NEW YORK STATE | Department of Health | Medicaid Redesign Team

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

Lindsay Cogan, PhD, MS| Office of Quality and Patient Safety
Douglas G. Fish, MD | Office of Health Insurance Programs
Patricia Lincourt, LCSW | Office of Alcoholism and Substance Abuse Services
Thomas Smith, MD | Office of Mental Health

August 8, 2018

Agenda

1. Introduction — 10 min
   - Roll Call
   - Future of VBP in New York State
   - CAG Timelines & Expectations for 2018
   - VBP Timeline: Measure Integration

2. National Quality Measurement Update — 5 min
   - Mental Health and Substance Use

3. 2017 HARP VBP Pilots: Feedback from Stakeholders, Results — 45 min
   - Mt. Sinai & Maimonides

   Q&A — 15 min

4. Behavioral Health - Work Under Development — 10 min
   - BH Outcome Measures in HARP
   - All BH Measures in HARP arrangement
   - BH Outcome Measures in IPC
   - All BH Measures in IPC arrangement

5. NYS Core Outcome Measure Strategy — 5 min
   - Update on Quality Measure Consolidation

6. MY 2018 Priority Clinical and Care Delivery Goals — 25 min
   - Identification of Gap Areas

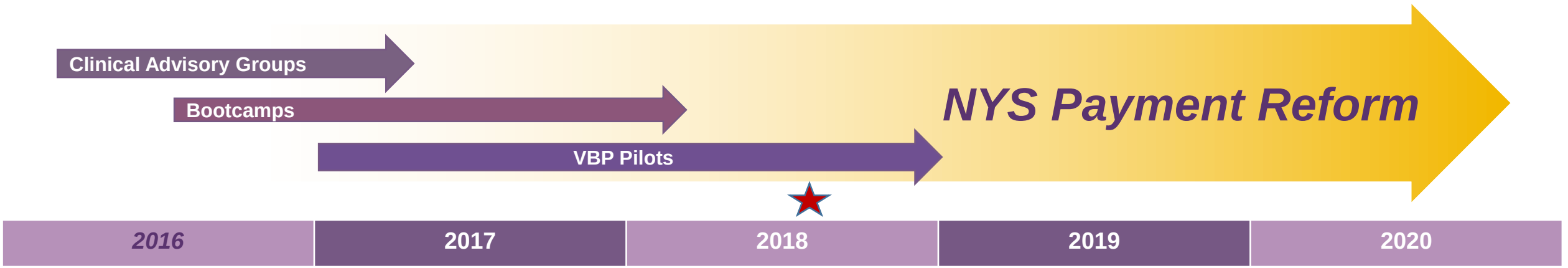
7. Wrap up and Next steps — 10 min

Section 1: Introduction

Roll Call
Future of VBP in New York State
CAG Timeline & Expectations for 2018
VBP Measure Integration Timeline

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.



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

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

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CAG Timeline & Expectations for 2018

2018 CAG Goals

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

Timeline

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

Behavioral Health Quality Measurement in NYS Medicaid VBP

- Behavioral Health (BH) Measures are included in all arrangements.

- Two arrangement types with particular BH focus
  - Health and Recovery Plan (HARP) Subpopulation arrangement
  - Integrated Primary Care (IPC), which has 4 BH-related episodes out of the 14 total episodes
    - Depression and Anxiety
    - Bipolar Disorder
    - Trauma and Stressors Disorder
    - Substance Use Disorder

VBP Quality Measure Integration Timeline

Summary of 2017 Measure Readiness by VBP Measure Set

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

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

- Of the **76** unique quality measures, **44** measures were identified as not ready for implementation based on technical specification requirements or feasibility concerns and were not included 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.

