NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

Using PSYCKES and the VSD for Health Disparities

We will begin shortly…

To hear the webinar, click "Call Me" in the Audio Connection box and enter your phone number - the WebEx system will call your phone

If you do not see the Audio Connection box, go to the top of your WebEx screen, click "Communicate" > "Audio Connection" > "Join Teleconference"

Michelle Hand
Research Scientist, Medical Informatics
Office of Population Health & Evaluation
September 12, 2023

Agenda

- PSYCKES overview
- Search using health disparity filters in Recipient Search
- Review client-level details within the Clinical Summary
- My QI Report
  - Health disparity-related measures
  - Race & Ethnicity view
- View prevalence rates in Statewide Reports
- Vital Signs Dashboard (VSD)
- Training and Technical Assistance

PSYCKES Overview

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What is PSYCKES?

- A secure, HIPAA-compliant online platform for sharing Medicaid billing data and other state administrative data
- Designed to support data-driven clinical decision-making, care coordination and quality improvement
- Ongoing data updates
  - Clinical Summary updated weekly
  - Quality Indicator reports updated monthly

Who is Viewable in PSYCKES?

- Over 11 million NYS Medicaid enrollees (currently or previously enrolled)
  - Fee for service claims
  - Managed care encounter data
  - Dual-eligible (Medicare/Medicaid): Medicaid data only
- Behavioral Health Population, i.e., at least one of the following:
  - Psychiatric or substance use service,
  - Psychiatric or substance use diagnosis, OR
  - Psychotropic medication
- Provides all data – general medical, behavioral health, residential

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What Data is Available in PSYCKES?

- Clinical Summary provides up to 5 years of data, updated weekly
- All Medicaid billing data, across treatment settings
  - Medications, medical and behavioral health outpatient and inpatient services, ER, health home care coordination, housing and residential, lab, and more!
- Multiple other state administrative databases (0-7 day lag):
  - New York City Department of Homeless Services (NYC DHS)
  - Health Home enrollment & CMA provider (DOH MAPP)
  - Managed Care Plan & HARP status (MC Enrollment Table)
  - MC Plan assigned Primary Care Physician (Quarterly, DOH)
  - Assisted Outpatient Treatment provider contact (OMH TACT)
  - Assertive Community Treatment provider contact (OMH CAIRS)
  - Adult Housing/Residential program Information (OMH CAIRS)
  - IMT and AOT Referral Under Investigation (DOHMH)
  - State Psychiatric Center EMR
  - Suicide attempt (OMH NIMRS)
  - Safety plans, screenings, assessments entered in PSYCKES MyCHOIS

Quality Indicators “Flags”

- PSYCKES identifies clients flagged for quality concern in order to inform the treating provider and to support clinical review and quality improvement
- When a client has a quality flag, the provider is allowed access to that individual’s Clinical Summary
- Examples of current quality flags include:
  - Vital Signs Dashboard – Child, e.g., No Well-Care Visit Past Year, Immunization for Adolescents – No HPV or Meningococcal
  - Vital Signs Dashboard – Adult., e.g., No Follow Up after MH Inpatient – 7 Days
  - Medication-Related, e.g., No Follow Up for Child on ADHD Med
  - Acute Care Utilization, e.g., High utilization, Readmission
  - General Medical, e.g., No Outpatient Medical Visit > 1 year

What Types of Reports Are Available?

- Individual Client Level Reports
  - Clinical Summary: Medicaid and State PC treatment history, up to 5 years
- Provider Agency Level Reports
  - Recipient Search Reports: run ad hoc reports to identify cohorts of interest and health disparities
  - My QI Report: current performance on all quality indicators, drill down to client-level views
  - PSYCKES Usage Reports: monitor PHI access by staff
  - Utilization Reports: support provider VBP data needs
- Statewide Reports
  - Can select a quality indicator and review statewide proportions by region, county, plan, network, or provider

Recipient Search

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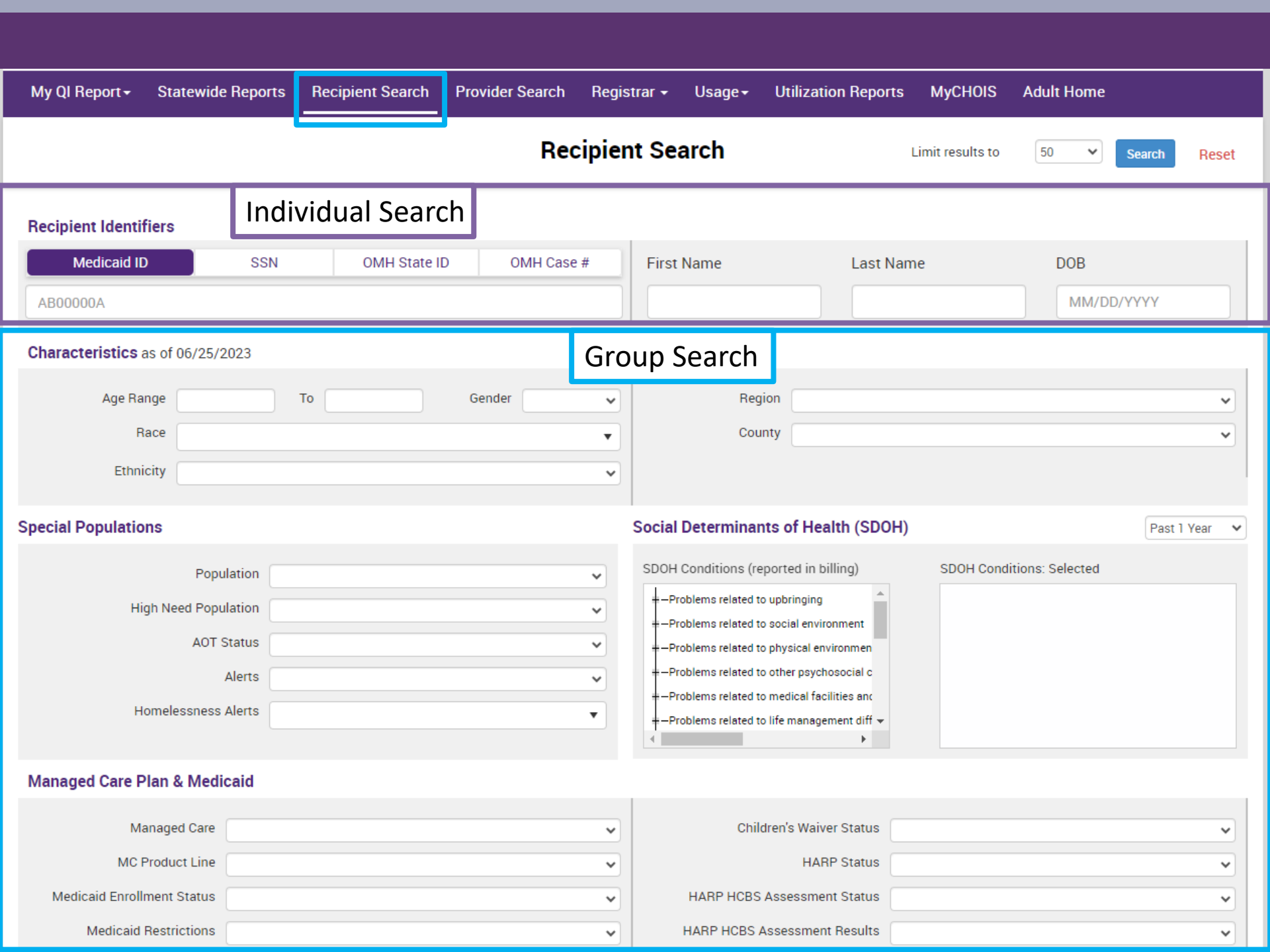
Recipient Search Options

- **Individual Search**
  - Look up one person to view their Clinical Summary
- **Group Search**
  - Flexible search to identify cohort of individuals served in your agency/hospital who meet specified criteria, for example:
    - Race or ethnicity
    - County or region
    - Social Determinants of Health (SDOH) domains or conditions
    - Those experiencing homelessness (any homelessness past year, shelter, unsheltered, outreach, etc.)
    - High utilizers or high-cost individuals
- We have **Advanced Views**! Focus your search results using any of the following Advanced View categories:
  - Care Coordination, High Need/High Risk, Hospital Utilization, Outpatient Providers


My QI Report
Statewide Reports
Recipient Search
Provider Search
Registrar
Usage
Utilization Reports
MyCHOIS
Adult Home
Recipient Search
Limit results to
50
Search
Reset
Individual Search
Recipient Identifiers
Medicaid ID
SSN
OMH State ID
OMH Case #
AB00000A
First Name
Last Name
DOB
MM/DD/YYYY
Group Search
Characteristics as of 06/25/2023
Age Range
To
Gender
Race
Ethnicity
Region
County
Special Populations
Population
High Need Population
AOT Status
Alerts
Homelessness Alerts
Social Determinants of Health (SDOH)
Past 1 Year
SDOH Conditions (reported in billing)
Problems related to upbringing
Problems related to social environment
Problems related to physical environmen
Problems related to other psychosocial c
Problems related to medical facilities and
Problems related to life management diff
SDOH Conditions: Selected
Managed Care Plan & Medicaid
Managed Care
MC Product Line
Medicaid Enrollment Status
Medicaid Restrictions
Children's Waiver Status
HARP Status
HARP HCBS Assessment Status
HARP HCBS Assessment Results

Social Determinants of Health (SDOH)

Past 1 Year

SDOH Conditions (reported in billing)

SDOH Conditions: Selected

- Problems related to housing and economic circumstances
  - Housing instability, housed, with risk of homelessness
  - Inadequate housing
  - Insufficient social insurance and welfare support
  - Other problems related to housing and economic circumstances
  - Material hardship
  - Transportation insecurity
  - Lack of adequate food
  - Extreme poverty

Select a domain category or expand the domain category to select a specific SDOH condition within that domain (up to 4 different SDOH filters can be selected at one time)

