NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

Continuous Quality Improvement Phase IV Project Overview

- 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
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How to Participate in Q&A via WebEx

- All phone lines are muted
- Access “Q&A” box in WebEx menu at the right of your screen; if you expanded the view of the webinar to full screen, hover cursor over green bar at top of screen to see menu
- Type questions using the “Q&A” feature
  - Submit to “all panelists” (default)
  - 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: July 28, 2016).

What is the OMH CQI Initiative for Freestanding Clinics?

NYS Office of Mental Health launched the CQI initiative in 2005. These initiatives have been PSYCKES-supported since 2008.

Aims:

- Foster data-driven quality improvement and clinical decision making within freestanding mental health clinics, D&TCs, and state operated clinics.
- Improve the safety, efficiency, and quality of care.
- Promote best practices in psychotropic prescribing, clinical services, and health integration in the NYS Medicaid population.
- Help clinics build readiness for participation in evolving public health environment.

Incentives for Participating Clinics:

- Eligible clinics receive enhancement (currently 3.84%) to Medicaid billing.
- Enhancement expires in March 2018 (NYC) and in June 2018 (ROS).

292 participants in Phase III:

- 221 Article 31 freestanding clinics, 16 D&TC's, 55 State PC's.

CQI: Project Impact, Phase III (3/13 – 3/16)

Average Yearly Improvement in Quality over Three Year Project (Aver. Annual Percent Change)

Reductions Preventable Medical Hospital Utilization:

- -6.8% 4+ Medical ER/Inpatient*
- -7.0% Preventable Diabetes Hospitalization*
- -15.6% Preventable Asthma Hospitalization*

Reductions in Preventable Behavioral Health Hospital Utilization and Medication Non-Adherence:

- -8.0% 4+ BH ER/Inpatient*
- -5.4% 45-day Readmission*
- -2.4% Low Antipsychotic Adherence
- -2.0% Low Mood Stabilizer Adherence
- -1.9% Antidepressant Trial < 12 Weeks*

*** = statistically significant change**

2016 CQI Projects

Three project options based on clinic input:

- **Care Transitions Network (CTN) – All Cause Readmission** project to promote readiness for Value Based Payment and DSRIP performance, and reduce hospital readmission and high utilization.
- **Integrating BH Managed Care Quality Assurance Reporting Requirements (QARR)**, to promote better provider awareness and performance on key behavioral health measures monitored by MCOs.
- **Suicide Prevention (SP)**, to promote evidence-based practices in suicide prevention and reduce the rate of suicide attempts and completed suicides among clinic populations.

CQI participating clinics receive…

- …ongoing training, consultation, and technical assistance provided via the PSYCKES team in collaboration with our project partners.
- …training in and access to new features in PSYCKES, to optimize the use of data to inform clinical care and decision making.
- …a QI enhancement to the APG rates.

Participation Requirements for All Projects

- Dedicated leadership to engage team in continuous quality improvement
- Engage in quality improvement activities to improve performance on measures for chosen project
- Submit self-reported QI data (content varies by project)
- Participate in project technical assistance and evaluation activities (e.g. calls, site visits, interim and wrap up surveys)

Common Outcome Measures for All Projects

- Proportion of HARP-enrolled individuals **not** enrolled in a health home. (From Medicaid data)
- Proportion of Clients with a quality flag with their PSYCKES Clinical Summary reviewed

Care Transitions Network, Reducing Readmissions

Project Manager: Samantha Holcombe, MPH
Quality Improvement Advisor: Elizabeth Arend, MPH

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Project Partners

- National Council for Behavioral Health (implementation, technical assistance)
- Montefiore Medical Center (data analysis, utilization and financial reports)
- Northwell Health & Center for Practice Innovations (EBP consultation & training)
- Netsmart Technologies (project dashboard)

Care Transitions Network for People with Serious Mental Illness

National Council for Behavioral Health
State Associations of Addiction Services
Stronger Together.

