Public DSRIP Project Group

Patient Engagement tracking strategy - Projects 3ai and 3bi

The recently revised version of the Actively Engaged counting methodology was posted to the DSRIP website. For those projects with Patient Engagement tracking for Preventative Care Screenings (2aii and 3ai - Models 1 and 2) as well as Self management goals in the Medical Record (3bi - Documented Self Management Goals in the Medical Record including diet, nutrition, physical activity and medication) , how are you approaching tracking Patient engagement? Are you engaging Primary Care sites for a roster of of Medicaid enrollees with Patient Identifiers (CIN, Date of Birth, Last and First name) with these specific CPT codes? Thanks, Priti

Question by Priti Bangia 1

On august 14, 2015 at 11:02 - 177 views, 3 replies, 5 followers

That is a good question. For the behavioral health preventative screenings, we will work with our primary care sites/RHIO to generate reports on the number of Medicaid patients with a visit in the relevant time period who received a screening (PHQ2/9 or SBIRT etc). I think summary level reports are sufficient. We would do a similar approach for the primary care preventative screenings but have not yet identified the set of CPT codes.
However, I am not certain how to demonstrate the Self-Management goals component as these are typically captured in the Progress Note section of the EHR which makes it challenging to report. It would be good to get some additional clarification on what evidence is required.

By Caitlin Verrilli, 6 months ago 0

On the self-management goals for the Cardiovascular project, we are currently doing an inventory of the various EMRs in the PPS and we plan to key on the education sections or anticipatory guidance sections to capture the goals.
On the BH project -Model 2, our report specs have included all CPT codes defined by HEDIS 2015 as "Access to Preventive and/or Ambulatory Care" which matches the logic DOH used in developing the attribution algorithm for "All Other Category 3".
I will share more as we progress.

By Olawale Akande, 6 months ago 0

Priti,
We will not be collecting any PHI from our partners until after NYS has completed the opt-out consent process and we have all privacy and security processes in place. Until then we are contemplating collecting a listing by month of the number of patients who completed each required service. For each reporting period we will require that the provider to remove any duplicates if a patient was screened more than once in the period. The first reporting period will be 4/1/15-9/30/15. To ensure that we are not double counting patients who are screened again, the next period will be 9 months: 4/1/15/-12/31/15, etc. Until we have PHI we will not be able to remove duplicates if the patient was screened in one measurement period by two unrelated providers. We will ask partners to attest that they have maintained an auditable record of the patients included in the report.
I would like to raise a related concern regarding the new guidance on activated patients from 8/5/2015. There are many significant changes but the red-lined clarification to 3ai Model 1 includes requirements that materially change the project requirements. I believe the new guidance unintentionally confounds what is required to comply with the structural and process milestones for project 3ai Model 1 completion with what is required for an activated patient. In 3ai, Model 3 the new guidance clearly makes this distinction: the measure of an activated patient is one screened with PHQ-2/9 or SBIRT while to satisfy the implementation milestones all components of IMPACT must be in place at implementing sites. Makes sense. I have to believe that in Model 1 the guidance should be the same: to meet the criteria for an “activated patient” a patient must receive behavioral health preventive screening; to satisfy the implementation milestones patients who screen positive should experience a “warm transfer” and receive BH services on site. That this is misunderstanding between the role of screening–the stated measure for patient activation--and integrated treatment for those screening positive is supported by the expectation in Milestone 3 that 90% of patients will be screened. While 90% is probably high even for a screening goal it is clearly not the case that 90% of patients presenting to primary care are in need of BH services. The August 5 guidance also restated the screening requirement for Model 1 in a way that could be interpreted to encompasses all age and gender appropriate screenings---but again, that would substantially change the measure from what was stated before we submitted our Speed and scale estimates. Therefore we understand the new guidance to mean: “the number of patients in a primary care setting who receive appropriate mental health or substance abuse preventive care screenings. “ I look forward to hear how others are responding to these changes. Jessie

By Janet (Jessie) Sullivan, 6 months ago 2

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