Children's Waiver Status

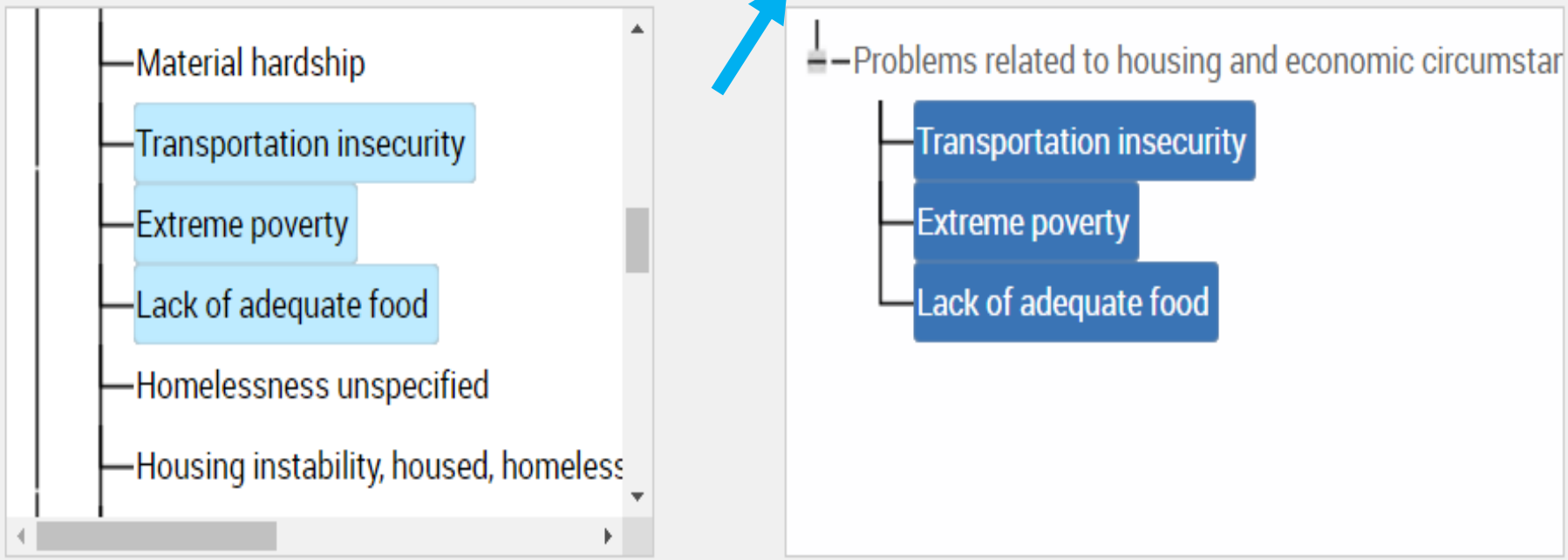
HARP Status

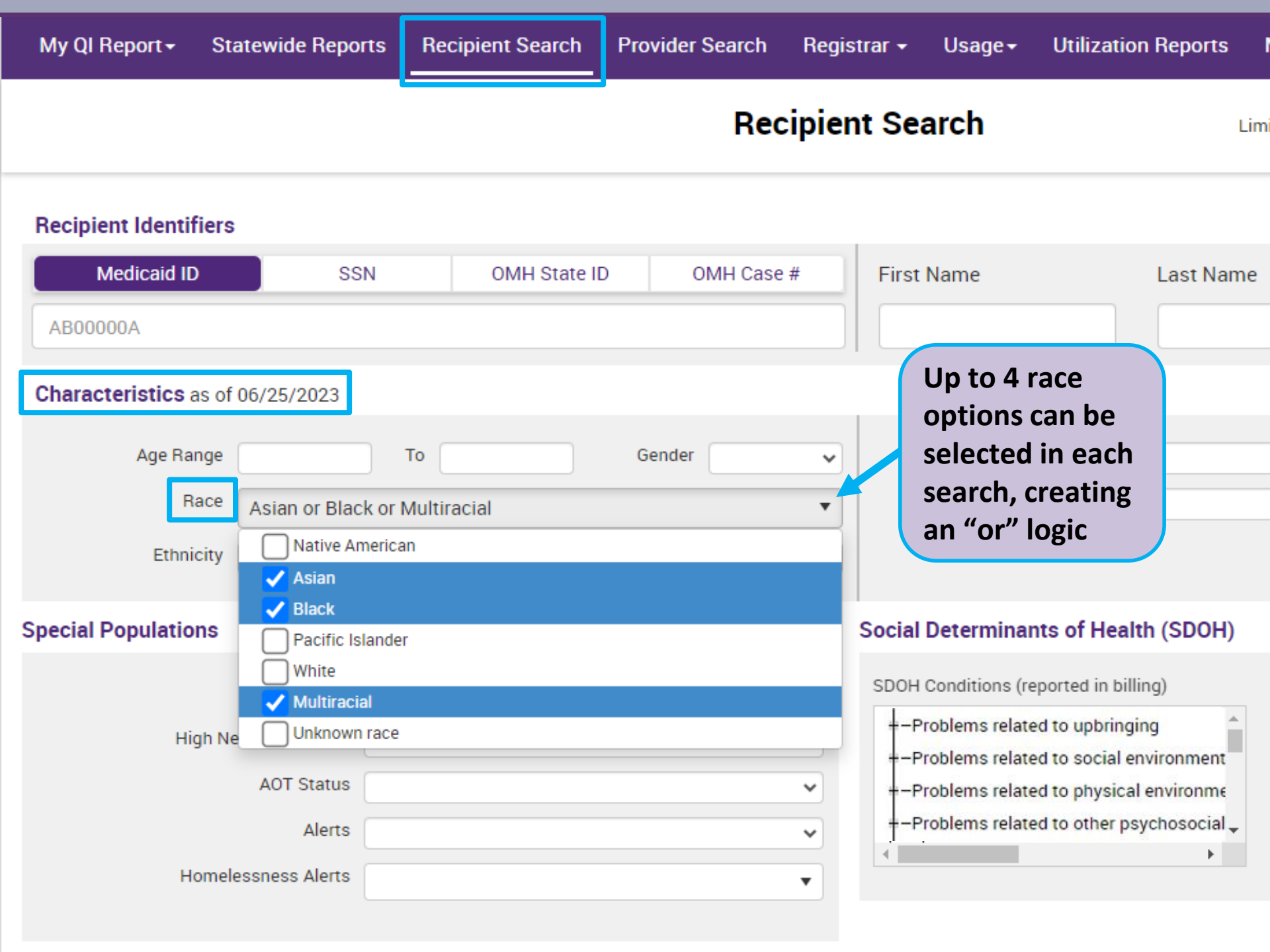
HARP HCBS Assessment Status

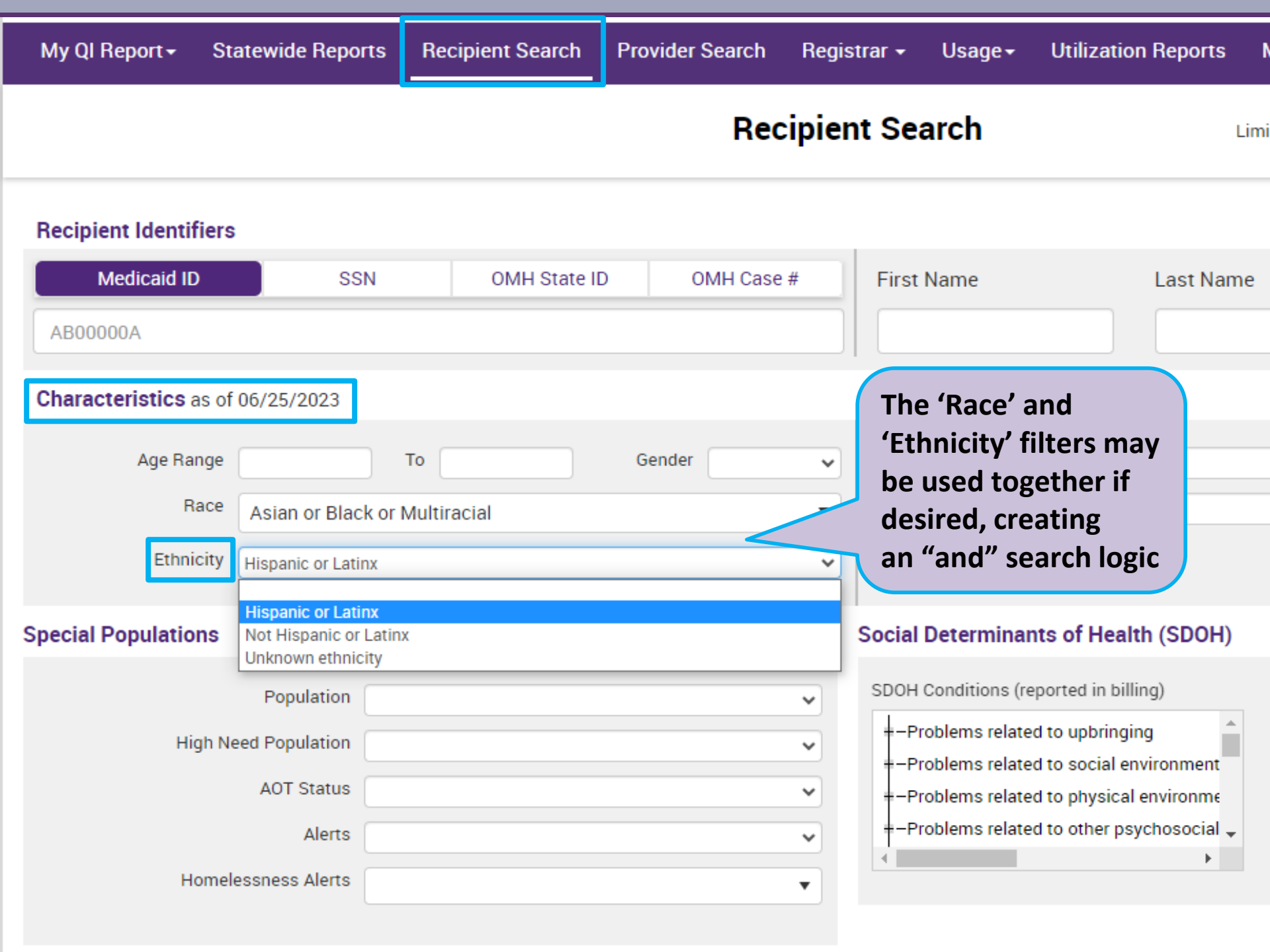
HARP HCBS Assessment Results

Social Determinants of Health (SDOH)

Past 1 Year




My QI Report
Statewide Reports
Recipient Search
Provider Search
Registrar
Usage
Utilization Reports
Recipient Search
Recipient Identifiers
Medicaid ID
SSN
OMH State ID
OMH Case #
AB00000A
First Name
Last Name
Characteristics as of 06/25/2023
Age Range
To
Gender
Race
Asian or Black or Multiracial
Ethnicity
Native American
Asian
Black
Pacific Islander
White
Multiracial
Unknown race
Up to 4 race options can be selected in each search, creating an “or” logic
Special Populations
High Ne
AOT Status
Alerts
Homelessness Alerts
Social Determinants of Health (SDOH)
SDOH Conditions (reported in billing)
--Problems related to upbringing
--Problems related to social environment
--Problems related to physical environme
--Problems related to other psychosocial


My QI Report
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Recipient Identifiers
Medicaid ID
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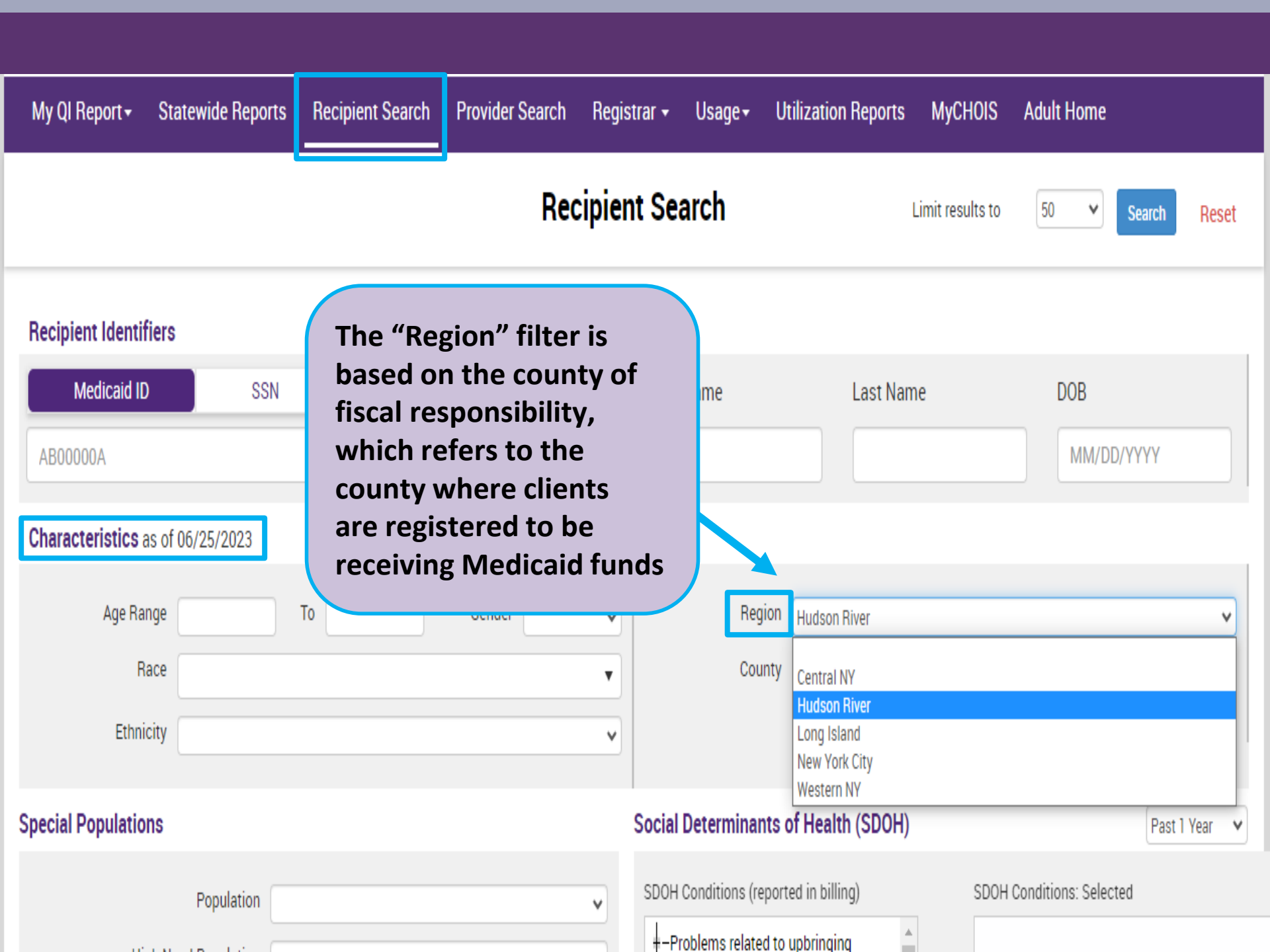
OMH Case #
AB00000A
First Name
Last Name
Characteristics as of 06/25/2023
Age Range
To
Gender
Race
Asian or Black or Multiracial
Ethnicity
Hispanic or Latinx
Hispanic or Latinx
Not Hispanic or Latinx
Unknown ethnicity
The 'Race' and 'Ethnicity' filters may be used together if desired, creating an "and" search logic
Special Populations
Population
High Need Population
AOT Status
Alerts
Homelessness Alerts
Social Determinants of Health (SDOH)
SDOH Conditions (reported in billing)
Problems related to upbringing
Problems related to social environment
Problems related to physical environme
Problems related to other psychosocial


My QI Report
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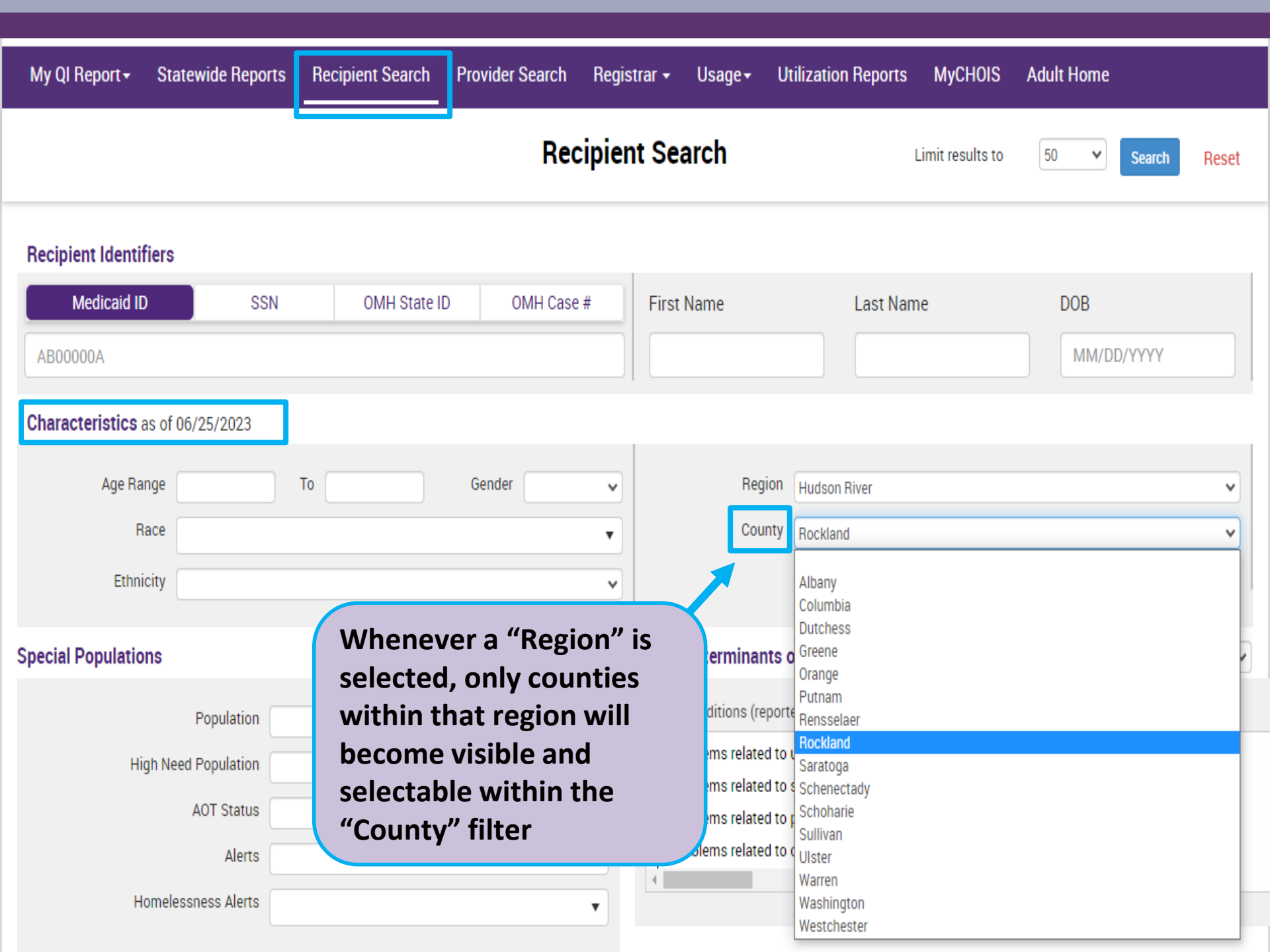
MyCHOIS
Adult Home
Recipient Search
Limit results to
50
Search
Reset
Recipient Identifiers
Medicaid ID
SSN
Last Name
DOB
AB00000A
MM/DD/YYYY
Characteristics as of 06/25/2023
The "Region" filter is based on the county of fiscal responsibility, which refers to the county where clients are registered to be receiving Medicaid funds
Age Range
To
Race
Ethnicity
Region
Hudson River
County
Central NY
Hudson River
Long Island
New York City
Western NY
Special Populations
Social Determinants of Health (SDOH)
Past 1 Year
Population
SDOH Conditions (reported in billing)
SDOH Conditions: Selected
Problems related to upbringing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Medicaid ID
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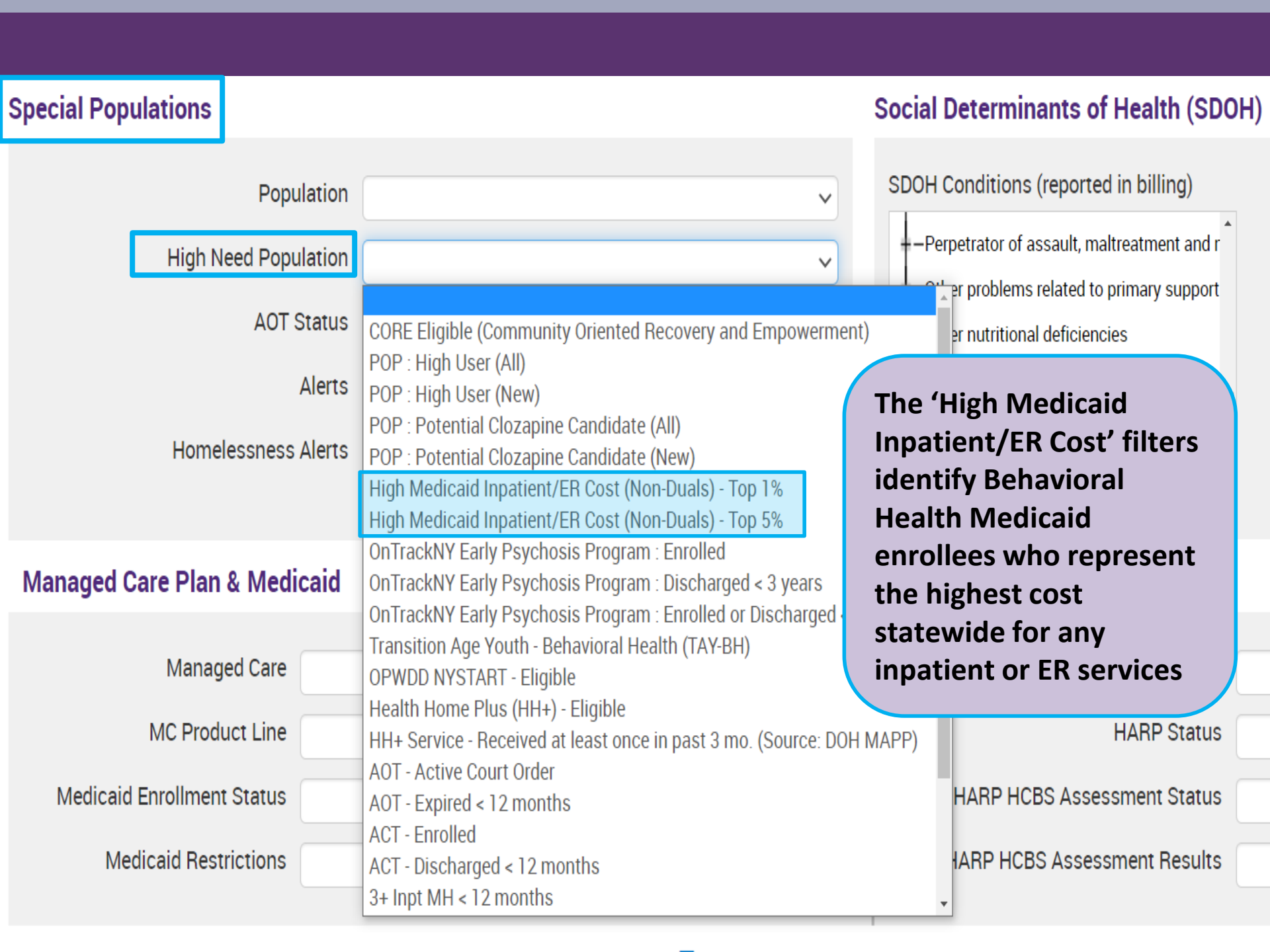
OMH Case #
AB00000A
First Name
Last Name
DOB
MM/DD/YYYY
Characteristics as of 06/25/2023
Age Range
To
Gender
Race
Ethnicity
Region
Hudson River
County
Rockland
Albany
Columbia
Dutchess
Greene
Orange
Putnam
Rensselaer
Rockland
Saratoga
Schenectady
Schoharie
Sullivan
Ulster
Warren
Washington
Westchester
Special Populations
Population
High Need Population
AOT Status
Alerts
Homelessness Alerts
Whenever a “Region” is selected, only counties within that region will become visible and selectable within the “County” filter


