BHNNY PPS Phase Three Pay for Performance Measures

Better Health for Northeast New York

A Partnership for Better Health

Measure Specification & Improvement Resource Guide

April 25, 2018

Contents:

- General overview and instructions for data collection with examples
- A synopsis of each measure including measure description, associated DSRIP P4P measure name, goal for each measure and applicable partner types
- Description of numerator and denominator for each measure
- Relevant ICD, CPT, HCPCS codes
- Recommended EHR structured elements for data entry and reporting
- Measure specific "best-practice" guidance on performance improvement based on literature review

Appendix:

A. General and category-specific resource guide on performance improvement.
B. NYS DOH Measure Specification Manual – 2017-2018
C. Suffolk Care Collaborative - Medication lists for HEDIS medication measures
D. NYS DSRIP Patient Engagement measure specifications

BHNNY PPS Phase Three Pay for Performance Measures

Better Health for Northeast New York (BHNNY) PPS is committed to supporting our partners in improving the quality and cost of care. The focus to date has been on improving processes, understanding the patient population, and practice transformation. Our next focus is to understand the impact of this focus on outcomes of care.

Goal: Develop incentive-based performance improvement program to achieve key BHNNY objectives;

- Enhance access to primary care and BH services
- Enhance care coordination across multiple healthcare settings
- Assure provision of evidence-based care to improve clinical outcomes
- Maximize MY 4 & MY 5 P4P incentive earning opportunities
- "BHNNY earns, BHNNY shares"
- Incentivize based on number of patients & performance by measure

Measure development and categorization:

- Align metrics to improvements in patient care
- Focus on majority of Domains 2 & 3 claims-based measures, all MR audit-based measures, and DOH patient engagement metrics
- Modify DSRIP P4P metrics and develop additional proxy measures, as appropriate, to align with partner activities, scope of services, and reporting capabilities
- Utilization of external resources for proxy measures – *PSYCKES, IHI, CMS, HEDIS, CPC+, NYSVBP*

Data source & reporting:

- Data sources: **Partner EHRs, PSYCKES, Practice Management, Finance**
- Eligible patients:
    - Medicaid / Medicaid Managed Care attributed to BHNNY
    - Uninsured
    - Dual Eligible, Medicare and Medicaid, **are not** eligible.
- Frequency
    - **Baseline data due May 11, 2018**
    - **Monthly reports due beginning July 10, 2018**

Measure Categories:

- Improving Access to Care
- Improving Effectiveness of Care
- Improving Efficiency of Care

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Applicable Provider Types:

- Primary Care (Primary care providers with or without integrated behavioral health services)
    - Adults
    - Child & Adolescents
    - Select – Providers providing limited primary care services
    - Eligible PCPs (3.a.i Model 1 and Model 3)
- Eligible Behavioral Health (3.a.i Model 2) – Outpatient
- Mental Health Outpatient (MH) (Primarily provide mental health services, are usually OMH licensed, and have a prescribing practitioner)
    - Adult
    - Child & Adolescent
- Mental Health (MH) Inpatient
- Substance Use Disorder (SUD) Treatment (Licensed by OASAS to provide Substance Use Disorder treatment services)
- Hospital
- SNFs & Other Residential Facilities
- Cardiology
- Pulmonary
- Allergy

PSYCKES vs. EMR:

- **IMPORTANT: For the following two measures, you will have an option to choose to report using either the PSYCKES data source or your practice's EMR systems. <u>The choice must be made at the time of reporting your baseline data and you must be consistent with the same data source when reporting subsequent monthly data</u>.**
    - **Measure 11** – Diabetes monitoring for people with diabetes and schizophrenia
    - **Measure 12** – Diabetes screening for people with schizophrenia and bipolar disease who are using antipsychotic medication

Metric Population:

- **Active Patients** are defined as all **Medicaid, Medicaid Managed Care, and Uninsured** members seen during the previous 24 months. Dual Eligible, Medicare and Medicaid, **should not** be included.
- Each measure's **Denominator** is comprised of a subset of individuals from the Active Patients who meet additional criteria (e.g., are prescribed a specific type of medication; were seen during a specific month).
- Each measure's **Numerator** is comprised of a subset of individuals from the Denominator who meet a final criterion (e.g., received a specific test in a specified date range).

Figure 1. Relationship between Active Patients, Denominator & Numerator

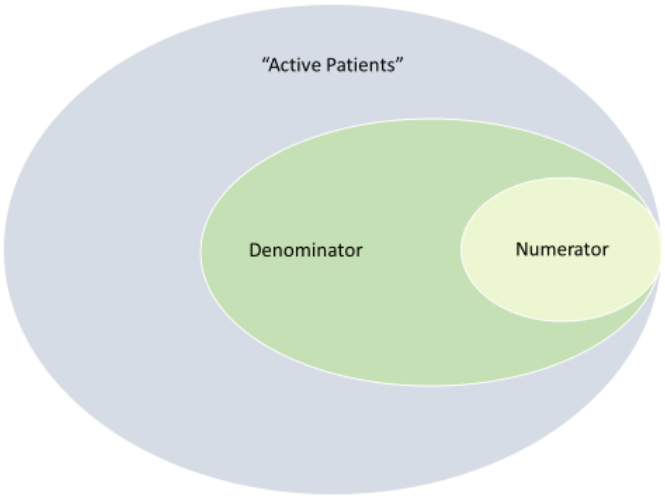
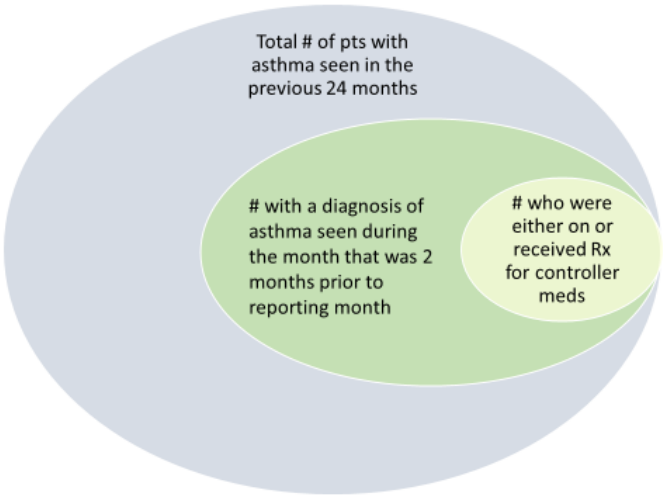


Figure 2. Relationship between Active Patients, Denominator & Numerator – **Asthma Metric Example**



Baseline Data:

- BHNNY will calculate partner- and metric-specific performance targets based on baseline data that partners submit. For each of their contract metrics, partners should submit **baseline data for the period of 04/01/2016 – 03/31/2018 by May 11, 2018**. Please see contract language for specifics on this date.
- Baseline reports should include **both list of patients (PHI) and aggregate data** for both the denominator and the numerator

- Where either the numerator or denominator is "0" a justification should be provided. Please refer to the drop-downs on the Contracted Measures tab on the phase III proxy measure reporting template when providing justification.
- The baseline report data will form the basis for determining targets for funds flow model starting in July 2018.
- **Baseline denominator**:
  Number of active patients for each measure seen by the practice between April 1, 2016 to March 31, 2018.
  There are many PxMs which are exceptions to the date range described for Baseline reports. This occurs in instances where the PxM is measuring a specific window of time for events such as select follow-up and medication adherence, readmissions, ED visits, etc. Examples of such measures are below:

  - PxM_9: Timely follow-up for patients with newly prescribed antidepressant medications
  - PxM_10: Outreach to increase adherence to antipsychotic medications
  - PxM_13: Follow-up care for children prescribed new ADHD medication
  - PxM_34: ED visits from SNFs and other residential facilities
  - PxM_35: Potentially preventable behavioral health ED visits - PSYCKES
  - PxM_43: Hospital readmission rate
  - PxM_44: Potentially avoidable readmissions of residents from SNFs and other residential facilities
  - PxM_45: BH readmission rate

  Baseline data for PxMs that are aligned with NYS DOH patient engagement requirements will report for the last quarter of the baseline period (January 1, 2018 – March 31, 2018) and move forward as a monthly report starting in July:

  - PxM_8: Initiation or review of person-centered care plan
  - PxM_19: Behavioral health preventive care screening
  - PxM_20: Primary care services at behavioral health integrated site
  - PxM_21: Depression screening as part of IMPACT Model
  - PxM_25: Documentation of self-management goals for patients with CVD
  - PxM_29: Completion of asthma action plans

- **Baseline Numerator:**
  Please use the numerator description outlined in the measure spec document

- **Additional Considerations and Clarifications:**
  - Project 3ai Patient Engagement Metrics (#s 19, 20, 21) are applicable only to eligible sites> Eligibility is defined as completed implementation of behavioral health or primary care service integration, as applicable, as defined in DSRIP Project 3ai, before April 1, 2018.

