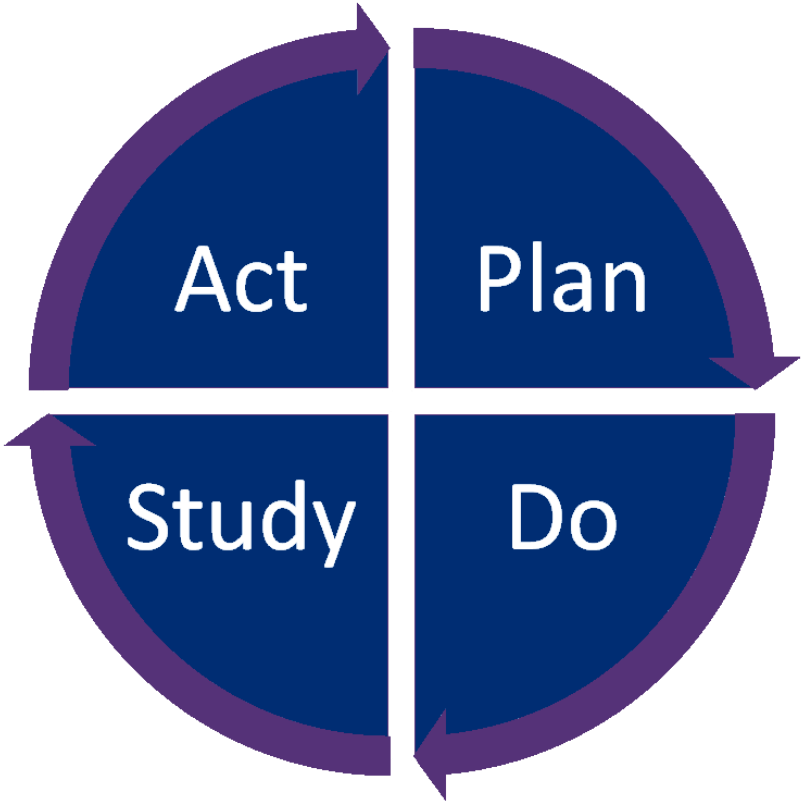
Health Home Quality: Where Are We?



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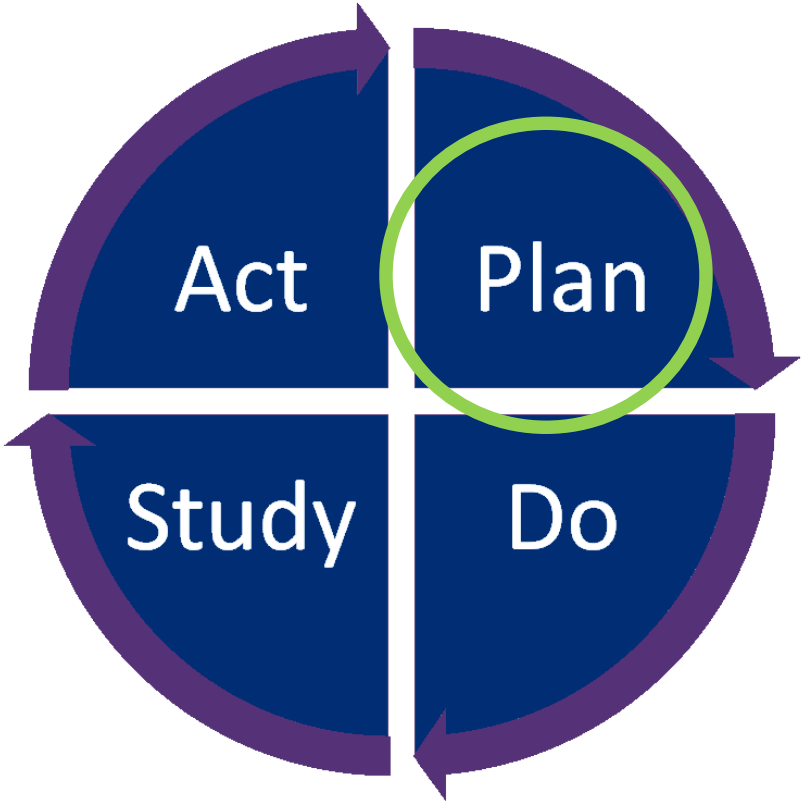
Health Home Quality: At The Beginning



