Measures for Whole Person Care

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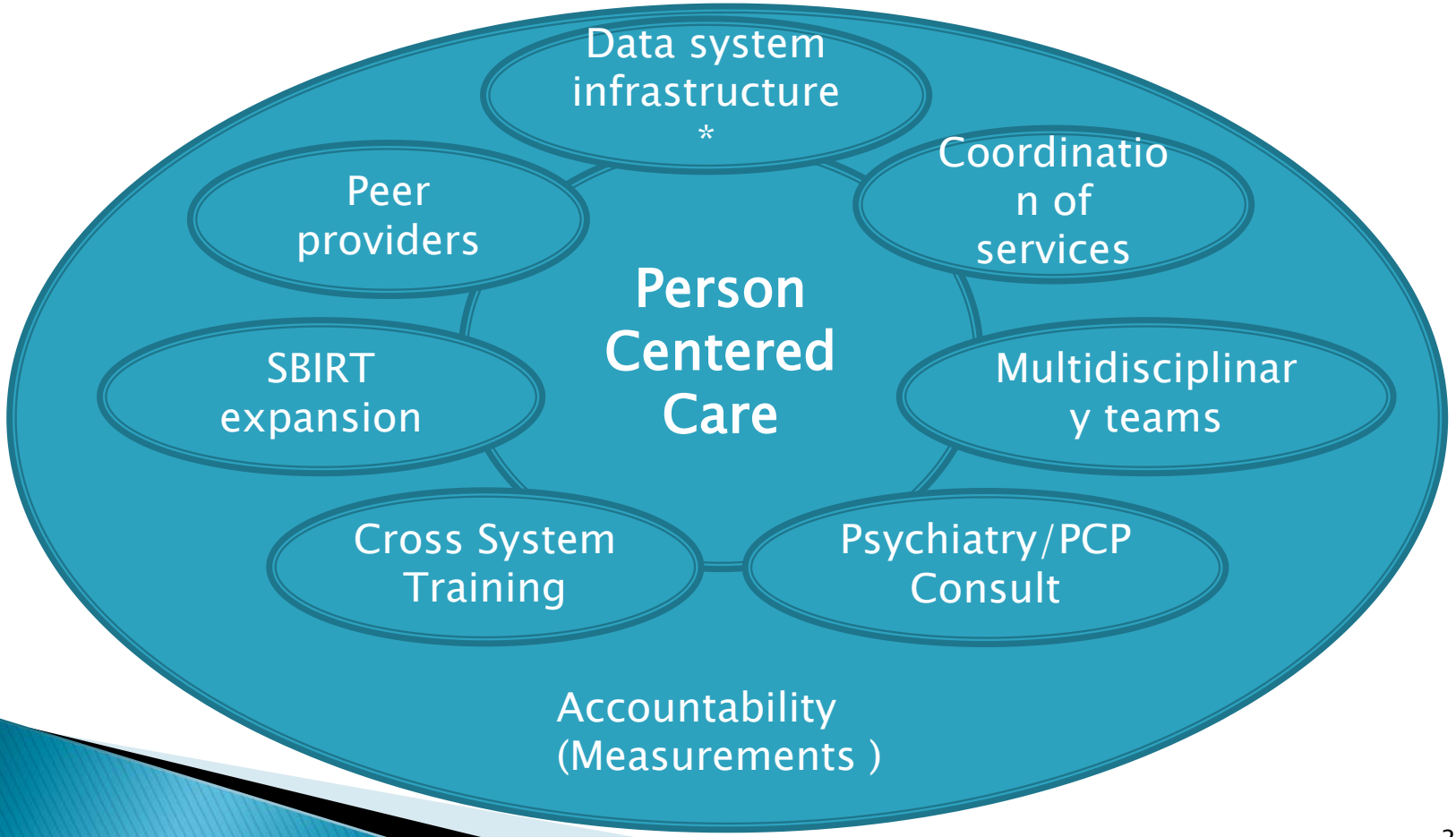
Efrat Eilat, MBA, PhD
Department of Health Care Services

in collaboration with Jennifer Clancy-CIBHS Julie Stone-Mathematica, Karen Linkins-IBHP and Darren Urada-UCLA-ISAP

Building blocks for Integration



Potential Measures

Condition/Area	Performance Measure *
Asthma	• Use of appropriate medications for people with asthma
Cardiovascular Care	• Cholesterol management for patients with cardiovascular condition (LDL-C <100 mg/dL) • Controlling high blood pressure (<140/90)*
Diabetes Care	• Comprehensive Diabetes Care (HbA1c level below 7) • Comprehensive Diabetes Care: Cholesterol management (LDL-C <100 mg/dL)
Management of Behavioral Health Conditions	• Client perception of care – National Outcome Measure • Proportion of Days Covered of Medication

- * CMS measures. (Still under development and review.)
- Most other measures are national measures taken from NQF/NCQA. A few are taken from other states (e.g., Ohio) or CA specific.

Potential Measures – cont.

Condition/Area	Performance Measure
Schizophrenia	• Annual assessment of weight/BMI • Glycemic Control • Lipids
Bipolar Disorder	• Annual assessment of weight/BMI • Glycemic Control • Lipids
Clinical Depression	• Screening • Follow-up plan*
Obesity	• BMI Assessment*

Potential Measures – cont.

Condition/Area	Performance Measure *
Utilization and Access	• Sensitive Condition Admission (1. Grand Mal and other Epileptic Convulsions, 2. COPD, 3. Asthma, 4. Diabetes, 5. Heart failure and Pulmonary Edema, 6. Hypertension, 7. Angina)* • ED Utilization rates • ED Utilization rates – mental health and SUD • Inpatient Utilization rates • Inpatient Utilization rates – mental health and SUD • Follow-up after MH hospitalization* • Successful Linkages to Integrated Care (including community services)
Access to Preventive/Ambulatory Health Visits	• All-cause readmission (number of acute 30-day readmissions for any diagnosis)

Potential Measures – cont.

Condition/Area	Performance Measure
Care Coordination	• Timely Transmission of Transition Record (transition record sent to health home within 24 hours of discharge)* • Medication Reconciliation Post-Discharge • Release of Information for sharing protected health information (PHI) across providers • Care Coordinator Assignment: Percentage of clients in the target population with an assigned care coordinator • Common Care Plan: Percentage of clients in the target population with a physical and behavioral health care plan accessible by all providers and payers • % of MH/SUD referrals that were actually admitted to treatment.

Potential Measures – cont.

Condition/Area	Performance Measure
Substance Use/Prevention	• Screening • SBIRT • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
Patient Experience	• Client experience with care • Client confidence • Satisfaction with coordination of care
Recovery	• Milestones of Recovery Scale (Improved mental health outcomes) • Housing stability • Employment • Food Access

Thank you!