Medication Management		
	Care Coordination	– Psychiatry consultation for treatment nonresponders	
	Proactive Follow Up and Tracking of Depression Outcomes	– Disease activity assessment using standardized scale and/or composite index – Functional status assessment using standardized scale and/or composite index – Pain assessment – Patient satisfaction	
	Relapse Prevention Plan for Patients Improving		
	Screening and Prevention of Drug Abuse and Excessive Alcohol Use		
	Suicide Risk Assessment and Prevention		
	Treat to Target	– Frequent measurement of symptoms using a validated scale – Treatment plan includes measurement of progress towards personal goals – Modification of treatment according to evidence-based guidelines	
	Additional goals?	*– Sub-goals?*	

1) Depression and Anxiety Disorders Episode *(continued)*

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	***Comments*** *(modifications, additional goals/ subgoals)*
4) Complex Treatment and Exacerbations	Care Coordination	– Use of shared care plans among primary care and behavioral health providers	
	Medication Management	– Modification of treatment according to evidence-based guidelines	
	Outcomes of Care		
	Additional goals?	– *Sub-goals?*	
5) Acute Care/ Hospitalization	Care Coordination		
	Outcomes of Care		
	Additional goals?	– *Sub-goals?*	
6) Remission	Relapse Prevention Plan for Patients in Remission		
	Additional goals?	– *Sub-goals?*	

2) Bipolar Disorder Episode

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	***Comments*** *(modifications, additional goals/ subgoals)*
1) Population at Risk	**No goals identified**		
	Additional goals?	– *Sub-goals?*	

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	Comments
2) Diagnosis, Initiation and Engagement in Treatment	Baseline Assessment	– Disease Activity Assessment and Classification – BMI assessment and monitoring for weight gain – Screening and Prevention of Drug Abuse and Excessive Alcohol Use – Suicide Risk Assessment and Prevention	
	Medication Management	– Effective Management of Antipsychotic Medications – Monitoring for adverse drug effects – Timely Initiation of Therapy	
	Patient Engagement/ Self-Management		
	Patient Education		
	Additional goals?	– *Sub-goals?*	

2) Bipolar Disorder Episode *(continued)*

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	***Comments*** *(modifications, additional goals/ subgoals)*
3) Evaluation and Ongoing Management	Chronic Disease Screening	– Cardiovascular Conditions – Diabetes	
	Disease Activity Assessment and Classification		
	Functional Status Assessment		
	Medication Management		
	Additional goals?	– *Sub-goals?*	

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	Comments
4) Acute Care/ Hospitalization	Care Coordination		
	Outcomes of Care		
	Timely Follow-Up after discharge from ED or Inpatient Care		
	Additional goals?	– *Sub-goals?*	

3) Substance Use Disorder Episode

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	*Comments* (*modifications, additional goals/ subgoals*)
1) Population at Risk	Prenatal and Postpartum Care: Substance Abuse Screening and Counseling		
	Assessment of Risky Behavior Assessment and Counseling for Adolescents		
	Screening and Counseling for Unhealthy Alcohol Use		
	Tobacco Avoidance and Cessation		
	Additional goals?	– *Sub-goals?*	

3) Substance Use Disorder Episode

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	***Comments*** *(modifications, additional goals/ subgoals)*
2) Initiation and Engagement in Treatment	Care Coordination	– Timely Initiation of Substance Abuse Treatment following Detoxification – Timely Follow-Up Care after Initiation of Treatment – Timely Initiation of Treatment after admission for substance abuse/dependence related care	
	Early Detection and Diagnosis		
	Medication	– Medication Assisted Therapy for Substance Abuse/ Dependence – Timely Initiation of Pharmacotherapy for Substance Dependence	
	Patient Engagement in Care	– Counseling regarding psychosocial and pharmacologic treatment Options for Substance Abuse	
	Additional goals?	– *Sub-goals?*	
3) Complex Treatment and Exacerbations	Substance Abuse/Dependence with Medical Co-Morbidity	– Blood Pressure Control – Healthy Weight / BMI – Depression Prevention and Management – Safe Pregnancy and Birth Outcomes – Prevention and Management of Generalized Anxiety Disorder	
	Relapse Prevention Plan for Patients Improving		
	Additional goals?	– *Sub-goals?*	

3) Substance Use Disorder Episode

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	***Comments*** *(modifications, additional goals/ subgoals)*
4) Therapeutic Interventions and Follow-up Care ***(continued on next slide)***	Completion of Treatment	– Chemical Dependency Treatment Program – Substance Abuse Treatment Program	
	Coordinated Care	– Timely Follow-Up after inpatient treatment of substance use disorders – Patient linkage to support services	
	Patient Self-Management and Engagement in Care	– Adherence to care plan – Patient education on disease management – Stable Housing – Development of skills to effectively manage cravings and urges – Patient/Family engagement of social supports	
	Psychosocial Health	– Healthy Personal Relationships – Social Connectedness – Stable Housing – Engagement in work, school, other roles – Prevention/Management of anxiety, depression, other emotional distress	
	Sustainment of Positive Treatment Outcomes	– Maintenance Pharmacotherapy for Substance Abuse	