Special Populations
Social Determinants of Health (SDOH)
Population
High Need Population
AOT Status
Alerts
Homelessness Alerts
SDOH Conditions (reported in billing)
Perpetrator of assault, maltreatment and r
er problems related to primary support
er nutritional deficiencies
CORE Eligible (Community Oriented Recovery and Empowerment)
POP : High User (All)
POP : High User (New)
POP : Potential Clozapine Candidate (All)
POP : Potential Clozapine Candidate (New)
High Medicaid Inpatient/ER Cost (Non-Duals) - Top 1%
High Medicaid Inpatient/ER Cost (Non-Duals) - Top 5%
OnTrackNY Early Psychosis Program : Enrolled
OnTrackNY Early Psychosis Program : Discharged < 3 years
OnTrackNY Early Psychosis Program : Enrolled or Discharged
Transition Age Youth - Behavioral Health (TAY-BH)
OPWDD NYSTART - Eligible
Health Home Plus (HH+) - Eligible
HH+ Service - Received at least once in past 3 mo. (Source: DOH MAPP)
AOT - Active Court Order
AOT - Expired < 12 months
ACT - Enrolled
ACT - Discharged < 12 months
3+ Inpt MH < 12 months
The 'High Medicaid Inpatient/ER Cost' filters identify Behavioral Health Medicaid enrollees who represent the highest cost statewide for any inpatient or ER services
Managed Care Plan & Medicaid
Managed Care
MC Product Line
Medicaid Enrollment Status
Medicaid Restrictions
HARP Status
HARP HCBS Assessment Status
HARP HCBS Assessment Results

Special Populations

Population

High Need Population

AOT Status

Alerts

Homelessness Alerts

Shelter (DHS) or Outreach (DHS) or Behavioral H...

Homelessness: All Sources

- [ ] Any (DHS/Medicaid)
- [ ] Any past 1 year (DHS/Medicaid)

Homelessness: NYC DHS

- [ ] Any (DHS)
- [ ] Any past 1 year (DHS)
- [x] Shelter (DHS)
- [ ] Shelter past 1 year (DHS)
- [x] Outreach (DHS)
- [ ] Outreach past 1 year (DHS)
- [x] Behavioral Health Shelter past 1 year (DHS)
- [ ] Safe Haven or Stabilization Shelter past 1 year (DHS)

Homelessness: Medicaid

- [ ] Any (Medicaid)
- [ ] Any past 1 year (Medicaid)
- [x] Unsheltered past 1 year (Medicaid)
- [ ] Sheltered past 1 year (Medicaid)

Up to 4 homelessness options can be selected in each search, creating an "or" logic

Social Determinants of Health (SDOH)

SDOH Conditions (reported in billing)

- Problems related to upbringing
- Problems related to social environment
- Problems related to physical environme
- Problems related to other psychosocial

Children's Waiver Status

HARP Status

HARP HCBS Assessment Status

HARP HCBS Assessment Results

Quality Flag as of 06/01/2023

HARP Enrolled - Not Health Home Enrolle
HARP-Enrolled - No Assessment for HCB
Eligible for Health Home Plus - Not Healt
Eligible for Health Home Plus - No Health
Eligible for Health Home Plus - No Health
HH Enrolled, Eligible for Health Home Plu

Services: Specific Provider as of 06/01/2023

Provider

Region

Current Access

Managed Care Plan & Medicaid

Managed Care

MC Product Line

Medicaid Enrollment Status

Medicaid Restrictions

Children's Waiver Status

HARP Status

HARP HCBS Assessment Status

HARP HCBS Assessment Results

Quality Flag as of 06/01/2023

Definitions

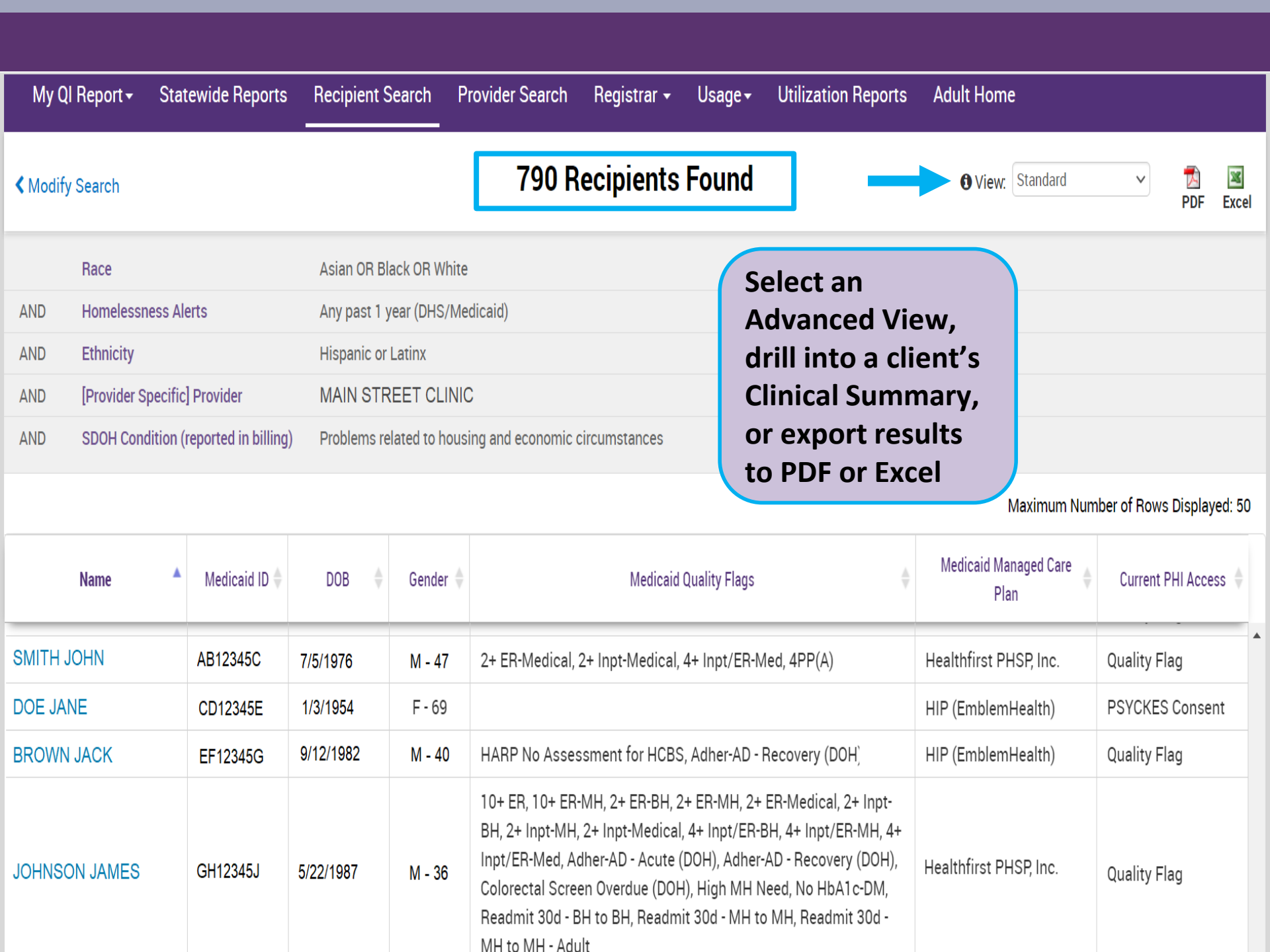
HARP Enrolled - Not Health Home Enrolled - (updated weekly)
HARP-Enrolled - No Assessment for HCBS - (updated weekly)
Eligible for Health Home Plus - Not Health Home Enrolled
Eligible for Health Home Plus - No Health Home Plus Service F, Adher-AD - Recovery (DOH)
Eligible for Health Home Plus - No Health Home Plus Service Past 3 Months
HH Enrolled, Eligible for Health Home Plus - Not Entered as Eligible in DOH MAPP Past 3 Months
High Mental Health Need
Antidepressant Medication Discontinued - Acute Phase
Antidepressant Medication Discontinued - Recovery Phase
Clozapine Candidate with 4+ Inpatient/ER - MH (adult)
Eligible for Health Home Plus - No Health Home Plus Service Past 12 Months (adult)
Low Antipsychotic Medication Adherence - Schizophrenia
No Diabetes Screening - Schizophrenia/Bipolar on Antipsychotic
No Follow Up After MH ED Visit - 7 Days (adult)
No Follow Up After MH ED Visit - 30 Days (adult)
No Follow Up after MH Inpatient - 7 Days (adult)
No Follow Up after MH Inpatient - 30 Days (adult)
Overdue for Colorectal Cancer Screening
Readmission (30d) from any Hosp: MH to MH (adult)
Vital Signs Dashboard Adult Summary

Search for disparity-related quality flags, such as "High MH Need" or any of the Adult or Child Vital Signs Dashboard (VSD) measures (up to 4 quality flags can be selected in each search)

Medication & Diagnosis as of 06/01/2023

Past 1 Year

Services by Any Provider as of 06/01/2023


My QI Report
Statewide Reports
Recipient Search
Provider Search
Registrar
Usage
Utilization Reports
Adult Home
Modify Search
790 Recipients Found
View: Standard
PDF
Excel
Race Asian OR Black OR White
AND Homelessness Alerts Any past 1 year (DHS/Medicaid)
AND Ethnicity Hispanic or Latinx
AND [Provider Specific] Provider MAIN STREET CLINIC
AND SDOH Condition (reported in billing) Problems related to housing and economic circumstances
Select an Advanced View, drill into a client's Clinical Summary, or export results to PDF or Excel
Maximum Number of Rows Displayed: 50
Name
Medicaid ID
DOB
Gender
Medicaid Quality Flags
Medicaid Managed Care Plan
Current PHI Access
SMITH JOHN AB12345C 7/5/1976 M - 47 2+ ER-Medical, 2+ Inpt-Medical, 4+ Inpt/ER-Med, 4PP(A) Healthfirst PHSP, Inc. Quality Flag
DOE JANE CD12345E 1/3/1954 F - 69 HIP (EmblemHealth) PSYCKES Consent
BROWN JACK EF12345G 9/12/1982 M - 40 HARP No Assessment for HCBS, Adher-AD - Recovery (DOH) HIP (EmblemHealth) Quality Flag
JOHNSON JAMES GH12345J 5/22/1987 M - 36 10+ ER, 10+ ER-MH, 2+ ER-BH, 2+ ER-MH, 2+ ER-Medical, 2+ Inpt-BH, 2+ Inpt-MH, 2+ Inpt-Medical, 4+ Inpt/ER-BH, 4+ Inpt/ER-MH, 4+ Inpt/ER-Med, Adher-AD - Acute (DOH), Adher-AD - Recovery (DOH), Colorectal Screen Overdue (DOH), High MH Need, No HbA1c-DM, Readmit 30d - BH to BH, Readmit 30d - MH to MH, Readmit 30d - MH to MH - Adult Healthfirst PHSP, Inc. Quality Flag

Clinical Summary

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

What is a PSYCKES Clinical Summary?

- Summarizes up to 5 years of treatment history for a client
- Creates an **integrated** view from all databases available through PSYCKES
  - E.g., Homelessness information, Social Determinants of Health (SDOH), High Mental Health Need reason (if applicable), active quality flags, care coordination, IVOS (Integrated View of Services), AOT status, hospitalizations from Medicaid billing, suicide risk (NIMRS), etc.
- Summarizes treatment episodes to support rapid review
- Episodes of care linked to detailed dates of service if needed (including diagnoses and procedures)
- Clinical Summary organized by sections like an EMR

Clinical Summary Viewing Options

- A client's clinical summary has 3 viewing tab options:
  - Brief Overview (default)
  - 1 Year Summary
  - 5 Year Summary
- The Brief Overview was a request by our users include a brief summary of a client's data that contained:
  - Most critical information, easily identifiable
  - Optimize time when reviewing clinical summary to get full clinical picture
  - Fits on a 1-2 pieces of paper, if printed

Recipient Search

SMITH, JOHN

Clinical Summary as of 6/25/2023

PDF

About included data sources

Brief Overview | 1 Year Summary | 5 Year Summary

Data with Special Protection (Show / Hide)
This report contains all available clinical data.

