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2016 Continuous Quality Improvement Project : Care Transitions Network

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  - Do not use Chat function for Q&A
  - You may type in your questions at any time. We will type a response as they come in.
  - During the last 20 minutes we will read project related question aloud during the Q&A portion.
- Slides will be emailed to attendees after the webinar kick-off series is complete (Last Webinar date: 9/21/16)

Webinar Learning Objectives

By participating in today's webinar, you will:

- Review CMS' vision for national transformation of clinical practice and the goals of the Care Transitions Network (CTN) project,
- Understand the approach and tools that you will use to achieve these goals as part of CTN,
- Learn about the infrastructure, process and clinical quality measures that you will track to assess your progress,
- Define the project activities, timeline, and resources, and
- Identify next steps you will be taking to implement the project

Care Transitions Network: Project Overview

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for People with Serious Mental Illness

Background

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The CMS Transforming Clinical Practice Initiative

- The Care Transitions Network is part of the Centers for Medicare and Medicaid Services (CMS) national "Transforming Clinical Practice Initiative"

- CMS's transformation initiative aims to help providers progress through the five "phases of transformation"
  - Move toward value based payment/ pay for performance
  - Achieve the triple aim: improved health, better care, lower cost
  - Intends to reach 140,000 clinicians nationwide

- Care Transitions Network is one of 29 Practice Transformation Networks (PTNs) nationwide
  - Only PTN focused on supporting clinicians who serve people with serious mental illness

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CTN Project Vision

By 2019, Care Transitions Network members will:

- ✓Strengthen clinical leadership to reduce costs and improve quality of care for people with serious mental illness
- ✓Build the necessary infrastructure and workforce capacity to successfully transition to value based payment
- ✓Have the **acumen to thrive as a business** in a rapidly-changing environment

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CTN Project Goal

To reduce all-cause re-hospitalization rates by **50 percent** for people with serious mental illness

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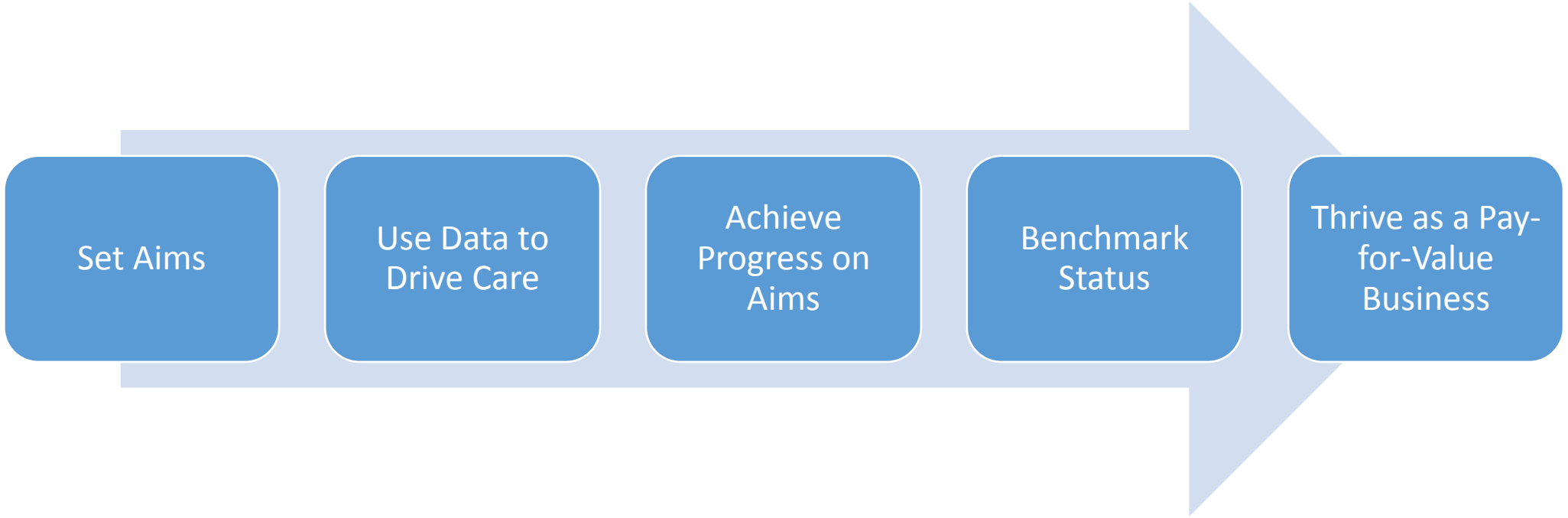
Change Model: Phases of Transformation

- The phases of transformation are how CMS defines an organization's progress towards preparedness for value based payment



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CMS Change Package:
Primary and Secondary Drivers