HARP VBP Arrangement Anticipated Measure Integration

	Anticipated Measure Integration			
Total New Measures	**2018**	**2019**	**2020**	**Integration Date Unknown**
	+ 3 *(1 unique)*	**+ 5** *(1 unique)*	**+ 4** *(1 unique)*	**3**
Category 1 Measures				
P4P	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	-	-	-
	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	-
	-	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)*	-
	-	-	Preventive Care and Screening: Influenza Immunization	-
	-	-	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 (As
	-	Use of Opioid Dependence Pharmacotherapy	-	Patient Self–Manag (As

Section 2: National Quality Measurement Updates

Mental Health & Substance Use

Initiation & Engagement in Treatment (IET)

HEDIS 2018 Updates and First-Year Results

• **Initiation of AOD** *(Alcohol and Other Drug Dependence)* **Treatment.** The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, *telehealth or medication assisted treatment (MAT)* within 14 days of the diagnosis.

• **Engagement of AOD** *(Alcohol and Other Drug Dependence)* **Treatment.** The percentage of members who initiated treatment and who had two or more additional AOD services *or MAT* within *34 days* of the initiation visit.

Measure	Diagnosis Cohort	Denominator	Initiation Numerator	Initiation Result	Engagement Numerator	Engagement Result
IET	Alcohol Abuse and Dependence	71,270	29,070	40.79%	9,748	13.68%
IET	Opioid Abuse and Dependence	29,805	16,137	54.14%	9,280	31.14%
IET	Other Drug Abuse and Dependence	77,380	36,171	46.74%	14,039	18.14%
IET	Total**	133,826	60,579	45.27%	26,494	19.80%

** The Total does not equal the sum of the diagnosis cohorts

National Quality Measurement Updates

Mental Health

HEDIS 2019

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

Substance Use

HEDIS 2019

- New Measure- Risk of Chronic Opioid Use

Section 3: 2017 HARP VBP Pilot Update – Mt. Sinai & Maimonides Hospital

Feedback from Stakeholders & Results

8/8 CAG Meeting

Dr. David Cohen, Maimonides Medical Center

Dr. Kishor Malavade, Maimonides Medical Center

Ms. Caroline Greene, Maimonides Medical Center

Ms. Sara Kaplan-Levenson, Maimonides Medical Center

Dr. Ian Shaffer, Healthfirst

Ms. Stephanie McLeod, Healthfirst

August 8, 2018

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Agenda

Agenda	Presenter	Time Allotment
• Data Collection and Reporting	Healthfirst	15 minutes

• Quality Measures
  • Baseline Performance
  • Performance Improvement
	Healthfirst
	MSHS, MMC, HF
		15 minutes

• Attribution Methodology	Healthfirst	5 minutes
• Patient Engagement	Mount Sinai Maimonides	10 minutes

Data Collection and Reporting

Dr. Shaffer, Healthfirst

Data Collection and Reporting

- Healthfirst collects data and reports on the existing Category 1 P4P measures
- HARP quality is extracted from the MedMeasures database
- Eligible population identification and the numerator compliance are based on the MedMeasures technical specifications
- Final selection of Category 2 measure to be determined by September 1, 2018; data collection and reporting methodology to follow

Quality Measures

Baseline performance – Dr. Shaffer, Healthfirst

Quality Measures - Baseline Performance – Mount Sinai

Quality Performance on selected quality measures

Measure	Baseline Pilot Year 1 Q1 and Q2 (Jan '17 June '17)	3 Month Consecutive Pilot Year 1 (CY2017)	
Comprehensive Diabetes Care (CDC) - HbA1c Testing	91.50%	92.22%	Numerator - 486 Denominator -527
Comprehensive Diabetes Care (CDC) - Medical Attention for Nephropathy	92.39%	92.03%	Numerator - 485 Denominator -527
Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependency (FUA) - 7 Day Rate	36.81%	34.25%	Numerator - 50 Denominator -146
Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependency (FUA) - 30 Day Rate	49.43%	45.21%	Numerator - 66 Denominator -146
Follow-up After Hospitalization for Mental Illness (FUH) - 7 Day	71.84%	70.83%	Numerator - 119 Denominator -168
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medication (SSD)	85.23%	85.02%	Numerator - 352 Denominator -414

Performance Metrics

- Pilot Year 1 annual performance in comparison to baseline (Y1 Q1 and Q2)
- Denominator – anyone who met pilot attribution for any consecutive 3 month period in the year
- Measures showing improvement are highlighted in green

