Phase II Reporting Specifications

June 30th Deliverables

2.a.i	
Activity ID: P_022	Primary Care (adult, pedi, and family med); MH (outpatient); Home Care; Outpatient Specialty Care; Hospitals (psych, inpatient, ED); SUD
Grouping: Stand Alone	Completion Date: 3/31/2017, **6/30/2017**, 9/30/2017, 12/31/2017, 3/31/2018
Bundle #: B01- Health Home at Risk High Performance Eligible? N	Reporting Date: 4/10/2017, **7/10/2017**, 10/10/2017, 1/10/2018, 4/10/2018

Report	- Number of Health Home eligible patients referred to appropriate Health Home Services - Number of patients with chronic diseases not eligible for Health Home Services referred to BHNNY-Cares for appropriate care management services
Cohort	• All patients belonging to the current and future clinical sites participating in DSRIP initiatives.

2.a.iii	
Activity ID: B01_004	Partner Type: Primary Care (adult, pedi, and family med)
Grouping: Bundle	Completion Date: 3/31/2017, **6/30/2017**, 9/30/2017, 12/31/2017, 3/31/2018
Bundle #: B01- Health Home at Risk High Performance Eligible? N	Reporting Date: 4/10/2017, **7/10/2017**, 10/10/2017, 1/10/2018, 4/10/2018

Report	Report of all patients with initiation or review of person-centered care plan as outlined in the patient engagement definition.
Cohort	Number of patients with one or more chronic diseases seen during the measurement period

2.b.iii – ED Care Triage

Activity ID: B11_003	Partner Type: Hospital (ED)
Activity Grouping: Bundle	Completion Date: 3/31/2017, **6/30/2017**, 9/30/2017, 12/31/2017, 3/31/2018
Bundle #: B11 - ED Utilization	Reporting Date: 4/10/2017, **7/10/2017**, 10/10/2017, 1/10/2018, 4/10/2018

Report	• Report of all patients with high ED utilization as defined by 3+ visits in the previous six months, their Health Home eligibility and referral status
Cohort	• All eligible patients seen in the ED during the measurement period
Linkage to Data Roadmap, if applicable	ED Utilization Roadmap

2.b.iii – ED Care Triage

Activity ID: B11_004	Partner Type: Primary Care (Adult, Pediatrics, and Family Medicine)
Activity Grouping: Bundle	Completion Date: 3/31/2017, **6/30/2017**, 9/30/2017, 12/31/2017, 3/31/2018
Bundle #: B11 - ED Utilization	Reporting Date: 4/10/2017, **7/10/2017**, 10/10/2017, 1/10/2018, 4/10/2018

Report	• Report of all patients who had and were made aware of an appointment with a PCP within 30 days after ED presentation
Cohort	• Total number of patients seen in ED during the previous 12 months

3.a.i - M1

Activity ID: B02_006	Partner Type: Primary Care (Adult, Pediatric, and Family Med)
Activity Grouping: Bundle	Completion Date: 3/31/2017, **6/30/2017**, 9/30/2017, 12/31/2017, 3/31/2018
Bundle #: B02 - BH/PC Integration - Model 1	Reporting Date: 4/10/2017, **7/10/2017**, 10/10/2017, 1/10/2018, 4/10/2018

Report	Report of all patients with completed BH screening as outlined in the patient engagement definition. • clinical depression screenings using a standardized screening tool for people 13 years and older • standardized behavioral, developmental and/or autism screening tool for children 12 years or younger,
Cohort	• All patients seen during the measurement period
Linkage to Data Roadmap, if applicable	Behavioral Health

3.a.i - M3

Activity ID: B03_007	Partner Type: Partner Type: Primary Care (Adult, Pediatric, and Family Med)
Activity Grouping: Bundle	Completion Date: 3/31/2017, **6/30/2017**, 9/30/2017, 12/31/2017, 3/31/2018
Bundle #: B03 - IMPACT Model	Reporting Date: 4/10/2017, **7/10/2017**, 10/10/2017, 1/10/2018, 4/10/2018

Report	• Report of all patients with completed PHQ-2, PHQ-9 screening as outlined in the patient engagement definition.
Cohort	• All eligible patients seen during the measurement period as outlined in the patient engagement definition

Behavioral Health Outcome Measure: Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication - Screening

Activity ID: B06_001- **Part 1**	Partner Type: Primary Care (Adult and Family Med.); MH (Outpatient Rx only)
Activity Grouping: Bundle	Completion Date: **6/30/2017**
Bundle #: B06 – Diabetes Monitoring with BH	Reporting Date: **7/10/2017**

Performance Activity	Supporting Documentation
Provide baseline report that meets data specifications for any three consecutive, complete months of data between January 2017 to June 2017 for: **1. Patients (ages 18-64) with schizophrenia or bipolar disease who were dispensed an antipsychotic medication and have been screened for diabetes.** 2. Patients (ages 18-64) with diabetes and schizophrenia that have received both, HbA1C and LDL-C screenings. **Data must be captured in structured fields in the EMR.**	Baseline report that meets BHNNY data specifications

BHNNY Responsibility
Provide data specifications for baseline report. Provide specifications and requirements for structured data fields in the EMR.