Patient and Family-Centered Care Design	1.1 Patient & family engagement 1.2 Team-based relationships 1.3 Population management 1.4 Practice as a community partner 1.5 Coordinated care delivery 1.6 Organized, evidence-based care 1.7 Enhanced access
Continuous, Data-Driven Quality Improvement	2.1 Engaged and committed leadership 2.2 QI strategy supporting a culture of quality and safety 2.3 Transparent measurement and monitoring 2.4 Optimal use of HIT
Sustainable Business Operations	3.1 Strategic use of practice revenue 3.2 Staff vitality and joy in work 3.3 Capability to analyze and document value 3.4 Efficiency of operation

CMS has identified the underlying provider infrastructure, systems and culture, called "drivers," that support program transformation

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The Practice Assessment Tool (PAT)

- The PAT is a self-assessment tool developed by CMS and is being used nationwide to support all Transforming Clinical Practice Initiatives
- The PAT is comprised of 22 milestones for each program to assess themselves based on provided scoring criteria
  - PAT score determines your program's phase of transformation
  - Each PAT milestone is tied to a primary/secondary driver of change
  - Milestone scores identify opportunities for improvement
  - Action Plans are developed, focusing on a few milestones at a time
  - A Change Package is then used to identify the change tactics that can be implemented to improve those milestone scores

Project Measures

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CTN Project Measures

The CTN project includes two types of measures:

1. Practice Assessment Tool (PAT):
    - 22 item self-assessment of a program's phase of transformation
    - Designed to assess infrastructure and capacity to deliver high quality care
    - Clinics will complete every 6 months

2. Clinical Quality Measures:
    - National measures of clinical care processes and outcomes
    - Medicaid claims data is the source for calculating these measures
    - Measures will be provided to clinics through PSYCKES and a Netsmart web-based application

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Clinical Quality Measures: Process & Outcomes of Care

- **All cause 30 day readmission.**
- Mental health 30 day readmission.
- Follow up after hospitalization for mental illness, 7 days and 30 days.
- Diabetes screening for people with schizophrenia or bipolar using antipsychotics
- LDL screening for people with schizophrenia or bipolar using antipsychotics
- Use of Clozapine
- Use of antipsychotic long acting injectable (LAIs) for schizophrenia
- Adherence to mood stabilizers for individuals with bipolar I disorder
- Adherence to antipsychotic medications for individuals with schizophrenia
- Use of multiple concurrent antipsychotics
- Initiation (14d), engagement (30d) of alcohol and other drug dependence treatment.
- **Proportion of HARP-enrolled individuals not enrolled in a health home.**

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Activities

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Project Activities Include:

- Submission of Enrollment Agreement
- At enrollment and every six months each clinic will:
  - Complete Practice Assessment Tool (PAT)
  - Review and update enrolled clinician form
  - Participate in a goal setting call
  - Development of action plan (with CTN coaches)
- Ongoing:
  - Implementation of action plan
  - Review clinical quality measures to assess progress; include measures that need improvement in action planning
  - Utilize CTN technical assistance as needed!

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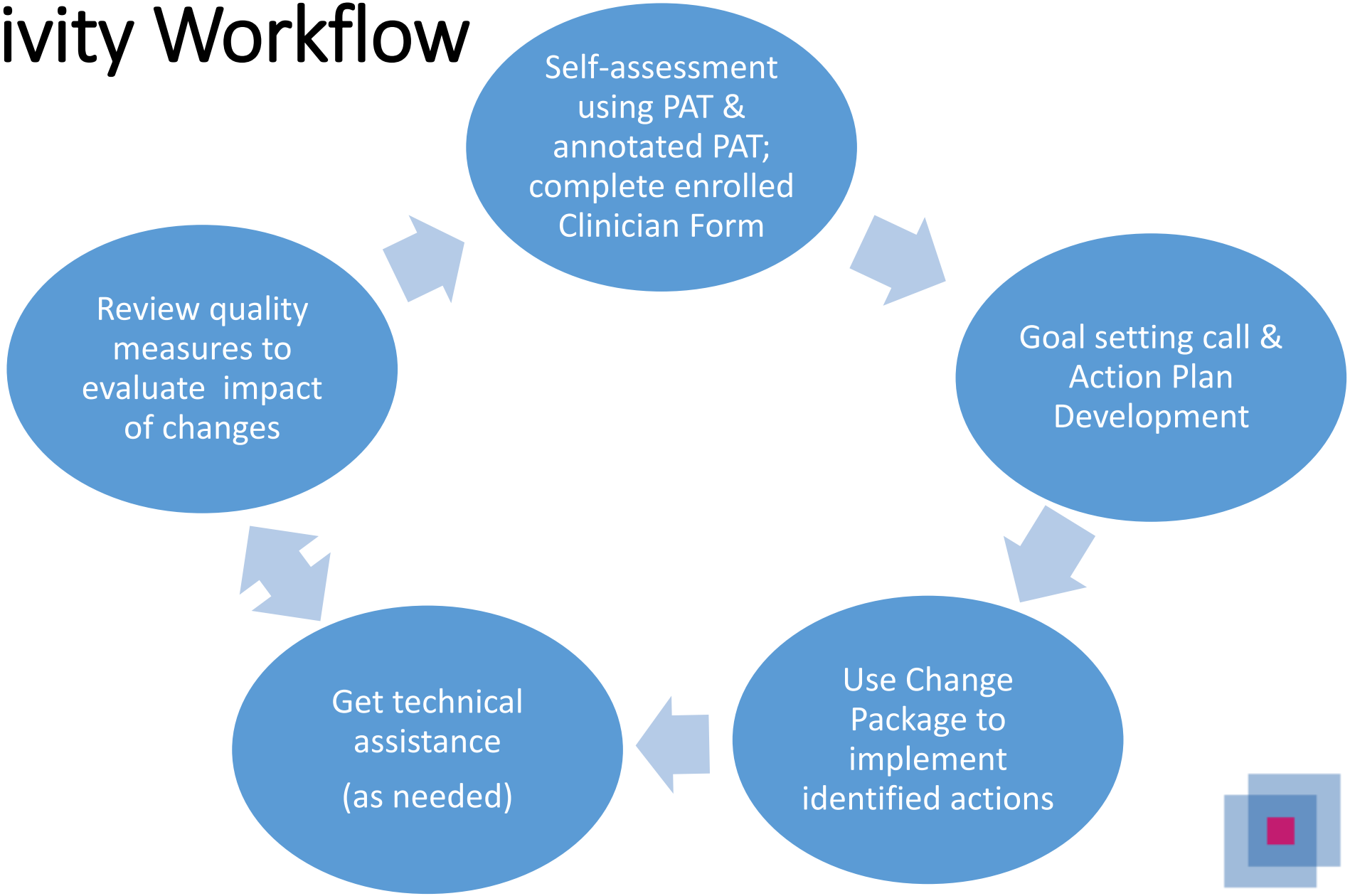
Activity Workflow