Quality Measures – Mount Sinai

Quality Performance on selected quality measures

Measure	Baseline Pilot Year 1 (CY2017)	3 Month Consecutive Pilot Year 2 Q1 (Jan '18 March '18)	
Comprehensive Diabetes Care (CDC) - HbA1c Testing	92.22%	71.90%	Numerator - 325 Denominator - 452
Comprehensive Diabetes Care (CDC) - Medical Attention for Nephropathy	92.03%	79.87%	Numerator - 361 Denominator - 452
Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependency (FUA) - 7 Day Rate	34.25%	20.63%	Numerator - 13 Denominator - 63
Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependency (FUA) - 30 Day Rate	45.21%	26.98%	Numerator - 17 Denominator - 63
Follow-up After Hospitalization for Mental Illness (FUH) - 7 Day	70.83%	68.63%	Numerator - 35 Denominator - 51
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medication (SSD)	85.02%	55.66%	Numerator - 172 Denominator - 309

Pilot Year 2 annual performance in comparison to baseline (Pilot Year 1)

- Metrics to date are flat.
- We expect the annual metrics to improve through the year.
- The two Alcohol metrics are managed through our HARP team
  - Receive daily notifications through the HIE for those who qualify for the measure
  - We are using care management resources to outreach that population
  - We anticipate managing performance on these measures to grow more sophisticated over time.

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Quality Measures - Baseline performance - Maimonides

Quality Performance on selected quality measures

Measure	Baseline Pilot Year 1 Q1 and Q2 (Jan '17 June '17)	3 Month Consecutive Pilot Year 1 (CY2017)	
Comprehensive Diabetes Care (CDC) - HbA1c Testing	89.70%	**90.80%**	Numerator - 187 Denominator - 206
Comprehensive Diabetes Care (CDC) - Medical Attention for Nephropathy	95.78%	95.60%	Numerator - 197 Denominator - 206
Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependency (FUA) - 7 Day Rate	40.18%	24.70%	Numerator - 18 Denominator - 73
Follow-up After Hospitalization for Mental Illness (FUH) - 7 Day		**74.00%**	Numerator - 74 Denominator - 100
		87.40%	Numerator - 215 Denominator - 246

Pilot Year 1 annual performance in comparison to baseline (Y1 Q1 and Q2)

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Quality Measures - Maimonides

Quality Performance on selected quality measures

Measure	Baseline Pilot Year 1 (CY2017)	3 Month Consecutive Pilot Year 2 Q1 (Jan '18 March '18)	
Comprehensive Diabetes Care (CDC) - HbA1c Testing	90.80%	68.83%	Numerator - 106 Denominator - 154
Comprehensive Diabetes Care (CDC) - Medical Attention for Nephropathy	95.60%	85.06%	Numerator - 131 Denominator - 154
Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependency (FUA) - 7 Day Rate	24.70%	16.00%	Numerator - 4 Denominator - 25
Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependency (FUA) - 30 Day Rate	31.50%	28.00%	Numerator - 7 Denominator - 25
Follow-up After Hospitalization for Mental Illness (FUH) - 7 Day	74.00%	60.00%	Numerator - 18 Denominator - 30
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medication (SSD)	87.40%	57.52%	Numerator - 88 Denominator - 153

Pilot Year 2 annual performance in comparison to baseline (Pilot Year 1)

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Quality Measures

Performance Improvement

Quality Measures

Performance Improvement – Maimonides

Maimonides is implementing various approaches to performance improvement, including:

- Ongoing HARP education with providers
- Restructuring of DSRIP agreements to integrate workflows and communication protocols across the ED, inpatient, ambulatory, and community settings
- Alignment of metrics across performance-based arrangements
- Implementation of a gaps in care pilot with BHH, CBC, and Healthfirst, to improve Health Home care managers' ability to promote closure of gaps
- Focus on Health Home care management as the node of change and implementation of action plans to enhance both overall performance and HCBS connectivity