BHNNY PPS Phase Three Pay for Performance Measures

1. Example for baseline report due by May 11, 2018: Example

Measure Name: **Prescription of Statin Medications**

BHNNY Measure Title	BHNNY P4P Metric Description	Numerator	Denominator - Baseline
Prescription of Statin Medications	Percentage of eligible patients who were prescribed at least one high or moderate intensity statin medication	Number of patients in the denominator who were **either on or prescribed** at least one high or moderate-intensity statin medications at the last visit	Number of patients, ages 21 to 75 years, with Atherosclerotic Cardiovascular Disease (ASCVD) seen between April 1, 2016 - March 31, 2018

Denominator: Number of Patients, ages 21 to 75 years, with Atherosclerotic Cardiovascular Disease (ASCVD) seen between **April 1, 2016 - March 31, 2018**

ICD Codes: **Ischemic Vascular Disease**: I20.0 –I20.9, I24.0 –I24.9, I25.10 –I25.119, I25.5 –I25.9, I63.00 –I66.9, I67.2, I70.0 –I70.92, I74.01 –I75.89

Numerator: Number of patients in the denominator who were **either on or prescribed** at least one high or moderate-intensity statin medications at the last visit

Statin Medication list: Atorvastatin (10-20 mg) (40–80 mg), Amlodipine-atorvastatin (10-20 mg) (40–80 mg), Ezetimibe-atorvastatin (10-20 mg) (40–80 mg), Rosuvastatin (5-10 mg) (20–40 mg), Simvastatin (20–40 mg) (80 mg), Ezetimibe-simvastatin (20–40 mg) (80 mg), Niacin-simvastatin 20-40 mg, Sitagliptin-simvastatin 20-40 mg, Pravastatin 40–80 mg, Aspirin-pravastatin 40-80 mg, Lovastatin 40 mg, Niacin-lovastatin 40 mg, Fluvastatin XL 80 mg, Fluvastatin 40 mg bid, Pitavastatin 2–4 mg

2. Example for monthly report due by July 10, 2018: Example

Measure Name: **Prescription of Statin Medications**

BHNNY Measure Title	BHNNY P4P Metric Description	Numerator	Denominator – Monthly Report
Prescription of Statin Medications	Percentage of eligible patients who were prescribed at least one high or moderate intensity statin medication	Number of patients in the denominator who were **either on or prescribed** at least one high or moderate-intensity statin medications at the last visit	Number of patients, ages 21 to 75 years, with Atherosclerotic Cardiovascular Disease (ASCVD) **seen during the month that was 2 months prior to reporting month**

Denominator: Number of Patients, ages 21 to 75 years, with Atherosclerotic Cardiovascular Disease (ASCVD) seen between **May 1, 2018 - May 31, 2018**
Numerator: as above

Phase III Pay for Performance Measures - Specifications

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 1

BHNNY Measure Title: Preventive or Ambulatory Care Visit: 20-44 years

Corresponding DSRIP P4P Measure: Adult Access to Preventive or Ambulatory Care: 20-44 years

Goal of Measure: Improving Access to Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Adult, Primary Care – Select, Primary Care – Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible adults who were up-to-date for a preventive or ambulatory care visit	Number of adults in the denominator with a preventive or an ambulatory care visit during the previous 12 months ending on the last day of the month that was 2 months prior to the reporting month	Number of adults, ages 20-44 years, seen for a preventive or ambulatory visit between April 1, 2016 - March 31, 2018	Number of adults, ages 20 to 44 years, seen during the previous 24 months ending on the last day of the month that was 2 months prior to reporting month

Numerator & Denominator: ICD, CPT & HCPCS Codes (Use all codes)	
ICD Codes: Z00.00-Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9	**CPT Codes:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429, 96160 **HCPCS:** G0402, G0438-G0439, G0463, T1015

Additional Recommendations / Structured Data Elements

• Determine visit appointment type
• Consider systematic and proactive outreach to be made to patients who are due for preventive or ambulatory care visits.
• Evaluate EMR capabilities to capture components of preventive visit:
  ○ Comprehensive history and physical exam findings
  ○ Description of status of chronic, stable conditions
  ○ Age-appropriate counseling, screening labs, and tests

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 2

BHNNY Measure Title: Preventive or Ambulatory Care Visit: 45-64 years

Corresponding DSRIP P4P Measure: Adult Access to Preventive or Ambulatory Care: 45-64 years

Goal of Measure: Improving Access to Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Adult, Primary Care – Select

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible adults who were up-to-date for a preventive or ambulatory care visit	Number of adults in the denominator with a preventive or an ambulatory care visit during the previous 12 months ending on the last day of the month that was 2 months prior to the reporting month	Number of adults, ages 45-64 years, seen for a preventive or ambulatory visit between April 1, 2016 - March 31, 2018	Number of adults, ages 45 to 64 years, seen during the previous 24 months ending on the last day of the month that was 2 months prior to reporting month

Numerator & Denominator: ICD, CPT & HCPCS Codes (Use all codes)	
ICD Codes: Z00.00-Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9	**CPT Codes:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, , 99429, 96160 **HCPCS:** G0402, G0438-G0439, G0463, T1015

Additional Recommendations / Structured Data Elements

- Determine visit appointment type.
- Consider systematic and proactive outreach to be made to patients who are due for preventive or ambulatory care visits.
- Evaluate EMR capabilities to capture components of preventive visit:
    - Comprehensive history and physical exam findings
    - Description of status of chronic, stable conditions
    - Age-appropriate counseling, screening labs, and tests

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 3

BHNNY Measure Title: Preventive or Ambulatory Care Visit: 65 years and older

Corresponding DSRIP P4P Measure: Adult Access to Preventive or Ambulatory Care: 65 years and older

Goal of Measure: Improving Access to Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Adult, Primary Care - Select

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible adults who were up-to-date for a preventive or ambulatory care visit	Number of adults in the denominator with a preventive or an ambulatory care visit during the previous 12 months ending on the last day of the month that was 2 months prior to the reporting month	Number of adults, ages 65 years and older, seen for a preventive or ambulatory visit between April 1, 2016 - March 31, 2018	Number of adults, ages 65 years and older, seen during the previous 24 months ending on the last day of the month that was 2 months prior to reporting month

Numerator & Denominator: ICD, CPT & HCPCS Codes (Use all codes)	
ICD Codes: Z00.00-Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9	**CPT Codes**: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, ,99429, 96160 **HCPCS:** G0402, G0438-G0439, G0463, T1015

Additional Recommendations / Structured Data Elements

- Determine visit appointment type.
- Consider systematic and proactive outreach to be made to patients who are due for preventive or ambulatory care visits.
- Evaluate EMR capabilities to capture components of preventive visit:
    - Comprehensive history and physical exam findings
    - Description of status of chronic, stable conditions
    - Age-appropriate counseling, screening labs, and tests

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 4

BHNNY Measure Title: Primary Care Visit: 12 to 24 months

Corresponding DSRIP P4P Measure: Children's Access to Primary Care: 12 to 24 months

Goal of Measure: Improving Access to Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible children who were up-to-date for age appropriate primary care visit	Number of children in the denominator with a primary care visit during the previous 12 months ending on the last day of the month that was 2 months prior to the reporting month	Number of children, ages 12 months to 24 months, seen for a primary care visit between April 1, 2016 - March 31, 2018	Number of children, ages 12 to 24 months, seen during the previous 24 months ending on the last day of the month that was 2 months prior to reporting month

Numerator & Denominator: ICD, CPT & HCPCS Codes (Use all codes)	
ICD Codes: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9	**CPT Codes:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429, 96160 **HCPCS:** G0402, G0438-G0439, G0463, T1015

Additional Recommendations / Structured Data Elements

• Determine visit appointment type.
• Consider systematic and proactive outreach to be made to caregivers of children who are due for preventive visits.
• Evaluate EMR capabilities to capture components of preventive visit
  ○ Comprehensive history and physical exam findings
  ○ Description of status of chronic, stable conditions
  ○ Age-appropriate counseling, screening, labs/tests, vaccines

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 5

BHNNY Measure Title: Primary Care Visit: 25 months to 6 years

Corresponding DSRIP P4P Measure: Children's Access to Primary Care: 25 months to 6 years

Goal of Measure: Improving Access to Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible children who were up-to-date for age appropriate primary care visit	Number of children in the denominator with a primary care visit during the previous 12 months ending on the last day of the month that was 2 months prior to the reporting month	Number of children, ages 25 months to 6 years, seen for a preventive or ambulatory visit between April 1, 2016 - March 31, 2018	Number of children, ages 25 month to 6 years, seen during the previous 24 months ending on the last day of the month that was 2 months prior to reporting month

Numerator & Denominator: ICD, CPT & HCPCS Codes (Use all codes)	
ICD Codes: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9	**CPT codes:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429, 96160 **HCPCS:** G0402, G0438-G0439, G0463, T1015

Additional Recommendations / Structured Data Elements

• Determine visit appointment type.
• Consider systematic and proactive outreach to be made to caregivers of children who are due for preventive visits.
• Evaluate EMR capabilities to capture components of preventive visit
  ○ Comprehensive history and physical exam findings
  ○ Description of status of chronic, stable conditions
  ○ Age-appropriate counseling, screening, labs/tests, vaccines

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 6

BHNNY Measure Title: Primary Care Visit: 7 – 11 years

Corresponding DSRIP P4P Measure: Children's Access to Primary Care: 7 to 11 years

Goal of Measure: Improving Access to Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible children who were up-to-date for age appropriate primary care visit	Number of children in the denominator with a primary care visit during the previous 12 months ending on the last day of the month that was 2 months prior to the reporting month	Number of children, ages 7-11 years, seen for a preventive or ambulatory visit between April 1, 2016 - March 31, 2018	Number of children, ages 7 to 11 years, seen during the previous 24 months ending on the last day of the month that was 2 months prior to reporting month

Numerator & Denominator: ICD, CPT & HCPCS Codes (Use all codes)	
ICD Codes: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9	**CPT codes:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429, 96160 **HCPCS:** G0402, G0438-G0439, G0463, T1015

Additional Recommendations / Structured Data Elements

- Determine visit appointment type.
- Consider systematic and proactive outreach to be made to caregivers of children who are due for preventive visits.
- Evaluate EMR capabilities to capture components of preventive visit
    - Comprehensive history and physical exam findings
    - Description of status of chronic, stable conditions
    - Age-appropriate counseling, screening, labs/tests, vaccines

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 7

BHNNY Measure Title: Primary Care Visi:12 to 19 years

Corresponding DSRIP P4P Measure: Children's Access to Primary Care: 12 to 19 years

Goal of Measure: Improving Access to Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Child & Adolescent, Primary Care – Adult, Primary Care - Select

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible children who were up-to-date for age appropriate primary care visit	Number of children in the denominator with a primary care visit during the previous 12 months ending on the last day of the month that was 2 months prior to the reporting month	Number of children, ages 12-19 years, seen for a preventive or ambulatory visit between April 1, 2016 - March 31, 2018	Number of children, ages 12 to 19 years, seen during the previous 24 months ending on the last day of the month that was 2 months prior to reporting month

Numerator & Denominator: ICD, CPT & HCPCS Codes (Use all codes)	
ICD Codes: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9	**CPT codes:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429, 96160 **HCPCS:** G0402, G0438-G0439, G0463, T1015

Additional Recommendations / Structured Data Elements

- Determine visit appointment type.
- Consider systematic and proactive outreach to be made to caregivers of children who are due for preventive visits.
- Evaluate EMR capabilities to capture components of preventive visit
    - Comprehensive history and physical exam findings
    - Description of status of chronic, stable conditions
    - Age-appropriate counseling, screening, labs/tests, vaccines

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 8

BHNNY Measure Title: Initiation or review of person-centered care plan

Corresponding DSRIP P4P Measure: Patient Engagement – Health Home at Risk

Goal of Measure: Improving Access to Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Adult; Primary Care - Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of patients with initiation or review of person-centered care plan	Number of patients in the denominator with initiation or review of person-centered care plan as outlined in the patient engagement definition	Number of patients with one or more chronic diseases seen between January 1, 2018 - March 31, 2018	Number of patients with one or more chronic diseases seen during the month that was 2 months prior to reporting month