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PAT Completion & Goal Setting Calls

- Enrolled Clinics participate in an initial hour-long goal setting call with Care Transitions Network staff to:
  - Review results of the PAT self-assessment
  - Identify specific goals and objectives tied to the PAT
  - Create an action plan to improve milestones
  - Identify TA content and support we can provide to achieve goals
- Every 6 months, Clinics are asked to reassess themselves with the PAT and another goal setting call will be scheduled to discuss progress, challenges, and new goals.

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Developing an Action Plan: Select Milestones

- During the goal setting call, your CTN coaches will support you in developing a strategic plan (Milestone 13)

SPECIALTY CARE 2.0		
	Change Concept Ref	Milestone
13	2.1.2	Practice has developed a vision and plan for transformation that includes specific clinical outcomes and utilization aims that are aligned with national TCPI aims and that are shared broadly within the practice.

- During the goal-setting call, the Clinic team and the CTN coaches will utilize the CMS Change Package as a roadmap to create the overall strategic plan and improvement processes for the next six months

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Using PSYCKES to Support Action Planning

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PSYCKES Support for Your Action Plan

- Consent all Medicaid enrollees
- Identify clients with quality flags
  - HARP/ Health Home enrollment
- Review clients clinical summary to support treatment
  - Identify care coordination contacts/ Health Home assignment

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Consent All Clients

- The need for consent
  - PSYCKES quality flags will allow you to see most of the clients data but not:
    - Substance Use,
    - HIV,
    - Family planning,
    - Safety Plans and other MyPSYCKES data
  - You will not be able to search & review data on clients with suicide attempts, HARP status, or other search criteria of interest
- PSYCKES has recently made consent easier
  - Any user can now consent (not just “Registrars”)
  - Can consent from Recipient Search (not just the Registrar tab)

Consent Clients: Project Planning

- Incorporate PSYCKES Consent into intake package for new clients
- One time effort to obtain PSYCKES consent for existing clients
    - Time with Treatment Plan Update, or
    - Front desk or clinician obtains on next visit
- Identify which staff will enter consent into PSYCKES
- Identify how clinical staff will obtain and review clinical summary
- Train staff – ongoing PSYCKES consent training webinars

HARP Enrolled - Not Health Home Enrolled

Why is this measure important?

- HARP is a Medicaid managed care program that offers individuals with serious mental illness an enriched benefit & services package
- Enrollment in a Health Home (HH), and development of a plan of care by the HH Care Manager is the only way your clients will be able to access their HARP benefits & services including Care Management and Home and Community Based Services
- Only about a third of HARP Enrollees are HH enrolled statewide

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HARP- HH Enrollment: Why Focus on this measure first?