Montefiore Medical Center

Northwell Health℠

Center for Practice Innovations℠
at Columbia Psychiatry
New York State Psychiatric Institute
Building best practices with you.

Netsmart

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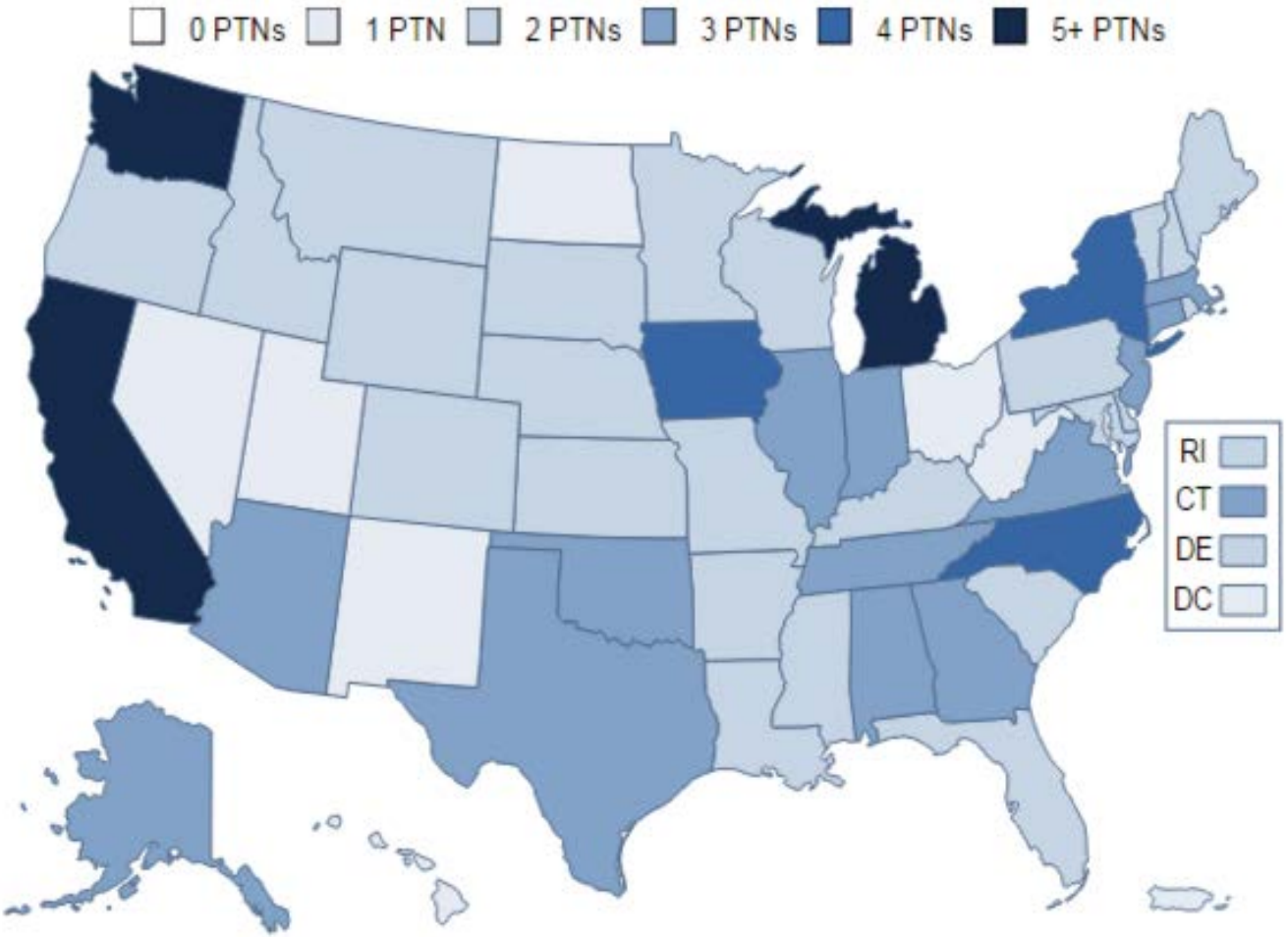
Transforming Clinical Practice Initiative
Practice Transformation Networks (PTNs)



