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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- 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 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
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.
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

1/1/2014 - 12/31/2014

Member outreach, data collection, and Progress monitoring

1/1/2015 - 5/15/2015

Data collection including medical record review

5/16/2015 - 6/15/2015

Audit, Medical record validation

9/1/2015 - 12/31/2015

QARR result data sets, publications, targeted improvement plans

4/1/2016

2015 Quality incentive goes into effect

Measurement Year begins
1/1/2014

Measurement Year Ends
12/31/2014

QARR Due
6/15/2015
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
Behavioral Health
QARR Measures
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
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.

* 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!
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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Where to Find Clients with this Measure</th>
<th>Where to Identify Performance on this Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Antipsychotic Medication Adherence</td>
<td>PSYCKES: BH QARR - Quality Incentive Subset</td>
<td>PSYCKES (to be developed)</td>
</tr>
<tr>
<td>2. Antidepressant Medication Adherence</td>
<td>PSYCKES: BH QARR - Quality Incentive Subset</td>
<td>PSYCKES (to be developed)</td>
</tr>
<tr>
<td>3. Diabetes Monitoring</td>
<td>PSYCKES: BH QARR - Quality Incentive Subset</td>
<td>PSYCKES (to be developed)</td>
</tr>
<tr>
<td>4. Follow-up After MH Hospitalization within 7 days</td>
<td>You do it! (program tracks internally)</td>
<td>PSYCKES (to be developed)</td>
</tr>
<tr>
<td>5. Follow-up care for children newly prescribed ADHD medication</td>
<td>You do it! (program tracks internally)</td>
<td>PSYCKES (to be developed)</td>
</tr>
<tr>
<td>6. # of HARP-enrolled clients not Health Home enrolled</td>
<td>PSYCKES: Recipient Search (to be developed for weekly refresh)</td>
<td>PSYCKES: “HARP enrolled not HH enrolled” (refreshed monthly in QI report)</td>
</tr>
</tbody>
</table>
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 additional care coordination
- Use APGs to conduct physicals and health monitoring
Using PSYCKES to Support your CQI Project
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
Step 1: In Recipient Search Tab Under Quality Flags Select "HARP Enrolled-Not HH Enrolled" and click Submit. This will give you a list of all of those with this flag in your agency. You may want to filter for those with MH clinic services under the Services by a Specific Provider section.
Determining Individual Patient Enrollment: Clinical Summary

Identify
- HH/CM agencies & referral numbers
- Whether a HH/CM has client in “outreach status”

Identify Managed Care Plan

Current Care Coordination Contact Information

Health Home (Outreach): MONTEFIORE MEDICAL CENTER (Begin Date: 01-JUN-16, End Date: 31-AUG-16), Main Contact: Referral - Jacqueline Santiago, 914-378-6171
jacsanti@montefiore.org, Vera Marvucic, 914-378-6518, Christine Whang, 914-378-6151 chwhan@montefiore.org, Member Referral Number: 855-680-CARE (2273)

Care Management (Outreach): MONTEFIORE MEDICAL CENTER

- This information is updated weekly from DOH Health Home file.
Self Analysis: Which MCOs serve these clients?

<table>
<thead>
<tr>
<th>Managed Care Name</th>
<th>Total Agency - MCO Census</th>
<th>Eligible Population for QI Flag</th>
<th># With QI Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthfirst PHSP, Inc.</td>
<td>26,498</td>
<td>2,100</td>
<td>1,198</td>
</tr>
<tr>
<td>Fidelis Care New York</td>
<td>8,637</td>
<td>617</td>
<td>349</td>
</tr>
<tr>
<td>MetroPlus Health Plan</td>
<td>4,855</td>
<td>783</td>
<td>337</td>
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</tbody>
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### Quality Indicator Overview As Of 07/01/2016

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

#### Select Indicator Set for Details

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