Quality Measures

Performance Improvement—Mount Sinai

- **Chase Lists for DM-related measures (similar to DSRIP)**
  - Patient must agree to enroll in Health Home for Care Coordinators to have impact
    - Therefore we still have to focus on Health Home enrollment
  - Part of general initiative in all MSHS PCP and BH practices and in affiliated practices
    - Many patients still have MSHS provider as PCP of record but no longer seeing and not seeing any PCP or BH provider
    - Again goes back to engaging into Health Home
- **FUA and FUH measures—continue to leverage ED/Inpatient Alerts**
  - Need to add diagnosis
- **Issue with data sharing/alerts and FUA:**
  - 42 CFR rules when in federally reimbursed substance abuse programs

Quality Measures

Performance Improvement – Healthfirst

Healthfirst's performance improvement strategy:

- Improve efficiency with our internal HIE so that we can better manage performance
- Drill down into the selected metrics to understand where to place emphasis
  - The value of the initial data helps point to where our efforts need to improve, i.e., the SUD follow-up measures

Attribution Methodology

Healthfirst

Attribution Methodology

Maimonides

- A HARP member who, in the applicable month:
  - (i) has been assigned to or enrolled in Brooklyn Health Home or CBC Health Home, and, is either
  - (ii) assigned to a PCP that is affiliated with Maimonides; or
  - (iii) assigned to the Healthfirst Risk pool

Mount Sinai

- A member who in the applicable month:
  - (i) has been assigned to or enrolled in the Mount Sinai Health Home and,
  - (ii) is assigned to a PCP that is affiliated with Mount Sinai.

Patient Engagement

Maimonides

Patient Engagement - Maimonides

Bedside engagement utilizing Healthix alerts and Prior Day Admissions Report

- Health Home care teams receive RHIO alerts for inpatient admissions and implement the hospitalization follow up protocol for discharge planning and post-discharge follow up
- Central staff activates multidisciplinary team for HARP members admitted to hospitals in the Community Care of Brooklyn network, including:
  - Inpatient Transitional Care Nurse
  - Inpatient Transitional Care Manager
  - Health Home Care Manager
  - Health Coach at primary care practice
- immediate deployment of a care manager from a designated CMA (ICL) to engage admitted members who are not yet Health Home enrolled to initiate enrollment, intake, and the HCBS process

Patient Engagement - Maimonides

- Provider education
  - Ongoing education and workflow sessions with ambulatory care providers: physicians, social workers, and primary care/behavioral health coaches to increase referrals and collaboration
  - Increase provider awareness by providing patient-level lists of HARP members in one large ambulatory setting
- Health Home Care Management
  - Deploy protocols to help members convert from HARP eligible to HARP enrolled
  - Provide education for care managers on HCBS services and benefits
  - Implement quality monitoring, performance improvement, and corrective action plan process for HCBS eligibility assessment and access to services
  - Deliver ongoing training and enhanced workflows on hospitalization follow up protocol and closure of gaps in care
  - Prioritization of HARP members for Health Home outreach
- HCBS education to members/potential members both at the bedside and in the community

Partner Engagement - Maimonides

HARP Network Service Providers

Providers	Scope of Services						
	Inpatient Care		Outpatient Care		Emergency Services	Health Home	Other or HCBS
	Medical Surgical	Behavioral Health	Primary Care	Behavioral Health			
Brookdale Hospital Medical Center	X	X	X	X	X		
Coordinated Behavioral Care Health Home						X	
Coordinated Behavioral Care IPA				X			
Housing Works			X	X			X
Interfaith Medical Center	X	X	X	X	X		
Kingsbrook Jewish Medical Center	X	X	X	X	X		
Maimonides Medical Center	X	X	X	X	X		
Southwest Brooklyn Health Home						X	
Wyckoff Heights Medical Center	X		X		X		
Primary Care Practices			X				
Behavioral Health Practices				X			
ICL							X

Patient Engagement

Mount Sinai

Patient Engagement – Mount Sinai

Mount Sinai/Healthfirst/Institute for Community Living HARP VBP Pilot

- **Primary Goals of Two-Year Pilot:**

1) *Increased Health Home enrollment*
2) *Increased HCBS enrollment*

Primary Aims in Year 1

3) Improvement in select quality metrics
4) Decreased ED and inpatient hospitalizations