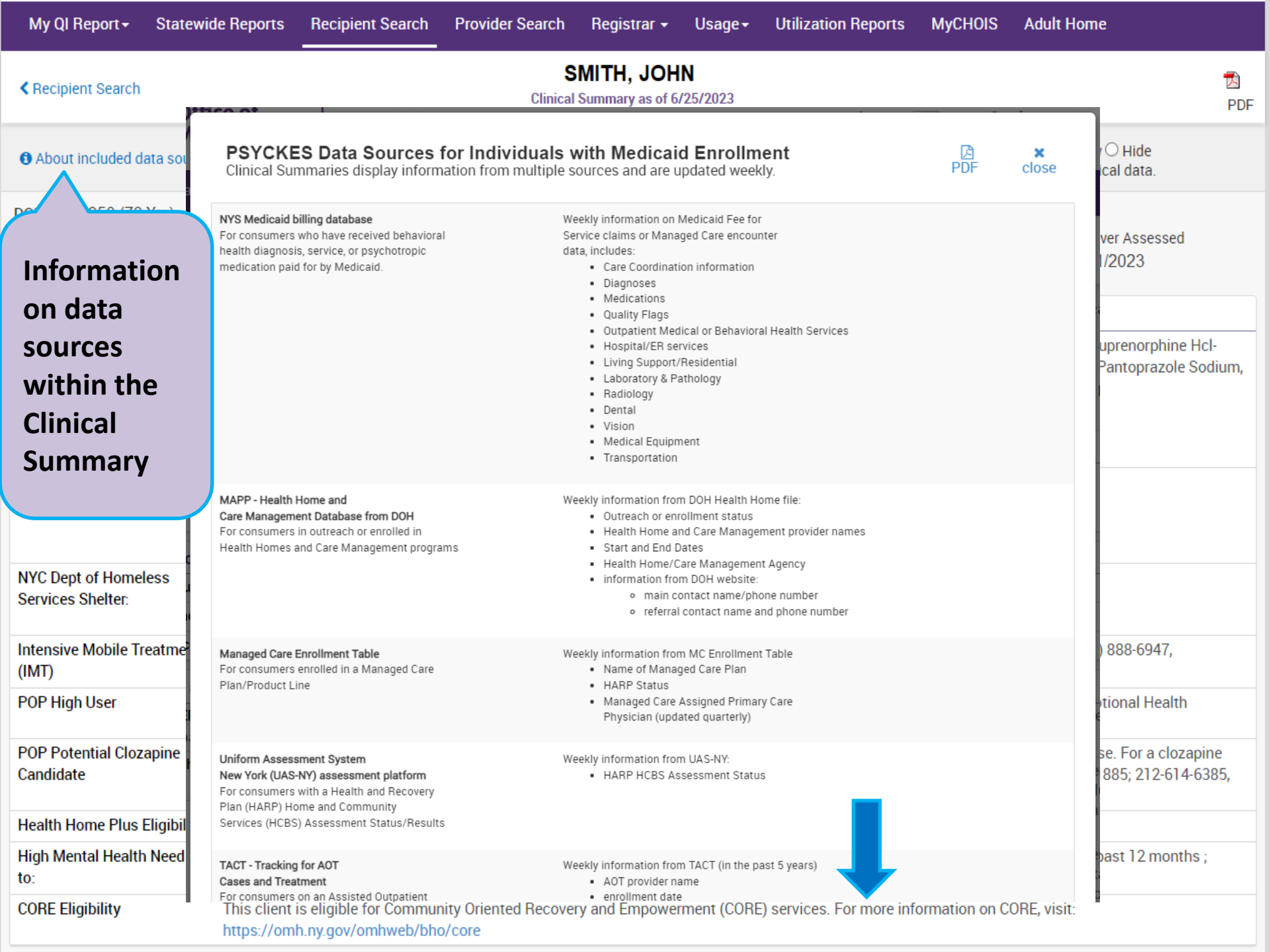
DOB: 2/1/1950 (73 Yrs)
Address: 123 MAIN STREET, NEW YORK, NY 12345
Phone (Source: NYC DHS): (333) 432-6223

Medicaid ID: AB12345C Medicare: No
Managed Care Plan: MetroPlus Health Plan (HARP)
MC Plan Assigned PCP: N/A

HARP Status: HARP Enrolled (H1)
HARP HCBS Assessment Status: Never Assessed
Medicaid Eligibility Expires on: 10/31/2023

Current Care Coordination

Prescription Prior Authorization	This client has been taking a prescription medication in the past 3 months that may require NYRx prior authorization: Aripiprazole, Buprenorphine Hcl-Naloxone Hcl, Clonazepam, Gabapentin, Glucose Blood (Contour Next Test), Hydromorphone Hcl, Insulin Lispro (Admelog Solostar), Pantoprazole Sodium, Zolpidem Tartrate. To obtain a prior authorization call (877) 309- 9493 or fax the appropriate Prior Authorization Form to (800) 268-2990. Standard PA Form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf Other Specialized PA Forms: https://newyork.fhsc.com/providers/pa_forms.asp
Health Home (Enrolled)	COMMUNITY CARE MANAGEMENT PARTNERS (Begin Date: 01-SEP-22, End Date: 31-MAR-23) • Status : Closed Main Contact Referral: Robert Ward: 646-799-1892, Robert.ward@ccmphealthhome.org Member Referral Number: 888-682-1377; referrals@ccmphealthhome.org **Care Management (Enrolled):** TRANSITIONAL SER FOR NY MH
NYC Dept of Homeless Services Shelter:	PROSPECT PLACE (Single Adult, Mental Health) • BROOKLYN Most Recent Placement Date: 01-JUN-23 Shelter Director Contact: Brooke Vanegas: 9292014723, brooke.vanegas@cucs.org
Intensive Mobile Treatment (IMT)	Visiting Nurse Service of NY (VNSNY) Queens IMT I (Admission Date: 03-NOV-22) • Main Contact: Cherylann Campbell-McCalla: (718) 888-6947, cherylann.campbell-mccalla@vnsny.org
POP High User	This client is enrolled in an episode of intensive care transition services. To coordinate contact: MetroPlus Health Plan • Vibrant Emotional Health Specialized Services: 1-866-728-1885; 212-614-6385, h2hsupervisors@vibrant.org
POP Potential Clozapine Candidate	Evaluate for potential clozapine initiation/referral due to schizophrenia, high psychiatric Inpatient/ER use, and no recent clozapine use. For a clozapine treatment provider referral or questions contact: MetroPlus Health Plan • Vibrant Emotional Health Specialized Services: 1-866-728-1885; 212-614-6385, h2hsupervisors@vibrant.org
Health Home Plus Eligibility	This client is eligible for Health Home Plus due to: 3+ Inpt Med & Schiz/Bipolar Dx < 12 months
High Mental Health Need due to:	1+ ER or Inpatient past 12 months with suicide attempt, suicide ideation, or self-harm diagnosis ; 3+ Inpt Med & Schiz/Bipolar Dx in past 12 months ; Intensive Mobile Treatment (IMT) in past 5 years
CORE Eligibility	This client is eligible for Community Oriented Recovery and Empowerment (CORE) services. For more information on CORE, visit: https://omh.ny.gov/omhweb/bho/core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Adult Home
Recipient Search
SMITH, JOHN
Clinical Summary as of 6/25/2023
PDF
About included data sou
Hide
cal data.
PSYCKES Data Sources for Individuals with Medicaid Enrollment
Clinical Summaries display information from multiple sources and are updated weekly.
PDF
close
NYS Medicaid billing database
For consumers who have received behavioral health diagnosis, service, or psychotropic medication paid for by Medicaid.
Weekly information on Medicaid Fee for Service claims or Managed Care encounter data, includes:
Care Coordination information
Diagnoses
Medications
Quality Flags
Outpatient Medical or Behavioral Health Services
Hospital/ER services
Living Support/Residential
Laboratory & Pathology
Radiology
Dental
Vision
Medical Equipment
Transportation
MAPP - Health Home and Care Management Database from DOH
For consumers in outreach or enrolled in Health Homes and Care Management programs
Weekly information from DOH Health Home file:
Outreach or enrollment status
Health Home and Care Management provider names
Start and End Dates
Health Home/Care Management Agency
information from DOH website:
main contact name/phone number
referral contact name and phone number
Managed Care Enrollment Table
For consumers enrolled in a Managed Care Plan/Product Line
Weekly information from MC Enrollment Table
Name of Managed Care Plan
HARP Status
Managed Care Assigned Primary Care Physician (updated quarterly)
Uniform Assessment System New York (UAS-NY) assessment platform
For consumers with a Health and Recovery Plan (HARP) Home and Community Services (HCBS) Assessment Status/Results
Weekly information from UAS-NY:
HARP HCBS Assessment Status
TACT - Tracking for AOT Cases and Treatment
For consumers on an Assisted Outpatient
Weekly information from TACT (in the past 5 years)
AOT provider name
enrollment date
Information on data sources within the Clinical Summary
NYC Dept of Homeless Services Shelter:
Intensive Mobile Treatme (IMT)
POP High User
POP Potential Clozapine Candidate
Health Home Plus Eligibil
High Mental Health Need to:
CORE Eligibility
This client is eligible for Community Oriented Recovery and Empowerment (CORE) services. For more information on CORE, visit:
https://omh.ny.gov/omhweb/bho/core

Alerts • all available		Most Recent	
3	**Suicidal Ideation** (1 Inpatient, 3 ER)	4/24/2023	BELLEVUE HOSPITAL CENTER (Inpatient - MH)
1	**Overdose - Opioid** (1 ER)	2/4/2023	BETH ISRAEL MEDICAL CENTER (ER - SU)
5	**Homelessness - reported in billing** (1 Sheltered, 4 Unspecified)	9/13/2022	CONEY ISLAND MEDICAL PRACTICE PLAN (ER - MH - Group - Physician - Psychiatry; Homelessness - Sheltered)
1	**Homelessness - NYC DHS Shelter**	8/27/2019	30TH ST. FASTTRACK (Single Adult, Diversion)

Social Determinants of Health (SDOH) Past Year - reported in billing

Problems related to housing and economic circumstances	Financial Insecurity • Transportation Insecurity • Unsheltered Homelessness • Sheltered Homelessness • Homelessness Unspecified
Problems related to other psychosocial circumstances	Imprisonment And Other Incarceration
Problems related to social environment	Other Problems Related To Social Environment

Active Quality Flags • as of monthly QI report 6/1/2023

BH QARR - Improvement Measure
No Metabolic Monitoring (LDL-C) on Antipsychotic

General Medical Health
No Metabolic Monitoring (Gluc/HbA1c and LDL-C) on Antipsychotic (All) • No Outpatient Medical Visit > 1Yr

Health Home Care Management - Adult
Eligible for Health Home Plus - No Health Home Plus Service Past 12 Months • Eligible for Health Home Plus - No Health Home Plus Service Past 3 Months • Eligible for Health Home Plus - Not Health Home Enrolled

High Mental Health Need
1+ ER or Inpatient past 12 months with suicide attempt, suicide ideation, or self-harm diagnosis | 1+ Inpt MH in past 12 months | ACT enrolled or discharged in past 5 years

High Utilization - Inpt/ER
2+ ER - BH • 2+ ER - MH • 2+ ER - Medical • 2+ Inpatient - BH • 2+ Inpatient - MH • 4+ Inpatient/ER - BH • 4+ Inpatient/ER - MH • Clozapine Candidate with 4+ Inpatient/ER - MH

MH Performance Tracking Measure (as of 11/01/2022)
Low Antipsychotic Medication Adherence - Schizophrenia • Low Mood Stabilizer Medication Adherence - Bipolar • No Follow Up after MH Inpatient - 7 Days

SUD Performance Tracking Measure (as of 11/01/2022)
No Follow Up after SUD ER Visit (30 days) • No Follow Up after SUD ER Visit (7 days) • No Utilization of Pharmacotherapy for Alcohol Abuse or Dependence

Vital Signs Dashboard - Adult (as of 11/01/2022)
Clozapine Candidate with 4+ Inpatient/ER - MH (adult) • Eligible for Health Home Plus - No Health Home Plus Service Past 12 Months (adult) • Low Antipsychotic Medication Adherence - Schizophrenia • No Follow Up after MH Inpatient - 7 Days (adult)

Diagnoses Past Year

Behavioral Health (7)	**5 Most Recent**: Other psychoactive substance related disorders • Schizoaffective Disorder • Adjustment Disorder • Schizophrenia • Unspecified/Other Bipolar ... **5 Most Frequent (# of services)**: Schizoaffective Disorder (3) • Tobacco related disorder (1) • Schizophrenia (4) • Unspecified/Other Bipolar (3) • Other psychoactive substance related disorders (5) ...
Medical (27)	**5 Most Recent**: Shock, not elsewhere classified • Other sepsis • Pain in throat and chest • Encounter for general examination without complaint, suspected or reported diagnosis • Cardiac arrest ... **5 Most Frequent (# of services)**: Superficial injury of knee and lower leg (2) • Superficial injury of head (2) • Cardiac arrest (7) • Other sepsis (6) • Shock, not elsewhere classified (6) ...

Medications Past Year	Last Pick Up	
Escitalopram Oxalate • Antidepressant	6/8/2023	Dose: 20 MG, 1.5/day • Quantity: 45
Ergocalciferol (Vitamin D (Ergocalciferol)) • Oil Soluble Vitamins	6/8/2023	Dose: 1.25 MG (50000 UT)/day • Quantity: 4
Fexofenadine Hcl • Antihistamines - Non-Sedating	5/9/2023	Dose: 180 MG, 1/day • Quantity: 30
Fluticasone Propionate (Nasal) (Fluticasone Propionate) • Nasal Steroids	5/9/2023	Dose: 50 MCG/ACT, .53/day • Quantity: 16
Ferrous Sulfate • Iron	5/2/2023	Dose: 325 (65 Fe) MG/day • Quantity: 30
Risperidone • Antipsychotic	3/28/2023	Dose: 2 MG, 2/day • Quantity: 60
Triamcinolone Acetonide • Corticosteroids - Topical	3/27/2023	Dose: 0.1 %, 15.13/day • Quantity: 454
Benztropine Mesylate • Antiparkinson Anticholinergics	3/13/2023	Dose: 0.5 MG, 2/day • Quantity: 28
Lamotrigine • Mood Stabilizer	3/6/2023	Dose: 25 MG, 4/day • Quantity: 120
Albuterol Sulfate • Sympathomimetics	1/27/2023	Dose: (2.5 MG/3ML) 0.083%/day • Quantity: 75
Albuterol Sulfate (Albuterol Sulfate Hfa) • Sympathomimetics	1/27/2023	Dose: 108 (90 Base) MCG/ACT/day • Quantity: 8
Hydroxyzine Hcl • Anxiolytic/Hypnotic	12/15/2022	Dose: 50 MG, 2/day • Quantity: 60
Covid-19 At Home Test (Ihealth Covid-19 Rapid Test) • Diagnostic Tests	11/8/2022	Dose: - -/day • Quantity: 2
Covid-19mrna Bival Vacc Pfizer (Pfizer Covid-19 Vac Bivalent) • Viral Vaccines	11/8/2022	Dose: 30 MCG/0.3ML, .3/day • Quantity: 0

Outpatient Providers Past Year	Last Service Date & Type	
MEDS OOS PHYSICIAN & OTHE	5/14/2023	Urgent Care - Medical Dx
JOSEPH P ADDABBO FAMILY HLTH	5/9/2023	Clinic - Medical Specialty
JOSEPH P ADDABBO FAMILY HEALTH CENT	5/9/2023	Clinic - Medical Specialty
NEW HORIZON COUNSELING CTR	4/18/2023	CCBHC
NEW YORK UNIVERSITY	3/30/2023	Physician Group
ADVANTAGECARE PHYSICIANS PC	3/27/2023	Physician Group
JAMAICA HOSPITAL	2/21/2023	Physician Group
TJH MEDICAL SERVICES P C	11/23/2022	Physicians Group - Internal Medicine