Health Home Quality Measures

- Measurement Years 2013 and 2014
  - Services for cohort of members from specified calendar years
- Measurement Year 2015 will be available later this year
- In the future, these may become part of the Health Home Performance Dashboards
- The reports we will send to each Health Home will include both Statewide and Health Home specific results
  - Will also contain definitions and supportive documentation.

Where The Quality Measures Come From

Health Home Quality Measures come from a wide variety of sources and inter-connect with other Medicaid initiatives such as Quality Assurance Reporting Requirements (QARR) and Delivery System Reform Incentive Payment (DSRIP).

Specific Measure Sources:

- CMS Health Home Core Set
- State Plan Amendment (SPA)
- Other Federal reporting requirements

Measure Specifications

Health Home measures currently follow **HEDIS** specifications

- Healthcare Effectiveness Data and Information Set
- National guidelines developed by NCQA
- Volume 2: Technical Specifications
  - Information to calculate quality measures

Measure Structure

- Each measure has its own specifications
- Data collection methodologies:
  - Administrative
  - Hybrid (Adult BMI Assessment)
- Results expressed by "rates"
  - Percentage of eligible population

How Measures are Reported

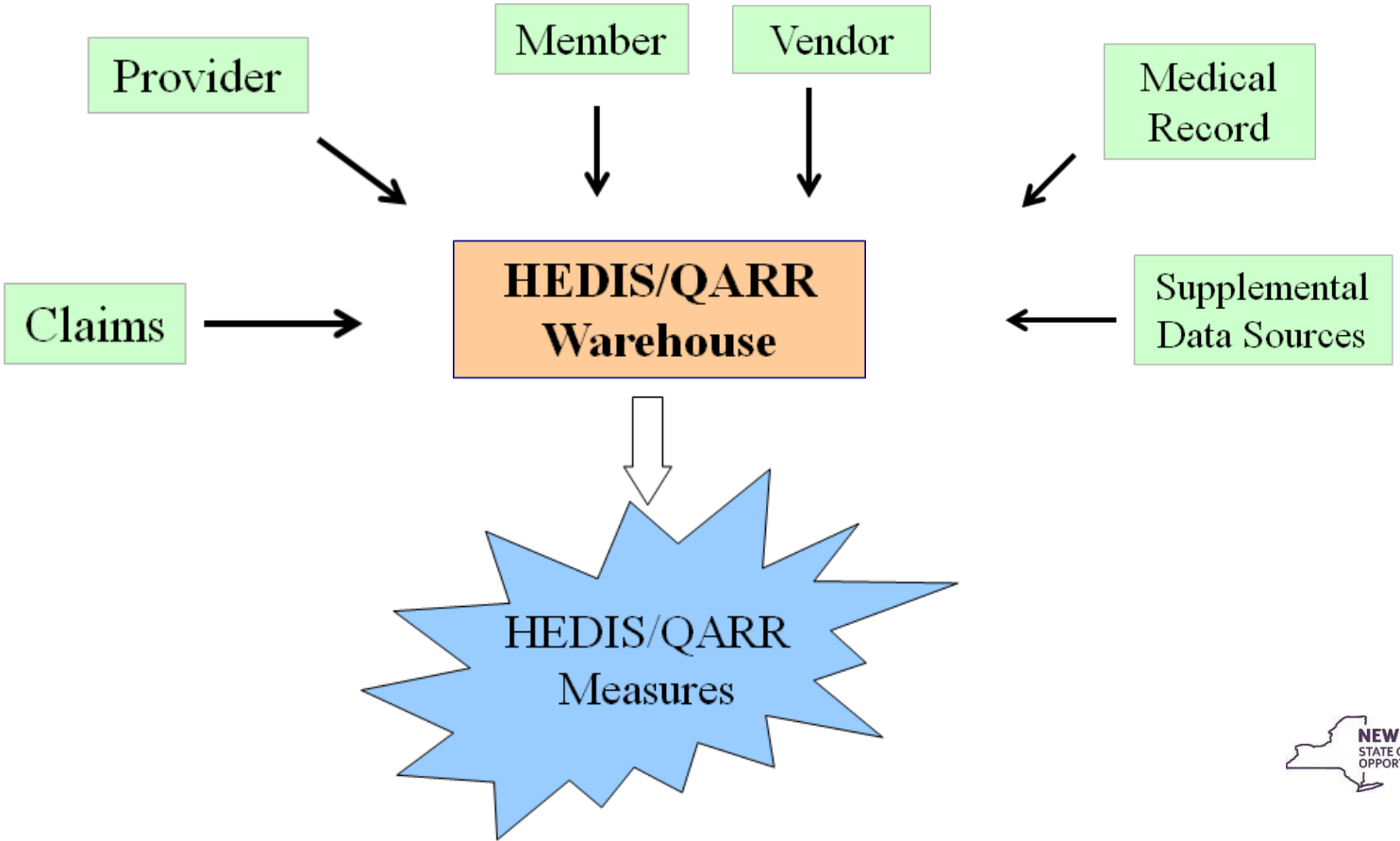
- **Numerator**
  - Number of persons in the denominator who received the appropriate diagnostic test or treatment
- **Denominator**
  - **Eligible population** or random sample of eligible population
    - All members who satisfy all specified criteria, including age, continuous enrollment, event and the anchor date enrollment requirement
  - **Health Home Attribution** – all members in YOUR Health Home at the end of the measurement period
- **"Rate"**
  - **Numerator/Denominator * 100**
    - Higher **generally** reflects 'better' peformance