Numerator: HCPCS Codes or EHR	Denominator: ICD Codes
S0280: Comprehensive care coordination and planning, initial plan **S0281:** Comprehensive care coordination and planning, maintenance **EHR:** Structured fields/Order sets	**Diabetes:** E10.10 –E10.351, E10.359, E10.36, E10.39 –E11.351, E11.359, E11.36, E11.39 –E13.351, E13.359, E13.36, E13.39 – E13.9, O24.011 –O24.33, O24.811 –O24.83 **Hypertension:** I10 **Asthma:** J45.20 –J45.998 **COPD:** J44.0-J44.1, J44.9

Additional Recommendations / Structured Data Elements
For care management notes: Consider adding visit codes or reason for visit such as “Initial Care Planning” or “Care Plan Maintenance” • Build and document care plan elements in structured templates in the EHR • Create structured fields in EHR templates to capture completion of care plan development and implementation

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 9

BHNNY Measure Title: Timely follow-up for patients with newly prescribed antidepressant medications

Corresponding DSRIP P4P Measure: Antidepressant Medication Management

Goal of Measure: Improving Effectiveness of Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: MH Outpatient-Adult, Primary Care-Adult, MH Outpatient- Child & Adolescent, Primary Care- Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients seen for follow-up within 6-weeks of new antidepressant prescription date	Number of patients in the denominator who were seen for follow-up visit with a practitioner within 6 weeks of the prescription date	Number of patients ages 18 and older with a diagnosis of depression who were **prescribed** a new antidepressant medication between April 1, 2016 - February 28, 2018	Number of patients, ages 18 years and older, with a diagnosis of depression who were **prescribed** a new antidepressant medication during the month that was 3 months prior to reporting month

Numerator: CPT Codes	Denominator: ICD Codes
CPT Codes: 99201-99205, 99211-99215, 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90867-90870, 90875-90876	**ICD Codes:** F32.0-F32.4, F32.9, F33.0-F333, F33.41, F33.9
Antidepressant medications: Bupropion, Vilazodone, Vortioxetinem, Isocarboxazid, Phenelzine, Selegiline, Tranylcypromine, Nefazodone, Trazodone, Amitriptyline-chlordiazepoxide, Amitriptyline-Perphenazine, Fluoxetine-olanzapine, Desvenlafaxine, Duloxetine, Levomilnacipran, Venlafaxine, Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline, Maprotiline, Mirtazapine, Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6 mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine	

Additional Recommendations / Structured Data Elements
• Systematic and proactive outreach to be made to patients who are prescribed applicable medications for pertinent follow up. • Conduct pre-visit planning activities by identifying patients on medications that need follow-up. • Consider care-planning around medication management and document the following at relevant visits: medication response, barriers patients are having taking medications, their overall level of understanding of how to take the medications and what they are for.

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 10

BHNNY Measure Title: Outreach to increase adherence to antipsychotic medications

Corresponding DSRIP P4P Measure: Adherence to Antipsychotic Medications for People with Schizophrenia

Goal of Measure: Improving Effectiveness of Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: MH Outpatient-Adult, Primary Care- Child & Adolescent, Primary Care- Adult, MH Outpatient- Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients prescribed antipsychotic medication who are successfully contacted for adherence support	Number of patients in the denominator who were successfully contacted by care team for medication adherence support between 12-16 weeks of the prescription date	Number of patients, ages 18-64 years, with a diagnosis of schizophrenia or schizoaffective disorder who were prescribed antipsychotic medication between April 1, 2016 - December 31, 2017	Number of patients, ages 18 to 64 years, with a diagnosis of schizophrenia or schizoaffective disorder who were prescribed antipsychotic medication during the previous 12 months

Numerator: CPT Codes or EHR	Denominator: ICD Codes
98966 – phone call 5 to 10 minutes 98967 – phone call 11 to 20 minutes 98968 – phone call 21 to 30 minutes **EHR:** Structured fields/Order sets	**Schizophrenia:** F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F25.0-F25.1, F25.8-F25.9
Antipsychotic medications: Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lursiadone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone, Chlorpromazine, Fluphenazine, Perphenazine, Perphenazine-amitriptyline, Prochlorperazine, Thioridazine, Trifluoperazine, Fluoxetine-olanzapine, Amitriptyline-perphenazine, Thiothixene, Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Risperidone, Olanzapine, Paliperidone palmitate	

Additional Recommendations / Structured Data Elements
• Create structured templates to capture interaction • Flag patients with diagnosis and medication in a registry to identify patients in need of follow-up contact • Alternative follow-up visits (telephonic) • Medication reconciliation at each visit • Consider care-planning around medication management and document the following at relevant visits: medication response, barriers patients are having to taking medications, their overall level of understanding of how to take the medications and what they are for.

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 11a. (Please choose either 11a. or 11b. and note that you must be consistent with the data source on reporting on these metrics)

BHNNY Measure Title: Diabetes monitoring for people with diabetes and schizophrenia -EMR

Corresponding DSRIP P4P Measure: Diabetes Monitoring for People with Diabetes and Schizophrenia

Goal of Measure: Improving Effectiveness of Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: MH Outpatient – Adult, Primary Care - Child & Adolescent, Primary Care - Adult, MH Outpatient - Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
EMR- Percentage of eligible patients with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test	EMR- Number of patients in the denominator who had both an LDL-C test and an HbA1c test during the previous 12 months	EMR- Number of patients, ages 18-64 years, with schizophrenia and diabetes seen between April 1, 2016 - March 31, 2018	EMR- Number of patients, ages 18 to 64 years, with schizophrenia and diabetes, seen during the month that was 2 months prior to reporting month

Numerator: CPT Codes or EHR Lab Data	Denominator: ICD Codes
LDL-C Test: 80061, 83700, 83701, 83704, 83721 / **CPT Category II Codes:** 3048F –3050F **HbA1c Test:** 83036, 83037 **CPT Category II Codes:** 3044F –3046F **EHR:** Lab data/ Structured fields	**Schizophrenia:** F20.0 –F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9 **Diabetes:** E10.10 –E10.351, E10.359, E10.36, E10.39 –E11.351, E11.359, E11.36, E11.39 –E13.351, E13.359, E13.36, E13.39 –E13.9, O24.011 –O24.33, O24.811 –O24.83

Additional Recommendations / Structured Data Elements
• Gaps in care- reports based on diagnosis • Huddle and pre-visit prep to identify patients needing screening • Closing the loop on testing and asking patients if they have had tests at other facilities • Connectivity to the testing facility portals • Access Hixny to verify need for testing • Enter lab values from Hixny and specialists' consultation notes as structured fields for data query

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 11b. (Please choose either 11a. or 11b. and note that you must be consistent with the data source on reporting on these metrics)

BHNNY Measure Title: Diabetes monitoring for people with diabetes and schizophrenia (using PSYCKES)

Corresponding DSRIP P4P Measure: Diabetes Monitoring for People with Diabetes and Schizophrenia

Goal of Measure: Improving Effectiveness of and Access to Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: MH Outpatient – Adult, Primary Care - Child & Adolescent, Primary Care - Adult, MH Outpatient - Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
PSYCKES- Percentage of eligible patients with schizophrenia and diabetes who did not receive both an LDL-C test and an HbA1c test	PSYCKES- Number of patients in the denominator who did not have an LDL-C test and an HbA1c test during the previous 12 months	PSYCKES- Number of patients, ages 18 to 64 years, with schizophrenia and diabetes, seen during the previous 9 months ending on March 31, 2018	PSYCKES: Number of patients, ages 18 to 64 years, with schizophrenia and diabetes, seen during the previous 9 months

ICD Codes	CPT Codes

Additional Recommendations / Structured Data Elements
• Gaps in care- reports based on diagnosis • Huddle and pre-visit prep to identify patients needing screening • Closing the loop on testing and asking patients if they have had tests at other facilities • Connectivity to the testing facility portals • Access Hixny to verify need for testing • Enter lab values from Hixny and specialists' consultation notes as structured fields for data query

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 12a. (Please choose either 12a. or 12b. and note that you must be consistent with the data source on reporting on these metrics)

BHNNY Measure Title: Diabetes screening for people with schizophrenia or bipolar disorder prescribed antipsychotic medication – EMR

Corresponding DSRIP P4P Measure: Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication

Goal of Measure: Improving Effectiveness of and Access to Care**,**

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: MH Outpatient – Adult, Primary Care - Child & Adolescent, Primary Care - Adult, MH Outpatient - Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
EMR - Percentage of eligible patients with schizophrenia or bipolar disorder and were prescribed antipsychotic medication who received a diabetes screening test	EMR - Number of patients in the denominator who had a diabetes screening test during the previous 12 months	EMR - Number of patients, ages 18-64 years, with schizophrenia or bipolar disorder who were either on or received prescription for an antipsychotic medication between April 1, 2016 - March 31, 2018	EMR - Number of patients, ages 18 to 64 years, with schizophrenia or bipolar disorder, who were either on received prescription for an antipsychotic medication during month that was 2 months prior to reporting month

Numerator: CPT Codes or EHR Lab Data	Denominator: ICD Codes
Glucose test: 80047-80048, 80050, 80053, 80069, 82947, 82950-82951 **HbA1c test:** 83036-83037, 3044F-3046F **EHR:** Lab data/ Structured fields	**Bipolar:** F30.10-F30.13; F30.2-F30.4; F30.8- F30.9; F31.0; F31.10-F31.13; F31.2; F31.30-F31.32; F31.4-F31.5; F31.60-F31.64; F31.70-F31.78 **Schizophrenia:** F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F25.0-F25.1, F25.8-F25.9
Antipsychotic medications: Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lursiadone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone, Chlorpromazine, Fluphenazine, Perphenazine, Perphenazine-amitriptyline, Prochlorperazine, Thioridazine, Trifluoperazine, Fluoxetine-olanzapine, Amitriptyline-perphenazine, Thiothixene, Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Risperidone, Olanzapine, Paliperidone palmitate	

Additional Recommendations / Structured Data Elements
• Gaps in care-reports based on diagnosis • Huddle and Pre-visit prep to identify patients needing screening • Closing the loop on testing and asking patients if they have had tests at other facilities • Access Hixny to verify need for testing • Enter lab values from Hixny and specialists' consultation notes as structured fields for data query