All Hospital and Crisis Utilization • 5 Years

ER Visits	# Providers	Last ER Visit
1 Substance Use	1	5/17/2022 at BELLEVUE HOSPITAL CENTER
9 Mental Health	5	7/13/2020 at ST LUKES ROOSEVELT HSP CTR
6 Medical	4	4/13/2020 at NYU LANGONE HOSPITALS
Inpatient Admissions	**# Providers**	**Last Inpatient Admission**
7 Mental Health	5	3/9/2023 at JAMAICA HOSPITAL
1 Substance Use	1	5/17/2022 at BELLEVUE HOSPITAL CENTER
Crisis Services	**# Providers**	**Last Crisis Service**
2 CPEP Mobile Crisis	1	3/14/2023 at JAMAICA HOSPITAL
1 Crisis Telephonic	1	5/8/2020 at WOODHULL MED & MNTL HLTH CTR

Brief Overview as of 6/25/2023

View 1 Year Summary | View 5 Year Summary | Export Overview

Current Care Coordination & Alerts

- Current Care Coordination section displays status/contact information, if applicable to the client, including:
  - Homelessness
  - Health Home/Care Management Agency Outreach/Enrollment
  - Health Home Plus Eligibility
  - High Mental Health Need Reasons
  - Medicaid Eligibility Alert: New York State of Health (NYSoH) alert for Medicaid recertification

- Alerts (All available NIMRS & Medicaid data)
  - Suicidal ideations
  - Suicide attempt
  - Self-inflicted harm
  - Opioid overdose
  - Homelessness
  - OMH unsuccessful discharge

SMITH, JOHN

Clinical Summary as of 6/25/2023

General

Name
SMITH, JOHN

DOB
2/1/1950 (73 Yrs)

Address
123 MAIN STREET, NEW YORK, NY 12345

Phone (Source: NYC DHS)
(333) 432-6223

Medicaid ID
AB12345C

Medicaid Aid Category
SSI

Medicaid Eligibility Expires on
10/31/2023

Medicare
No

Managed Care Plan
MetroPlus Health Plan (HARP)

MC Plan Assigned PCP
N/A

HARP Status
HARP Enrolled (H1)

HARP HCBS Assessment Status
Never Assessed

Current Care Coordination

Prescription Prior Authorization: This client has been taking a prescription medication in the past 3 months that may require NYRx prior authorization: Aripiprazole, Buprenorphine Hcl-Naloxone Hcl, Clonazepam, Gabapentin, Glucose Blood (Contour Next Test), Hydromorphone Hcl, Insulin Lispro (Admelog Solostar), Pantoprazole Sodium, Zolpidem Tartrate.
To obtain a prior authorization call (877) 309- 9493 or fax the appropriate Prior Authorization Form to (800) 268-2990.
Standard PA Form: *https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf*
Other Specialized PA Forms: *https://newyork.fhsc.com/providers/pa_forms.asp*

Health Home (Enrolled) - Status : Closed, COMMUNITY CARE MANAGEMENT PARTNERS (Begin Date: 01-SEP-22, End Date: 31-MAR-23), Main Contact: Referral - Robert Ward, 646-799-1892, Robert.ward@ccmphealthhome.org; Member Referral Number: 888-682-1377; referrals@ccmphealthhome.org

Care Management (Enrolled) : TRANSITIONAL SER FOR NY MH

- This information is updated weekly from DOH MAPP.

NYC Dept of Homeless Services Shelter: PROSPECT PLACE (Single Adult, Mental Health)., BROOKLYN Most Recent Placement Date: 01-JUN-23 Shelter Director Contact: Brooke Vanegas, 3334326225, brooke.vanegas@cucs.org.

- This information is updated weekly from NYC DHS.

Care Coordination Alert - This client is eligible for Health Home Plus due to: 3+ Inpt Med & Schiz/Bipolar Dx < 12 months

High Mental Health Need due to: 1+ ER or Inpatient past 12 months with suicide attempt, suicide ideation, or self-harm diagnosis ; 3+ Inpt Med & Schiz/Bipolar Dx in past 12 months ; Intensive Mobile Treatment (IMT) in past 5 years

Alerts & Incidents

The "Alerts" section contains information on suicidality, homelessness, positive screenings, and opioid overdose

Alerts Incidents from NIMRS, Service invoices from Medicaid | Details

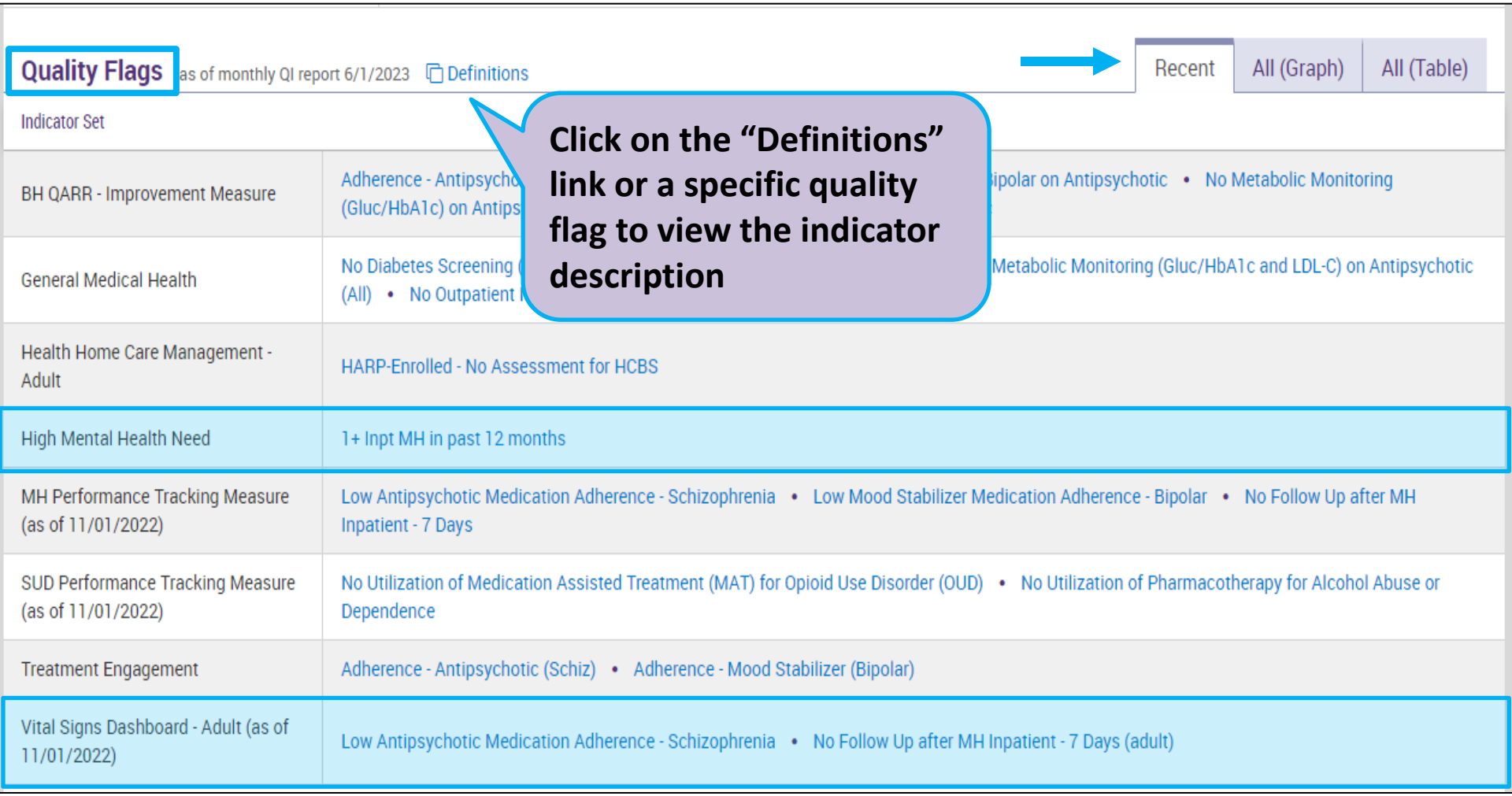
Table | Graph

Alert Type	Number of Events/Meds/Positive Screens	First Date	Most Recent Date	Provider Name(s)	Program Name	Severity/Diagnosis/Meds/Results
Homelessness - NYC DHS Shelter	15	5/4/2022	6/1/2023	PROSPECT PLACE	Single Adult	
Homelessness - reported in billing	3	4/13/2023	4/15/2023	NEW YORK UNIVERSITY	Inpatient - Medical - Physician Group	
Intentional Overdose - Opioid	4	11/26/2022	11/29/2022	LINCOLN MEDICAL/MENTAL HLTH	ER - SU	Poisoning by methadone, intentional self-harm, initial encounter
Treatment for Suicidal Ideation	27	4/24/2009	8/12/2019	BRONXCARE HOSPITAL CENTER	Inpatient - Medical	Suicidal ideations
Overdose - Opioid	2	8/19/2016	6/12/2017	ELMHURST HOSPITAL CENTER	Inpatient - SU	Poisoning by other opioids, accidental (unintentional), initial encounter

Social Determinants of Health (SDOH)

- The SDOH section includes social and environmental conditions that impact a wide range of health risks and outcomes (e.g., education & literacy, upbringing, social environment, etc.)

Quality Flags & PSYCKES Registries



My QI Report

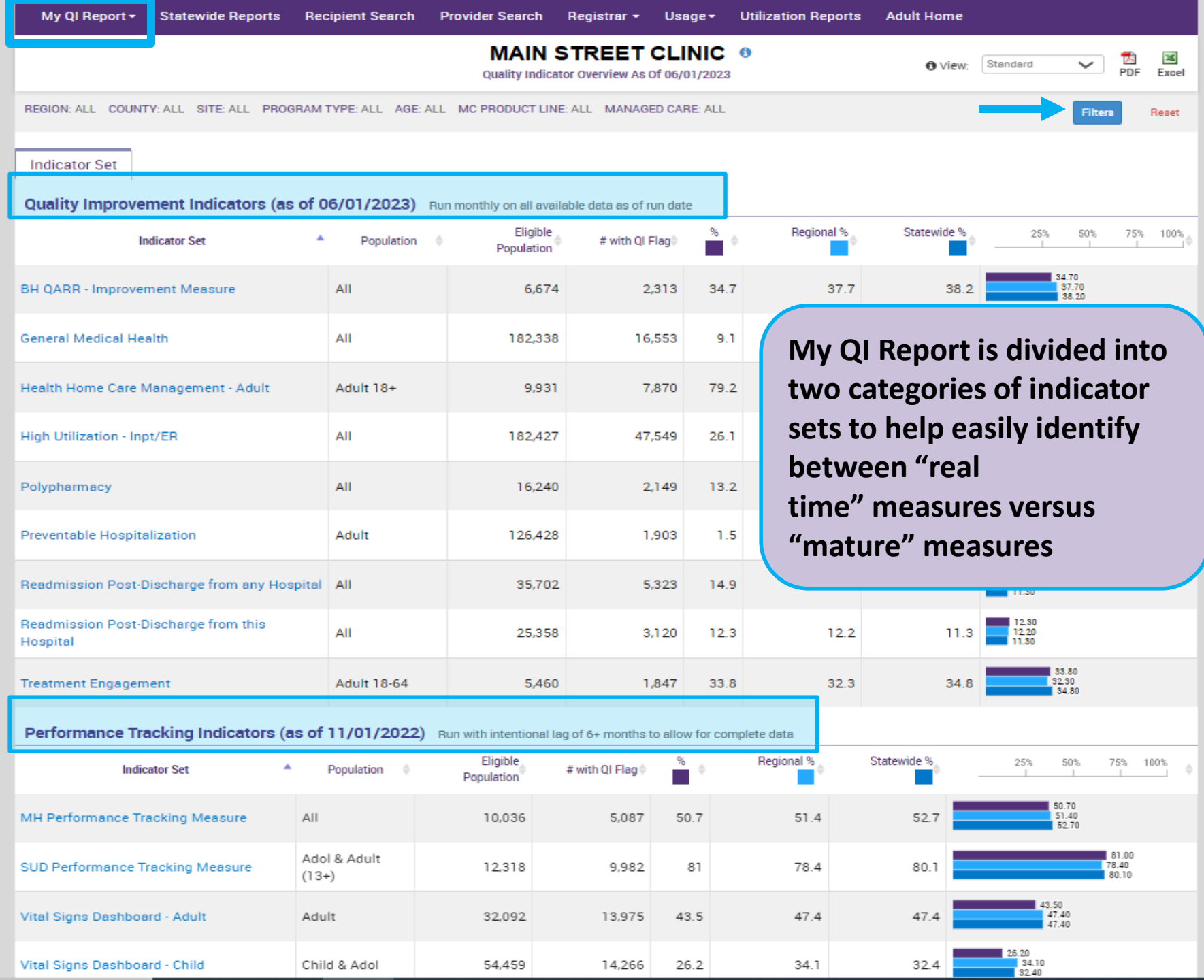
NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

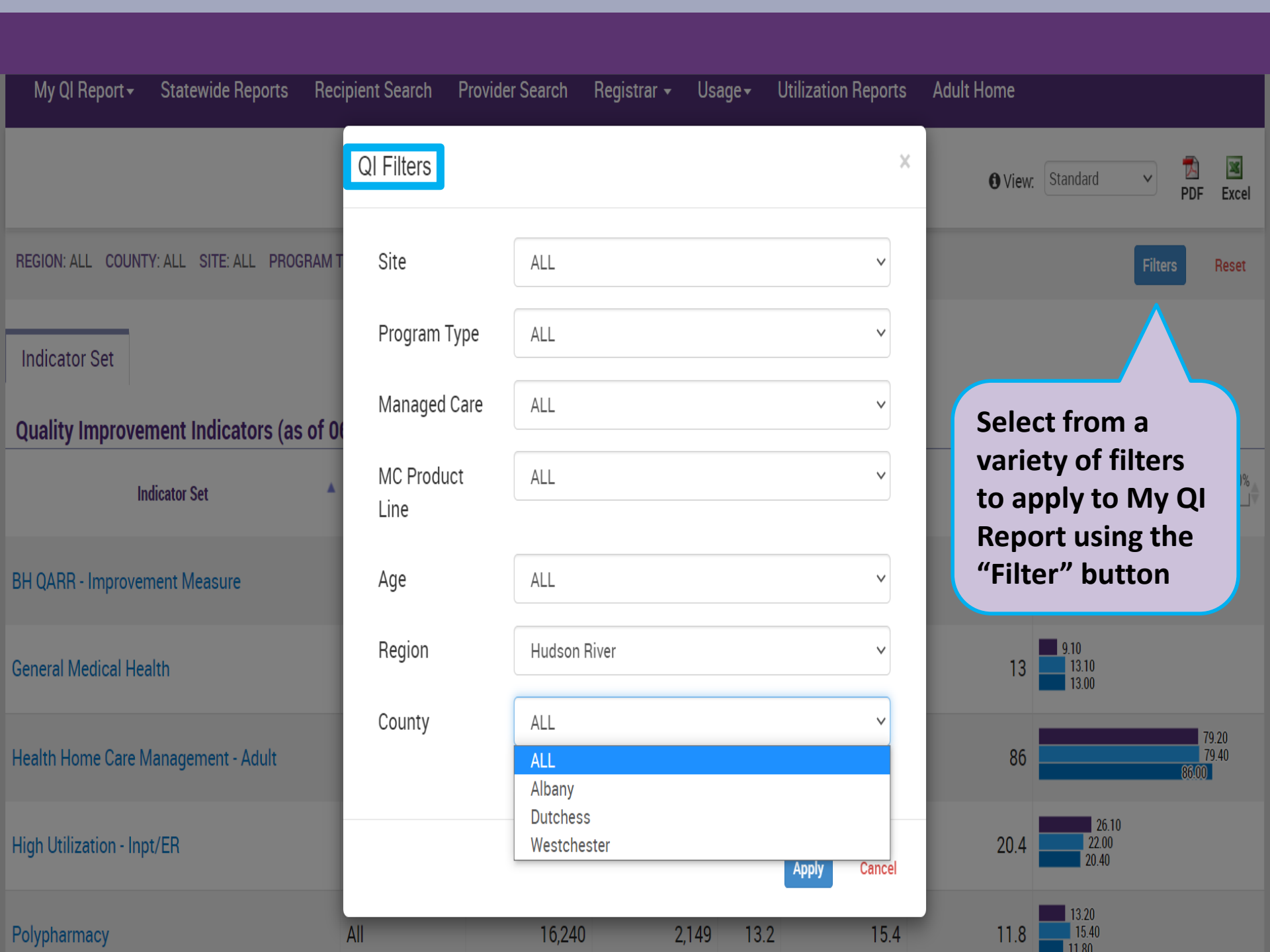
My QI Report

- Tool for managing quality improvement efforts
- Updated on a monthly basis
- Eligible Population (denominator): clients served plus other parameters depending on quality indicator specifications
- Number with QI Flag (numerator): clients who meet criteria for the flag
- Compare prevalence rates for provider agency, region, state
- Filter report by: Program Type, MC Plan, Age
- Drill down into list of recipients who meet criteria for flag
- Reports can be exported to Excel and PDF