- **Year 1 Goals (April 2017—December 2017):**
  - Establish and refine intensive and organized communication workflows and pathways (human and electronic)
  - Inter-agency data collection, organization and analysis
  - Performance measurement methodology
  - Develop best strategies re: Engagement

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Patient Engagement – Mount Sinai

April—December 2017 MSHS/ICL/HF HARP VBP Pilot Summary

KEY ACTIVITIES/ACCOMPLISHMENTS

1. **ED-based real time electronic alerts – on average 20 patients per week**
2. **Site-Based Strategy: Major PCP Practices and ED**
3. **HARP SWAT Team (for ED and inpatient)**
4. **Upfront focus on HCBS services**
5. **Average # of HH Enrollments from 11 to 24 per month**
6. **MSHS Internal CMA has highest # of HCBS Authorizations of all CMAs**

PATIENT ENGAGEMENT STRATEGY, YEAR 1

1. **<u>Point of Engagement #2: Major PCP Practices</u>**
   - Focus on Practices with largest volumes of HARP members
2. **<u>Point of Engagement #1: ED/Inpatient</u>**
   - Instituted real-time ED/Inpatient admission alerts across 5 hospitals
   - Attempted real time Face-to-Face or rapid follow up post discharge
3. **<u>Content of Engagement:</u>**
   - Use the benefits of HCBS services to drive the content of engagement

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Patient Engagement – Mount Sinai

Patient Engagement Strategy and Plan—Year 2

YEAR 2—Phase 1 (Jan – June 2018)

1. <u>Chase List strategy for High and Super High Utilizers</u>

- Develop clinical and psychosocial profile of high and super high utilizers
- Weekly review of high and super high utilizers to plan engagement strategy

2. <u>MSHS Short Term Care Management team</u> (essentially functioning as an SDE)

- For patients refusing Health Home services—extended period of engagement

3. <u>Addition of BH practices to site-based strategy</u>

- BH providers may be the best to engage these patients
- Heavy education and training, case conferencing of BH providers across system
- "Build HCBS services into the treatment plan"

YEAR 2—Phase 2 (July 2018 forward)—additional steps

1. Contracting with ICL as formal SDE for patients not regularly seen in MSHS practices
2. Contracting with ICL for peer services (as part of SDE) but also for on-site patient engagement in BH clinics with significant HARP membership

Mount Sinai

Patient Engagement – Mount Sinai

IDENTIFIED ENGAGEMENT BARRIERS/CHALLENGES

1. **Provider-level and Health Home-level barriers**

- Lack of understanding of what HCBS services and what kind of patients would benefit most
- Even with expedited process, the multiple steps and multiple people the patient must engage with is in and of itself a barrier
- Length of time allotted for Health Home Outreach (two months) may not be enough for HARP members
- Operational issues
- Provider and Coordinator expertise and understanding of the behavioral health system and working with complex behavioral health patients

2. **Patient-level**

- Extremely varied population with multiple co-morbid behavioral health and physical health conditions
- Patients not recognizing need for behavioral health treatment
- "Engaging the most difficult to engage"

KEY LESSON LEARNED: HARP MEMBERS WOULD BENEFIT FROM A STABLE AND SMALL TEAM OF PEOPLE EXPERT IN WORKING WITH COMPLEX BEHAVIORAL HEALTH CONDITIONS

Q&A/Discussion

Section 4: Behavioral Health: Work Under Development

BH Outcome Measures in HARP
All BH Measures in HARP arrangement
BH Outcome Measures in IPC
All BH Measures in IPC arrangement

Recommended HARP Behavioral Health Outcome Measures

BH / Health And Recovery Plans (HARP) Subpopulation - Outcome Measure Set 2018			
Measure	Category	Claims Based	Non-Claims Based
Comprehensive Diabetes Care: HbA1c Control < 8%	1	No	Claims, Electronic Health Data, Electronic Health Records (E.H.R.), Paper Medical Records
Comprehensive Diabetes Care: HbA1c Poor Control > 9%	1	No	Claims, Electronic Health Data, Electronic Health Records, Paper Medical Records
Controlling High Blood Pressure	1	No	E.H.R., CMS Web Interface
Maintenance of Stable or Improved Housing Status	1	No	UAS
No or Reduced Criminal Justice Involvement	1	No	UAS
Maintaining and Improving Employment or Higher Education Status	1	No	UAS