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 12b. (Please choose either 12a. or 12b. and note that you must be consistent with the data source on reporting on these metrics)

BHNNY Measure Title: Diabetes screening for people with schizophrenia or bipolar disorder prescribed antipsychotic medication (using PSYCKES)

Corresponding DSRIP P4P Measure: Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication

Goal of Measure: Improving Effectiveness of and Access to Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: MH Outpatient – Adult, Primary Care - Child & Adolescent, Primary Care - Adult, MH Outpatient - Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
PSYCKES - Percentage of eligible patients with schizophrenia or bipolar disorder and were prescribed antipsychotic medication who did not receive a diabetes screening test	PSYCKES - Number of patients in the denominator who did not have a glucose or HbA1C test during the previous 12 months	PSYCKES - Number of patients, ages 18 to 64 years, with schizophrenia or bipolar disorder, on an antipsychotic medication during the previous 9 months ending on March 31, 2018	PSYCKES: Number of patients, ages 18 to 64 years, with schizophrenia or bipolar disorder, on an antipsychotic medication during the previous 9 months

ICD Codes	CPT Codes

Additional Recommendations / Structured Data Elements
• Gaps in care-registry based on diagnosis • Huddle and Pre-visit prep to identify patients needing screening • Closing the loop on testing and asking patients if they have had tests at other facilities • Connectivity to the testing facility portals • Access Hixny to verify need for testing • Enter lab values from Hixny and specialists' consultation notes as structured fields for data query

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 13

BHNNY Measure Title: Follow-up care for children prescribed new ADHD medication

Corresponding DSRIP P4P Measure: Follow-up care for Children Prescribed ADHD Medications - Initiation Phase

Goal of Measure: Improving Effectiveness of Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care - Child & Adolescent, MH Outpatient - Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients prescribed ADHD medication who had a follow-up visit within 30-days of starting the medication	Number of patients in the denominator who had one follow-up visit with a practitioner within the 30 days after starting the medication	Number of patients, ages 6-12 years, who were newly prescribed ADHD medication between April 1, 2016 - February 28, 2018	Number of patients, ages 6 to 12 years, who were newly prescribed ADHD medication during the month that was 3 months prior to reporting month

Numerator: CPT Codes	Denominator: Medication list
90791 –90792, 90801 –90829, 90832 –90840, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876, 96150 –96154, 98960 –98962, 99078, 99201-99205, 99211 –99215, 99217 –99223, 99231 –99233, 99238 – 99239, 99241 –99245, 99251 –99255, 99341 –99350, 33891 –99394, 99401 –99404, 99411 –99412, 99510	**CNS stimulants:** Amphetamine-dextroamphetamine, Dexmethylphenidate, Dextroamphetamine, Lisdexamfetamine**,** Methamphetamine, Methylphenidate **Alpha-2 receptor agonists:** Clonidine, Guanfacine **Miscellaneous:** Atomoxetine

Additional Recommendations / Structured Data Elements
• Flag patients with diagnosis and medication in a registry to identify patients in need of follow-up contact • Medication reconciliation at each visit • Consider care-planning around medication management and document the following at relevant visits: medication response, barriers patients are having to taking medications, their overall level of understanding of how to take the medications and what they are for. • Follow-up telephonic/portal communication • Ensure access available for patients to accommodate follow up appointments • Schedule follow-up appointment before patient leaves Prescribe new medication for 14-21 days to assure follow-up within 30 days, assess efficacy and possible dose changes

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 14

BHNNY Measure Title: Mental health hospitalization- Referral to care management services prior to discharge

Corresponding DSRIP P4P Measure: Follow-up after hospitalization for Mental Illness

Goal of Measure: Improving access to care and care management services

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Hospital, MH Inpatient

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients who were referred to BHNNY Cares / Health Homes / other care management services prior to discharge	Number of patients in the denominator who were referred to BHNNY Cares / Health Homes / other care management services prior to discharge	Number of patients, ages 6 years and older, that were discharged after a hospitalization for mental illness between March 1, 2018 - March 31, 2018	Number of patients, ages 6 years and older, that were discharged after a hospitalization for mental illness during the month that was 2 months prior to reporting month

Numerator: EHR	Denominator: ICD Codes
Structured fields and Referral tracking process	F20.0 –F39, F42 –F43.9, F44.89, F53, F60.0 –F63.9, F68.10 –F68.8, F84.0 –F84.9, F90.0 –F94.9

Additional Recommendations / Structured Data Elements
• Develop structured templates to document referrals • Determine care management needs and NYS Health Home eligibility at admission and initiate consent process and referral to care management entities • Warm handoff to care management services • For established patients, notify current care management organizations for post-discharge support and follow-up • Inclusion of referral to care management entity as part of transition of care records and discharge instructions

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 15

BHNNY Measure Title: Mental health hospitalization - Outreach prior to MH outpatient appointment

Corresponding DSRIP P4P Measure: Follow-up after hospitalization for Mental Illness

Goal of Measure: Improving appointment completion rates

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: MH Outpatient - Adult, MH Outpatient - Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients who were successfully contacted by a BH outpatient care manager prior to their appointment to address any potential barriers for completion of follow-up visits	Number of patients in the denominator who were successfully contacted by a BH outpatient care manager prior to their appointment to address any potential barriers for completion of follow-up visits	Number of patients with a scheduled 7-day post-hospitalization follow-up appointment during April 1, 2016 - March 31, 2018	Number of patients with a follow-up appointment to be seen within 7 days after a Mental Health Inpatient discharge in the month that was 2 months prior to reporting month

Numerator: CPT Codes or EHR	**Denominator** **Source:** Practice management system
98966 – phone call 5 to 10 minutes 98967 – phone call 11 to 20 minutes 98968 – phone call 21 to 30 minute **EHR:** Structured fields/Order sets	All Medicaid, Medicaid Managed Care Plan and Uninsured patients see in the psychiatric unit of the hospital who had a follow-up appointment scheduled 7-day post-hospitalization.

Additional Recommendations / Structured Data Elements
• Implement a tracking system to identify patients scheduled for 7-day and 30-day follow-up after a mental health inpatient discharge • Develop structured templates to document outreach • Determine care management needs and refer to Health Homes or other care management services • For patients linked with community care management services, notify current care manager to facilitate keeping the appointment

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 16

BHNNY Measure Title: Mental health outpatient visit - No show follow-up

Corresponding DSRIP P4P Measure: Follow-up after hospitalization for Mental Illness

Goal of Measure: Improve access to care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: MH Outpatient - Adult, MH Outpatient - Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients who were successfully contacted by a BH outpatient care management team member for missed initial follow-up appointment	Number of patients in the denominator who were successfully contacted by a BH outpatient care management team member to schedule another follow-up appointment	Number of patients with a no-show for an initial follow-up appointment to be seen within 7 days after a Mental Health inpatient discharge between April 1, 2016 - March 31, 2018	Number of patients with a no-show for an initial follow-up appointment to be seen within 7 days after a Mental Health inpatient discharge in the month that was 2 months prior to reporting month

Numerator: CPT Codes or EHR	**Denominator** **Source:** Practice management system
98966 – phone call 5 to 10 minutes 98967 – phone call 11 to 20 minutes 98968 – phone call 21 to 30 minute **EHR:** Structured fields/Order sets	All Medicaid, Medicaid Managed Care Plan and Uninsured patients see in the psychiatric unit of the hospital who were a NO-SHOW for their follow-up appointment scheduled 7-day post-hospitalization.

Additional Recommendations / Structured Data Elements
• Establish a no-show management process • Implement a tracking system to identify patients with no-show for 7-day and 30-day follow-up after a mental health inpatient discharge • Develop structured templates to document outreach • Determine care management needs and refer to Health Homes or other care management services • For patients linked with community care management services, notify current care manager to facilitate keeping the appointment • Patient survey/feedback

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 17

BHNNY Measure Title: Screening for clinical depression

Corresponding DSRIP P4P Measure: Screening for Clinical Depression and follow-up

Goal of Measure: Improving access to and effectiveness of care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care - Adult, Primary Care – Select, Primary Care - Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients who received a depression screening	Number of patients in the denominator screened for clinical depression using a standardized depression screening tool in the previous 12 months	Number of Patients, ages 18 years and older, seen between April 1, 2016 - March 31, 2018	Number of patients, ages 18 years and older, seen during the month that was 2 months prior to reporting month

Numerator: Depression Screening	Denominator: CPT Codes
ICD: Z13.89 (screening for depression) **CPT:** 96127, 99420 **HCPCS:** G8510, **HCPCS:** G8431	**CPT:** 90791-90792, 90832, 90834, 90837, 90839, 92625, 96116, 96118, 96150-96151, 97003, 99201-99205, 99212-99215, 99384-99387, 99394-99397 **HCPCS:** G0101, G0402, G0438-G0439, G0444

Additional Recommendations / Structured Data Elements
• Gaps in care reports to identify patients in need of screening • CDSS and evidence-based guidelines to treatment • Workflow and standing order implementation • Consider implementing “every patient, every visit” approach to increase screening rates • Documentation in the EMR/scanning screening tools – process evaluation • Education and training

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 18

BHNNY Measure Title: Documentation of follow-up after positive depression screen

Corresponding DSRIP P4P Measure: Screening for Clinical Depression and follow-up

Goal of Measure: Improving Effectiveness of Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care - Adult, Primary Care – Select, Primary Care - Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients with a positive depression screen with a documented follow-up plan	Number of patients in the denominator with a follow-up plan documented on the day of the positive depression screen	Patients, ages 18 years and older, with positive depression screen following the use of a standardized depression screening tool seen between April 1, 2016 - March 31, 2018	Number of patients, ages 18 years and older, with positive depression screen following the use of a standardized depression screening tool seen during the month that was 2 months prior to reporting month

Numerator: HCPCS Code	Denominator: HCPCS Codes
HCPCS Codes: G8431 (Screening for clinical depression is documented as positive and follow up plan is documented)	**HCPCS Codes:** G8431 (Screening for clinical depression is documented as positive and follow up plan is documented) **HCPCS Code:** G8511 (Screening for Clinical Depression Documented as Positive, Follow-up Plan Not Documented

Additional Recommendations / Structured Data Elements
• EMR structured templates for documentation of screening and follow-up • Gaps in care reports to identify patients in need of screening • Workflow and standing order implementation Make a follow-up plan mandatory in EMR for a positive screen

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 19 (*Eligible PCPs: PCP sites with integrated behavioral health services as per DSRIP Project 3ai Model 1 specifications, before April 1, 2018)

BHNNY Measure Title: Behavioral health preventive care screening

Corresponding DSRIP P4P Measure: Patient Engagement: BH Mod-1

Goal of Measure: Improving effectiveness of care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: All eligible PCPs*

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients actively engaged in project 3.a.i Model 1	Number of patients in the denominator that received screening for depression between January 1, 2018 - March 31, 2018	Number of patients, ages 13 years and older, seen at a site participating in Project 3.a.i Model 1, between January 1, 2018 - March 31, 2018	Number of patients, ages 13 years and older seen during the month that was 2 months prior to reporting month

Numerator: ICD and CPT Codes	Denominator: CPT Codes
Depression: **ICD:** Z13.89 (screening for depression) **CPT:** 96160 **HCPCS:** G8510, **HCPCS:** G8431 **Other BH conditions:** **CPT:** 96127	**CPT:** 90791-90792, 90832, 90834, 90837, 90839, 96116, 96118, 96150-96151, 97003, 99201-99205, 99212-99215, 99384-99387, 99394-99397 **HCPCS:** G0101, G0402, G0438-G0439, G0444

Additional Recommendations / Structured Data Elements
• CDSS alerts and guidelines • Pre-visit planning/huddles • Care coordination and tracking and identifying self-referred testing outside of practice • Education • Registry management and reconciliation/gaps in care • Workflow and standing order implementation

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 20 (*All eligible BH outpatient - Behavioral health sites with embedded primary care services as per DSRIP Project 3ai Model 2 specifications, before April 1, 2018)

BHNNY Measure Title: Primary care services at behavioral health integrated site

Corresponding DSRIP P4P Measure: Patient Engagement: BH Mod-2

Goal of Measure: Improving Access to Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: All eligible BH Outpatient*

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients actively engaged in project 3.a.i Model 2	Number of patients in the denominator that received primary care services at a participating mental health or substance abuse site between January 1, 2018 - March 31, 2018	Number of patients, ages 6 years and older, seen at a site participating in Project 3.a.i Model 2, between January 1, 2018 - March 31, 2018	Number of patients, ages 6 years and older, seen during the month that was 2 months prior to reporting month

Numerator: ICD Codes	Denominator: CPT Codes
Z13.0-Z13.9	**CPT:** 90791-90792, 90832, 90834, 90837, 90839, 92625, 96116, 96118, 96150-96151, 97003, 99201-99205, 99212-99215, 99384-99387, 99394-99397 **HCPCS:** G0101, G0402, G0438-G0439, G0444

Additional Recommendations / Structured Data Elements
• CDSS alerts and guidelines • Pre-visit planning/huddles • Care coordination and tracking and identifying self-referred testing outside of practice • Education • Registry management and reconciliation/gaps in care • Workflow and standing order implementation

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 21 (*Eligible PCPs: PCP partners who have implemented the IMPACT Model as per DSRIP Project 3ai Model 3 specifications, before April 1, 2018)

BHNNY Measure Title: Depression screening as part of IMPACT Model

Corresponding DSRIP P4P Measure: Patient Engagement: BH Mod-3

Goal of Measure: Improving Access to Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: All eligible PCPs*

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients actively engaged in project 3.a.i Model 3	Number of patients in the denominator with completed PHQ-2, PHQ-9 screening between January 1, 2018 - March 31, 2018	Number of patients, ages 18 years and older, seen at a site participating in Project 3.a.i Model 3, between January 1, 2018 - March 31, 2018	Number of patients, ages 18 years and older, seen during the month that was 2 months prior to reporting month

Numerator: ICD, CPT & HCPCS Codes	Denominator: CPT & HCPCS Codes
ICD: Z13.89 (screening for depression) **CPT:** 96127, 96160**HCPCS:** G8510, **HCPCS:** G8431	**CPT:** 90791-90792, 90832, 90834, 90837, 90839, 96116, 96118, 96150-96151, 97003, 99201-99205, 99212-99215, 99384-99387, 99394-99397 **HCPCS:** G0101, G0402, G0438-G0439, G0444

Additional Recommendations / Structured Data Elements
• CDSS alerts and guidelines • Pre-visit planning/huddles • Care coordination and tracking and identifying self-referred testing outside of practice • Education • Registry management and reconciliation/gaps in care • Workflow and standing order implementation

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 22

BHNNY Measure Title: Timely initiation of substance dependence treatment

Corresponding DSRIP P4P Measure: Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)

Goal of Measure: Improving Access to Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: SUD Treatment

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of patients with new substance dependence diagnosis who initiated treatment within 14 days	Number of patients in the denominator who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode	Number of patients, ages 13 years and older, with a new episode of alcohol or other drug (AOD) dependence, seen between April 1, 2016 - March 31, 2018, who were referred to the SUD program	Number of patients, ages 13 years and older, with a new episode of alcohol or other drug (AOD) dependence **referred to the SUD program** during the month that was 3 months prior to reporting month

Numerator Codes: AOD Visit	Denominator Codes:
CPT: 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341- 99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408-99409, 99411-99412, 99510 **HCPCS:** G0155, G0176-G0177, G0396-G0397, G0409-G0411, G0433, G0463, H0001-H0002, H0004-H0005, H0007, H0015-H0016, H0020, H0022, H0031, H0034-H0037, H0039-H0040, H2000-H2001, H2010-H2020, H2035-H2036, M0064, S0201, S9480, S9484-S9485, T1006, T1012, T1015	**ICD Codes:** F10.10 –F10.20, F10.220 –F11.20, F11.220 –F13.20, F13.220 – F14.20, F14.220 –F15.20, F15.220 – F16.20, F16.220 –F16.99, F18.10 – F18.20, F18.220 –F19.20, F19.220 – F19.99

Additional Recommendations / Structured Data Elements
• Reconciliation of registries based on diagnosis codes • Care coordination and closing the loop/follow up • Care transition process • Telephonic follow up • Screenings implemented • Pre-visit planning and huddles • Make pre-visit calls

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 23

BHNNY Measure Title: Improving patient engagement in substance dependence treatment

Corresponding DSRIP P4P Measure: Engagement of Alcohol and Other Drug Dependence Treatment (initiation and 2 visits within 44 days)

Goal of Measure: Improving Access to and Effectiveness of Care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: SUD Treatment

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of patients with new substance dependence diagnosis who initiated and engaged in treatment within specified time frame	Number of patients in the denominator who initiated treatment AND who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	Number of patients, ages 13 years and older, with a new episode of alcohol or other drug (AOD) dependence, seen between April 1, 2016 - March 31, 2018, who were referred to the SUD program	Number of patients ages 13 years and older with a new episode of alcohol or other drug (AOD) dependence, seen during the month that was 3 months prior to reporting month, who were **referred to the SUD program**

Numerator Codes: Three AOD Visits in 30 days	Denominator Codes:
CPT: 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341- 99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408-99409, 99411-99412, 99510 **HCPCS:** G0155, G0176-G0177, G0396-G0397, G0409-G0411, G0433, G0463, H0001-H0002, H0004-H0005, H0007, H0015-H0016, H0020, H0022, H0031, H0034-H0037, H0039-H0040, H2000-H2001, H2010-H2020, H2035-H2036, M0064, S0201, S9480, S9484-S9485, T1006, T1012, T1015	**ICD Codes:** F10.10 –F10.20, F10.220 –F11.20, F11.220 –F13.20, F13.220 – F14.20, F14.220 –F15.20, F15.220 – F16.20, F16.220 –F16.99, F18.10 – F18.20, F18.220 –F19.20, F19.220 – F19.99

Additional Recommendations / Structured Data Elements
• Reconciliation of registries based on diagnosis codes • Care coordination and closing the loop/follow up • Care transition process • Care planning and self-management (teach back) • Community resources and education • Telephonic follow up • Pre-visit planning and huddles • Make pre-visit phone call

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 24

BHNNY Measure Title: Prescription of Statin Medications

Corresponding DSRIP P4P Measure: Statin Therapy for Patients with Cardiovascular Disease

Goal of Measure: To ensure patients with CVD are prescribed statin medications as recommended.

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Adult, Cardiology

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients who were prescribed at least one high or moderate intensity statin medication	Number of patients in the denominator who were either on or prescribed at least one high or moderate-intensity statin medications at the last visit	Number of patients, ages 21 to 75 years, with Atherosclerotic Cardiovascular Disease (ASCVD) seen between April 1, 2016 - March 31, 2018	Number of patients, ages 21 to 75 years, with Atherosclerotic Cardiovascular Disease (ASCVD) seen during the month that was 2 months prior to reporting month

Numerator: Statin Medication List:	Denominator: ICD Codes
Atorvastatin (10-20 mg) (40–80 mg), Amlodipine-atorvastatin (10-20 mg) (40–80 mg), Ezetimibe-atorvastatin (10-20 mg) (40–80 mg), Rosuvastatin (5-10 mg) (20–40 mg), Simvastatin (20–40 mg) (80 mg), Ezetimibe-simvastatin (20–40 mg) (80 mg), Niacin-simvastatin 20-40 mg, Sitagliptin-simvastatin 20-40 mg, Pravastatin 40–80 mg, Aspirin-pravastatin 40-80 mg, Lovastatin 40 mg, Niacin-lovastatin 40 mg, Fluvastatin XL 80 mg, Fluvastatin 40 mg bid, Pitavastatin 2–4 mg	**IVD**: I20.0 –I20.9, I24.0 –I24.9, I25.10 –I25.119, I25.5 –I25.9, I63.00 –I66.9, I67.2, I70.0 –I70.92, I74.01 –I75.89

Additional Recommendations / Structured Data Elements
• CDSS alerts and guidelines • Use daily huddles and pre-visit prep process to identify eligible patients • Prescribe statin medication as appropriate and authorize monthly refills • Provide education to patient on diagnosis, symptom management, medication adherence, medication side effects • Ensure monthly refills • Collaborate with pharmacy team and/or CBOs on self-management support • 2-4-week post-visit phone call for high-risk patients to assure adherence • Train practitioners and care management staff on Motivational Interviewing, Teach-back Method and other self-management support techniques. • Implement reminder systems/ gap list management across the continuum

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 25

BHNNY Measure Title: Documentation of self-management goals for patients with CVD

Corresponding DSRIP P4P Measure: Patient Engagement - CVD

Goal of Measure: Tracking the number of patients with a documented self-management goal

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Adult, Primary Care – Child & Adolescent, Cardiology

