DMHAS Proposed Health Home Quality Measures

Introduction and Goals
The Department of Mental Health and Addiction Services (DMHAS) is developing a health home model for individuals with SPMI. DMHAS's health home quality measurement goal is to continuously improve the quality, cost effectiveness and satisfaction of care provided to health home enrollees through the systematic collection, analysis and distribution of a broad array of data at both the provider and the program levels. Our objectives are to:

- Identify opportunities and track improvements in care for individuals with behavioral health care needs;
- Meet all the Center for Medicare and Medicaid Services (CMS) requirements through the selection of the health home measures;
- Collect a comprehensive array of data, consistent with critical Health Home goals that will improve outcomes for individuals with mental illness;
- Minimize the level of burden associated with data collection on providers and the state; and,
- Select and execute on measures that are actionable and can result in improved outcomes.

CMS developed health home core quality measures which are closely aligned with the Department of Health and Human Services (HHS) National Strategy for Quality Improvement in Health Care, the Electronic Health Record (EHR) Meaningful Use program measures, and the core set of quality measures for Medicaid-eligible adults. These health home core measures, which are intended to support a consistent health home evaluation across states, incorporate extensive stakeholder input and address key priority areas such as behavioral health and preventive care. CMS further intends for states to supplement health home core quality measures with state-specific measures.

CMS Health Home Core Quality Measures
The CMS health home core quality measures (all of which are proposed by DMHAS for the health home initiative) include:

a. Adult Body Mass Index (BMI) Assessment
b. Ambulatory Care – Sensitive Condition Admission
c. Care Transition – Transition Record Transmitted to Health care Professional
d. Follow-up After Hospitalization for Mental Illness
e. Plan- All Cause Readmission
f. Screening for Clinical Depression and Follow-up Plan
g. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
h. Controlling High Blood Pressure (Core Adult Measure)

Recommended Connecticut-Specific Health Home Measures
Below is a list of proposed DMHAS Health Home outcome goals and quality measures. The measures are listed under each specific goal and include alignment with other quality measurement initiatives, desired clinical outcome, data source, and a description of the overall measure, the numerator and the denominator.

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GOAL 1: IMPROVE QUALITY BY REDUCING UNECCESSARY HOSPITAL ADMISSIONS AND READMISSIONS

A. **Plan All-Cause Readmissions:** (CMS Core Health Home Set, Medicaid Adult Core Set Measure, HEDIS, National Quality Forum (NQF))

Desired Clinical Outcome: Decrease the readmission rate within 30 days of an acute hospital stay for individuals aged 18 years of age and older.

Data Source: Claims data

Measure Description: For individuals 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Numerator: Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination

Denominator: Count the number of Index Hospital Stays for each age, gender, and total combination

B. **Ambulatory Care-Sensitive Conditions Admissions:** (CMS Core Health Home Set)

Desired Clinical Outcome: To decrease the rate of Ambulatory Care- Sensitive Admissions for conditions where appropriate ambulatory care prevents or reduces the need for inpatient admission to a hospital.

Data Source: Claims data

Measure Description: Age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years

Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years

Denominator: Total mid-year population under age 75

C. **Emergency Department Visits: (**algorithm from SAMHSA National Outcome Measures)

Desired Clinical Outcome: To reduce ambulatory care-sensitive emergency room visits.

Data Source: Claims data

Measure Description: Age-standardized emergency department visit rate for conditions where appropriate ambulatory care prevents or reduces the need for an emergency department visit, per 100,00o population, under 75 years

Numerator: Total number of emergency room visits for ambulatory care sensitive conditions under age 75 years

Denominator: Total mid-year population under age 75

GOAL 2: REDUCE SUBSTANCE USE

A. Tobacco Cessation Intervention (Collected as part of HEDIS CAHPS Supplemental Survey, Medicaid Adult Core Set, NQF)

Desired Quality Outcome: Increase the number of tobacco users who received cessation intervention.

Data Source: Paper Record, HIT

Measure Description:
Eligible providers will be required to report two numerators and two denominators for this measure. The first population criteria include current smokers or tobacco users; the second population criteria include current smokers or tobacco users who have received tobacco use cessation counseling.

Numerator: Total number of tobacco users who received cessation intervention

Denominator: Total number of tobacco users

B. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (CMS Health Home Core Set , Meaningful Use 1 and 2, Medicaid Adult Core Set, HEDIS, NQF)

Desired Quality Outcome: Increase the percent of adolescents and adults with a new episode of alcohol or other drug dependence (AOD) who initiated AOD treatment or engaged in AOD treatment.

Data Source: Claims data

Measure Description:
Numerator:
Initiation: individuals with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis

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Engagement: individuals with initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted

Denominator: Individuals 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reporting in two age stratifications (13-17, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators

GOAL 3: IMPROVE TRANSITIONS OF CARE

A. **Transition Record Transmitted to Health Care Professional** (CMS Health Home Core Set, Medicaid Adult Core Set, NQF)

Desired Clinical Outcome: Increase the percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

Data Source: Paper records, HIT

Measure Description:
Numerator: Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge

Denominator: All patients, regardless of age, discharged from an inpatient facility (e.g. hospital, inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care

B. **Follow-up After Hospitalization for Mental Illness** (CMS Health Home Core Set, Medicaid Adult Core Set, HEDIS, NQF)

Desired Clinical Outcome: Increase the percentage individuals who have a follow up visit within 7 days of discharge from an acute hospitalization for mental health.