Understanding My QI Report

- Attributing clients to agency QI reports:
  - Billing: Clients linked to provider agency if billed by agency in the past 9 months
  - This rule is used to automatically link clients to providers so that current clients are included in the report each month
- Period of observation for the quality indicator:
  - Assessed by a measure, varies for each measure
  - For example, the period of observation for the High Utilization quality indicator is 13 months
- QI Reports trending over time:
  - QI Trends Past Year show the prevalence rates of quality flags by provider over time


My QI Report
Statewide Reports
Recipient Search
Provider Search
Registrar
Usage
Utilization Reports
Adult Home
MAIN STREET CLINIC
Quality Indicator Overview As Of 06/01/2023
View:
Standard
PDF
Excel
REGION: ALL COUNTY: ALL SITE: ALL PROGRAM TYPE: ALL AGE: ALL MC PRODUCT LINE: ALL MANAGED CARE: ALL
Filters
Reset
Indicator Set
Quality Improvement Indicators (as of 06/01/2023)
Run monthly on all available data as of run date
Indicator Set
Population
Eligible Population
with QI Flag
%
Regional %
Statewide %
25%
50%
75%
100%
BH QARR - Improvement Measure
All
6,674
2,313
34.7
37.7
38.2
34.70
37.70
38.20
General Medical Health
All
182,338
16,553
9.1
Health Home Care Management - Adult
Adult 18+
9,931
7,870
79.2
High Utilization - Inpt/ER
All
182,427
47,549
26.1
Polypharmacy
All
16,240
2,149
13.2
Preventable Hospitalization
Adult
126,428
1,903
1.5
Readmission Post-Discharge from any Hospital
All
35,702
5,323
14.9
Readmission Post-Discharge from this Hospital
All
25,358
3,120
12.3
12.2
11.3
12.30
12.20
11.30
Treatment Engagement
Adult 18-64
5,460
1,847
33.8
32.3
34.8
33.80
32.30
34.80
Performance Tracking Indicators (as of 11/01/2022)
Run with intentional lag of 6+ months to allow for complete data
Indicator Set
Population
Eligible Population
with QI Flag
%
Regional %
Statewide %
25%
50%
75%
100%
MH Performance Tracking Measure
All
10,036
5,087
50.7
51.4
52.7
50.70
51.40
52.70
SUD Performance Tracking Measure
Adol & Adult (13+)
12,318
9,982
81
78.4
80.1
81.00
78.40
80.10
Vital Signs Dashboard - Adult
Adult
32,092
13,975
43.5
47.4
47.4
43.50
47.40
47.40
Vital Signs Dashboard - Child
Child & Adol
54,459
14,266
26.2
34.1
32.4
26.20
34.10
32.40
My QI Report is divided into two categories of indicator sets to help easily identify between “real time” measures versus “mature” measures


My QI Report
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Indicator Set
Quality Improvement Indicators (as of 0
Indicator Set
BH QARR - Improvement Measure
General Medical Health
Health Home Care Management - Adult
High Utilization - Inpt/ER
Polypharmacy
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ALL
Program Type
ALL
Managed Care
ALL
MC Product Line
ALL
Age
ALL
Region
Hudson River
County
ALL
ALL
Albany
Dutchess
Westchester
Apply
Cancel
Select from a variety of filters to apply to My QI Report using the "Filter" button
All
16,240
2,149
13.2
15.4
11.8
13
9.10
13.10
13.00
86
79.20
79.40
86.00
20.4
26.10
22.00
20.40
13.20
15.40

My QI Report | Statewide Reports | Recipient Search | Provider Search | Registrar | Usage | Utilization Reports | Adult Home

MAIN STREET CLINIC

Quality Indicator Overview As Of 06/01/2023

View: Standard PDF Excel

REGION: ALL COUNTY: ALL SITE: ALL PROGRAM TYPE: ALL AGE: ALL MC PRODUCT LINE: ALL MANAGED CARE: ALL

Filters Reset

Indicator Set

Quality Improvement Indicators (as of 06/01/2023)

Run monthly on all available data as of run date

Indicator Set	Population	Eligible Population	# with QI Flag	%	Regional %	Statewide %
BH QARR - Improvement Measure	All	6,674	2,313	34.7	37.7	38.2
General Medical Health	All	182,338	16,553	9.1	13.1	13
Health Home Care Management - Adult	Adult 18+	9,931	7,870	79.2	79.4	86
High Utilization - Inpt/ER	All	182,427	47,549	26.1	22	20.4
Polypharmacy	All	16,240	2,149	13.2	15.4	11.8
Preventable Hospitalization			1,903	1.5	0.9	0.8
Readmission Post-Discharge from any Hosp				14.9	13.6	11.3
Readmission Post-Discharge from this Hospital				12.3	12.2	11.3
Treatment Engagement				33.8	32.3	34.8

Performance Tracking Indicators (as

w for complete data

Indicator Set					Regional %	Statewide %
MH Performance Tracking Measure	All			50.7	51.4	52.7
SUD Performance Tracking Measure	Ad	12,318	9,982	81	78.4	80.1
Vital Signs Dashboard - Adult	Adult	32,092	13,975	43.5	47.4	47.4
Vital Signs Dashboard - Child	Child & Adol	54,459	14,266	26.2	34.1	32.4

Drill down to health disparity-related quality indicators in the "Vital Signs Dashboard" adult and child indicator sets

My QI Report | Statewide Reports | Recipient Search | Provider Search | Registrar | Usage | Utilization Reports | Adult Home

MAIN STREET CLINIC

Quality Indicator Overview As Of 06/01/2023

View: Standard PDF Excel

REGION: ALL COUNTY: ALL SITE: ALL PROGRAM TYPE: ALL AGE: ALL MC PRODUCT LINE: ALL MANAGED CARE: ALL

Filters Reset

Indicator Set: Vital Signs Dashboard - Adult

Indicator Set | Indicator

Indicator	Population	Eligible Population	# with QI Flag	%	Regional %	Statewide %	25% 50% 75% 100%
Antidepressant Medication Discontinued - Acute Phase	Adult 18+	2,645	1,111	42	42.7	44.1	42.00 42.70 44.10
Antidepressant Medication Discontinued - Recovery Phase	Adult 18+	2,645	1,500	56.7	56.4	58.7	56.70 56.40 58.70
Clozapine Candidate with 4+ Inpatient/ER - MH	Adult 18+	251	239	95.2	91.1	92.4	95.20 91.10 92.40
Eligible for Health Home Plus - No Health Home Plus Service Past 12 Months	Adult 18+	979	746	76.2	48.6	60.5	76.20 48.60 60.50
Low Antipsychotic Medication Adherence - Schizophrenia	Adult (18-64)	2,122	724	34.1	31.3	34	34.10 31.30 34.00
No Diabetes Screening - Schizophrenia/Bipolar on Antipsychotic	Adult (18-64)	3,237	435	13.4	20.9	23	13.40 20.90 23.00
No Follow Up After MH ED Visit - 7 Days	Adult 18+	1,023	436	42.6	42	35.9	42.60 42.00 35.90
No Follow Up After MH ED Visit - 30 Days	Adult 18+	1,023	332	32.5	29.8	26.9	32.50 29.80 26.90
No Follow Up after MH Inpatient - 7 Days	Adult 18+	955	415	43.5	41	43	43.50 41.00 43.00
No Follow Up after MH Inpatient - 30 Days	Adult 18+	955	261	27.3	24.3	26.8	27.30 24.30 26.80
Overdue for Colorectal Cancer Screening	Adult (50-75)	22,976	8,816	38.4	45.7	45.4	38.40 45.70 45.40
Readmission (30d) from any Hosp: MH to MH	Adult 18+	1,505	230	15.3	13.4	11.3	15.30 13.40 11.30
Vital Signs Dashboard Adult Summary	**Adult**	**28,405**	**12,029**	**42.3**	**47.4**	**47.4**	42.30 47.40 47.40

My QI Report | Statewide Reports | Recipient Search | Provider Search | Registrar | Usage | Utilization Reports | Adult Home

MAIN STREET CLINIC

Quality Indicator Overview As Of 06/01/2023

View: Standard PDF Excel

REGION: ALL COUNTY: ALL SITE: ALL PROGRAM TYPE: ALL AGE: ALL MC PRODUCT LINE: ALL MANAGED CARE: ALL Filters Reset

Indicator Set: Vital Signs Dashboard - Adult **Indicator:** No Follow Up after MH Inpatient - 7 Days

Indicator Set | Indicator | Site | HH/CM Site(s) | MCO | Attending | Recipients | New QI Flag | Dropped QI Flag

Recipient	Medicaid ID	DOB	Race & Ethnicity	Quality Flags	Most Recent BH Outpatient Attending	Clinical Summary Last Viewed
DOE JOHN B	AB12345C	01/22/1990	Black	10+ ER, 2+ ER-Medical, 2+ Inpt-BH, 2+ Inpt-MH, HHPlus No HHPlus Service > 12 mos, HHPlus No HHPlus Service > 3 mos, HHPlus Not HH Enrolled, High MH Need, No MH Inpt F/U 30d (DOH), No MH Inpt F/U 30d (DOH) - Adult, No MH Inpt F/U 7d (DOH), No MH Inpt F/U 7d (DOH) - Adult		
SMITH JANE A	ED56789F	11/11/1960	Unknown	2+ Inpt-Medical, No MH Inpt F/U 30d (DOH), No MH Inpt F/U 30d (DOH) - Adult, No MH Inpt F/U 7d (DOH), No MH Inpt F/U 7d (DOH) - Adult, PrevHosp-DM	None Identified	No

Drill into a client's Clinical Summary or export to PDF or Excel

First Previous 1 Next Last

Race & Ethnicity View

My QI Report | Statewide Reports | Recipient Search | Provider Search | Registrar | Usage | Utilization Reports | Adult Home

MAIN STREET CLINIC

View: Race & Ethnicity | PDF | Excel

REGION: ALL COUNTY: ALL SITE: ALL PROGRAM TYPE: ALL AGE: | Filters | Reset

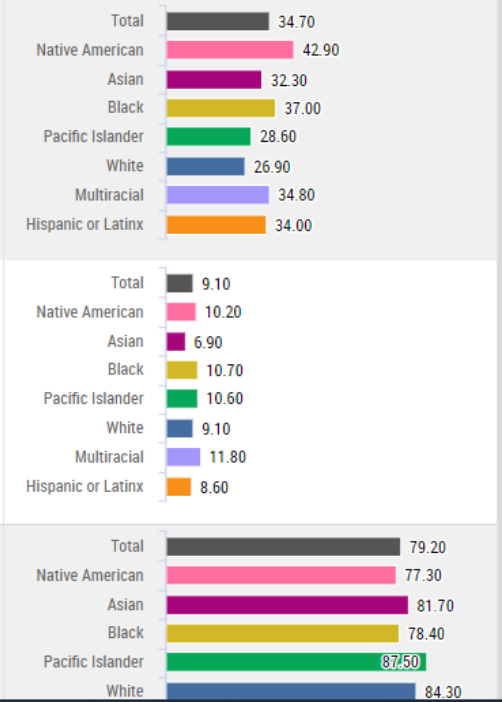
Race & Ethnicity view is available for both "Indicator Set" and "Indicator" tabs, displaying measure performance for each population group

Indicator Set

Quality Improvement Indicators (as of 06/01/2023)

Clients with QI Flags by Percentage (%) and Number

Indicator Set	Population	Total	Native American	Asian	Black	Pacific Islander	White	Multiracial	Hispanic or Latinx
BH QARR - Improvement Measure	All	34.7%	42.9%	32.3%	37%	28.6%	26.9%	34.8%	34%
		2,313	6	42	750	2	110	40	1,061
General Medical Health	All	9.1%	10.2%	6.9%	10.7%	10.6%	9.1%	11.8%	8.6%
		16,553	39	477	4,462	34	843	237	6,997
Health Home Care Management - Adult	Adult 18+	79.2%	77.3%	81.7%	78.4%	87.5%	84.3%	87.9%	77.5%
		7,870	17	85	2,455	14	595	145	4,013



Race & Ethnicity View

My QI Report | Statewide Reports | Recipient Search | Provider Search | Registrar | Usage | Utilization Reports | Adult Home

MAIN STREET CLINIC

View: Race & Ethnicity | PDF | Excel

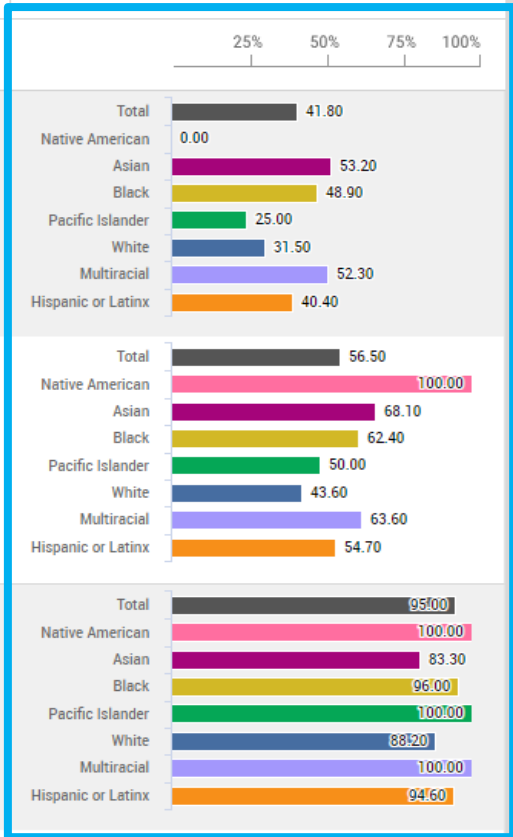
REGION: ALL COUNTY: ALL SITE: ALL PROGRAM TYPE: | Filters | Reset