3) Substance Use Disorder Episode

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	***Comments*** *(modifications, additional goals/ subgoals)*
(Continued)	Systematic Measurement and Outcomes Tracking	– Assessment and classification of Substance Use Disorder (SUD) severity using a standardized scale or composite index – Functional Status Assessment: – Improved Functioning in Activities of Daily Living (ADL)	
	Treat to target	– Frequent measurement of symptoms using a validated scale – Modification of treatment according to evidence-based guidelines – Treatment plan includes measurement of progress towards personal goals – Use of a standardized scale or composite index to track patient symptoms and response to treatment	
	Additional goals?	– *Sub-goals?*	

5) Remission	Relapse Prevention	– Effectively control cravings and urges – Effective coping skills for handling high-risk situations – Maintenance of lifestyle changes to prevent lapse or relapse	
	Follow-Up Care and Re-Evaluation		
	Additional goals?	– *Sub-goals?*	

4)Trauma and Stressor Disorder Episode

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	***Comments*** *(modifications, additional goals/ subgoals)*
1) Population at Risk	Screening for PTSD		
	Additional Goals?	– *Subgoals?*	
2) Diagnosis, Initiation and Engagement in Treatment	Early Detection and Diagnosis of PTSD		
	Baseline Assessment of Symptom Severity		
	Additional Goals?	– *Subgoals?*	
3) Evaluation and Ongoing Management	Symptom Management and Monitoring		
	Additional Goals?	– *Subgoals?*	
4) Acute Care/ Hospitalization	Care Coordination		
	Treatment Outcomes		
	Additional Goals?	– *Subgoals?*	

HOMEWORK: Identification of Gap Areas

Addition and Modification of Goals

- The previous slides present a view of the identified BH episode Priority Clinical and Care Delivery goals along with targeted sub-goals to support the progression to improved outcomes for the episode populations.
- The CAG is asked to review and provide recommendations to revise, strengthen, and improve the priority clinical and care delivery goals for the BH episodes included in the IPC Arrangement.
  - For example, a potential gap area is Suicide Prevention.
- Identify sub-goals or important underlying objectives for goals where possible. These sub-goals will highlight critical steps and opportunities for improvement to achieve the identified clinical goals.
- Please provide responses by May 1st

Thank you!

Please send questions and feedback to:

vbp@health.ny.gov

Appendix: Priority Clinical and Care Delivery Goals

Depression and Anxiety Disorders Episode

Phase of Care	Priority Clinical and Care Delivery Goals	
Population at Risk	Systematic screening for Depression and Anxiety Disorders	
Diagnosis, Initiation and Engagement in Treatment	Care Coordination Early Identification and Diagnosis	Initiation of Therapy Systematic Measurement of Disease Activity and Classification Using a Standardized Scale to Facilitate Decision Making
Evaluation and Ongoing Management	Enhance Patient Self-Management Medication Management Care Coordination Proactive Follow Up and Tracking of Depression Outcomes Relapse Prevention Plan for Patients Improving	Screening and Prevention of Drug Abuse and Excessive Alcohol Use Suicide Risk Assessment and Prevention Treat to Target
Complex Treatment and Exacerbations	Care Coordination Medication Management	Outcomes of Care
Acute Care/ Hospitalization	Care Coordination	Outcomes of Care
Remission	Relapse Prevention Plan for Patients in Remission	

Bipolar Disorder Episode

Phase of Care	Priority Clinical and Care Delivery Goals	
Population at Risk	*No goals identified*	
Diagnosis, Initiation and Engagement in Treatment	Baseline Assessment Medication Management	Patient Engagement/ Self-Management Patient Education
Evaluation and Ongoing Management	Chronic Disease Screening Disease Activity Assessment and Classification	Functional Status Assessment Medication Management
Acute Care/ Hospitalization	Care Coordination Outcomes of Care	Timely Follow-Up after discharge from ED or Inpatient Care

Substance Use Disorder Episode

Phase of Care	Priority Clinical and Care Delivery Goals	
Population at Risk	Prenatal and Postpartum Care: Substance Abuse Screening and Counseling Risky Behavior Assessment or Counseling for Adolescents	Screening and Counseling for Unhealthy Alcohol Use Tobacco Avoidance and Cessation
Initiation and Engagement in Treatment	Care Coordination Early Detection and Diagnosis	Medication Management Patient Engagement in Care
Complex Treatment and Exacerbations	Substance Abuse/Dependence with Medical Co-Morbidity	Relapse Prevention Plan for Patients Improving
Therapeutic Interventions and Follow-up Care	Completion of Treatment Coordinated Care Patient Self-Management and Engagement in Care Psychosocial Health	Sustainment of Positive Treatment Outcomes Systematic Measurement and Outcomes Tracking Treat to target
Remission	Relapse Prevention	Follow-Up Care and Re-Evaluation

Trauma and Stressor Disorder Episode

Phase of Care	Priority Clinical and Care Delivery Goals	
Population at Risk	Screening for post-traumatic stress disorder (PTSD)	
Diagnosis, Initiation and Engagement in Treatment	Early Detection and Diagnosis of PTSD	Baseline Assessment of Symptom Severity
Evaluation and Ongoing Management	Symptom Management and Monitoring	
Acute Care/ Hospitalization	Care Coordination	Treatment Outcomes