Sources of Measure Data

- **Outreach / Enrollment:**
  - Health Home Tracking System

- **Quality:**
  - Medicaid Claims and Encounters Data
  - Quality Assurance Reporting Requirements (QARR)
    - Managed Care Plan Submitted Data
    - Includes sampled record reviews, lab results, etc. not available in Medicaid Claims and Encounters.

Sources of Data



Quality Measures: Four Categories

Based on SPA goals and in-line with DSRIP and HARPs

1. Improving Preventive Care (Preventive Care Worksheet)
2. Improving Disease Related Care For Chronic Conditions (Chronic Conditions Worksheet)
3. Improving Outcomes For Persons With Mental Illness (Mental Illness Worksheet)
4. Improving Outcomes For Persons With Substance Use Disorders (Substance Use Disorder Worksheet)

Improving Preventive Care

Services which prevent illness and keep people healthy.

- Adult BMI Assessment
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening In Women
- Colorectal Cancer Screening

Reports will include detailed definitions, methodology, etc.

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Improving Disease Related Care For Chronic Conditions

Services related to the maintenance of chronic diseases.

- Comprehensive Diabetes Care
- Comprehensive Care For People Living With HIV/AIDS
- Medication Management For People With Asthma

Improving Outcomes For Persons With Mental Illness

Services for Severe and Mental Illness (SMI).

- Adherence to Antipsychotic Medication For Individuals With Schizophrenia
- Antidepressant Medication Management
- Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia
- Diabetes Monitoring People With Diabetes and Schizophrenia
- Diabetes Screening For People With Schizophrenia Or Bipolar Disorder who are using Antipsychotic Medications
- Follow Up After Hospitalization For Mental Illness

Improving Outcomes For Persons With Substance Use Disorders

Services for Substance Use Disorders (SUD).