- These measures represent recommended BH outcome measures in the HARP (including physical health) set
- Looking for feedback on these measures

2018 Behavioral Health Measures Included in the HARP Quality Measure Set

Measure	State Category	Classification	BH Category
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1	P4P	BH/SUD
Continuing Engagement in Treatment (CET) Alcohol and Other Drug Dependence	2	P4R	SUD
Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care	1	P4P	SUD
Continuity of Care from Inpatient Detox to Lower Level of Care	1	P4P	SUD
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	1	P4P	Bipolar
Follow-Up After Emergency Department Visit for Alcohol or Other Drug Dependence	1	P4P	SUD
Follow-Up After Emergency Department Visit for Mental Illness	1	P4P	Depression /Anxiety
Follow-up After Hospitalization for Mental Illness (within 7 and 30 days)	1	P4P	Depression /Anxiety
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence	1	P4P	SUD
Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence	2	P4R	SUD

* Measure overlaps with Tobacco use measure in IPC Measure Set

2018 Behavioral Health Measures Included in the HARP Quality Measure Set (cont.)

Measure	State Category	Classification	BH Category
Maintaining/Improving Employment or Higher Education Status	1	P4R	SDH
Maintenance of Stable or Improved Housing Status	1	P4R	SDH
Mental Health Engagement in Care 30 Days	2	P4R	BH
No or Reduced Criminal Justice Involvement	1	P4R	SDH
Potentially Preventable Mental Health Related Readmission Rate 30 days	1	P4P	Depression/ Anxiety
Percentage of Members Enrolled in a Health Home	1	P4R	BH/SUD
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*	1	P4P	SUD
Use of Pharmacotherapy for Alcohol Abuse or Dependence	1	P4R	SUD
Use of Pharmacotherapy for Opioid Dependence	2	P4R	SUD

Recommended TCGP/IPC Health Outcome Measures

BH / Health And Recovery Plans (HARP) Subpopulation - Outcome Measure Set 2018			
Measure	Category	Claims Based	Non-Claims Based
Comprehensive Diabetes Care: HbA1c Control < 8%	1	No	Claims, Electronic Health Data, Electronic Health Records (E.H.R.), Paper Medical Records
Comprehensive Diabetes Care: HbA1c Poor Control > 9%	1	No	Claims, Electronic Health Data, Electronic Health Records, Paper Medical Records
Controlling High Blood Pressure	1	No	E.H.R., CMS Web Interface

- There are currently **no** BH outcome measures in the IPC set
- Looking for feedback on two options:
  1. Include a process-measure as a placeholder (If yes, which measure)
  2. Include an outcome measure in the future that ties back to priority clinical and delivery goals

2018 Behavioral Health Measures Included in the TCGP/IPC Quality Measure Set

Measure	State Category	Classification	BH Category
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	1	P4P	Bipolar
Adolescent Preventive Care –(4 part) Assessment and Counseling of Adolescents on Sexual Activity, Tobacco Use, Alcohol and Drug Use, Depression	1	P4R	BH/SUD
Antidepressant Medication Management - Effective Acute Phase Treatment & Effective Continuation Phase Treatment	1	P4P	Depression & Anxiety
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	1	P4P	Bipolar
Continuing Engagement in Treatment (CET) Alcohol and other Drug Dependence*	2	P4R	SUD
Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care*	2	P4R	SUD
Continuity of Care from Inpatient Detox to Lower Level of Care*	2	P4P	SUD
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Ages 13+	2	P4R	SUD
Follow-Up After Emergency Department Visit for Mental Illness Ages 6 +	2	P4R	Depression & Anxiety
Initiation and Engagement of Alcohol and other Drug Abuse Dependence Treatment (IET)*	1	P4P	SUD