Indicator Set: Vital Signs Dashboard - Adult

Indicator Set | Indicator

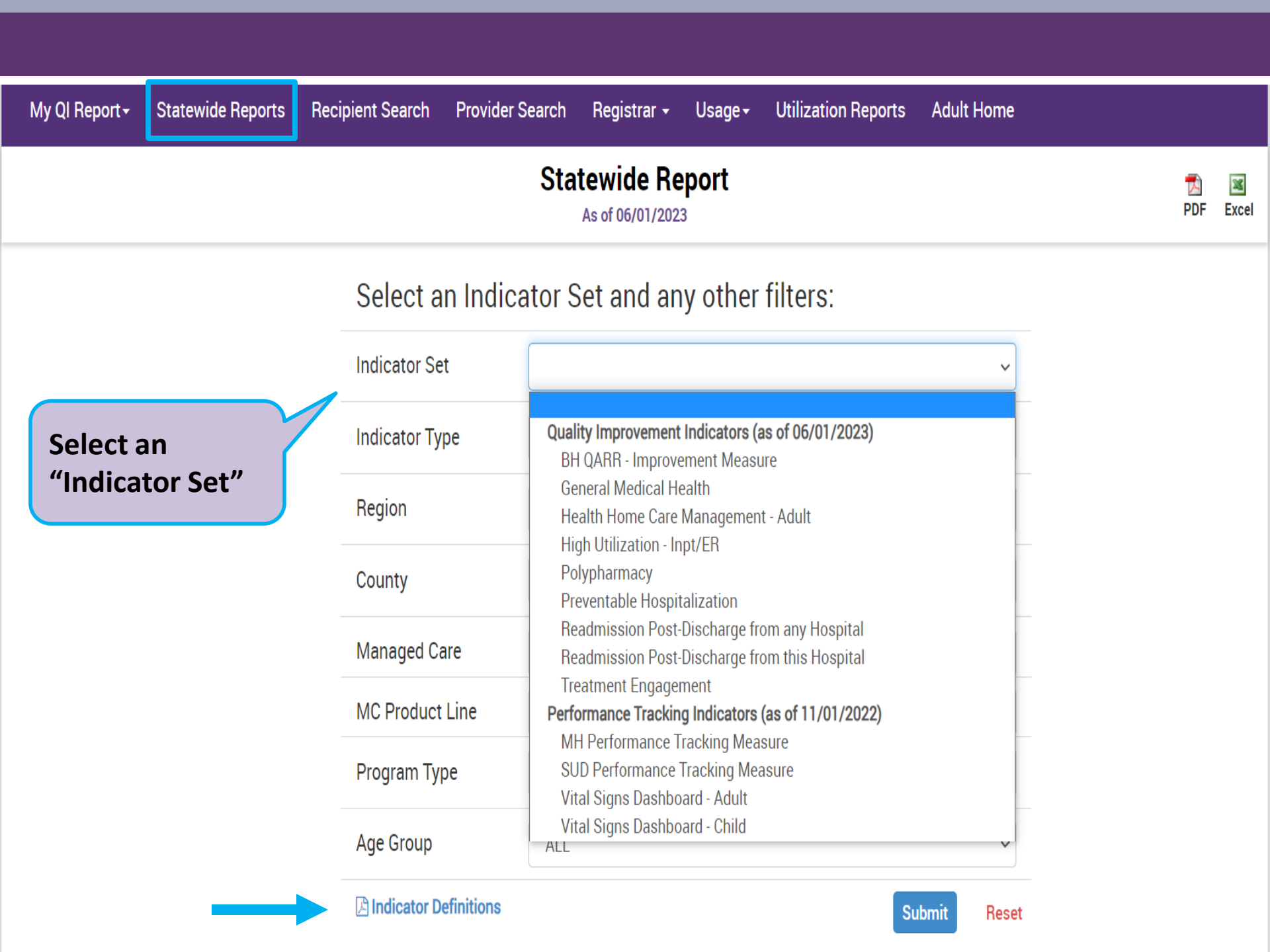
Use visual bar chart to quickly identify any disparities for a given quality indicator; drill-in to indicator to view flagged clients

Indicator	Population	Total	Native American	Asian	Black	Pacific Islander	White	Multiracial	Hispanic or Latinx
Antidepressant Medication Discontinued - Acute Phase	Adult 18+	41.8% 1,183	0% 0	53.2% 25	48.9% 325	25% 1	31.5% 47	52.3% 23	40.4% 550
Antidepressant Medication Discontinued - Recovery Phase	Adult 18+	56.5% 1,597	100% 1	68.1% 32	62.4% 415	50% 2	43.6% 65	63.6% 28	54.7% 745
Clozapine Candidate with 4+ Inpatient/ER - MH	Adult 18+	95% 285	100% 1	83.3% 5	96% 119	100% 2	88.2% 15	100% 8	94.6% 105



Statewide Reports

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health


My QI Report
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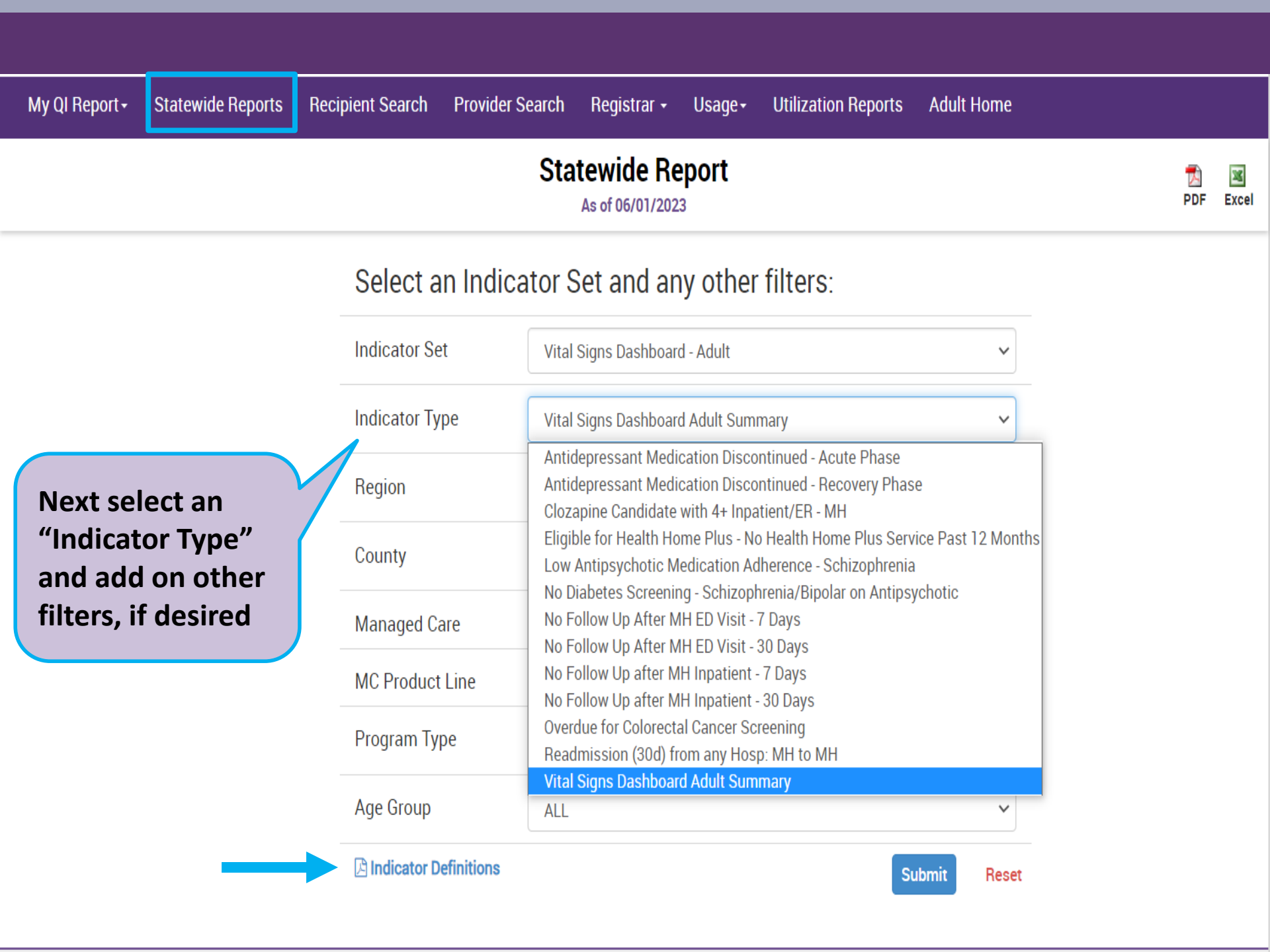
Provider Search
Registrar
Usage
Utilization Reports
Adult Home
Statewide Report
As of 06/01/2023
PDF
Excel
Select an Indicator Set and any other filters:
Indicator Set
Indicator Type
Region
County
Managed Care
MC Product Line
Program Type
Age Group
ALL
Quality Improvement Indicators (as of 06/01/2023)
BH QARR - Improvement Measure
General Medical Health
Health Home Care Management - Adult
High Utilization - Inpt/ER
Polypharmacy
Preventable Hospitalization
Readmission Post-Discharge from any Hospital
Readmission Post-Discharge from this Hospital
Treatment Engagement
Performance Tracking Indicators (as of 11/01/2022)
MH Performance Tracking Measure
SUD Performance Tracking Measure
Vital Signs Dashboard - Adult
Vital Signs Dashboard - Child
Indicator Definitions
Submit
Reset
Select an "Indicator Set"


My QI Report
Statewide Reports
Recipient Search
Provider Search
Registrar
Usage
Utilization Reports
Adult Home
Statewide Report
As of 06/01/2023
PDF
Excel
Select an Indicator Set and any other filters:
Indicator Set
Vital Signs Dashboard - Adult
Indicator Type
Vital Signs Dashboard Adult Summary
Region
County
Managed Care
MC Product Line
Program Type
Age Group
ALL
Antidepressant Medication Discontinued - Acute Phase
Antidepressant Medication Discontinued - Recovery Phase
Clozapine Candidate with 4+ Inpatient/ER - MH
Eligible for Health Home Plus - No Health Home Plus Service Past 12 Months
Low Antipsychotic Medication Adherence - Schizophrenia
No Diabetes Screening - Schizophrenia/Bipolar on Antipsychotic
No Follow Up After MH ED Visit - 7 Days
No Follow Up After MH ED Visit - 30 Days
No Follow Up after MH Inpatient - 7 Days
No Follow Up after MH Inpatient - 30 Days
Overdue for Colorectal Cancer Screening
Readmission (30d) from any Hosp: MH to MH
Vital Signs Dashboard Adult Summary
Indicator Definitions
Submit
Reset
Next select an "Indicator Type" and add on other filters, if desired

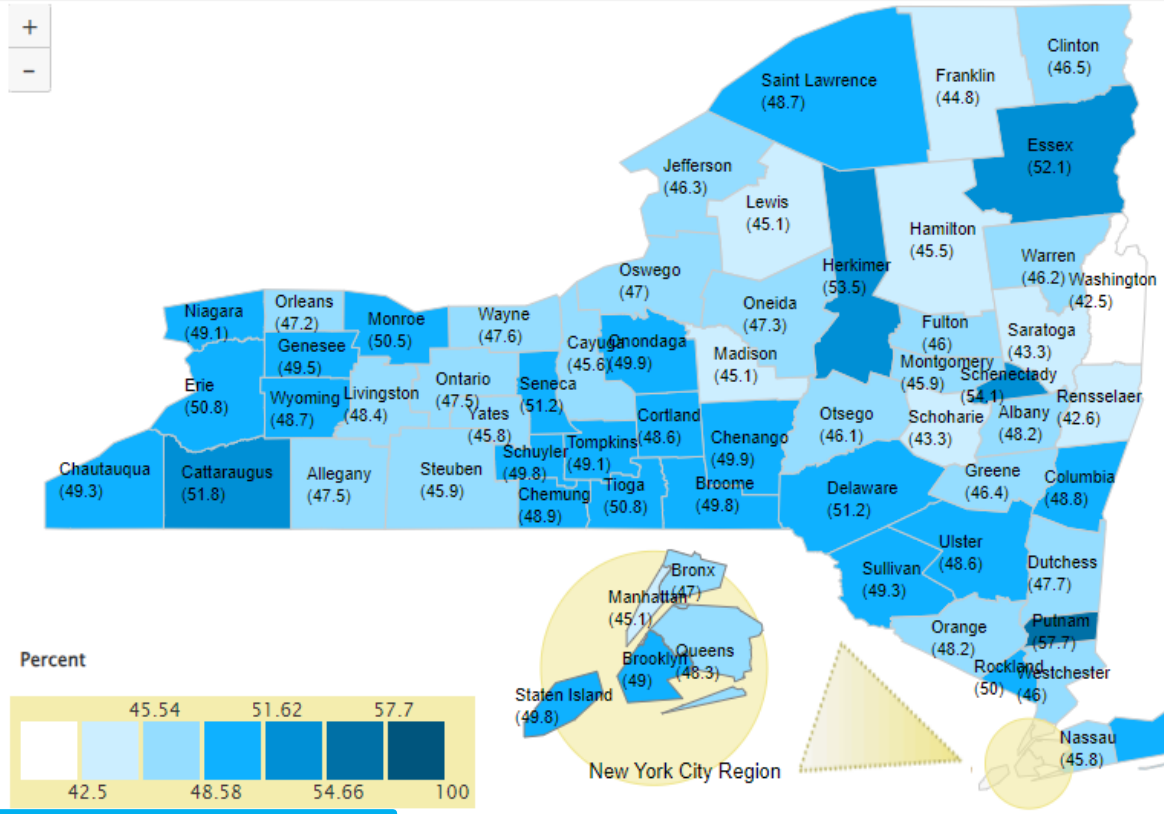
Statewide Report

As of 06/01/2023

PDF Excel

INDICATOR SET: VITAL SIGNS DASHBOARD - ADULT **INDICATOR**: VITAL SIGNS DASHBOARD ADULT SUMMARY

Filters



The map of New York State provides a visual of the percentage of positive cases flagged for the selected quality indicator, organized by county

Region | County | Network | Provider | Plan

Region	Eligible Population	# with QI Flag	%
STATE	490,821	232,548	47.4
Central NY	54,124	26,644	49.2
Hudson River	111,475	52,878	47.4
Long Island	56,047	26,309	46.9
New York City	261,990	121,005	46.2

Vital Signs Dashboard (VSD)

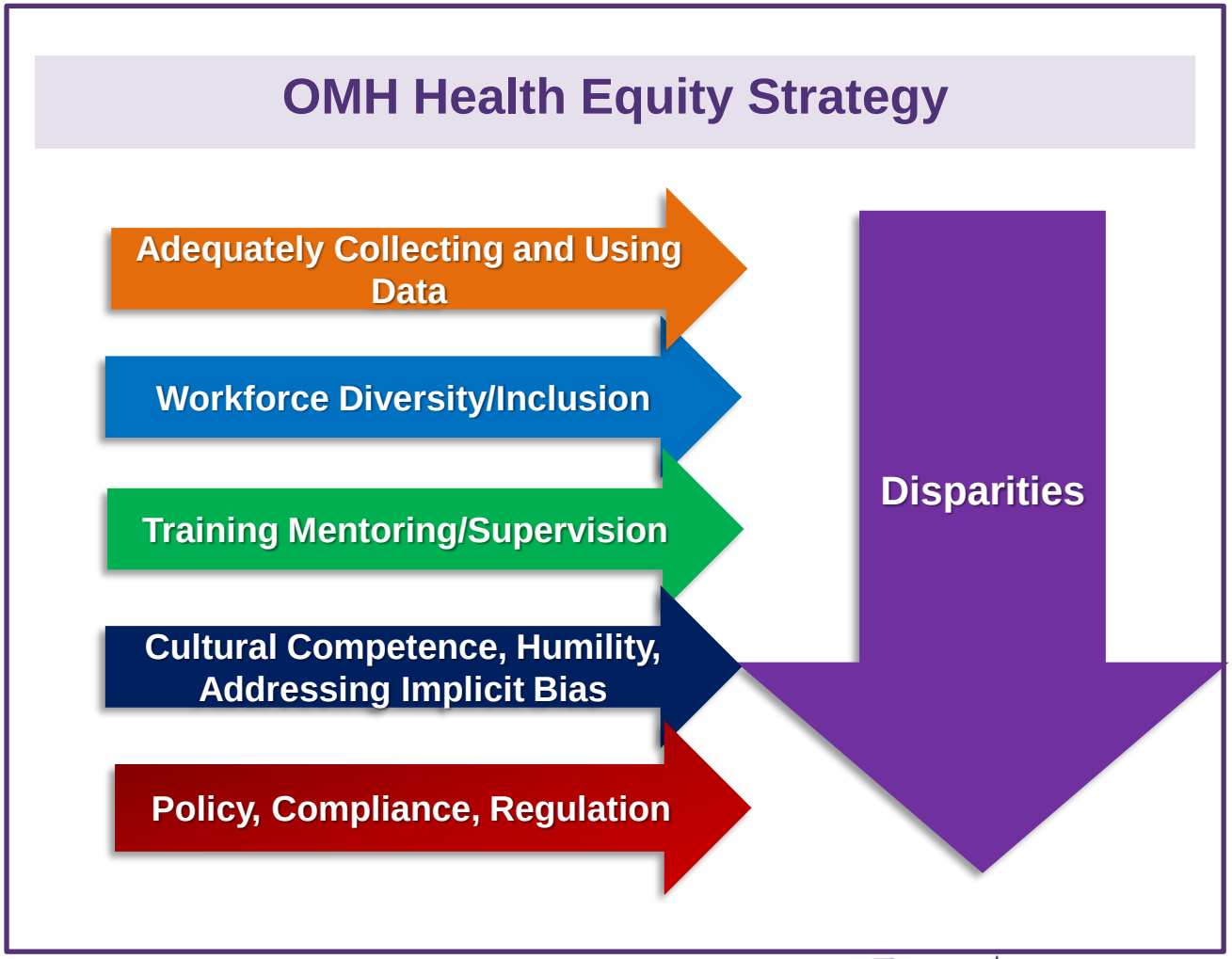
NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

What is the VSD?