Source: Centers for Medicare & Medicaid Services

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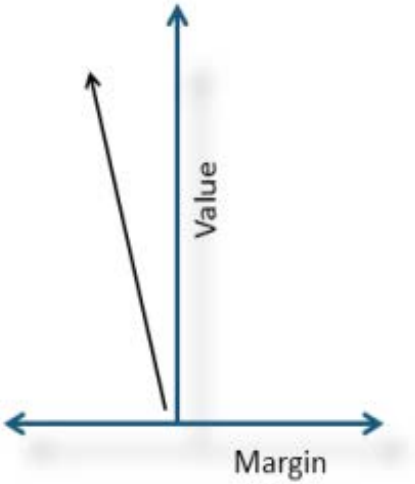
Moving Toward Value over Volume in New York State

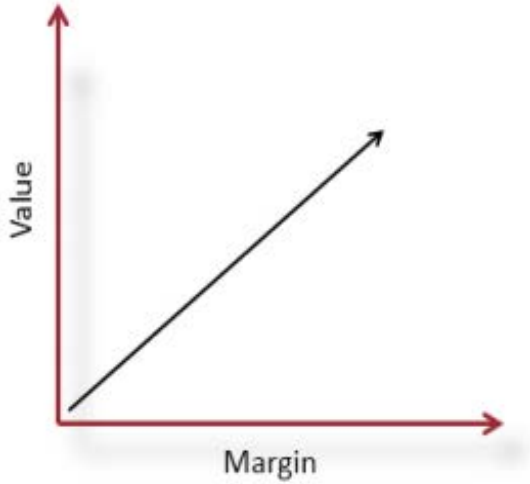
Current State

Increasing the value of care delivered more often than not threatens providers' margins



Future State

When VBP is done well, providers' margins go up when the value of care delivered increases



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Project Vision

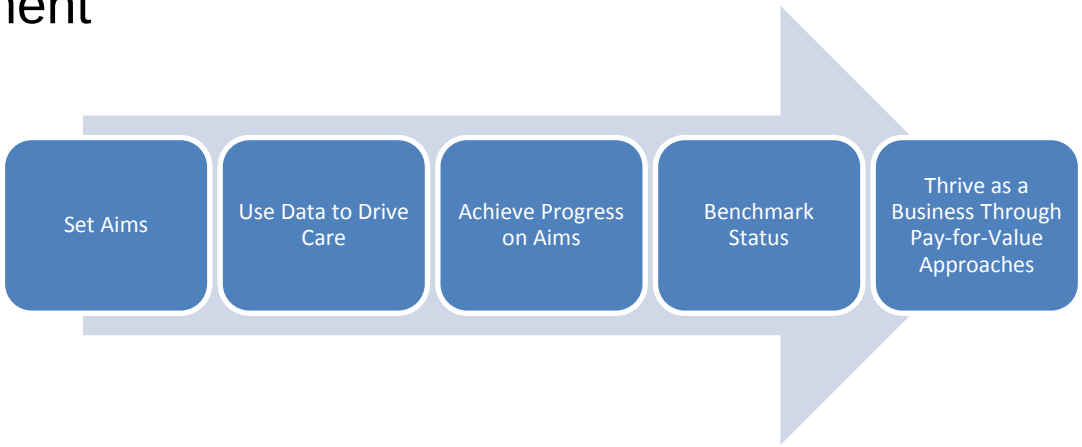
By 2019, Care Treatment Network members will:

✓Strengthen clinical leadership to reduce costs and improve quality of care for people with serious mental illness

✓Inform local and national discussion and decision-making on value-based payment reform's implications for behavioral health care

✓Build the necessary infrastructure and workforce capacity to successfully transition to and thrive in the context of federal and state pay-for-performance programs