* Measure overlaps with HARP Measure Set

2018 Behavioral Health Measures Included in the TCGP/IPC Quality Measure Set (cont.)

Measure	State Category	Classification	BH Category
Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence*	2	P4R	SUD
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence*	1	P4P	SUD
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	1	P4R	Depression & Anxiety
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*	1	P4R	SUD
Use of Pharmacotherapy for Alcohol Abuse or Dependence*	1	P4R	SUD
Use of Pharmacotherapy for Opioid Dependence*	2	P4R	SUD

* Measure overlaps with HARP Measure Set

Additional Behavioral Health Measures

- In Total Care General Population/Integrated Primary Care
  - Adherence to Mood Stabilizers for Individuals with Bipolar Disorder
  - Initiation of Pharmacotherapy upon New Episode of Opioid Dependence
  - Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

- Measures not in Arrangements *(More work needed)*
  - Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
  - Depression Remission or Response for Adolescents and Adults

Follow-up on Question from April 2018 BH CAG

- Patient Characteristics Survey (PCS) data
  - Provider and County level data

Section 5: NYS Core Outcome Measure Strategy

Update on Quality Measure Consolidation

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)

Quality Measure Prioritization: Goals for 2018

- Prioritize a focused list of high value quality measures for VBP in MY 2019.

- Key Principles in measure prioritization:
  - Process → Outcome
  - Gather feedback from stakeholders on what are the “right” outcomes
  - Focus on efficient measurement

- Align quality measurement efforts across stakeholder communities and State and Federal-led quality programs

- Reduce the number of measures in use for VBP

Section 6: MY 2018 Priority Clinical and Care Delivery Goals

Identification of Gap Areas / Recommendations from Stakeholders

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 were 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 helps 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 related to the 4 Behavioral Health episodes in the IPC arrangement. 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 Stressor Disorders

1) Depression and Anxiety Disorders Episode

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	*Comments* *(modifications, additional goals/ subgoals)*
	Systematic screening for Depression and Anxiety Disorders		
1) Population at Risk	**Feedback /Suggestions:** -Address Timeliness of Access for primary, secondary and tertiary access – National Council for Behavioral Health **Same Day Access Model**: https://www.thenationalcouncil.org/areas-of expertise/same-day-access/ -Perform Suicide Risk assessment e.g. Columbia Suicide Severity Rating Scale (**C-SSRS**) following a positive screen for Depression using for ex: the PHQ-9. -Use of safety and Wellness Recovery Action Plan **(WRAP)** plans, Initial Needs Assessment to appropriately gauge clinical risk. -Assess linkage to localized crisis services/unit -Explore Transitional housing gaps /respite for those in crisis but who don't rise to level of inpatient admission. (*particularly for individuals not enrolled in HARP).* -Effective engagement policies present/intact?	− *Subgoals?*	

1) Depression and Anxiety Disorders Episode

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	*Comments* *(modifications, 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 PHQ-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		
	Feedback /Suggestions: -Address Timeliness of Access for primary, secondary and tertiary access – National Council for Behavioral Health **Same Day Access Model**: https://www.thenationalcouncil.org/areas-of expertise/same day-access/ - Daily Living Activities-20 (DLA-20) –Functional needs assessed value methodology -Use of transitional case management services – particularly for those not enrolled in a Health Home.	− *Subgoals?*	

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

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	*Comments* *(modifications, additional goals/ subgoals)*
		– Patient education / Improve health literacy – Self-management support	
		– Disease activity assessment using standardized scale and/or composite index – Functional status assessment using standardized scale and/or composite index (**ex**: DLA 20 – functional needs assessed at entry and every 90 days / at treatment plan review). – Pain assessment – Patient satisfaction – internal surveys / Are you performing Collaborative Documentation in behavioral health care delivery setting?	
		- Incorporate Tobacco cessation screening	
		– 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	
	Feedback /Suggestions: -Measuring sufficient Health Home Care Management Services & HCBS linkage? -Sufficient clinical engagement **and** No-Show policy? -Non-Four walls approach? Offsite ability?		