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Quality Measures: Stratifications

- Includes Measurement Years 2013 and 2014
- Mutually Exclusive Stratifications:
  - Enrollment: Enrolled, Outreach Only
- Stratifications / Subpopulations
  - **NOT** Mutually Exclusive Stratifications
  - Patient Characteristics: Chronic, HIV, Substance Use, Mental Health

Example Health Home: Information Page

Definitions	
Health Home Data Source	Patient Tracking System ONLY
SS	Small sample size. Rates are suppressed where denominator is less than 30
Populations *Ever Enrolled and Never Enrolled ARE mutually exclusive*	
Over-all	All non-dual, MMC and FFS, Health Home members for specified calendar year
Stratifications of Population *Both groups are included in Over-all*	
Enrolled	Non-dual, MMC and FFS members that have ever been enrolled in a Health Home for specified calendar year
Outreach Only	Non-dual, MMC and FFS members that have never been enrolled in a Health Home for specified calendar year
Stratifications of Population *Substance Use, Mental Health and HIV are NOT mutually exclusive and members in these categories may also have Chronic conditions*	
Substance Use Disorder	Non-dual, MMC and FFS Health Home members who had an alcohol or other drug service with any diagnosis of chemical dependency during the measurement year
Mental Health	Non-dual, MMC and FFS Health Home members who were identified as having Serious Mental Illness (SMI) per the SAMHSA definition; A MDC of '191' with at least one visit or inpatient stay with one or more of the specified mental illness diagnosis during the measurement year
HIV	Non-dual, MMC and FFS Health Home members who had at least one HIV/AIDS inpatient claim or at least two HIV/AIDS outpatient claims with any diagnosis of HIV/AIDS during the measurement year
Chronic	Non-dual, MMC and FFS Health Home members who do not qualify for Substance Use Disorder, Mental Health, or HIV for specified calendar year

Example Health Home: Information Page

Demographics *Duals excluded*					
Population	Stratification	Calendar year	Total Members (N)	Enrolled Members (N)	Outreach Only Members (N)
All Health Homes	Over-all	2013	130,212	50,272	79,940
		2014	266,828	84,686	182,142
Your Health Home	Over-all	2013	8,322	874	7,448
		2014	12,404	2,296	10,108
	Substance Use	2013	1,899	357	1,542
		2014	2,226	812	1,414
	Mental Health	2013	2,666	221	2,445
		2014	5,998	1,859	4,139
	HIV	2013	125	42	83
		2014	289	86	203
	Chronic	2013	5,553	303	5,250
		2014	6,000	305	5,695

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Reading The Worksheets

Improving Preventive Care												
Percentage of Eligible Members	*All Health Homes*		*Your Health Home*		*All Health Homes Enrolled*		*Your Health Home Enrolled*		*All Health Homes Outreach Only*		*Your Health Home Outreach Only*	
Measure	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**
Adult BMI Assessment (ABA) - % of members (sample of **MMC members only**), with an OP visit, who had their BMI documented during the measurement year or the year prior the measurement year												
Over-all	87.6	N/A	86.3	N/A	87.1	N/A	SS	N/A	88.2	N/A	86.5	N/A
Substance Use Disorder	87.7	N/A	SS	N/A	85.7	N/A	SS	N/A	92.6	N/A	SS	N/A
Mental Health	89.4	N/A	SS	N/A	88.7	N/A	SS	N/A	90.3	N/A	SS	N/A
HIV	83.8	N/A	SS	N/A	84.3	N/A	SS	N/A	SS	N/A	SS	N/A
Chronic	88.8	N/A	SS	N/A	97.6	N/A	SS	N/A	86.7	N/A	SS	N/A
Breast Cancer Screening (BCS)- % of women who had one or more mammograms to screen for breast cancer at any time two years prior up through the measurement year												
Over-all	63.6	65.5	59.8	62.9	64.1	64.1	66.7	60.5	64.1	66.1	59.3	62.4
Substance Use Disorder	50.8	51.3	36.1	46.6	54.6	53.8	SS	47.1	54.6	49.0	37.9	46.5
Mental Health	60.9	64.4	53.2	60.2	62.1	62.7	58.7	56.3	62.1	65.4	52.4	60.5
HIV	66.6	65.4	SS	82.1	66.9	65.1	SS	SS	66.9	65.9	SS	82.4
Chronic	66.7	67.8	62.8	64.6	69.9	68.9	73.7	64.7	69.9	67.6	62.2	64.6