Behavioral Health Outcome Measure: Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication - Screening

Activity ID: B06_001- **Part 1**	Partner Type: Primary Care (Adult and Family Medicine); MH (outpatient Rx only)
Activity Grouping: Bundle	Completion Date: **6/30/2017**
Bundle #: B06 – Diabetes Monitoring with BH. High Performance Metric? Y	Reporting Date: **7/10/2017**

Numerator	Denominator	Common ICD-10 Codes, ages 18-64 years, with schizophrenia and diabetes
Number of people who had a diabetes screening test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication	**ICD-10:** Schizophrenia: F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9 Bipolar Disorder: 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 Other Bipolar Disorders: F31.81, F31.89, F31.9 **CPT II:** 3044F, 3045F, 3046F

Behavioral Health Outcome Measure: Diabetes Monitoring for People with Diabetes and Schizophrenia (AHPP)	
Activity ID: B06_001- **Part 2**	Partner Type: Primary Care (Adult and Family med); MH (outpatient Rx only)
Activity Grouping: Bundle	Completion Date: **6/30/2017**
Bundle #: B06 – Diabetes Monitoring with BH	Reporting Date: **7/10/2017**
Performance Activity	**Supporting Documentation**
Provide baseline report that meets AMCH PPS data specifications for any three consecutive, complete months of data between January 2017 to June 2017 for: 1. Patients (ages 18-64) with schizophrenia or bipolar disease who were dispensed an antipsychotic medication and have been screened for diabetes. **2. Patients (ages 18-64) with diabetes and schizophrenia that have received both, HbA1C and LDL-C screenings.** Data must be captured in structured fields in the EMR.	Baseline report that meets BHNNY data specifications
BHNNY Responsibility	
Provide data specifications for baseline report. Provide specifications and requirements for structured data fields in the EMR.	

Behavioral Health Outcome Measure: Diabetes Monitoring for People with Diabetes and Schizophrenia (AHPP)

Activity ID: B06_001- **Part 2**	Partner Type: Primary Care (Adult and Family Med); MH (Outpatient Rx only)
Activity Grouping: Bundle	Completion Date: **6/30/2017**
Bundle #: B06 – Diabetes Monitoring with BH. High Performance Metric? Y	Reporting Date: **7/10/2017**

Numerator	Denominator	Common ICD-10 Codes, ages 18-64 years, with schizophrenia and diabetes
Number of people who had both an LDL-C test and an HbA1c test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia and diabetes	**ICD-10:** Schizophrenia: F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9 Diabetes: Use the appropriate code family: E or O (pre-existing DM in pregnancy) **CPT II:** 3044F, 3045F, 3046F, 3048F, 3049F, 3050F

3.b.i Patient Engagement; Self Management

Activity ID: B10_007	Partner Type: Primary Care (Adult and Family Medicine)
Activity Grouping: Bundle	Completion Date: 3/31/2017, **6/30/2017**, 9/30/2017, 12/31/2017, 3/31/2018
Bundle #: B10 - CVD/HTN Management	Reporting Date: 4/10/2017, **7/10/2017**, 10/10/2017, 1/10/2018, 4/10/2018

Report	• Report of all patients with documented self-management goals in the EMR, as outlined in the patient engagement definition
Cohort	• All eligible patients seen during the measurement period as outlined in the patient engagement definition
Linkage to Data Roadmap, if applicable	CVD Roadmap
Common ICD-10 Codes / CPT Codes	ICD-10: CPT/CPT II:

3.b.i CVD Registry

Activity ID: B10_006	Partner Type: Primary Care (Adult and Family Medicine); Outpatient Specialty Care
Activity Grouping: Bundle	Completion Date: 3/31/2017, **6/30/2017**, 9/30/2017, 12/31/2017, 3/31/2018
Bundle #: B10 - CVD/HTN Management	Reporting Date: 4/10/2017, **7/10/2017**, 10/10/2017, 1/10/2018, 4/10/2018

Report	• Completed registry data of eligible patients seen between July 1, 2016 – June 30, 2017
Cohort	• All patients with HTN and CVD seen during the previous 12 months
Linkage to Data Roadmap, if applicable	CVD Roadmap

Asthma Measures

Activity ID: B13_003	Partner Type: Primary Care (Adult, Pediatric, and Family Medicine); Specialists (Pulmonologists/Allergists)
Activity Grouping: Bundle	Completion Date: 3/31/2017, **6/30/2017**, 9/30/2017, 12/31/2017, 3/31/2018
Bundle #: B13 - Poorly Controlled Asthma High Performance Eligible? N	Reporting Date: 4/10/2017, **7/10/2017**, 10/10/2017, 1/10/2018, 4/10/2018

Report	Completed registry data of eligible patients seen between July 1, 2016 – June 30, 2017
Cohort	• All patients, 5 to 64 years of age, with persistent or poorly controlled asthma seen during the previous12 months
Linkage to Data Roadmap, if applicable	Asthma Roadmap
Common ICD-10 Codes / CPT Codes	ICD-10: J45.3x mild persistent asthma J45.4x moderate persistent asthma J45.5x severe persistent asthma CPT/CPT II:

3.d.iii

Activity ID: B13_004	Partner Type: Primary Care (Adult, Pediatric, and Family Medicine)
Activity Grouping: Bundle	Completion Date: 3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018
Bundle #: B13 - Poorly Controlled Asthma High Performance Eligible? N	Reporting Date: 4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018

Report	• Number of all patients with a current Asthma Action Plan at the last visit
Cohort	• All eligible patients, 5 to 64 years of age, seen during the measurement period as outlined in the patient engagement definition
Linkage to Data Roadmap, if applicable	Asthma Roadmap
Common ICD-10 Codes / CPT Codes	ICD-10: J45.3x mild persistent asthma J45.4x moderate persistent asthma J45.5x severe persistent asthma CPT/CPT II: