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2016 Continuous Quality Improvement Project: Managed Care Readiness/ Quality Assurance Reporting Requirements (QARR)

- We will begin shortly
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How to Participate in Q&A via WebEx

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  - 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 date: 10/13/16)

Webinar Learning Objectives:

After participating in today's webinar, you will understand:

- New York State Quality Assurance and Reporting Requirements
- How QARR and other quality monitoring measures effect Managed Care Plans (MCOs)
- The key behavioral health measures you will be monitoring with the QARR project
- The activities and strategies you will be using as part of the QARR project
- Next steps

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QARR Overview

What is NYS QARR?

- QARR are the measurement sets collected by NYS Department of Health (DOH) that reflects quality of health care delivery by Managed Care Plans:
  - Healthcare Effectiveness Data & Information Set (HEDIS ®) is 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 health plans.
  - Consumer Assessment of Healthcare Providers and Systems-Satisfaction (CAHPS®) is a DOH-sponsored consumer satisfaction survey for Managed Care Plans
  - New York State-specific measures
- Managed Care Plans can be fiscally incentivized or penalized based on their performance on QARR measures

QARR Background

- In 1993, NYS DOH began to transition Medicaid beneficiaries into Managed Care
- DOH begins to measure the performance of all licensed Health Plans in order to ensure that enrollees receive equal, if not better, quality care:
    - DOH participated in the nascent Medicaid HEDIS® workgroup to develop standardized performance measures
    - DOH contracted with NCQA to audit Plans to:
        - Ensure health plan reported data had integrity,
        - Accurately reflect differences in Plan performance.
    - QARR measurement results were published for HEDIS® reporting year 1994
    - By 2016, all Qualified Health Plans (QHP), Medicaid/CHP, and Commercial HMOs & PPOs certified by NYS must report on all QARR measures.

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The Quality Strategy for New York

- Then in 1997, NYS received approval from CMS to implement a mandatory managed care program through an 1115 Waiver, called the Partnership Plan Demonstration.
- Overarching goal to improve the health status of Medicaid recipients by:
    - Increasing access to health care.
    - Improving the quality of health care, and
    - Expanding coverage to additional low-income Individuals.
- A requirement of the 1115 Waiver is produce a yearly report - the Quality Strategy- that:
    - delineates the goals of the Managed Care Program, and
    - the actions taken by DOH to ensure quality of care delivered to enrollees by Managed Care Plans.

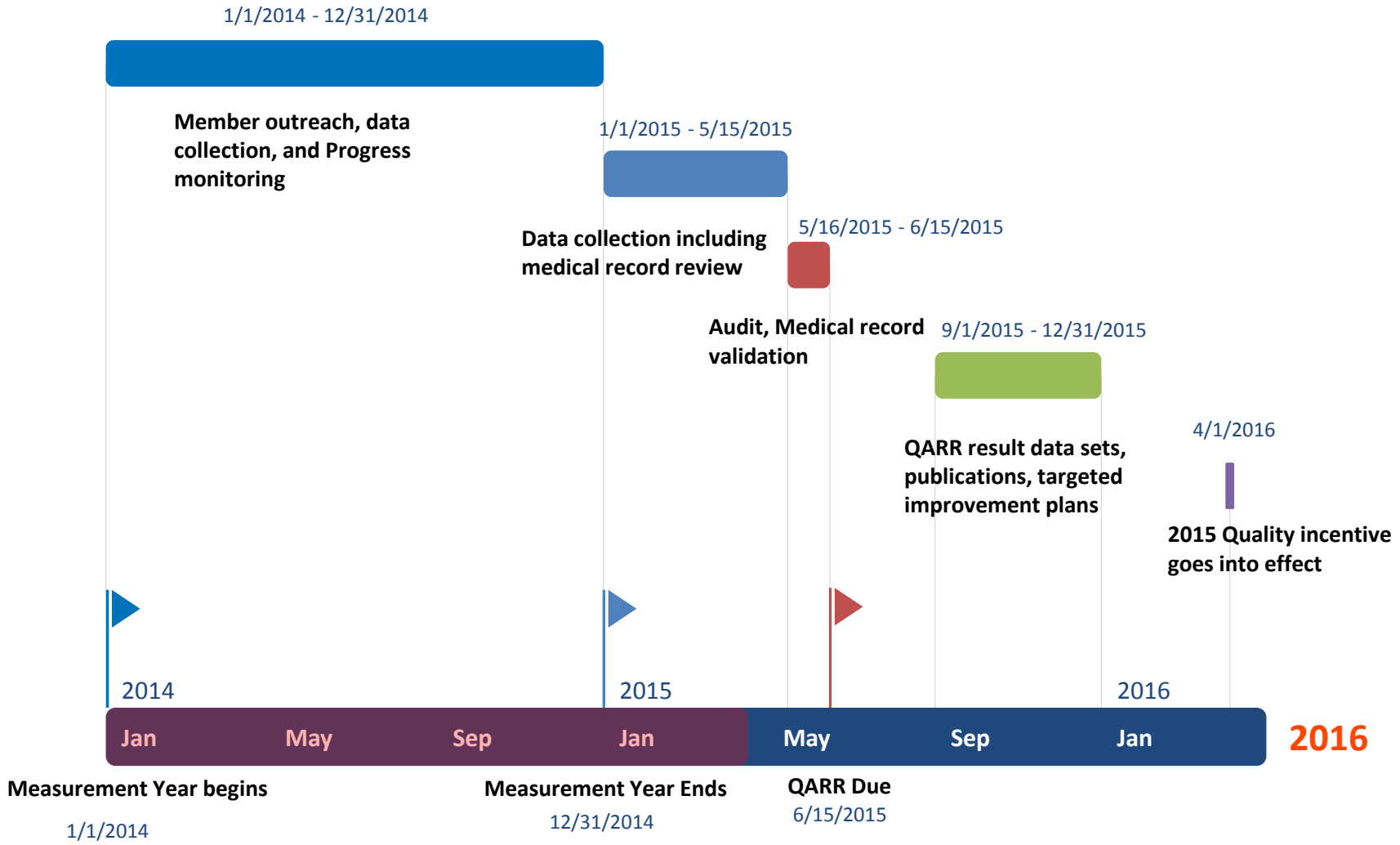
The Quality Strategy Report Objectives

- Within the Quality Strategy Report are Behavioral Health objectives to:
  - improve health care services and population health
  - reduce costs consistent with the Medicaid Redesign Team and CMS' Triple Aim
  - identify and reduce disparities in access and outcomes for individuals with serious behavioral health conditions
  - increase provider implementation of evidence-based practices that support the integration of behavioral and physical health
  - improve care coordination
  - increase measurement in behavioral health
- New Managed Care Plans are incorporated into The Quality Strategy as they become operational, including HARPs, FIDAs-IIDs, and DISCOS
- The Quality Strategy informs and sets the stage for QARR

2016 Medicaid Managed Care Quality Incentives

- In 2002, the NYS DOH initiated a Quality Incentive Program that financially rewards Managed Care Plans that demonstrate superior performance in specific QARR measures.
- These “Incentive Measures” are based on yearly results from QARR and CAHPs and chosen by DOH each year
- The DOH objective of the incentive methodology is to:
    - Reward comprehensive quality care
    - Expand the scope of accountability
    - Provide continued encouragement for improvement.

QARR Collection, Reporting and Use – Annual Cycle



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Performance Improvement Projects (PIP)s

- In addition to the Quality Incentives, in 2009 NYS targets improvement by requiring all mainstream Managed Care Plans to participate in a Performance Improvement Project (PIP).
- Yearly PIPs are chosen by the plans based on shared improvement goals
- The new PIP for 2017 is: Follow-up after MH Hospitalization **within 7 days** for children and adults

Quality Strategy Progression for MCOs

QARR

- All Plans Must report annually on QARR Measures

Quality Incentive Program

- Plans are given an additional incentive if they meet the Quality Incentive Program Measures

PIP

- Plans must participate in a PIP, which this year, overlaps with a QARR and Quality Incentive Measure: 7 day post hospitalization follow-up

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Behavioral Health QARR Measures

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The Behavioral Health QARR Measures

- The major areas of performance included in QARR are:
  - Effectiveness of Care
  - Access to/Availability of Care
  - Satisfaction with the experience
  - Use of Services; i.e. mental health utilization
  - Health Plan Descriptive Information i.e. Enrollment by Product Line
  - NYS Specific Measures i.e. HIV/AIDS comprehensive care
- 12 behavioral health measures (Effectiveness of Care)
  - Address quality of behavioral health care
  - Reflect the interface between physical health and mental health:
    - through health promotion measures, including diabetes monitoring for individuals with Schizophrenia, and
    - BH coordination, i.e. depression medication adherence

QARR/HEDIS® BH Measures

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) for children and adults *
7. Substance use treatment initiation and engagement for children and adults *
8. Utilization of PHQ-9 to monitor Depression/Suicide for adolescents and adults *
9. Antipsychotic polypharmacy for children & adolescents;
10. Metabolic monitoring for children and adolescents on antipsychotics;
11. Provision of psychosocial services for children and adolescents prior to starting antipsychotics;
12. Follow-up with a prescriber for children newly prescribed ADHD medication; 30 days and continuation and maintenance phase - 9 months.

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* Three measures overlap between adults and children

Clinical Importance of the BH QARR Measures

- Despite known data that individuals with serious mental illness die 25 years earlier than the general population, there continues to be:
  - High levels of medical and mental health co-morbidity
  - Higher rates of serious health problems including Heart disease, Diabetes, Hypertension and Asthma
- Each of the 12 BH QARR measures targets key quality concerns that effect high mortality and morbidity rates:
  - Comorbid substance use
  - Medication Adherence
  - Antipsychotic use in children
  - Underutilization of measurement based care
  - Expeditious follow up after hospitalization to community care

Behavioral Health Quality Incentive Measures

- Five BH QARR measures have been prioritized by DOH and included in their Quality Incentive Program:
    1. Adherence to Antipsychotic Medications for Adults with Schizophrenia
    2. Adult Antidepressant Medication Adherence: acute 12 weeks, and continuation phase 6 months
    3. Diabetes Monitoring for Adults with Diabetes and Schizophrenia
    4. Follow-up after MH Hospitalization **within 7 days** for children and adults.
    5. Follow-up care for children newly prescribed ADHD medication, initial and, continuation and maintenance phase 6 months.

Why these 5 Measures?

1. **Adherence to AP Medication for Individuals with Schizophrenia**
   - 40% of hospitalizations costs among individuals with schizophrenia is due to non-adherence.
   - Improving adherence may be the best investment for addressing chronic conditions. (WHO)
2. **Adult Antidepressant Adherence**
   - DOH notes deterioration in performance from the previous measurement year in both phases, acute and continuation.
3. **Diabetes Monitoring for Individuals with Diabetes and Schizophrenia**.
   - Despite improvements, uncontrolled diabetes coupled with Schizophrenia has led to poor client outcomes; ER use and avoidable hospitalizations.
   - Complex/chronic conditions costs the Medicaid program billions per year.

The first three measures are familiar- they are already in PSYCKES and were included in last years' CQI projects!

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Why these 5 Measures?

4. **Follow-up after MH Hospitalization within 7 days for children and adults.**
    - ½ of all individuals discharged from an Inpatient Hospitalization do not link to service. These clients are vulnerable to relapse, re-hospitalization, and increased risk of suicide.
    - Nearly 73% of people who have attempted or died by suicide were seen in an outpatient mental health setting less than six months prior. More than 60% had outpatient contact less than 30 days prior.
5. **Follow-up care for children newly prescribed ADHD medication, continuation and maintenance phase 6 months.**
    - ADHD Medications are overprescribed and are federally controlled substances (CII) because they can be abused or lead to dependence.
    - These medications have been linked to health side-effects.
    - Adherence is related to parent/guardian engagement

NYS OMH Measure: Health Home Enrollment

- All CQI projects include a measure for clients enrolled in HARP but not enrolled in a Health Home.
- This is not a QARR measure, but it is critical for coordination, and will help achieve other project measures.
- What is HARP?
  - 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
- Statewide, of 45,000 HARP enrollees only 25% are enrolled in a HH (June 2016)

QARR CQI Project Measure List

For the 2016 QARR CQI Project, Clinics will focus on the following clinical quality measures:

1. Adherence to Antipsychotic Medications for Adults with Schizophrenia
2. Adult Antidepressant Medication Adherence: acute 12 weeks,
3. Diabetes Monitoring for Adults with Diabetes and Schizophrenia
4. Follow-up after MH Hospitalization within 7 days for children and adults.
5. Follow-up care for children newly prescribed ADHD medication, initial phase (30 days) and maintenance phase 6 months.
6. HARP-enrolled clients who are eligible for Health Home enrollment

Measure 1: Adherence to AP Medications for Individuals with Schizophrenia

Who's is eligible population (denominator): your clinic consumers 18 -64 diagnosed with schizophrenia

Who's the identified population (numerator): clinic consumers diagnosed with schizophrenia whose PDC – the total # of days covered with an AP divided by the total days in treatment- is less than 80%

Goal: ensure regular adherence to AP medications

Measure 2: Antidepressant Medication Adherence

Who's is eligible population (denominator): clinic consumers diagnosed with major depression and newly started an antidepressant in the past year

Who's the identified population (numerator): clinic consumers diagnosed with major depression who were newly started on an antidepressant who had less than 12 weeks (84 days) of continuous treatment with an antidepressant

Goal: ensure adherence to antidepressant medications

Measure 3: Diabetes Monitoring for Individuals with Diabetes and Schizophrenia

Who's is eligible population (denominator): clinic consumers diagnosed with diabetes and schizophrenia

Who's the identified population (numerator): clinic consumers diagnosed with diabetes and schizophrenia without an HbA1C and LDL-C test in the past 12 months. These individuals are identified in PSYCKES

Goal: annual monitoring of diabetes to promote better health outcomes

Measure 4: Follow-up After MH Hospitalization within 7 days

Who's is eligible population (denominator): clinic consumers 6 years and older who had a MH hospitalization during the reporting year

Who's the identified population (numerator): clinic consumers 6 years and older who were not seen at the clinic within 7 days of discharge from a MH hospitalization

Goal: to ensure timely connection to community care and treatment engagement for individuals discharged from a MH hospitalization

Measure 5: Follow-up care for children newly prescribed ADHD medication

Who's is eligible population (denominator): clinic consumers, 6 to 12 years of age, diagnosed with ADHD, newly prescribed ADHD medication during the year

Eligibility considerations: no new prescriptions during the four months prior

Who's the identified population (numerator): clinic consumers, 6 to 12 years of age, diagnosed with ADHD and newly prescribed medication, who do not have a first follow-up visit within 30 days of prescribing

Goal: to ensure an initial follow-up with a prescriber in the 30 days following the first medication prescription

Measure 6: Number of HARP-enrolled clients not enrolled in a Health Home

Who's is eligible population (denominator): Clinic consumers enrolled in HARP

Who's the identified population (numerator): Clinic consumers enrolled in HARP but NOT enrolled in a health home

Goal: to ensure that HARP enrollees can access enhanced services by enrolling in a Health Home

Location of Measure Data

Measure	Where to Find Clients with this Measure	Where to Identify Performance on this Measure
1. Antipsychotic Medication Adherence	PSYCKES: BH QARR - Quality Incentive Subset	PSYCKES (to be developed)
2. Antidepressant Medication Adherence	PSYCKES: BH QARR - Quality Incentive Subset	PSYCKES (to be developed)
3. Diabetes Monitoring	PSYCKES: BH QARR - Quality Incentive Subset	PSYCKES (to be developed)
4. Follow-up After MH Hospitalization within 7 days	You do it! (program tracks internally)	PSYCKES (to be developed)
5. Follow-up care for children newly prescribed ADHD medication	You do it! (program tracks internally)	PSYCKES (to be developed)
6. # of HARP-enrolled clients not Health Home enrolled	PSYCKES: Recipient Search (to be developed for weekly refresh)	PSYCKES: “HARP enrolled not HH enrolled” (refreshed monthly in QI report)

Project Activities

Project Activities: Self-Assessment

As part of the 2016 QARR Project, Clinic CQI Teams will

- Assess current clinical practices and workflows for the measure set:
  - How do clinical staff currently become aware of, and intervene on, each of the measures? (i.e. how do they know when labs for clients with diabetes are required, and have/have not been completed)?
  - How does current practice reflect best practice?
  - What does your data say?
    - Use PSYCKES to review performance in 4 quality indicators
    - Gather program data in 2 quality indicators (follow-up visit post MH discharge; follow-up prescriber visits for children prescribed ADHD meds)
- Based on assessment, identify goals and develop strategies for improvement

Project Activities: Quality Improvement

After change goals have been identified, CQI Teams will:

- Develop workflows to implement identified strategies (and data collection to measure success).
- Train staff on new strategies and workflows
- Review data monthly and identify areas for process tweaks or further improvement
- Provide feedback to staff
- Participate in monthly collaborative calls to share successful strategies and learn about best practices
- Report back to OMH monthly

First Measure for Improvement: Health Home Enrollment

- Establishing relationships with Health Homes, Care Management Agencies and MCOs is an infrastructure development process that will support your other project goals and measures
  - You are the most effective route for referral
  - Care Management Agencies 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

Improvement Strategies: 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)

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

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

Improvement Strategies: Medication Adherence

For the two measures on medication adherence (anti-depressant and anti-psychotic medication):

- Flag charts for front desk monitoring
- Follow-up on no shows
- Refer client to HH for additional care coordination
- Check for side effects and barriers to taking medications
- Provide education for client and other support persons
- Provide cue-dose training/ behavioral training to take medications at a specific time.
- Use APG add-ons and modifiers for increased psychiatric or other NPP interventions.
- Increase clinic hours for more accessibility – use after hours APGs.

Improvement Strategies: ADHD Medication Follow-up

- Engagement with child's care taker
- Provide education for child and child's care taker regarding the need to take medication as prescribed.
- Reminders for parents – notifications programmed into a cell phone; calls from Clinic staff.
- Follow-up on no shows
- Robust use all APGs – modifiers and add-ons to increase psychiatric and other NPP time and reimbursement.
- Increase clinic accessibility – after hours modifier
- Utilize children's off-site provision of services modifier for 50% increase in reimbursement.

Improvement Strategies: 7 Day Follow-up Post Hospitalization

- Insure a warm hand-off from hospital to your clinic by:
  - Connect with all hospitals in your area (sign MOUs)
  - Develop material regarding your services, hours of operations, after hours coverage, etc. for your website and distribute to key staff in ERs, In-patient Units, CPEPS, Mobile Crisis services. etc.
  - Connect with MCOs and form relationship with their Care Management Staff.
  - Connect with all HHs in your borough and as many outside as possible.
- Identify and flag the charts of new clients who have histories of high utilization of in-patient services.
- Contact hospitals when flagged clients do not show up for treatment.

Improvement Strategies: Diabetes Monitoring (Labs)

- Flag charts for front desk monitoring
- Partner with a lab/medical provider
- Refer to HH for addional care coordination
- Use APGs to conduct physicals and health monitoring

Using PSYCKES to Support your CQI Project

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PSYCKES Support for Your CQI Project

- Consent all Medicaid enrollees
- Identify clients with quality flags – e.g. HARP/ Health Home
- Review client's clinical summary to support treatment

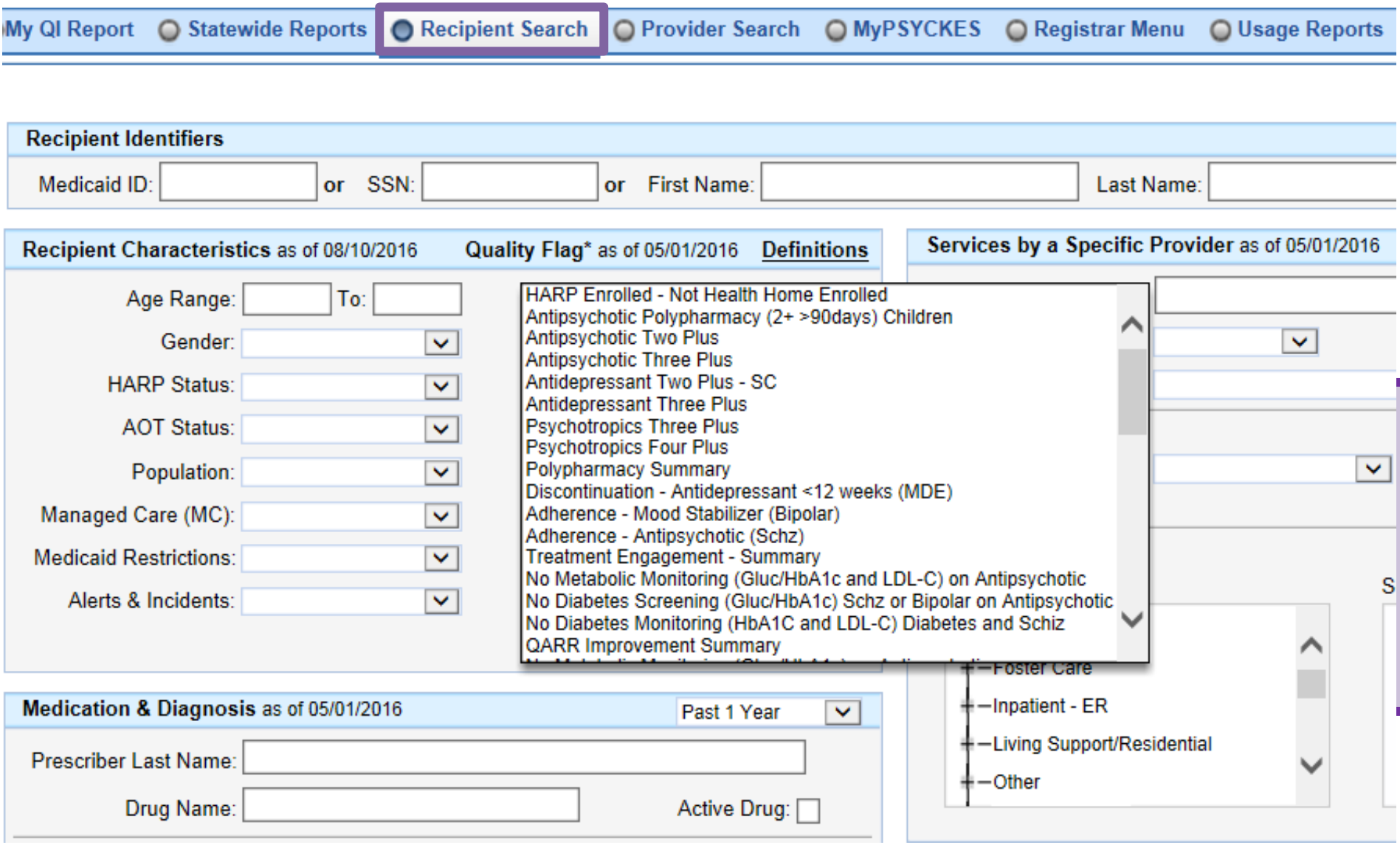
Consent All Clients

- 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)