- Establishing relationships with HHs, CMs and MCOs is an infrastructure development process that will support your other project goals and measures
  - You are the most effective route for referral
  - CMs will develop the Plan of Care determining service package – they need your input
  - Many of the quality measures require linkages and outreach that are challenging for clinics but where CMs can help:
    - post hospital discharge outreach,
    - community outreach to support attendance at appointments
    - links to medical or laboratory services

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Action Plan to Increase Health Home Enrollment

1. Build your Health Home and Managed Care Organization network and contact sheet
2. Develop a workflow for referrals and enrollment
3. Educate staff on:
   - The importance and value of HH enrollment
   - Identifying if a client has a Care Manager
   - Making a Health Home referral
4. Use PSYCKES Recipient Search to identify individuals in need of a Health Home referral (updated weekly)
5. Use PSYCKES QI Reports to track progress (updated monthly)

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Building your Health Home & MCO Network

- Identify Health Homes in your area using the DOH Health Home Contact List: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/contact_information/
    - Call the referral number for local Health Homes
    - Introduce the Clinic and confirm:
        - The best phone # for referrals
        - The format and process for making referrals
        - The best phone # to coordinate care for enrolled clients
- Work with your MCOs to determine their process for referrals
    - Clients have to go to a HH that has a contract with their MCO
- If your agency includes Care Management programs, collaborate with them regarding referrals and training
- Develop a HH/CM and MCO contact sheet and referral protocols for your clinic

Guidance on Making Health Home Referrals

- Use PSYCKES to identify HARP-enrolled but not HH-enrolled
- Patient engagement: review benefits of CM, & obtain consent to refer
- Send referral:
  - Use the contact sheet and protocols you developed
  - You can send to the MCO, HH or directly to CM program
  - You are not obliged to send to the outreach/ assigned HH/CM- you can send to any HH/CM that contracts with that client's MCO
- Referral processes may vary by HH, by CM program, and by Managed Care Plan – get to know your partners!
- Document barriers and share lessons learned
  - Challenges and strategies will be reviewed in Learning Collaborative calls
  - You can also call DOH Provider HH Hotline (518) 473-5569