Data Source: Claims

Measure Specification; Percentage of discharges for individuals 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge

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Numerator: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge

Denominator: Individuals 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 31 of the measurement year

GOAL 4: IMPROVE THE PERCENT OF INDIVIDUALS WITH MENTAL ILLNESS WHO RECEIVE PREVENTIVE CARE

A. **Adult Body Mass Index (BMI) Assessment** (CMS Health Home Core Set, Medicaid Adult Core Set, HEDIS)

   Desired Clinical Outcome: Improve BMI education and health promotion for enrolled individuals.

   Data Source: Claims, Paper Records

   Measure Description: Percentage of individuals 18-74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year

   Numerator: Body mass index documented during the measurement or the year prior to the measurement year

   Denominator: Members age 18-74 of age who had an outpatient visit

B. **Screening for Clinical Depression and Follow-up** (CMS Health Home Core Set, PQRS, CMS QIP, Medicare Shared Savings Program, Medicaid Adult Core Set, Meaningful Use 2, NQF)

   Desired Clinical Outcome: Early intervention for individuals diagnosed with depression

   Data Source: Claims data

   Measure Description: Percentage of patients age 18 years and older screened for clinical depression using a standardized tool AND follow-up is documented

   Numerator: Total number of individuals from the denominator who have follow-up documentation

   Denominator: All patients 18 years and older screened for clinical depression using a standardized tool

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GOAL 5: IMPROVE CHRONIC CARE DELIVERY FOR INDIVIDUALS WITH SPMI

A. Adult Asthma Control (Medicaid Adult Core Set, AHRQ Quality Indicator)

Desired Clinical Outcome: Increase the percentage of individuals 18-64 years of age who identified as having persistent asthma during the measurement year and the year prior to the measurement year and who were dispensed a prescription for either an inhaled corticosteroid or acceptable alternative medication during the measurement year

Data Source: Claims data

Measure Description:
Numerator: The number of members who were dispensed at least one prescription for a preferred therapy during the measurement year

Denominator: All health plan members 18–64 years of age during the measurement year who were identified as having moderate to severe persistent asthma

B. Controlling High Blood Pressure (CMS Health Home Core Set, Medicaid Adult Core Set, NQF, Meaningful Use 2)

Desired Clinical Outcome: Increase the percentage of individuals 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year

Data Source: Claims

Measure Description:
Numerator: Number of individuals in the denominator who had a systolic blood pressure of less than 140 **and** a diastolic blood pressure of less than 90

Denominator: Individuals 18-85 with hypertension. An individual is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first 6 months of the measurement year

C. HbA1c Level Screening (Medicaid Adult Core Set, NQF)

Desired Clinical Outcome: Increase the percentage of adults, age 18 to 75, with diabetes whose Hemoglobin HbA1c was within a normal range during the measurement period.

Data Source: Claims, Medical Record, HIT

Measure Description: Individuals ages 18-75 with a diagnosis of diabetes, who have HbA1c < 8.0

Numerator: Number of individuals in the denominator who had an HbA1c level of less than 8.0

Denominator: Number of individuals 18-75 years of age with diabetes

D. Improve Cardiovascular Care for Individuals with CAD (Medicaid Adult Core Set, NQF)

Desired Clinical Outcome: Increase the percentage of adults, over age 18, with coronary artery disease (CAD) whose LDL was within a normal range during the measurement period.

Data Source: Claims, Medical Record, HIT

Measure Description: Percentage of adults, age 18 years and older, diagnosed with CAD with lipid level adequately controlled (LDL<100)

Numerator: Number of individuals in the denominator who had an LDL level of less than 100

Denominator: Number of individuals over 18 years of age with CAD

Goal 6: INCREASE PERSON-CENTEREDNESS AND SATISFACTION WITH CARE DELIVERY

A. General Satisfaction With Care, Access, Quality and Appropriateness (SAMHSA National Outcome Measures (NOMS)

Desired Quality Outcome: Increase general satisfaction with care; access to care; quality and appropriateness of care; participation in treatment; cultural competence

Data Source: Satisfaction survey, HIT

Measure Specification:
Numerator: Number of individuals in the denominator who report scorers of 2.5 or higher on each of the instrument's sub-scales

Denominator: The total number of survey responses

Goal 7: INCREASE CONNECTION TO RECOVERY SUPPORT SERVICES

A. Decrease Homelessness

Desired Outcome: To decrease the number of individuals who experienced homelessness *and* increase housing stability

Data Source: Medical Record, HIT

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Measure Specification:
Numerator: Number of individuals in the denominator who had stable housing during the measurement period

Denominator: The number of individuals in the program

B. Increase Employment and Education Opportunities

Desired Clinical Outcome: Increase the number of individuals who become involved in employment and/or educational activities

Data Source: Medical Record, HIT

Measure Specification:
Numerator: Number of individuals in the denominator involved in employment or educational activities

Denominator: Total number of individuals in the program.

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