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients with documented self-management goals in EMR	Number of patients in the denominator with documented self-management goals in the EMR on the day of the visit	Number of patients, with cardiovascular disease seen between January 1, 2018 - March 31, 2018	Number of eligible patients with cardiovascular disease seen during the month that was 2 months prior to reporting month

Numerator: HCPCS Codes or EHR Structured Fields	Denominator: ICD Codes
HCPCS: S0280, S0281 **EHR**: Structured fields/order sets	**IVD**: I20.0 –I20.9, I24.0 –I24.9, I25.10 –I25.119, I25.5 –I25.9, I63.00 –I66.9, I67.2, I70.0 –I70.92, I74.01 –I75.89 **Hypertension:** I10

Additional Recommendations / Structured Data Elements
Clarifying information from DOH: • Core components require documentation of patient-driven, self-management goals in the medical record which are reviewed at every appointment. • Information must be updated in the medical record on an on-going basis and goals should be reviewed at every appointment. Recommendations: • Registry reconciliation • Engaging care teams to support self-management and documentation of goals • Using daily team huddles and pre-visit prep process to identify patients in need of self-management support and plan

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 26
BHNNY Measure Title: Controlling high blood pressure

Corresponding DSRIP P4P Measure: Controlling High Blood Pressure

Goal of Measure: Ensuring patients with hypertension have blood pressure under control

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Adult, Primary Care- Child & Adolescent, Cardiology

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of patients with HTN whose blood pressure is adequately controlled based on the numerator criteria	Number of people whose blood pressure was adequately controlled at the last visit as follows: • below 140/90 if ages 18-59; • below 140/90 for ages 60 to 85 with diabetes diagnosis; or • below 150/90 ages 60 to 85 without a diagnosis of diabetes	Number of patients, ages 18 to 85 years, with hypertension seen between April 1, 2016 - March 31, 2018	Number of patients, ages 18 to 85 years, with hypertension seen during the month that was 2 months prior to reporting month

Numerator: CPT Codes or EHR	Denominator: ICD Code
CPT Category II Codes (Blood Pressure): • 3074F (systolic less than 130) • 3075F (systolic 130 -139) • 3077F (systolic greater than/equal to 140), • 3078F (diastolic less than 80), • 3079F (diastolic 80-89), • 3080F (diastolic greater than/equal to 90) **EHR:** BP value at the last visit	I10

Additional Recommendations / Structured Data Elements
• Implement strategies from Million Hearts Initiative to improve blood pressure control • Train staff on accurate blood pressure measurement technique • Implement walk-in blood pressure screening service • Once daily or fixed combination medication therapy as appropriate • Promote self-measured blood pressure monitoring at home • Proactive outreach to uncontrolled and undiagnosed hypertensive patients for diagnosis and improvements • Consider assigning CPT Category II Code • Reinforce patient education regarding chronic disease, medication adherence, and life-style/ behavior modification

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 27

BHNNY Measure Title: Asthma control assessment

Corresponding DSRIP P4P Measure: Asthma Medication Ratio (5-64 years)

Goal of Measure: Ensuring patients with asthma have a control assessment

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Adult, Primary Care – Child & Adolescent, Pulmonary, Allergy

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients who were evaluated for asthma control during the previous 12 months using a standardized tool	Number of patients in the denominator who were evaluated for asthma control during the previous 12 months using a standardized tool approved by BHNNY PMO	Number of patients, ages 5 to 64 years, with asthma seen between April 1, 2016 - March 31, 2018	Number of patients, ages 5 to 64 years, with a diagnosis of asthma seen during the month that was 2 months prior to reporting month

Numerator: CPT II or EHR	Denominator: ICD Codes
CPT II Codes: **2015F –** Asthma impairment assessed **2016F –** Asthma risk assessed **EHR:** Structured fields	J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998

Additional Recommendations / Structured Data Elements
• CDSS alerts and guidelines • Use daily huddles and pre-visit prep process to identify eligible patients • Provider and staff training on asthma control assessment tools (e.g., ACT tool) • Implement reminder systems/ gap list management across the continuum • Develop structured EMR templates to capture completion of control assessment

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 28

BHNNY Measure Title: Prescription of asthma controller medications

Corresponding DSRIP P4P Measure: Asthma Medication Ratio (5 – 64 Years)

Goal of Measure: Ensuring patients with asthma are prescribed a controller medication

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Adult, Primary Care – Child & Adolescent, Pulmonary, Allergy

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of patients with a diagnosis of asthma who are prescribed a controller	Number of patients in the denominator, who were either on or received a prescription for asthma controller medication at the last visit	Number of patients, ages 5 to 64 years, with a diagnosis of asthma seen between April 1, 2016 - March 31, 2018	Number of patients, ages 5 to 64 years, with a diagnosis of asthma seen during the month that was 2 months prior to reporting month

Numerator: CPT II Codes or EHR	Denominator: ICD Codes
CPT II Codes: **4140F –** Inhaled corticosteroids prescribed **4144F –** Alternative long-term control medication prescribed **EHR:** Current list of medications	J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
Asthma Controller Medications: Dyphylline-guaifenesin, Guaifenesin-theophylline, Omalizumab, Budesonide-formoterol, Fluticasone-salmeterol, Flutivasone-vilanterol, Mometasone-formoterol, Beclomethasone, Budesonide, Ciclesonide, Flunisolide, Fluticasone CFC free, Mometasone, Montelukast, Zafirlukast, Zileuton, Cromolyn, Aminophylline, Dyphylline, Theophylline	

Additional Recommendations / Structured Data Elements
• CDSS alerts and guidelines • Use daily huddles and pre-visit prep process to identify eligible patients • Routine use of asthma control assessment tools to identify patients needing controller medications • Provide education to patient on diagnosis, symptom management, medication adherence, medication side effects • Collaborate with pharmacy team and/or CBOs on self-management support • 2-4-week post-visit phone call for high-risk patients to assure adherence • Train practitioners and care management staff on Motivational Interviewing, Teach-back Method and other self-management support techniques. • Implement reminder systems/ gap list management across the continuum

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 29

BHNNY Measure Title: Completion of asthma action plans

Corresponding DSRIP P4P Measure: Patient Engagement - Asthma

Goal of Measure: Ensuring patients with asthma receive an asthma action plan.

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Adult, Primary Care – Child & Adolescent, Pulmonary, Allergy

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients with asthma action plan	Number of patients in the denominator with a current asthma action plan	Number of patients with a diagnosis of asthma, seen between January 1, 2018 - March 31, 2018	Number of patients, ages 5 to 64 years, with asthma seen during the month that was 2 months prior to reporting month

Numerator	Denominator: ICD Codes
EHR: Structured field and/or Order sets **CPT II - 5250F** – Asthma discharge plan provided	J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998

Additional Recommendations / Structured Data Elements
Registry reconciliation • Engaging care teams to support self-management and documentation of goals • Using daily team huddles and pre-visit prep process to identify patients in need of self-management support and plan

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 30

BHNNY Measure Title: Engagement by ED patient navigators

Corresponding DSRIP P4P Measure: Potentially Preventable Emergency Room Visits

Goal of Measure: Improve patient engagement and efficiency of care

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Hospitals

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of patients engaged by ED patient navigators for care coordination	Number of patients in the denominator engaged by ED patient navigators for care coordination	Number of Medicaid/Medicaid Managed Care/Uninsured patients seen in the ED between March 1, 2018 - March 31, 2018	Number of Medicaid/Medicaid Managed Care/Uninsured patients seen in the ED during the month that was 2 months prior to reporting month

Numerator: EHR	**Denominator:** **Source**: ED ADT system
ED care management records	All Medicaid, Medicaid Managed Care Plan and Uninsured patients seen in the ED during the reporting timeframe.

Additional Recommendations / Structured Data Elements
• Consider adding a code in ED electronic medical records (ex: Allscripts CM) • Consider adding a code or reason specific to the Patient Navigator Note

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 31

BHNNY Measure Title: Self-pay ED discharges

Corresponding DSRIP P4P Measure: ED use by uninsured

Goal of Measure: To identify patients that don't have insurance and link them with community navigators.

Eligible Patients: Medicaid, Medicaid Managed Care and Uninsured (self-pay at time of service)

Applicable Partners: Hospitals

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of self-pay ED discharges	Number of ED visits identified as self-pay	Number of ED visits between March 1, 2018 - March 31, 2018	The number of ED visits during the month that was 2 months prior to reporting month

Numerator:	**Denominator:** **Source:** ED Practice Management System
ED Practice Management System	All Medicaid, Medicaid Managed Care Plan and Uninsured patients seen in the ED during the reporting timeframe.

Additional Recommendations / Structured Data Elements
• Consider pulling reports based on billing codes of self-pay patients

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 32

BHNNY Measure Title: ED discharge summary transmitted within 24 hours

Corresponding DSRIP P4P Measure: Potentially Preventable Emergency Room visits

Goal of Measure: To ensure effectiveness of care and improve communication between ED and community providers

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Hospitals

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of ED discharges with transmitted discharge summaries and/or Transition of Care record within 24 hours of discharge	Number of ED discharges in the denominator with transmitted discharges summaries and/or Transition of Care record within 24 hours of discharge	Number of ED discharges between March 1, 2018 - March 31, 2018	The number of ED discharges during the month that was 2 months prior to reporting month

Numerator: EHR	**Denominator: Source**: ED Practice Management System
Meaningful Use (MU) report	All Medicaid, Medicaid Managed Care Plan and Uninsured patients seen in the ED during the reporting timeframe.

Additional Recommendations / Structured Data Elements
• Meaningful Use related measure

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 33

BHNNY Measure Title: PCP Same-Day Appointment

Corresponding DSRIP P4P Measure: Potentially Preventable Emergency Room Visits

Goal of Measure: Ensure PCP offices have same-day appointments available for urgent visits to reduce avoidable ED visits.

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Adult, Primary Care – Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (July 2018)
Percentage of patients seen same-day	Number of appointments listed in the denominator 5-day report that were utilized for same-day access	Number of same-day appointments available between March 1, 2018 - March 31, 2018 (5-day report per NCQA PCMH standards)	Number of same-day appointments available during the month that was 2 months prior to reporting month (5-day report per NCQA PCMH standards)

Numerator	Denominator: **Source:** Practice management system
Practice management system	Use the current PCMH guidelines to determine the five-day schedule. (Because you may have more than one five-day schedule within the reporting period, you only need to report on one.)