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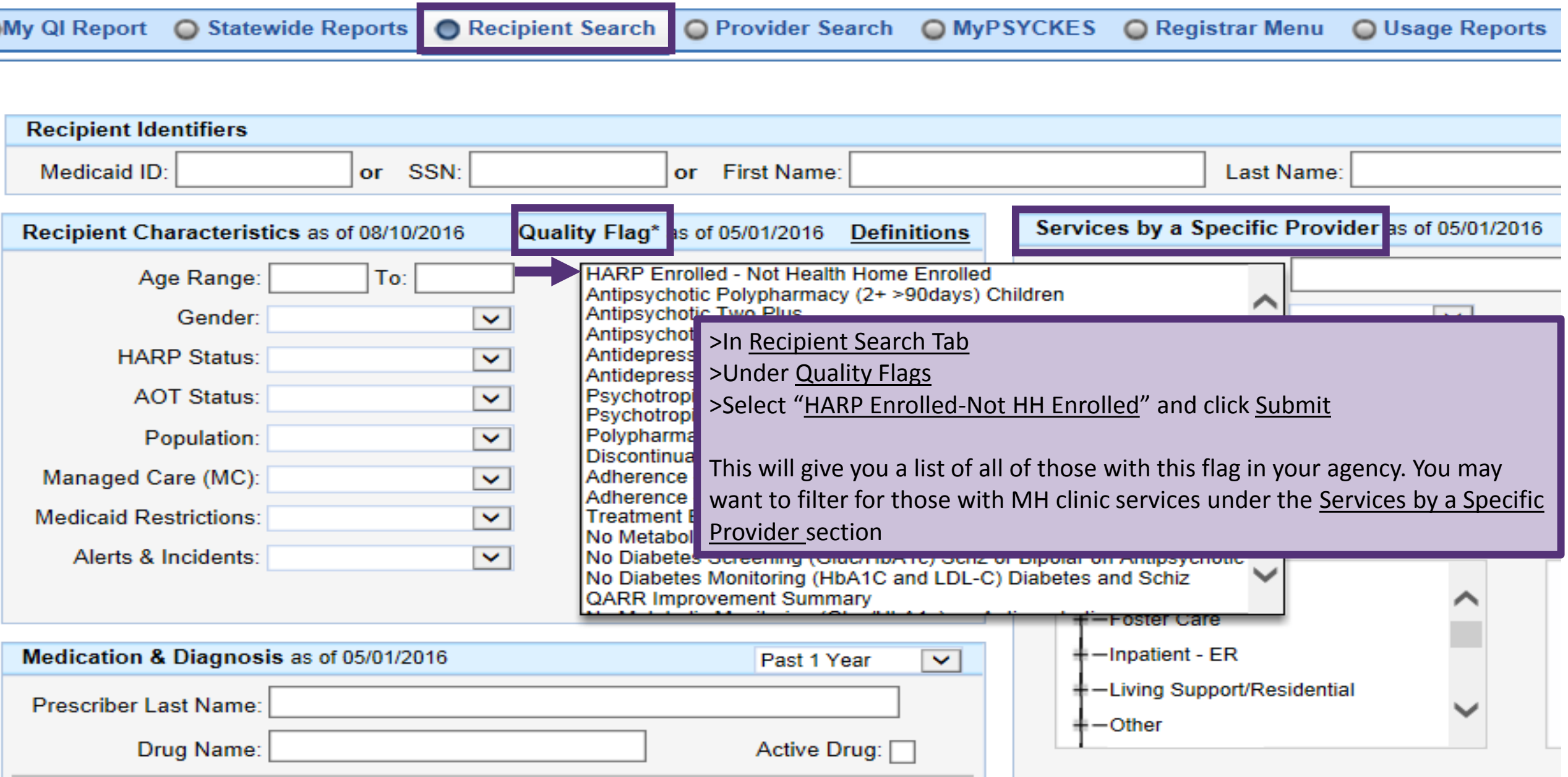
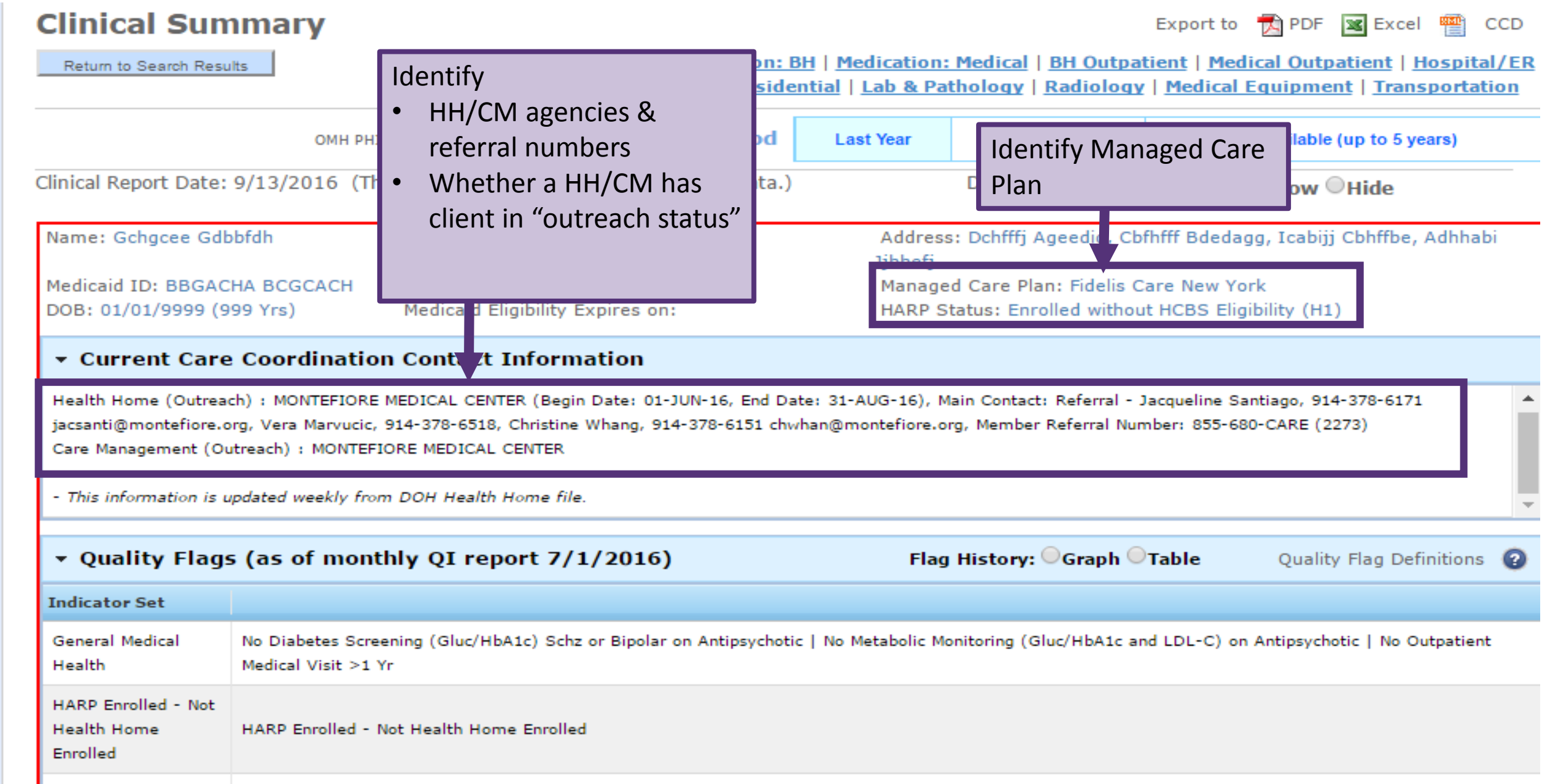
Workflow Development

- Develop a workflow for tracking HH/CM referrals and enrollment, including:
  - Providing clinicians with their list of clients who need a HH referral
  - Receiving information on which clients have received a referral
  - Tracking HH/CM enrollment
  - Feedback to staff on progress
  - Outreach to CM to ensure input on Plan of Care
  - Outreach to CM when need their support for client care
- Develop Policies & Procedures with new workflows & train staff