✓Have the **acumen to thrive as a business** in a rapidly-changing environment



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Goal

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

Benefits

- **Free, on demand 1-to-1 coaching and expert consultation** to support implementation of patient and family-centered care, data-driven QI strategies, and sustainable business operations available to your **entire workforce**
- **$200-$1,000 incentive payment** per eligible clinician (MD, LCSW, Ph.D., Psy.D, PA, NP/NPP) based on performance.
- **Free** contact hours that contribute to CEUs for clinical staff
- **Technical resources tailored to meet individual clinic needs**

CMS Change Package

- CMS Change Package includes Primary and Secondary Drivers of Transformation to VBP.
- Clinics will complete a 21-item self-assessment every 6 months, and will set goals for improvement.
- They will receive individualized TA based on review of PAT by National Council and IPRO.

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 QI	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

Project Measures:

- 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.

Requirements

- Signed enrollment agreement
- Provide licensure, NPI, contact information of all eligible clinicians (MD, LCSW, Ph.D., Psy.D, PA, NP/NPP)
- PAT (21 item self assessment) completed every 6 months
- PAT review and goal-setting call with National Council and IPRO, following PAT completion every 6 months

Note: If your agency has already enrolled in the CTN it can also serve as your CQI project option. You will still need to complete the project selection forms and meet PSYCKES requirements.

Thank you!

www.CareTransitionsNetwork.org

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Disclaimer: The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

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Integrating BH Managed Care Quality Assurance Reporting Requirements (QARR)

Project Manager: Patricia Gallo Goldstein, LMSW

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Partners

- Center for Practice Innovations (Columbia/ NYSPI) (EBP consultation on training)
- MCTAC – NYU (Consultation on Training)
- NYS Department of Health (QARR measures)
- Developing relationships – MCOs

What is NYS QARR?

Measurement Sets collected by NYSDOH that reflects quality of health care delivery by Managed Care Plans

- **Healthcare Effectiveness Data & Information Set (HEDIS ®)** a set of standardized performance measures designed to ensure that consumers have information they need to reliably compare performance of MCOs;
  - HEDIS is sponsored, supported and maintained by the **National Committee for Quality Assurance (NCQA) –** a not-for-profit national accrediting body for MCOs;
- **CAHPS®**: Consumer Assessment of Healthcare Providers and Systems-Satisfaction.
  - NYSDOH sponsors a CAHPS survey for Medicaid managed care enrollees every two years.

What is the Behavioral Health QARR?

- NYS DOH has currently included 12 HEDIS ® measures specific to behavioral health that:
  - Address quality of behavioral health care
  - Reflects the interface between physical health and mental health through **health promotion measures**, i.e. diabetes monitoring for individuals with Schizophrenia; and **BH coordination**, i.e. depression medication adherence.
- All QHPs, MCOS and Medicaid HIV SNPs certified by NYS must report all applicable QARR measures.

QARR Project Goal

- To educate providers about the importance of these measures and their future impact beyond 2018.

Why are the BH QARR Measures Clinically Important?

- **Despite progress these measures are still of concern**
- Individuals with serious mental illness die 25 years earlier
  - Higher rates of serious health problems including:
    - Heart disease
    - Diabetes
    - Hypertension
    - Asthma
- Comorbid substance use disorders are undertreated & have worse outcomes
- Antipsychotics are often prescribed to children without a primary clinical indication; these medications have serious side-effects with potential for life long impact
- Medication adherence is a problem in all of health and may be the single greatest opportunity for improving health outcomes (WHO)
- Post hospital discharge is a critical time to engage clients to improve outcomes- increased vulnerability for relapse and suicide in first 30 days
- Measurement based care yields better outcomes for depression but is underutilized in behavioral health