N/A= Not Applicable; Measure results not available for CY
SS= sample size less than 30

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Use Case!

How can this information be used to improve the quality of services delivered to Health Home Members?

The following slides will present an example use case:

- **Mental Illness:** Follow Up After Hospitalization (FUH)

Follow Up After Hospitalization

- The % of members who were seen on an ambulatory basis or were in intermediate treatment with a mental health provider within **7** days of discharge.
- The % of members who were seen on an ambulatory basis or were in intermediate treatment with a mental health provider within **30** days of discharge.

Follow Up After Hospitalization

- “Eagle Street Health Home” Outcomes
  - “All Health Homes” – Real numbers
  - “Your Health Home” – Fiction
- Look at these numbers critically
  - What do you see?
  - What questions would you ask?
  - How could you use this information to understand or improve service delivery?

Follow Up After Hospitalization

Improving Outcomes for Persons with Mental Illness												
Percentage of Eligible Members	*All Health Homes*		*Your Health Home*		*All Health Homes Enrolled*		*Your Health Home Enrolled*		*All Health Homes Outreach Only*		*Your Health Home Outreach Only*	
Measure	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**
Follow Up After Hospitalization for Mental Illness - 7 days (FUH)- The % of members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 7 days of discharge												
Over-all	43.7	42.9	42.8	44.8	45.5	44.0	50.0	47.5	40.1	40.8	39.2	42.0
Substance Use Disorder	41.0	40.5	33.5	37.9	43.2	42.0	42.3	41.1	36.3	37.7	29.7	34.8
Mental Health	43.8	42.9	42.8	44.8	45.6	44.0	50.0	47.5	40.1	40.9	39.2	42.0
HIV	34.4	37.6	SS	SS	34.4	38.7	SS	SS	34.4	33.2	SS	SS
Chronic	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS	36.6	SS
Follow Up After Hospitalization for Mental Illness - 30 days (FUH)- The % of members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 30 days of discharge												
Over-all	60.6	60.0	57.9	63.3	63.0	61.9	59.2	64.2	63.0	56.7	57.3	62.5
Substance Use Disorder	57.8	57.6	52.2	58.6	60.9	60.1	54.6	59.7	60.9	53.2	53.7	58.9
Mental Health	60.7	60.1	57.9	63.3	63.0	61.9	59.2	64.2	63.0	56.9	57.3	62.5
HIV	50.6	54.0	SS	SS	51.5	54.8	SS	SS	51.5	50.8	SS	61.2
Chronic	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS

Follow Up After Hospitalization

Improving Outcomes for Persons with Mental Illness												
Percentage of Eligible Members	*All Health Homes*		*Your Health Home*		*All Health Homes Enrolled*		*Your Health Home Enrolled*		*All Health Homes Outreach Only*		*Your Health Home Outreach Only*	
Measure	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**
Follow Up After Hospitalization for Mental Illness - 7 days (FUH)- The % of members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 7 days of discharge												
Over-all	43.7	42.9	42.8	44.8	45.5	44.0	50.0	47.5	40.1	40.8	39.2	42.0
Substance Use Disorder **A**	41.0	40.5	33.5	37.9	43.2	42.0	42.3	41.1	36.3	37.7	29.7	34.8
Mental Health	43.8	42.9	42.8	44.8	45.6	44.0	50.0	47.5	40.1	40.9	39.2	42.0
HIV	34.4	37.6	SS	SS	34.4	38.7	SS	SS	34.4	33.2	SS	SS
Chronic	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS	36.6	SS
Follow Up After Hospitalization for Mental Illness - 30 days (FUH)- The % of members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 30 days of discharge												
Over-all	60.6	60.0	57.9	63.3	63.0	61.9	59.2	64.2	63.0	56.7	57.3	62.5
Substance Use Disorder	57.8	57.6	52.2	58.6	60.9	60.1	54.6	59.7	60.9	53.2	53.7	58.9
Mental Health	60.7	60.1	57.9	63.3	63.0	61.9	59.2	64.2	63.0	56.9	57.3	62.5
HIV	50.6	54.0	SS	SS	51.5	54.8	SS	SS	51.5	50.8	SS	61.2
Chronic	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS

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Follow Up After Hospitalization

Improving Outcomes for Persons with Mental Illness												
Percentage of Eligible Members	*All Health Homes*		*Your Health Home*		*All Health Homes Enrolled*		*Your Health Home Enrolled*		*All Health Homes Outreach Only*		*Your Health Home Outreach Only*	
Measure	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**
Follow Up After Hospitalization for Mental Illness - 7 days (FUH)- The % of members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 7 days of discharge												
Over-all	43.7	42.9	42.8		45.5	44.0	50.0	47.5	40.1	40.8	39.2	42.0
Substance Use Disorder	41.0	40.5	33.5		43.2	42.0	42.3	41.1	36.3	37.7	29.7	34.8
Mental Health	43.8	42.9	42.8	44.8	45.6	44.0	50.0	47.5	40.1	40.9	39.2	42.0
HIV	34.4	37.6	SS	SS	34.4	38.7	SS	SS	34.4	33.2	SS	SS
Chronic	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS	36.6	SS
Follow Up After Hospitalization for Mental Illness - 30 days (FUH)- The % of members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 30 days of discharge												
Over-all	60.6	60.0	57.9	63.3	63.0	61.9	59.2	64.2	63.0	56.7	57.3	62.5
Substance Use Disorder	57.8	57.6	52.2	58.6	60.9	60.1	54.6	59.7	60.9	53.2	53.7	58.9
Mental Health	60.7	60.1	57.9	63.3	63.0	61.9	59.2	64.2	63.0	56.9	57.3	62.5
HIV	50.6	54.0	SS	SS	51.5	54.8	SS	SS	51.5	50.8	SS	61.2
Chronic	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS

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Follow Up After Hospitalization

Improving Outcomes for Persons with Mental Illness												
Percentage of Eligible Members	*All Health Homes*		*Your Health Home*		*All Health Homes Enrolled*		*Your Health Home Enrolled*		*All Health Homes Outreach Only*		*Your Health Home Outreach Only*	
Measure	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**	**CY2013**	**CY2014**
Follow Up After Hospitalization for Mental Illness - 7 days (FUH)- The % of members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 7 days of discharge												
Over-all	43.7	42.9	42.8		45.5	44.0	50.0	47.5	40.1	40.8	39.2	42.0
Substance Use Disorder	41.0	40.5	33.5		43.2	42.0	42.3	41.1	36.3	37.7	29.7	34.8
Mental Health	43.8	42.9	42.8	44.8	45.6	44.0	50.0	47.5	40.1	40.9	39.2	42.0
HIV	34.4	37.6	SS	SS	34.4	38.7	SS	SS	34.4	33.2	SS	SS
Chronic	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS	36.6	SS
Follow Up After Hospitalization for Mental Illness - 30 days (FUH)- The % of members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 30 days of discharge												
Over-all	60.6	60.0	57.9	63.3	63.0	61.9	59.2	64.2	63.0	56.7	57.3	62.5
Substance Use Disorder	57.8	57.6	52.2	58.6	60.9	60.1	54.6	59.7	60.9	53.2	53.7	58.9
Mental Health	60.7	60.1	57.9	63.3	63.0	61.9	59.2	64.2	63.0	56.9	57.3	62.5
HIV	50.6	54.0	SS	SS	51.5	54.8	SS	SS	51.5	50.8	SS	61.2
Chronic	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS	SS