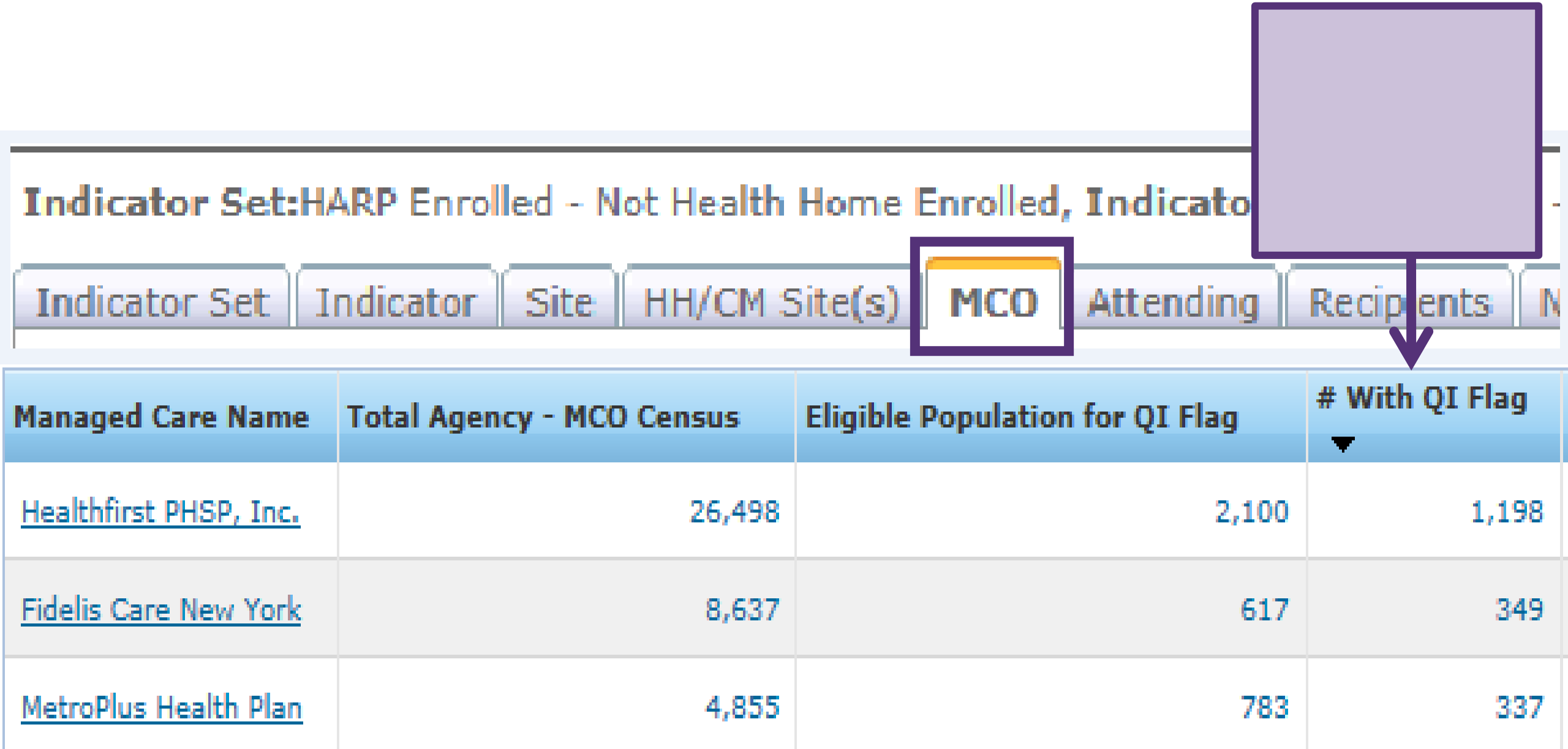
Identifying Clients in Need of HH Referral: Recipient Search



