Outpatient Learning Collaborative – June 20, 2017

Attendees
In Person: Chris Picciotto, **Oswego Family Physicians**; Robin Jones, **Mohawk Valley Health Care;** Sarah Paolini, **Circare**; Kelly Stevens, **NOCHSI**; Erika Allen, **ARISE**; Harisa Begic, **Rome Medical Group**, George Blakeslee, **Upstate University Hospital;** Kristin Saintano, Erica Colacino, **United Healthcare**
Phone: April Miles, **East Hill Family Medical**; Carol Jank, **Lewis County General Hospital**; Michelle Slade, Mini Malhotra, **Upstate University Hospital;** Tara Costello, **Upstate Cerebral Palsy**; Sherry Buglione, **Oneida Healthcare**; Sarah Dawson, **Auburn Community Hospital**; Tricia Clark, Nancy Deavers, **NOCHSI;** Melissa Carey, **The Neighborhood Center;** Lori Decker, **Rome Memorial Hospital;** Jillian Gross, Christina Lounsbury, **Central NY Health Home Network;**
CNYCC: Wendy Knight, Karen Joncas, Shana Rowan

Update on Learning Collaborative Schedule Changes & Structure
Moving forward, Learning Collaboratives will be round table discussions that include content experts (VBP, etc.) We hope the Collaboratives can be a forum for partners to talk and ask questions, and will be relying less on PowerPoints in order to encourage more conversation and sharing of best practices.

We will be moving to one Learning Collaborative per month, the first Tuesday from 10-12 so that each collaborative (The combined Acute, Post-Acute and CBO) group meets every other month.

The next meeting of the Outpatient Learning Collaborative is August 1st, at 10am-12pm.

The next meeting of the Combined Learning Collaborative is July 11th and will remain in its standing time slot, 10am-12pm.

Performance Outcome: Management Dashboards
Please see slide deck for additional details
We will be sharing management dashboards during each meeting. This is a way for us to gauge progress on performance measures, some of which are tied to projects. Please note that there is a significant lag in the data we have access to currently.

Wendy briefly reviewed the performance outcomes and explained that DSRIP's focus and available funding will shift from paying for reporting to paying for Performance.

HEDIS Measures and Performance Outcomes/Q & A – Erika Colacino and Kristin Sainato, United Healthcare

Participants asked Kristin and Erica for clarification on the outcome measures presented in the Management Dashboards.

Potentially Avoidable Readmissions
Though we understand it happens with even the best care management, we are looking for a lower rate and avoidance of the ED. If patients are getting appropriate outpatient care, filling and adhering to meds, etc. then in theory there should not be a need for an ED visit. This allows us to compare and gather data when looking at health plans.

Potentially Preventable ED Visits
This measure is based on patient diagnosis. Participants wanted to know which diagnoses/criteria are used to establish what is avoidable or not and also asked how their organization could track, for example, a walk-in crisis service that prevents the patient from visiting the ED. Utilization can be tracked looking at a decrease in ED use and an increase in walk-in /outpatient services.

Adherence to Antipsychotic Medication for People with Schizophrenia
This measure tracks if medications are being filled, picked up, and adhered to by the patient.

Antidepressant Medication Management (Acute/Effective Phase)
This measure tracks if a person with a diagnosis of depression starting new medication is filled, picked up, and taken as prescribed for a period of three months (acute) and six months (effective.) We only look at these two points in time.

Engagement of Alcohol and Other Drug Dependence Treatment
This measure tracks if a person with related diagnoses and in need of treatment is admitted and receives treatment within 44 days of their diagnoses.

Follow up After Hospitalization (within 7/within 30 days)
Any mental health admission should have a follow-up with a mental health provider at 7 and 30 days (ideally 7, since this counts for both measures.) The patient must show up to the appointment. Participants explained this is not always possible due to lack of availability of mental health providers and asked if a visit with a nurse would suffice. Kristin explained that in order for it to count against this measure, the provider needs to be an advanced practice nurse, nurse practitioner, doctor or therapist. A PCP is acceptable but behavioral health provider is preferred, even if a patient receives their BH medication through a PCP.