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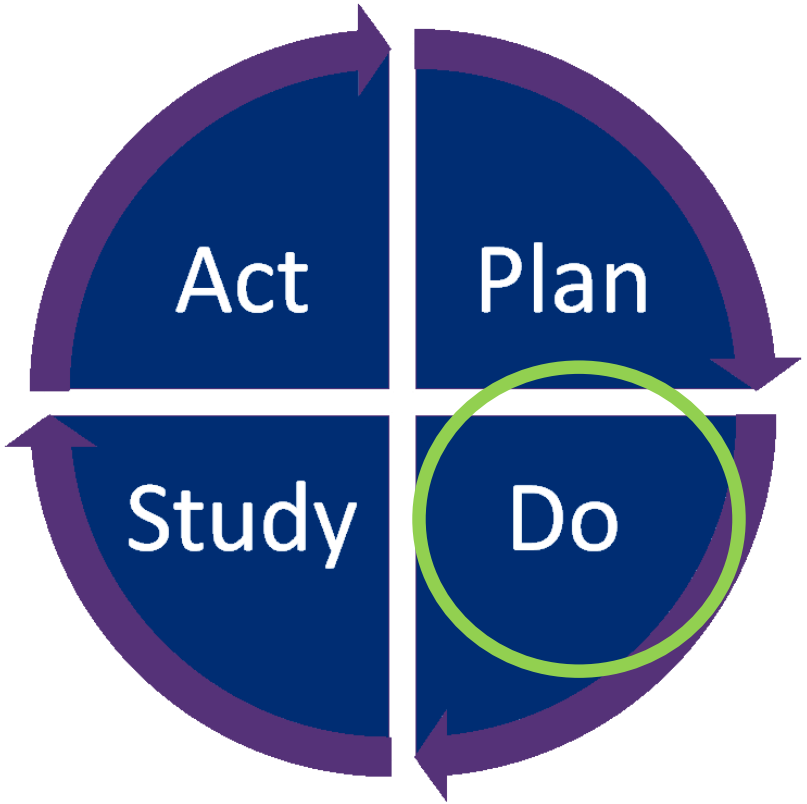
Act
Plan
Study
Do

Critical Thinking!

- Incomplete list of questions to consider:
  - Who?
  - Where?
  - When?
  - What?
  - How?
- Lots of overlap!

Critical Thinking: Who?

- Who is driving your current quality?
- What group has the worst quality on that measure?
- What group has the best? Why are they different?
- Groups to consider:
  - Gender
  - Race
  - Age
  - Medical Diagnoses
  - Severity / Complexity

Critical Thinking: Where?

- Does quality vary across CMAs?
- Is there a regional difference?
- Does quality vary based on referral source?
  - If yes, is there some important difference in the demographics of these referral sources?

Critical Thinking: When?

- Was quality better in 2014 than 2013?
- Was quality better in 2013 than 2014?
- What changed across these two years that could affect quality?
  - A new downstream provider?
  - A downstream provider left?
  - A new referral source?
  - A new internal rule or external regulation that affected practice?

Critical Thinking: What?

- What is different about members who get better outcomes?

Critical Thinking: How?

- How can we address these differences?
- Do we need a new policy to address a weakness?
- Do we need a renewed focus on a specific group or problem?

Next Steps

- OQPS will send each Health Home THEIR workbook
- Review the numbers. Where would you like to improve?
  - Ask the hard questions
  - Identify your targets:
    - Who?
    - Where?
    - When?
    - What?
    - How?
- Start developing a Quality Improvement Plan

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Let's Talk

- Email / Web Form:
  - https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action
  - Subject: Health Home Performance Targets** *(updated subject)*
- Phone: 518-473-5569