Identifying Clients in Need of HH Referral: Clinical Summary

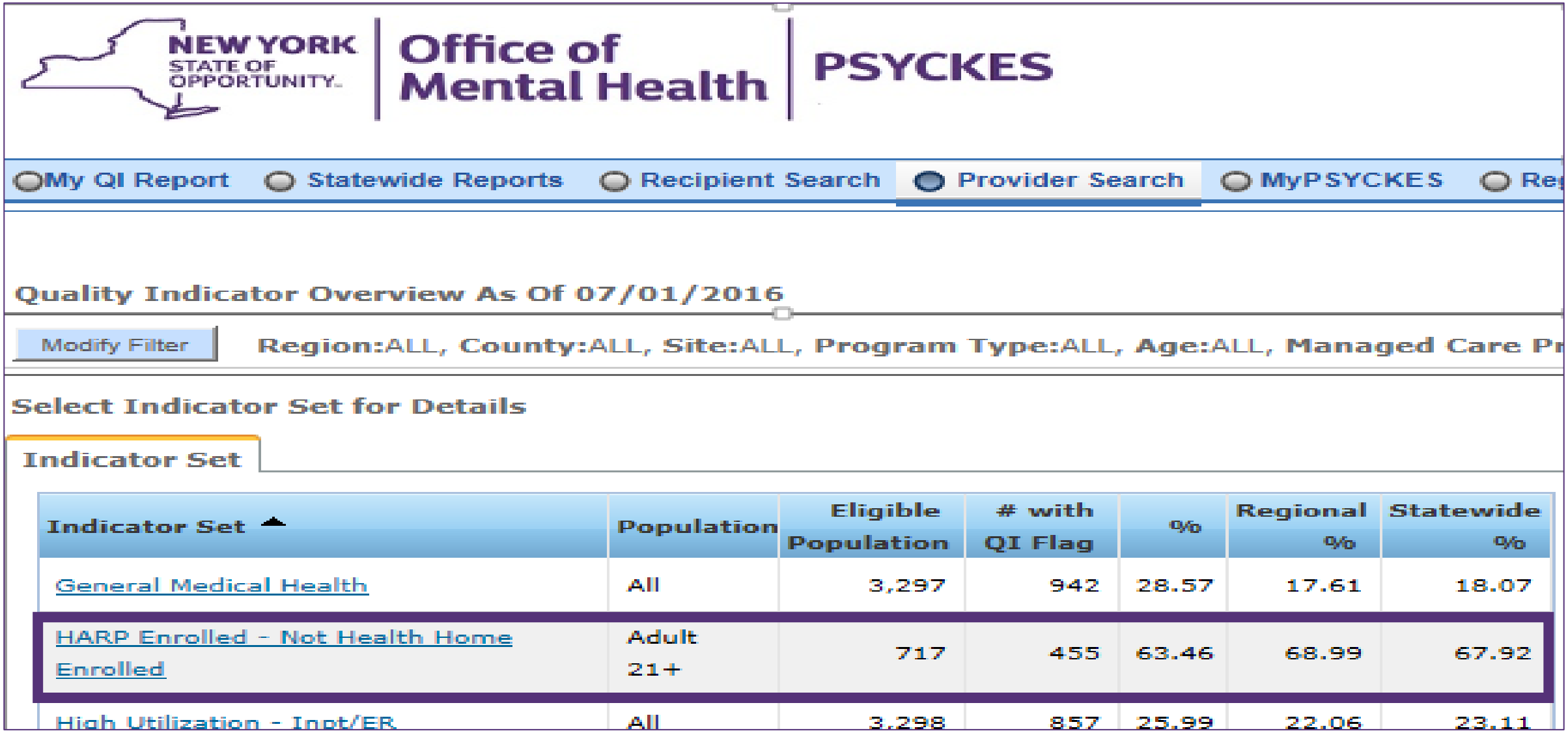


Self Analysis: Which MCOs serve these clients?



Managed Care Name	Total Agency - MCO Census	Eligible Population for QI Flag	# With QI Flag
Healthfirst PHSP, Inc.	26,498	2,100	1,198
Fidelis Care New York	8,637	617	349
MetroPlus Health Plan	4,855	783	337

Tracking Progress in PSYCKES QI Report



Indicator Set	Population	Eligible Population	# with QI Flag	%	Regional %	Statewide %
General Medical Health	All	3,297	942	28.57	17.61	18.07
HARP Enrolled - Not Health Home Enrolled	Adult 21+	717	455	63.46	68.99	67.92
High Utilization - Inpt/ER	All	3,298	857	25.99	22.06	23.11