QARR Project Measures: Adult Clinics

1. Antipsychotic medication adherence for individuals with schizophrenia
2. Antidepressant medication adherence, acute (12wks.) and continuation phase (6 months)
3. Diabetes monitoring for individuals with diabetes and schizophrenia
4. Diabetes screening for adults with schizophrenia or bipolar disorder using antipsychotics
5. Cardiovascular monitoring for adults with schizophrenia and cardiovascular disease
6. Follow-up after MH hospitalization(with 7 and 30 days)
7. Substance use treatment initiation and engagement
8. Utilization of PHQ-9 to monitor Depression/Suicide for adolescents and adults
9. *% of Harp-enrolled individuals **not** enrolled in a Health Home.*

Project Measures: Children & Adolescents Clinics

1. Follow-up care for children prescribed ADHD medication
2. Provision of psychosocial services for children and adolescents prior to starting antipsychotics
3. Antipsychotic polypharmacy for children & adolescents
4. Metabolic monitoring for children and adolescents on antipsychotics
5. Follow-up after MH hospitalization (with 7 and 30 days)*
6. Substance use treatment initiation and engagement*
7. Utilization of PHQ-9 to monitor Depression/Suicide for adolescents and adults*

**Note: there are 3 measures that overlap between adults and adolescents*

QARR Project Specific Requirements

- Participate in Survey Monkey data reporting on the four Monthly QI Self Report Measures

- Participate in monthly Learning Collaborative calls to be developed based on participating clinic needs

Monthly Clinic QI Self Report Measures:

1. Number of newly identified clients with quality concerns during the month;
2. Total number of identified clients with quality concerns;
3. Number of clients with quality concerns who received an intervention related to the concern; and,
4. Number of clients with quality concerns for whom a PSYCKES clinical summary was reviewed.

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Ideas for Monthly QARR Learning Collaborative Calls

- NYSDOH Presentation on QARR
- Interviews with MCOS for Input on QARR
- Using APGs to bill for QARR Measures
- Monthly learning collaborative calls. It's your monthly meeting - **what do you need?**

Last But Not Least… Business Reasons to Like the QARR Project

- Builds on previous CQI projects and still earns Medicaid enhancement
- Plan performance is transparent on DOH website

  http://health.ny.gov/health_care/managed_care/reports
- Builds readiness for MCO Quality Initiatives and Contracts
- Plans that meet selected measures are financially rewarded
- Agencies can help plans maximize their performance
- Plans invest resources into improving their performance, and may offer incentives to high-performing agencies
- Plans can direct patient volume to better providers
- Coincides with DSRIP Domain 3 measures

Suicide Prevention (SP)

Project Manager: Prabu Vasan, LCSW-R

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Partners

- OMH Suicide Prevention Office, Jay Carruthers, MD
- Center for Practice Innovations (CPI) Suicide Prevention-Training Implementation and Evaluation Group
- Columbia University
- University of Pennsylvania

Resources/ Training Materials

- Zero Suicide / Suicide Prevention Resource Center – Educational Development Center
- National Strategy for Suicide Prevention grant (SAMHSA)

Scope of the Problem…

American Foundation for Suicide Prevention

10 Leading Causes of Death by Age Group, United States

	Age Groups							
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54
1	Congenital Anomalies 4,746	Unintentional Injury 1,216	Unintentional Injury 730	Unintentional Injury 750	Unintentional Injury 11,836	Unintentional Injury 17,357	Unintentional Injury 16,048	Malignant Neoplasms 44,834
2	Short Gestation 4,173	Congenital Anomalies 399	Malignant Neoplasms 436	Suicide 425	Suicide 5,079	Suicide 6,569	Malignant Neoplasms 11,267	Heart Disease 34,791
3	Maternal Pregnancy Comp. 1,574	Homicide 364	Congenital Anomalies 192	Malignant Neoplasms 416	Homicide 4,144	Homicide 4,159	Heart Disease 10,368	Unintentional Injury 20,610
4	SIDS 1,545	Malignant Neoplasms 321	Homicide 123	Congenital Anomalies 156	Malignant Neoplasms 1,569	Malignant Neoplasms 3,624	Suicide 6,706	Suicide 8,767