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			
	Feedback /Suggestions: - Informed discharge plan prior to exit? - Follow up post discharge in place? - Adequate Transportation? - Address communication to grow compliance /linkage between inpatient provider and downstream outpatient care. - Qualified Entity (QE/RHIO) connectivity? Informed about patient being discharged in E.H.R?		
6) Remission	Relapse Prevention Plan for Patients in Remission		
	Feedback /Suggestions: -What is your clinical engagement policy?	− *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?*	
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	– *Health Literacy Assessment?*	
	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	− DLA 20 or similar –performed at initiation and engagement in treatment and at each treatment plan review	
	Medication Management		
		− *Sub-goals?*	
4) Acute Care/ Hospitalization	Care Coordination Outcomes of Care Timely Follow-Up after discharge from ED or Inpatient Care		
	Feedback /Suggestions: - Informed discharge plan prior to exit? - Follow up post discharge in place? - Adequate Transportation? - Address communication to grow compliance /linkage between inpatient provider and downstream outpatient care. -QE (RHIO) connectivity? Informed about patient being discharged in E.H.R?	− *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	***Use of SBIRT / LOCDTR***	
	Tobacco Avoidance and Cessation		
	Feedback /Suggestions: -Address Timeliness of Access for primary, secondary and tertiary access – National Council for Behavioral Health **Same Day Access Model**: https://www.thenationalcouncil.org/areas-of expertise/same day-access/ -Clinical engagement policies? -Just-In-Time scheduling – innovative scheduling methodology – promotes quick access to psychiatry, encourages self-management of care, decreases no shows and patient engagement. -Use of Ancillary Detox and Withdrawal services as needed -Groups -Link to Community supports -Vaping or Nicotine Inhalation Avoidance and Cessation -Screening for Tobacco and Nicotine Inhalation -Counseling for Tobacco and Nicotine Avoidance and Cessation	– *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	− *Screening tools – SBIRT and LOCDTR*	
	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	
	Feedback /Suggestions: - Use of Treatment planning, interventions and groups, focused on different stages of recovery - Use of Ancillary Detox. and Withdrawal services in conjunction with care provision. - Care management services to address social determinants of health. - Groups	− *Sub-goals?*	

3) Substance Use Disorder Episode

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	Subgoals	*Comments* *(modifications, additional goals/ subgoals)*
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		
	Feedback /Suggestions: -PTSD Screening tool possibly PTSD Checklist-Civilian, Adverse Childhood Experiences (CACS)	– *Subgoals?*	
2) Diagnosis, Initiation and Engagement in Treatment	Early Detection and Diagnosis of PTSD		
	Baseline Assessment of Symptom Severity		
	Feedback /Suggestions: -Use of Trauma informed care, clinically effective treatment interventions e.g. Cognitive Therapy (CT), Dialectical Behavior Therapy (DBT), Exposure therapy, Eye Movement Desensitization and Reprocessing (EMDR), use of “non-4 walls” approach to care.	– *Subgoals?*	
3) Evaluation and Ongoing Management	Symptom Management and Monitoring		
	Feedback /Suggestions: -see above, use of support groups -ongoing risk assessment -Physical Health assessment and referral to PCP	– *Subgoals?*	

4)Trauma and Stressor Disorder Episode

4) Acute Care/ Hospitalization	Care Coordination Treatment Outcomes **Feedback /Suggestions:** -reduce barriers to treatment adherence through enhanced outreach. -referrals to specialized hospitals -increase in training for inpatient units regarding trauma informed care.	− *Subgoals?*	

Summary / Takeaways

- Please provide any feedback on the HARP VBP Quality Measure set and send suggestions or recommendations.
- Consider the content of the *Closing Care Gaps* document and provide any recommendations of BH outcome measures that drive value.
- Provide any additional feedback and send your recommendations to Valerie Clark Valerie.clark@health.ny.gov by August 22, 2018.

Next Steps

- In early October, we will present the 2019 measure set to the approving body, the VBP Workgroup.

- Expect release of the 2019 VBP Quality Measure sets and the MY 2018 VBP Reporting Requirements Technical Specifications Manual in late October or early November.

Thank you!

Please send questions and feedback to:

vbp@health.ny.gov