Additional Recommendations / Structured Data Elements

- Utilize NCQA PCMH process to generate reports

PCMH 1 Patient-Centered Access
Element A – Critical Factor

- Factor 1: Providing same day appointments for routine and urgent care.
- Documentation: NCQA reviews a documented process for scheduling same day appointments that includes defining their appointment types. NCQA reviews a report with at least 5 days of data, showing the availability and use of same day appointments for both urgent and routine care.
  - Source: *PCMH Standards and Guidelines 2015*

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 34

BHNNY Measure Title: ED visits from SNFs and other residential facilities

Corresponding DSRIP P4P Measure: Potentially Preventable Emergency Room Visits

Goal of Measure: To capture ED transfer rates to assess preventable ED visits.

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: SNFs & Other Residential Facilities

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of residents with one of more ED visits within 30 days of entry/re-entry (Ref: CMS-QM Program)	Number of residents in the denominator with one or more ED visits within 30 days of entry/re-entry	Number of Medicaid/Medicaid Managed Care enrollees who entered or re-entered the SNF or other residential facility between April 1, 2016 - February 28, 2018	Number of Medicaid/Medicaid Managed Care enrollees who entered or re-entered the SNF or other residential facility during the month that was 3 months prior to reporting month

Numerator:	**Denominator:** **Source:** SNF ADT systems
SNF Practice management system	Use the last week of the reporting period. Use your Nursing Home Weekly Bed Census and select only Medicaid/Medicaid Managed Care residents to get your denominator list of residents.

Additional Recommendations / Structured Data Elements
• Consider developing and implementing a structured template in the EHR called “Transfer to ED” to track transfers or “ED Visits” to track unique ED visits • Implement INTERACT initiatives to improve performance

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 35

BHNNY Measure Title: Potentially preventable behavioral health ED visits - PSYCKES

Corresponding DSRIP P4P Measure: Potentially Preventable Emergency Department Visits (for persons with BH diagnosis)

Goal of Measure: Decreasing Preventable Utilization

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: MH Outpatient – Adult, MH Outpatient - Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of Medicaid members with 2 or more ER visits for a behavioral health cause (mental health and/or substance use) in the past 12 months	Medicaid members in the denominator with 2 or more ER visits for a behavioral health cause (mental health and/or substance use) in the past 12 months	Medicaid members who had received one or more BH outpatient or inpatient service(s) in the 9 months prior to the report date	Medicaid members who had received one or more BH outpatient or inpatient service(s) in the 9 months prior to the report date

ICD Codes	CPT Codes

Additional Recommendations / Structured Data Elements
• Linkages to NYS Health Homes to decrease future ED visits • Utilization of ED Patient Navigators to ensure outpatient follow-up • Patient education and support for self-management • Telephonic follow up and proactive outreach

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 36

BHNNY Measure Title: Hospital discharges with a primary diagnosis of COPD or Asthma

Corresponding DSRIP P4P Measure: Prevention Quality Indicator # 5 (COPD)

Goal of Measure: Identify patients with COPD/Asthma to assess future preventable hospitalizations and provide appropriate care management.

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Hospitals

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients who required hospitalization following an ED encounter	Number of patients in the denominator who were discharged from an inpatient facility with either • a principal ICD-10-CM diagnosis code for COPD; or • a principal ICD-10-CM diagnosis code for asthma	Number of patients, ages 18 years and older, seen in ED between April 1, 2016 - March 31, 2018 with a principal ICD-10-CM diagnosis of either COPD or asthma	Number of patients, ages 18 years and older, seen in ED during the month that was 3 months prior to reporting month with a principal ICD-10-CM diagnosis of either COPD or asthma

Numerator: ICD codes	**Denominator: Source:** Hospital ADT & Coding systems
COPD: J410, J411, J418, J42, J430, J431, J432, J438, J439, J440, J441, J449, J470, J471, J479 **Asthma:** J4521, J4522, J4531, J4532, J4541, J4542, J4551, J4552, J45901, J45902 J45990, J45991, J45998	All Medicaid, Medicaid Managed Care Plan and Uninsured patients seen in the ED during the reporting timeframe with the specified Principal Diagnosis codes.

Additional Recommendations / Structured Data Elements
• Evaluate coding practices and train to assign appropriate primary discharge diagnosis • Utilize inpatient care management system to link patients with community care management services

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 37

BHNNY Measure Title: Hospital discharges with a primary diagnosis of hypertension

Corresponding DSRIP P4P Measure: Prevention Quality Indicator # 7 (HTN)

Goal of Measure: Identify patients with HTN to assess future preventable hospitalizations and provide appropriate care management.

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Hospitals

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients who required hospitalization following an ED encounter	Number of patients in the denominator who were discharged from an inpatient facility with a principal ICD-10-CM diagnosis code for hypertension	Number of patients, ages 18 years and older, seen in ED between April 1, 2016 - March 31, 2018 a principal ICD-10-CM diagnosis code for hypertension	Number of patients, ages 18 years and older, seen in ED during the month that was 3 months prior to reporting month with a principal ICD-10-CM diagnosis code for hypertension

Numerator: ICD Codes	**Denominator:** Hospital **Source:** Hospital ADT systems & coding systems
I10: Essential (primary) hypertension **I129:** Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease **I119:** Hypertensive heart disease without heart failure **I1310:** Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease **I160:** Hypertensive urgency **I161:** Hypertensive emergency **I169:** Hypertensive crisis, unspecified	All Medicaid, Medicaid Managed Care Plan and Uninsured patients seen in the ED during the reporting timeframe with the specified Principal Diagnosis codes

Additional Recommendations / Structured Data Elements
• Evaluate coding practices and train staff to assign appropriate primary discharge diagnosis • Utilize inpatient care management system to link patients with community care management services

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 38

BHNNY Measure Title: Hospital discharges with a primary diagnosis of Heart Failure

Corresponding DSRIP P4P Measure: Prevention Quality Indicator # 8 (Heart Failure)

Goal of Measure: Identify patients with CHF to assess future preventable hospitalizations and provide appropriate care management.

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Hospitals

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients who required hospitalization following an ED encounter	Number of patients in the denominator who were discharged from an inpatient facility with a principal ICD-10-CM diagnosis code for heart failure	Number of patients, ages 18 years and older, seen in ED between April 1, 2016 - March 31, 2018 with a principal ICD-10-CM diagnosis code for heart failure	Number of patients, ages 18 years and older, seen in ED during the month that was 3 months prior to reporting month with a principal ICD-10-CM diagnosis code for heart failure

Numerator: ICD Codes	Denominator **Source:** Hospital ADT & Coding systems
Heart failure: I0981, I110, I130, I132, I501, I5020, I5021, I5022, I5023, I5030, I5031, I5032, I5033, I5040, I5041, I5042, I5043, I509	All Medicaid, Medicaid Managed Care Plan and Uninsured patients seen in the ED during the reporting timeframe with the specified Principal Diagnosis codes

Additional Recommendations / Structured Data Elements
• Evaluate coding practices and train staff to assign appropriate primary discharge diagnosis • Utilize in-patient care management system to link patients with community care management services

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 39

BHNNY Measure Title: Hospital discharges with a primary diagnosis of UTI

Corresponding DSRIP P4P Measure: Prevention Quality Indicator # 12 (UTI)

Goal of Measure: Identify patients with UTI to assess future preventable hospitalizations and provide education on appropriate use of ED**.**

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Hospitals

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients who required hospitalization following an ED encounter	Number of patients in the denominator who were discharged from an inpatient facility with a principal ICD-10-CM diagnosis code for UTI	Number patients, ages 18 years and older, seen in ED between April 1, 2016 - March 31, 2018 with a principal ICD-10-CM diagnosis code for UTI	Number of patients, ages 18 years and older, seen in ED during the month that was 3 months prior to reporting month with a principal ICD-10-CM diagnosis code for UTI

Numerator: ICD Codes	Denominator **Source:** Hospital ADT & Coding systems
UTI Diagnosis Codes: N10, N119, N12, N151, N159, N16, N2884, N2885, N2886, N3000, N3001, N3090, N3091, N390	All Medicaid, Medicaid Managed Care Plan and Uninsured patients seen in the ED during the reporting timeframe with the specified Principal Diagnosis codes

Additional Recommendations / Structured Data Elements
• Evaluate coding practices and train staff to assign appropriate primary discharge diagnosis • Utilize inpatient care management system to link patients with community care management services

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 40

BHNNY Measure Title: Pediatric hospital discharges with a primary diagnosis of Asthma

Corresponding DSRIP P4P Measure: Pediatric Quality Indicator # 14 (Pediatric Asthma)

Goal of Measure: Identify pediatric patients with asthma to assess future preventable hospitalizations and provide appropriate care management

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Hospitals

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients who required hospitalization following an ED encounter	Number of patients in the denominator who were discharged from an inpatient facility with a principal ICD-10-CM diagnosis code for Asthma	Number of patients, ages 2 to 17 years, seen in ED between April 1, 2016 - March 31, 2018 with a principal ICD-10-CM diagnosis code for Asthma	Number of patients, ages 2 to 17 years, seen in ED during the month that was 3 months prior to reporting month with a principal ICD-10-CM diagnosis code for Asthma

Numerator: Asthma	**Denominator** **Source:** Hospital ADT and Coding systems
Asthma ICD Codes: J4521, J4522, J4531, J4532, J4541, J4542, J4551, J4552, J45901, J45902, J45990, J45991, J45998	All Medicaid, Medicaid Managed Care Plan and Uninsured patients seen in the ED during the reporting timeframe with the specified Principal Diagnosis codes

Additional Recommendations / Structured Data Elements
• Evaluate coding practices and train staff to assign appropriate primary discharge diagnosis • Utilize inpatient care management system to link patients with community care management services

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 41

BHNNY Measure Title: Hospital discharges with a primary diagnosis of Asthma

Corresponding DSRIP P4P Measure: Prevention Quality Indicator # 15 (Younger Adult Asthma)

Goal of Measure: Identify young adults with asthma to assess future preventable hospitalizations and provide appropriate care management

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Hospitals

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients who required hospitalization following an ED encounter	Number of patients in the denominator who were discharged from an inpatient facility with a principal ICD-10-CM diagnosis code for Asthma	Number of patients, ages 18 to 39 years, seen in ED between April 1, 2016 - March 31, 2018 with a principal ICD-10-CM diagnosis code for Asthma	Number of patients, ages 18 to 39 years, seen in ED during the month that was 3 months prior to reporting month with a principal ICD-10-CM diagnosis code for Asthma

Numerator	Denominator **Source:** Hospital ADT and Coding systems
Asthma ICD Codes: J4521, J4522, J4531, J4532, J4541, J4542, J4551, J4552, J45901, J45990, J45991, J45998	All Medicaid, Medicaid Managed Care Plan and Uninsured patients seen in the ED during the reporting timeframe with the specified Principal Diagnosis codes

Additional Recommendations / Structured Data Elements
• Evaluate coding practices and train staff to assign appropriate primary discharge diagnosis • Utilize inpatient care management system to link patients with community care management services

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 42

BHNNY Measure Title: Pediatric hospital discharges with a primary diagnosis of Gastroenteritis

Corresponding DSRIP P4P Measure: Pediatric Quality Indicator # 16 (Gastroenteritis)

Goal of Measure: Identify patients with Gastroenteritis to assess future preventable hospitalizations and provide appropriate care management.