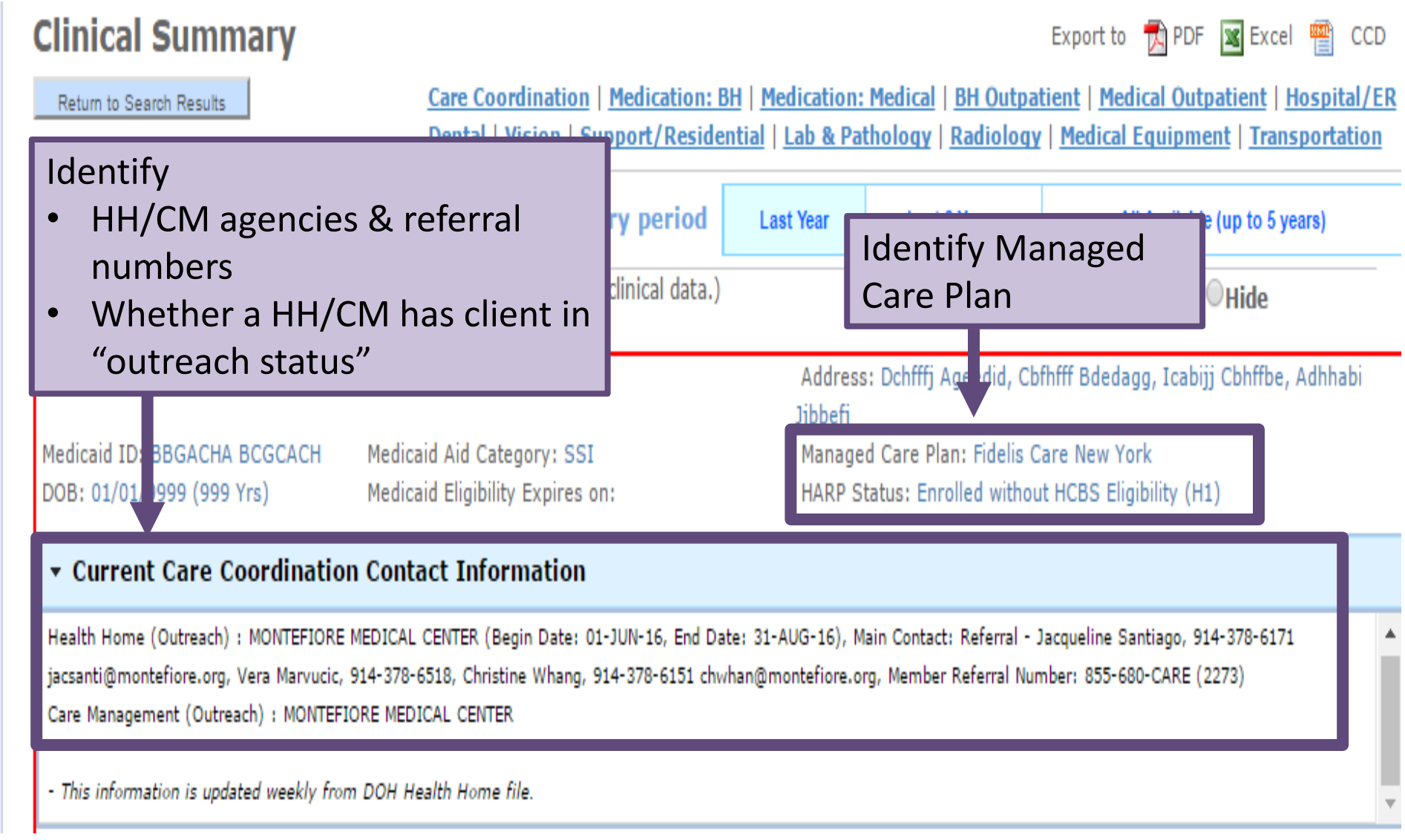
Consent Clients: Project Planning

- 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

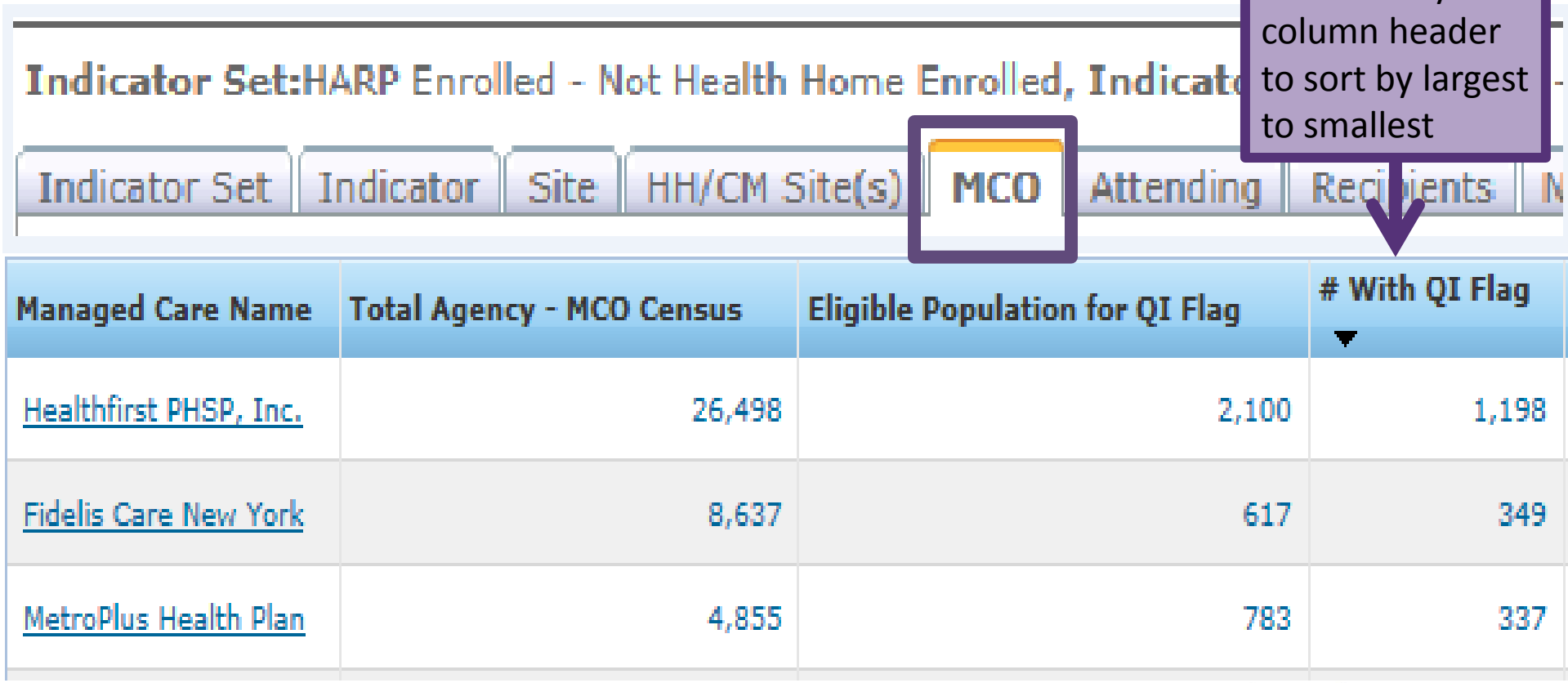
Identifying Clients in Need of HH Referral: Recipient Search



Determining Individual Patient Enrollment: 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

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My QI Report | Statewide Reports | Recipient Search | Provider Search | MyPSYCKES | Reg

Quality Indicator Overview As Of 07/01/2016

Modify Filter **Region:ALL, County:ALL, Site:ALL, Program Type:ALL, Age:ALL, Managed Care Pr**

Select Indicator Set for Details

Indicator Set

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

Next Steps

Next Steps

- Slides and a project handbook will be distributed
- A Project Planning Form will be distributed to guide Clinic planning for project activities
- Monthly Learning Collaborative calls will be scheduled