- A tool to visualize public mental health system performance within domains of access, quality and treatment outcomes
  - Data is derived from Medicaid claims and encounters, refreshed monthly (currently July 2021 – June 2022)
  - Includes full Medicaid mental health (MH) population
- Data is available by:
  - County, Region, Provider Agency or Network
  - Population: Full MH population, OMH-licensed Programs, Program type
  - Disparity population: Race/ethnicity, gender, region
- Assess results of strategic planning and serve as input into program management
- Share metrics with county planning and mental health providers for planning and quality improvement purposes

Why is the VSD Important?

- The Vital Signs Dashboard is part of OMH's multi-faceted health equity approach to address needs and reduce health disparities
  - VSD can aid in **identifying disparities**
  - Data within VSD can be leveraged to **inform program and policy**



VSD Measures - Adult

Domain	Measure Name
Access	Colorectal Cancer Screening
	Proportion of Individuals Eligible for HH+ that are Receiving HH+
Treatment Outcome	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
	Antidepressant Medication Management, Acute Phase Treatment (1st 12 Weeks)
	Antidepressant Medication Management, Continuation Phase Treatment (1st 6 Month)
	Psychiatric Inpatient Readmission within 30 Days of Discharge
Quality	Clozapine Utilization among Potential Clozapine Candidates with Schizophrenia
	Diabetes Screening for Individuals with Schizophrenia/Bipolar on Antipsychotic Medication
	Follow-Up After Emergency Department Visit within 7 Days
	Follow-Up After Emergency Department Visit within 30 Days
	Follow-Up After Hospitalization for Mental Illness within 7 Days
	Follow-Up After Hospitalization for Mental Illness within 30 Days

VSD Measures - Child

Domain	Measure Name
Access	Immunization for Adolescents, HPV
	Immunization for Adolescents, Meningococcal
	Immunization for Adolescents, TDAP
	Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics
Treatment Outcome	Psychiatric Inpatient Readmission within 30 Days of Discharge
Quality	Follow-Up After Emergency Department Visit within 7 Days
	Follow-Up After Emergency Department Visit within 30 Days
	Follow-Up After Hospitalization for Mental Illness within 7 Days
	Follow-Up After Hospitalization for Mental Illness within 30 Days
	Follow-Up Care for Children Prescribed ADHD Medication, Initiation
	Follow-Up Care for Children Prescribed ADHD Medication, Continuation

VSD Access

- Release to Mental Health Providers: August 2022
- VSD Tableau is accessed through a weblink
- OMH providers were sent the link and encouraged to forward the link to any staff that would benefit from using the VSD in their work
- Link works best on Chrome, Edge, or Safari web browsers
- Link to the VSD:

  https://mypublicdashboard.ny.gov/t/OMH/views/OMHVitalSignsDashboardVSD/VSDHome-Adult?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n

- Public release: August 2023

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

OMH Vital Signs Dashboard (VSD) - Adult

The OMH Vital Signs Dashboard (VSD) visualizes the public mental health system's performance in select mental health programs and focuses on disparities in access, quality, and treatment outcomes among Medicaid individuals with mental health needs.

Select Region, County, Network, or Agency: STATEWIDE

Select Population: Full MH Population

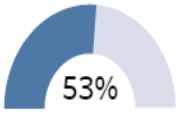
Reset

STATEWIDE Full MH Population Vital Signs Measure Distribution from Medicaid (Adult, July 2021 - June 2022)

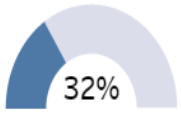
Hover over % for measure definitions (full list in 'Definitions' tab). All measures leverage Medicaid data.

Access

Statewide Medicaid: 46%^

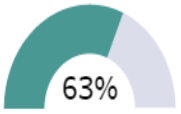


Colorectal cancer screening

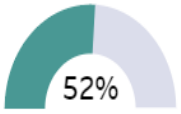


Received HH+ Service Among Individuals Eligible for HH+

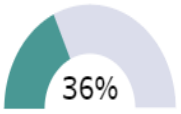
Treatment Outcome



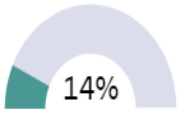
Adherence to Antipsychotic for Individuals w/ Schizophrenia



Antidepressant Med Management - Acute Phase

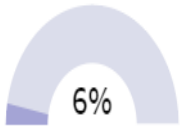


Antidepressant Med Management – Continuation Phase

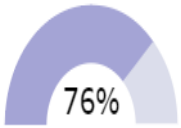


Readmission 30 Day Any Hospital MH-MH

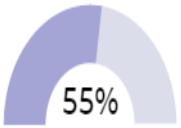
Quality Domain



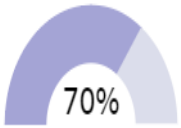
Clozapine Utilization among Potential Clozapine Candidates with Schizophrenia



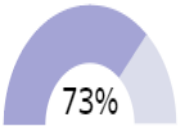
Diabetes Screening for Individuals w/ Schizophrenia/Bipolar Prescribed Antipsychotic



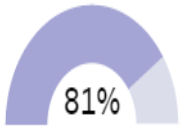
Follow-Up After Hospitalization for Mental Illness, 7 Day



Follow-Up After Hospitalization for Mental Illness, 30 Day



Follow-Up After MH ED Visit, 7-day



Follow-Up After MH ED Visit, 30-day

VSD Home - Adult | VSD Home - Child | Data Download | Definitions

OMH Vital Signs Dashboard (VSD) - Adult

The OMH Vital Signs Dashboard (VSD) visualizes the public mental health system's performance in select mental health programs and focuses on disparities in access, quality, and treatment outcomes among Medicaid individuals with mental health needs.

Select Region, County, Network, or Agency
STATEWIDE

Select Population
Full MH Population

Reset

STATEWIDE Full MH Population Vital Signs Measure Distribution from Medicaid (Adult, July 2021 - June 2022)

Hover over % for measure definitions (full list in 'Definitions' tab). All measures leverage Medicaid data.

Access | Treatment Outcome

Statewide Medicaid: 46%^

Domain	Measure	Measure Description	Age Specification	Denominator	Numerator	Data Collection Timeframe
Access	Colorectal cancer screening	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.	Adult (50-75)	N=537425 The number of Medicaid members 50–75 years old.	N=283608 The number of members 50–75 years old with one or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following: • FOBT during the measurement year. • Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. • Colonoscopy during the measurement year or the nine years prior to the measurement year. • CT colonography during the measurement year or the four years prior to the measurement year. • FIT-DNA during the measurement year or the two years prior to the measurement year.	Jul. 1, 2021 - Jun. 30, 2022

53%
Colorec cancer s

6%
Clozapine Utilization amc
Clozapine Candidates with Schizophrenia

Schizophrenia/Bipolar Prescribed Antipsychotic

Mental Illness, 7 Day

Mental Illness, 30 Day

ny Hospital MH-

ED Visit, 30-day

Scroll down

Select Disparity Population

Race/Ethnicity

Select to View Chart/Table

Table

STATEWIDE Full MH Population Disparities by Race/Ethnicity (Adult, July 2021 - June 2022)

§Statewide Average Performance is Referring To Statewide Full MH Population Average Rate.

Higher than Statewide Average Performance**
Equal to Statewide Average Performance**
Lower than Statewide Average Performance**

Measure	Population	Statewide Average Performance§	Disparity Cateogory	Numerator	Denominator	Performance	Lower than Statewide**	Equal to Statewide**	Higher than Statewide**
Antidepressant – Acute Phase	Full MH Population	52%	Total	24,408	46,808	52%		●	
			Asian/PI	856	1,701	50%	●		
			Black	3,416	7,793	44%	●		
			Hispanic	3,826	7,629	50%	●		
			Multiracial	5,802	10,840	54%			●
			Native American	104	202	51%	●		
			White	9,585	17,010	56%			●
			Unknown	819	1,633	50%	●		
Antidepressant – Continuation Phase	Full MH Population	36%	Total	17,033	46,808	36%		●	
			Asian/PI	572	1,701	34%	●		
			Black	2,284	7,793	29%	●		
			Hispanic	2,695	7,629	35%	●		
			Multiracial	3,921	10,840	36%		●	
			White	9,585	17,010	56%			●
			Unknown	819	1,633	50%	●		
Antidepressant – Continuation Phase	Full MH Population	36%	Total	17,033	46,808	36%		●	
			Asian/PI	572	1,701	34%	●		
			Black	2,284	7,793	29%	●		
			Hispanic	2,695	7,629	35%	●		
			Multiracial	3,921	10,840	36%		●	
			Native American	70	202	35%	●		
			White	6,918	17,010	41%			●
			Unknown	573	1,633	35%	●		
Clozapine Utilization (Schizophrenia)	Full MH Population	6%	Total	242	3,966	6%		●	
			Asian/PI	16	168	10%			●

*** Difference from statewide average performance is determined by 99% confidence interval of the statewide average performance.*
Data are suppressed where the total number of events (denominator) is less than 5, or the individual cell size (numerator) is less than 5 as well as the risk for re-identification (performance) is greater than 5%.

Select Disparity Population: Race/Ethnicity

Select to View Chart/Table: Table

STATEWIDE Full MH Population Disparities by Race/Ethnicity (Adult, July 2021 - June 2022)

§Statewide Average Performance is Referring To Statewide Full MH Population Average Rate.

Higher than Statewide Average Performance**
Equal to Statewide Average Performance**
Lower than Statewide Average Performance**

Measure	Population	Statewide Average Performance§	Disparity Cateogory	Numerator	Denominator	Performance	Lower than Statewide**	Equal to Statewide**	Higher than Statewide**
Antidepressant – Acute Phase	Full MH Population	52%	Total	24,408	46,808	52%		●	
			Asian/PI	856	1,701	50%	●		
			Black	3,416	7,793	44%	●		
			Hispanic	3,826	7,629	50%	●		
			Multiracial						●
			White						●
Antidepressant – Continuation Phase	Full MH Population	36%	Total	17,033	46,808	36%		●	
			Asian/PI	572	1,701	34%	●		
			Black	2,284	7,793	29%	●		
			Hispanic	2,695	7,629	35%	●		
			Multiracial	3,921	10,840	36%		●	
			White	9,585	17,010	56%			●
			Unknown	819	1,633	50%	●		
Antidepressant – Continuation Phase	Full MH Population	36%	Total	17,033	46,808	36%		●	
			Asian/PI	572	1,701	34%	●		
			Black	2,284	7,793	29%	●		
			Hispanic	2,695	7,629	35%	●		
			Multiracial	3,921	10,840	36%		●	
			Native American	70	202	35%	●		
			White	6,918	17,010	41%			●
			Unknown	573	1,633	35%	●		
Clozapine Utilization (Schizophrenia)	Full MH Population	6%	Total	242	3,966	6%		●	
			Asian/PI	16	168	10%			●

856 out of 1,701 (50%) Asian/PI beneficiaries remained on an antidepressant medication for 12 weeks. Asian/PI rate is lower than statewide full MH population average rate.

*** Difference from statewide average performance is determined by 99% confidence interval of the statewide average performance.*
Data are suppressed where the total number of events (denominator) is less than 5, or the individual cell size (numerator) is less than 5 as well as the risk for re-identification (performance) is greater than 5%.

Select Disparity Population: Race/Ethnicity

Select to View Chart/Table: Chart

STATEWIDE Full MH Population Disparities by Race/Ethnicity (Adult, July 2021 - June 2022)

§Statewide Average Performance is Referring To Statewide Full MH Population Average Rate.
Click on icons within the below key to highlight the respective group. Hover over points on graph to see rates.

Total (T) | White (W) | Black (B) | Hispanic (H) | Asian/PI (A) | Native American (N) | Multiracial (M) | Unknown (U) | Statewide Full MH Population Average Performance

Measure	Population	Statewide Average Performance§	Lower than Statewide**	Equal to Statewide**	Higher than Statewide**
Colorectal Screening	Full MH Population	53%			
Adherence to AP (Schizophrenia)	Full MH Population	52%			
Antidepressant – Acute Phase	Full MH Population	52%			
Antidepressant – Continuation Phase	Full MH Population	36%			
Clozapine Utilization (Schizophrenia)	Full MH Population	6%			
Diabetes Screening (Schiz/Bipolar AP)	Full MH Population	76%			
Follow-up MH Hospitalization 7 Day	Full MH Population	55%			
Follow-up MH Hospitalization 30 Day	Full MH Population	70%			

47,479 out of 71,722 (66%) Asian/PI beneficiaries had colorectal cancer screening. Asian/PI rate is higher than statewide full MH population average rate.

*** Difference from statewide average performance is determined by 99% confidence interval of the statewide average performance.*
Data are suppressed where the total number of events (denominator) is less than 5, or the individual cell size (numerator) is less than 5 as well as the risk for re-identification (performance) is greater than 5%.

Training & Technical Assistance

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

PSYCKES Training

- PSYCKES website: www.psyckes.org
- PSYCKES Training Webinars
  - Live webinars: Register on PSYCKES Training Webinars page
  - Recorded webinars: Slides and recordings available
    - Introduction to PSYCKES
    - Where to Start: Getting Access to PSYCKES
    - Using PSYCKES Quality Indicator Reports
    - Navigating PSYCKES Recipient Search for Population Health
    - Using the PSYCKES Clinical Summary
    - Consent, Emergency, Quality Flag: PSYCKES Levels of Access
    - PSYCKES Mobile App for iPhones & iPads
- PSYCKES User Guides & Short How-To Videos
  - www.psyckes.org > PSYCKES Training Materials

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

Helpdesk Support

- PSYCKES Help (PSYCKES support)
  - 9:00AM – 5:00PM, Monday – Friday
  - PSYCKES-help@omh.ny.gov
- Data OPHE Help (VSD support)
  - 9:00AM – 5:00PM, Monday – Friday
  - DataOPHE@omh.ny.gov
- Help Desk (Token, Login & SMS support)
  - ITS (OMH Employee) Helpdesk:
    - 1-844-891-1786; fixit@its.ny.gov
  - Provider Partner (Non-OMH Employee) Helpdesk:
    - 518-474-5554, opt 2; healthhelp@its.ny.gov