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Hospitals

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of eligible patients who required hospitalization following an ED encounter	Number of patients in the denominator who were discharged from an inpatient facility with either • a principal ICD-10-CM diagnosis code for gastroenteritis; or • any secondary ICD-10-CM diagnosis codes for gastroenteritis and a principal ICD-10-CM diagnosis code for dehydration	Number of patients, ages 3 months to 17 years, seen in ED between April 1, 2016 - March 31, 2018 with either: • a principal ICD-10-CM diagnosis code for gastroenteritis; or • any secondary ICD-10-CM diagnosis codes for gastroenteritis and a principal ICD-10-CM diagnosis code for dehydration	Number of patients, ages 3 months to 17 years, seen in ED during the month that was 3 months prior to reporting month with either • a principal ICD-10-CM diagnosis code for gastroenteritis; or • any secondary ICD-10-CM diagnosis codes for gastroenteritis and a principal ICD-10-CM diagnosis code for dehydration

Numerator: ICD Codes	**Denominator Source:** ED management system
Gastroenteritis: A080, A0811, A0819, A082, A0831, A0832, A0839, A084, A088, A09, K5289, K523, K529 **Dehydration**: E860, E861, E869	All Medicaid, Medicaid Managed Care Plan and Uninsured patients seen in the ED during the reporting timeframe with the specified Principal Diagnosis codes

Additional Recommendations / Structured Data Elements
• Evaluate coding practices and train staff to assign appropriate primary discharge diagnosis • Utilize inpatient care management system to link patients with community care management services

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 43

BHNNY Measure Title: Hospital readmission rate

Corresponding DSRIP P4P Measure: Potentially Preventable Readmissions

Goal of Measure: To identify readmission risk and provide proactive care management outreach**.**

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Hospitals

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Hospital readmission rate *(Ref: IHI)*	Number of patients in the denominator with readmission for any cause within 30 days of discharge (Exclusions: Labor and Delivery, transfers to another acute care hospital, patients who die before discharge)	Number of inpatient discharges between April 1, 2016 - February 28, 2018 (Exclusions: Labor and Delivery, transfers to another acute care hospital, patients who die before discharge)	The number of inpatient discharges during the month that was 3 months prior to reporting month Exclusions: Labor and Delivery, transfers to another acute care hospital, patients who die before discharge)

ICD Codes	CPT Codes

Additional Recommendations / Structured Data Elements
• Utilize LACE tool to identify risk of readmission • Partner with community physicians and SNFs for effective transitions of care • Patient-centered education using Teach-back methods to improve self-care skills on discharge • Implement effective medication reconciliation at admission and discharge • Develop a patient-friendly care plan in collaboration with the patient/family prior to discharge • Optimize communication between hospital and community physicians including timely transmission of discharge summaries and physician-physician direct communication as necessary • Schedule PCP/specialist follow-up before discharge • Assign staff to follow up on test results that return after the patient is discharged and communicate the results to PCP • Referrals to NYS Health Homes, BHNNY Cares, and other care management services

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 44

BHNNY Measure Title: Potentially avoidable readmissions of residents from SNFs and other residential facilities

Corresponding DSRIP P4P Measure: Potentially Preventable Readmissions

Goal of Measure: To identify patients at risk for readmission

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: SNFs & Other Residential Facilities

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of all residents from SNFs & other residential facilities admitted to their facilities from the hospital who are then readmitted to the hospital within 30 days (Ref: CMS QM Program)	Number of residents in the denominator who had one or more unplanned inpatient admissions or one or more outpatient claims for an observation stay within 30 days of entry/re-entry	Number of residents who entered or re-entered SNFs and other residential facilities between April 1, 2016 - February 28, 2018	Number of residents who entered or re-entered the nursing home from a hospital during the month that was 3 months prior to reporting month

Numerator	Denominator **Source:** SNF Practice Management System
SNF Practice Management System & EHR documentation	List of Patients who were re-admitted one or more times to the SNF (or other residential facility) from the hospital during the reporting timeframe.

Additional Recommendations / Structured Data Elements
• Establish formal agreements with regional hospitals for timely and effective bi-directional communication between providers and care management teams • Implement multicomponent interventions such as Interventions to Reduce Acute Care Transfers (INTERACT) • Engage patient and families early for advance care planning • Implement safe and effective medication reconciliation procedures

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 45

BHNNY Measure Title: BH readmission rate

Corresponding DSRIP P4P Measure: Potentially Preventable Readmissions

Goal of Measure: To identify BH patients at risk for readmission

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Hospitals

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
BH readmission rate	Number of patients in the denominator with a readmission for a behavioral health cause within 30 days of discharge (mental health or substance use)	Number of inpatient discharges from behavioral health units between April 1, 2016 - February 28, 2018 (mental health or substance use)	Number of inpatient discharges from behavioral health units during the month that was 3 months prior to reporting month (mental health or substance use)

Numerator	Denominator
	List of patients that were discharged directly from the Psychiatric Unit of the Hospital during the reporting timeframe.

Additional Recommendations / Structured Data Elements
• In the numerator please include hospital-wide readmissions *not just* readmissions to inpatient behavioral health units. • Readmission risk factors assessed and addressed in discharge plan • Family/caregiver meeting focused on readmission reduction during admission • Medication fill at discharge • Follow-up phone call to client/caregiver post discharge • Case conference review of each readmission: why were they readmitted, what can we do differently this time • Improved communication and coordination between inpatient and outpatient • Verify insurance coverage for medication prior to discharge • Increase referrals to ACT/ Health Home / case management / other high-intensity services

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 46

BHNNY Measure Title: Outpatient follow-up visit scheduled prior to discharge

Corresponding DSRIP P4P Measure: Potentially Preventable Readmissions

Goal of Measure: To improve continuity and effectiveness of care and ensure patients have PCP follow ups

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Hospitals

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of patients discharged who had a follow-up visit scheduled before discharge *(Ref: IHI)*	Number of inpatient discharges with a follow-up visit scheduled before discharge (Ref: IHI)	Number of inpatient discharges between March 1, 2018 - March 31, 2018	Number of inpatient discharges during the month that was 2 months prior to reporting month

Numerator	Denominator **Source:** Hospital ADT system
Hospital EHR/Case Management system	All Medicaid, Medicaid Managed Care Plan and Uninsured patients discharged from the Hospital

Additional Recommendations / Structured Data Elements
• Partner with community physicians for effective transitions of care and timely follow-up post-discharge • Optimize communication between hospital and community physicians including timely transmission of discharge summaries and physician-physician direct communication as necessary • Refer patients to NYS Health Homes or other care management services that can assist with linking with a PCP or ensuring PCP follow-up • Consider developing and implementing a field within the hospital EHR system for PCP follow-up documentation

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 47

BHNNY Measure Title: PCP nurse call within 48 hours of discharge

Corresponding DSRIP P4P Measure: Potentially Preventable Readmissions

Goal of Measure: Ensuring patients receive a call with a nurse within 48 hours to assess status, complete medication reconciliation, and schedule an in-office visit within 14 days of discharge.

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Adult, Primary Care – Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of inpatient discharges with a successful nurse contact and medication reconciliation within 2 business days of discharge	Number of patients in the denominator with a successful nurse contact and medication reconciliation within 2 business days of discharge	Number of inpatient discharges between April 1, 2016 - March 31, 2018	Number of inpatient discharges during the month that was 2 months prior to reporting month

Numerator: CPT or EHR	**Denominator** **Source:** Practice EHR
CPT: 99495 **EHR:** Structured fields/Order sets	Use your structured data element to identify all patients discharged from the inpatient setting during the reporting timeframe.

Additional Recommendations / Structured Data Elements
• Establish linkages with Hospitalists inpatient case management teams for timely communication on discharge plans before patient is discharged • Collaborate with hospital teams to schedule a post-discharge follow-up visit with the PCP • Collaborate with care management agencies for transition of care needs • Proactive outreach by Medical Home care management teams within 2 days of discharge and prior to appointment with PCP for assistance with medication issues and to ensure timely follow-up with PCP

BHNNY PPS Phase Three Pay for Performance Measures

Metric ID: 48

BHNNY Measure Title: PCP follow-up within 14 days of discharge

Corresponding DSRIP P4P Measure: Potentially Preventable Readmissions

Goal of Measure: Ensuring all patients with a hospital admission have a follow up appointment with PCP within 14 days of discharge.

Eligible Patients: Medicaid, Medicaid Managed Care, Uninsured

Applicable Partners: Primary Care – Adult, Primary Care – Child & Adolescent

Description	Numerator	Baseline Denominator	Monthly Denominator (starting July 2018)
Percentage of inpatient discharges with a completed provider follow-up visit within 14 days of discharge	Number of patients in the denominator with a completed provider follow-up visit within 14 days of discharge	Number of inpatient discharges between April 1, 2016 - March 31, 2018	Number of inpatient discharges during the month that was 2 months prior to reporting month

Numerator	Denominator: **Source:** Practice EHR system
CPT: 99495 Practice EHR system	Use your structured data element to identify all patients discharged from the inpatient setting during the reporting timeframe.

Additional Recommendations / Structured Data Elements
• Establish linkages with Hospitalists inpatient case management teams for timely communication on discharge plans before patient is discharged • Collaborate with hospital teams to schedule a post-discharge follow-up visit with the PCP • Collaborate with care management agencies for transition of care needs • Proactive outreach by Medical Home care management teams within 2 days of discharge and prior to appointment with PCP for assistance with medication issues and to ensure timely follow-up with PCP