Follow up Care for Children Prescribed ADHD Medications (Continuation/Initiation)
This measure aims to ensure children are staying on their medication and receiving a follow-up visit with a prescriber within 30 days. This can be a PCP or prescriber. It was noted that many patients in our PPS do not have vehicles and rely on public transportation to get to appointments, which can sometimes make it impossible for them to get to an appointment in the allotted time frame. Kristin acknowledged that this measure will never be at 100% and geographical considerations need to be made.

Cardiovascular Disease Monitoring for People with CVD and Schizophrenia
BH providers can refer a patient to a PCP for monitoring, just as PCPs can refer to BH providers. This is connected to a cholesterol-related measure.

Adult Access to Preventative or Ambulatory Care (all ages)
Adult access refers to any outpatient visit, including specialists, excluding the ED.

Children's Access to Primary Care (all ages)
Children's access requires that the patient have a visit with a PCP. It does not need to be their assigned PCP.

PDI 90
This measure refers to potentially preventable admissions for children (bronchitis, UTI, etc. - conditions that children should not be admitted for if they are receiving appropriate outpatient care.)

Overall
United Healthcare is able to share member panel data with large primary care providers on a regular basis, and is starting to move into the BH measures with PCPs. They are still working to make it more accessible, and are not quite there yet. Clinical practice consultants deliver score cards, meet with providers, discuss measures and strategize on how to improve outcomes which has been helpful in incentivizing PCPs. Although there is not enough manpower to offer this across all providers, they are currently working with over 350 organizations.

Measures are based on the idea that if access goes up, admissions should go down. In terms of prevention quality, if a condition is being managed appropriately, it should not turn into an ED admission. All measures are reported to the state

and NCQA. The state looks at things retrospectively since they are measuring Medicaid plans against other Medicaid plans.

It was suggested that tying the Schizophrenia-Diabetes measures to a financial requirement may improve their outcome, perhaps rewarding providers based on how detailed their notes are.

Outstanding Concerns

A concern regarding the transition to VBP was raised: might patients with language or intellectual barriers be asked to rate the care they receive from providers?

Kristin responded that right now, patient experience is reported but not necessarily included in these types of agreements. The state performs member satisfaction surveys every other year; health plan is rated on this. Beyond this, it has not really been included in any discussions around these arrangements. Erica mentioned that it may have been discussed historically in their clinical advisory groups, and will check to see any references to this issue.

Our region has very, very limited psychiatrists and a shortage of child psychiatrists in some areas. If a PCP writes in a note that a patient needs to be referred to psychiatry, does he lose out because there is no one to refer to? Kristin responded that these measures are compared the regional measures. Region by region can vary.

Some providers require behavioral health patients to make their own appointments once they make the referral. In those instances, if the patient fails to contact services, it can result in the provider losing credit for the referral. A possible way to combat this would be to implement warm handoffs or have a case manager make a house call to the patient.

United Healthcare provides behavioral health outreach for patients who have higher needs, and more intense case management for those identified as super utilizers. Kristin will find out for partners whom they can contact at United Healthcare if they are concerned about a patient.

Increasing early interventional care/more multi-specialty collaborations make it less likely a member will need a more costly service. This model should show work taking place towards that collaboration.

Next Steps

- Next Outpatient Learning Collaborative: August 1, 10am-12pm *please note new meeting time!* (click here to RSVP)
- Next Combined Learning Collaborative: July 11, 10am-12pm (click here to RSVP)

Action Items

- United Healthcare to share which diagnoses/criteria are connected to the Potentially Avoidable ED Visits measure
- United Healthcare to provide contact information for their intense case management unit for providers concerned about patients