Center for Disease Control

Suicide and Community Mental Health

- Suicide rate among MH consumers ~5 times higher than general population.
- A review* of NIMRS data matched to Medicaid claims revealed that among MH consumers who died by suicide, 49% had an outpatient Mental Health visit 30 days prior to their death.
- Justice Center data: in NYS ~80% suicide deaths among public MH consumers were among community care clients
    - Of 17% classified as inpatient related, vast majority (85%) were within 30 days of discharge.
    - Within 72 hours post-discharge: 2 times as many suicide deaths as on inpatient units
    - 72 hours-30 days post-discharge: almost 4 times as many deaths as on inpatient units

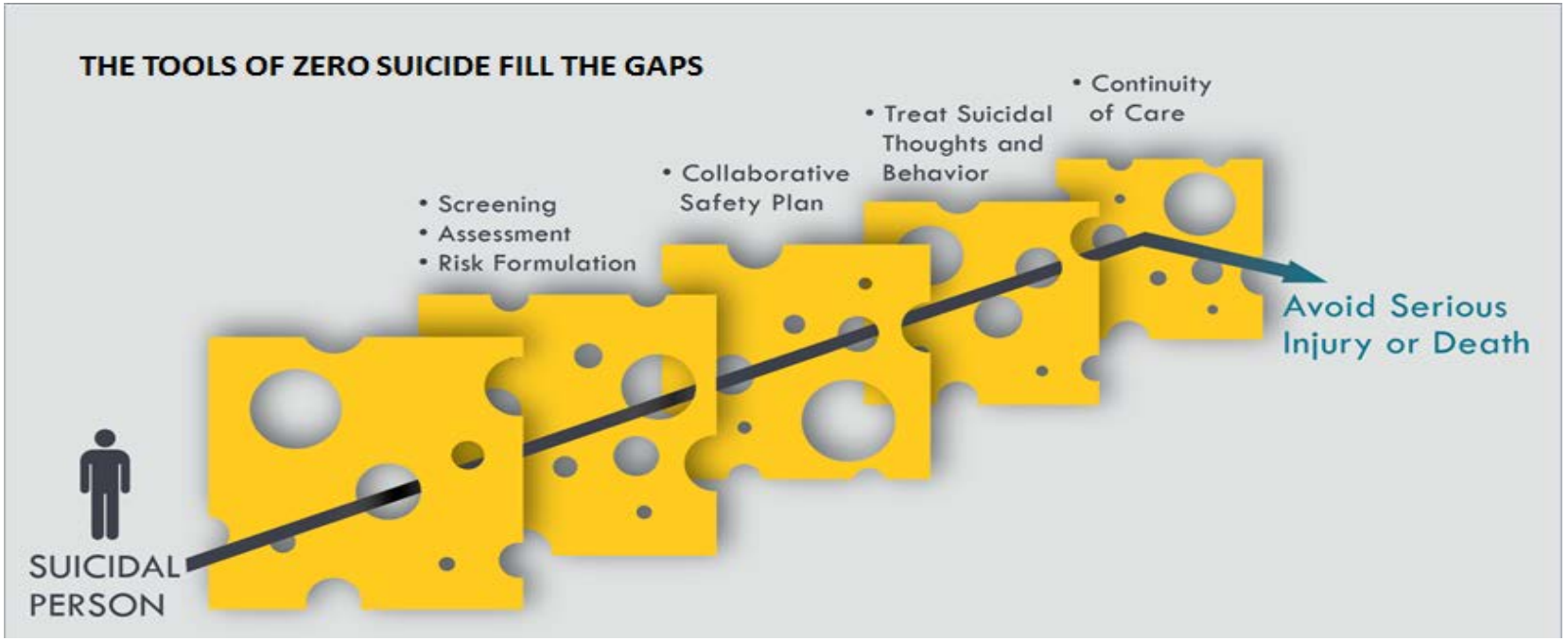
*Office of Performance Measures & Evaluation (PME)

Insufficient Training & Support for Clinicians

- 64% reported they had little or no specialized training in suicide-specific interventions
- About 33% reported they did not feel they had sufficient training to assist suicidal clients
- 43% stated they did not feel confident in their ability to manage client suicidality with an evidence-based approach.
- Nearly 50% reported a need for greater training in risk assessment and suicide-specific treatments

Source: 2014 OMH Survey of Art. 31 clinics; N = 1,585

Implementation of Zero Suicide Strategies Can Fill the Gaps



Participation in this Suicide Prevention CQI project will help you:

1. Improve screening of suicidal clients;
2. Assist you in what to do when someone screens positive;
3. Help with assessing risk and how to link risk to levels of intervention;
4. Help you develop safety plans to help clients manage their suicidal feelings

Adapted from James Reason's "Swiss Cheese" Model of Accidents – EDC © 2016

Suicide Prevention Project Aim

To promote evidence-based practices in suicide prevention and reduce the rate of suicide attempts and completed suicides among clinic populations.

Preventing suicide deaths in health care requires a *systematic clinical approach*, not “the heroic efforts of crisis staff and individual clinicians.” – Action Alliance for Suicide Prevention

Project Measures: Based on PSYCKES (Medicaid & Clinic Entered Data) and NIMRS

1. Proportion of clients with a (+) CSSRS screen with a safety plan entered into PSYCKES
2. Proportion of current clinic census on the suicide care pathway (SCP)
3. Proportion of clients seen weekly among those on the suicide care pathway.
4. Acute Care Transition (seen for an appointment within 72 hours of hospital discharge)
5. Rate of Completed Suicide among ALL Clients
6. Rate of Completed Suicide among those on the suicide care pathway.
7. Suicide Attempt Rate among ALL Clients
8. Suicide Attempt Rate among those on the suicide care pathway.
9. Emergency Department Usage
10. Inpatient Admissions
11. *Proportion of HARP-enrolled individuals not enrolled in a health home.*

Monthly Clinic Self-Report Questions

1. Number of clients enrolled during the reporting period.
2. Number of clients with 1 or more screens during reporting period.
3. Number of clients with a positive CSSRS during the reporting period.
4. Number of clients who received a suicide-specific risk assessment among those with a positive screen only.
5. Number of clients in the current census as of last day of reporting period.

Project Requirements

- Completed project planning form and workforce survey on suicide prevention readiness
- Monthly online data reporting (clinic self-report data)
- Screen clients on intake & enter (+) CSSRS scores into PSYCKES
- Designate clients on the Suicide Care Pathway in PSYCKES
- Upload safety plan into PSYCKES for clients on SCP
- Clinicians complete 3 online training modules (assessment, safety planning, high risk pathway)
- Learning Collaborative Calls: 1-2/ month on project implementation, operational and clinical issues

Project Benefits

- Expert training to increase staff comfort and competence in the clinical management of suicidal individuals
- Assistance adapting and implementing a *system of care* for managing suicidal individuals based on national best practices
- Adherence to Joint Commission's latest standards of care
- Adherence to OMH licensing standards
- Alignment and opportunity to shape developing statewide Crisis Management System

Next Steps

Next Steps: Enrollment Process – For All Projects

- Complete online Clinic Contact Form (July)
- Select a project and complete online Project Selection Form (August)
- Agency CEO or designee to approve enrollment and project selection for all agency clinics
- Agency CEO or designee to sign updated PSYCKES Confidentiality Agreement
- Attend project specific training webinar- 2 staff/clinic (Sept.)
- Complete a baseline project planning form - content varies by project (October)

Reminder: all participating clinics must follow enrollment steps as noted above, including clinics already enrolled in the CTN project

Questions?

Note: Slides will be distributed at the end of the webinar series (concluding July 28, 2016) and posted to the PSYCKES web-pages along with a recording of the webinar and written answers to questions (FAQs).

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