Resources

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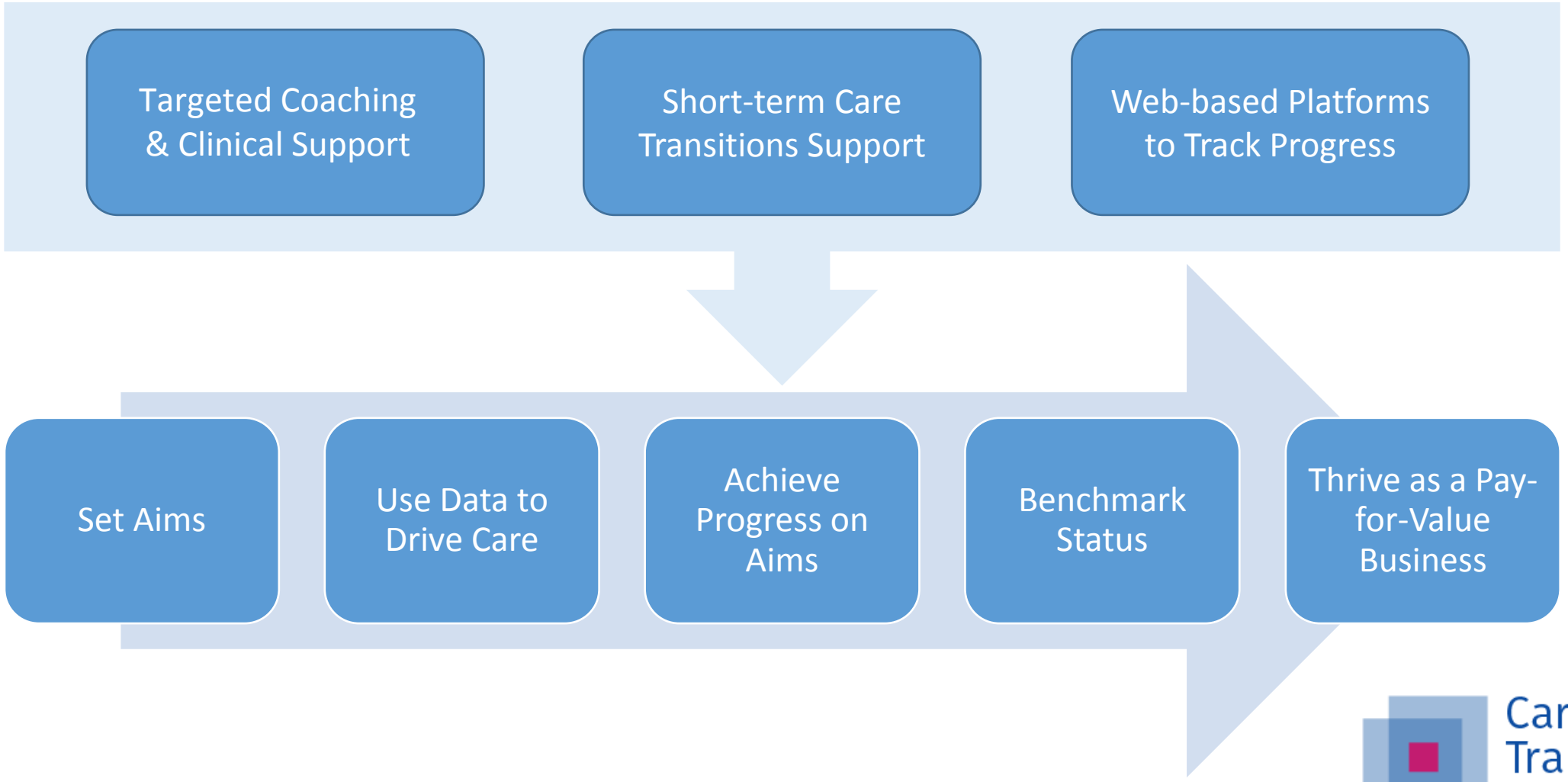
Technical Assistance Approach



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Technical Assistance – Between Goal Setting Calls

- Technical assistance is available to the entire workforce in your program or agency as frequently as you'd like it between goal setting.
  - Your Care Transitions Network point of contact will likely check in occasionally to share TA opportunities or see if you need anything.
- As a member of the Network, you now have access to:
  - Best clinical practice support services
  - Technical assistance
  - Care Transitions support

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Best Clinical Practice Support Services

- Northwell Health faculty include psychiatrists and an internist who specialize in medical-SMI co-morbidity
- Your enrolled clinicians can access information about best practices directly from the Care Transitions Network website, 24/7
- Clinicians can also request individual consultations, which can take place over email or telephone.

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Care Transitions Support

- Through partnership with Montefiore/UBA, the Care Transitions Network is providing short-term care transitions support to ensure connection to outpatient care for adult patients after discharge from psychiatric hospitalizations
- As an outpatient clinic, this intervention could result in:
  - Referrals of patients nearing discharge from psychiatric hospitalization
  - Improved patient attendance at outpatient appointments following discharge
  - Support with patient engagement in outpatient services following discharge

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Netsmart Web-based Platform for Quality Improvement

Regular dashboard reports on:

- Readmission rates (all-cause and psychiatric)
- Medication adherence and polypharmacy
- Preventive care screening and follow up (e.g., tobacco, BMI, depression)

Data sources

- Data derived from Medicaid claims - PSYCKES
- Participating organizations may submit additional data sources for a more complete QI picture (e.g., non-claims based measures that align with Meaningful Use, commercial, etc.)

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Incentive Payments

- Care Transitions Network offices incentive payments of up to $1,000 per eligible clinician
- Incentive payments are determined by two things:
  - Number of enrolled clinicians
  - Practice progression through Phases of Transformation
- Incentive payments will be distributed at baseline assessment and goal setting call and as organizations progress through the phases of transformation during six month PAT reassessments/goal setting calls
- As an organization progresses through each of the transformation phases, it will receive $200 for each enrolled eligible clinician

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Next Steps

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What's Next

- Submit enrollment documents (if you haven't already!)
- Schedule a goal setting call with Care Transitions Network staff
  - Our staff will reach out and work with you to set this up
  - Some people on this webinar may have already participated in or scheduled their call
- Share information about the Network and its resources with staff

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Questions?

Visit our website or contact us:

www.CareTransitionsNetwork.org

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