

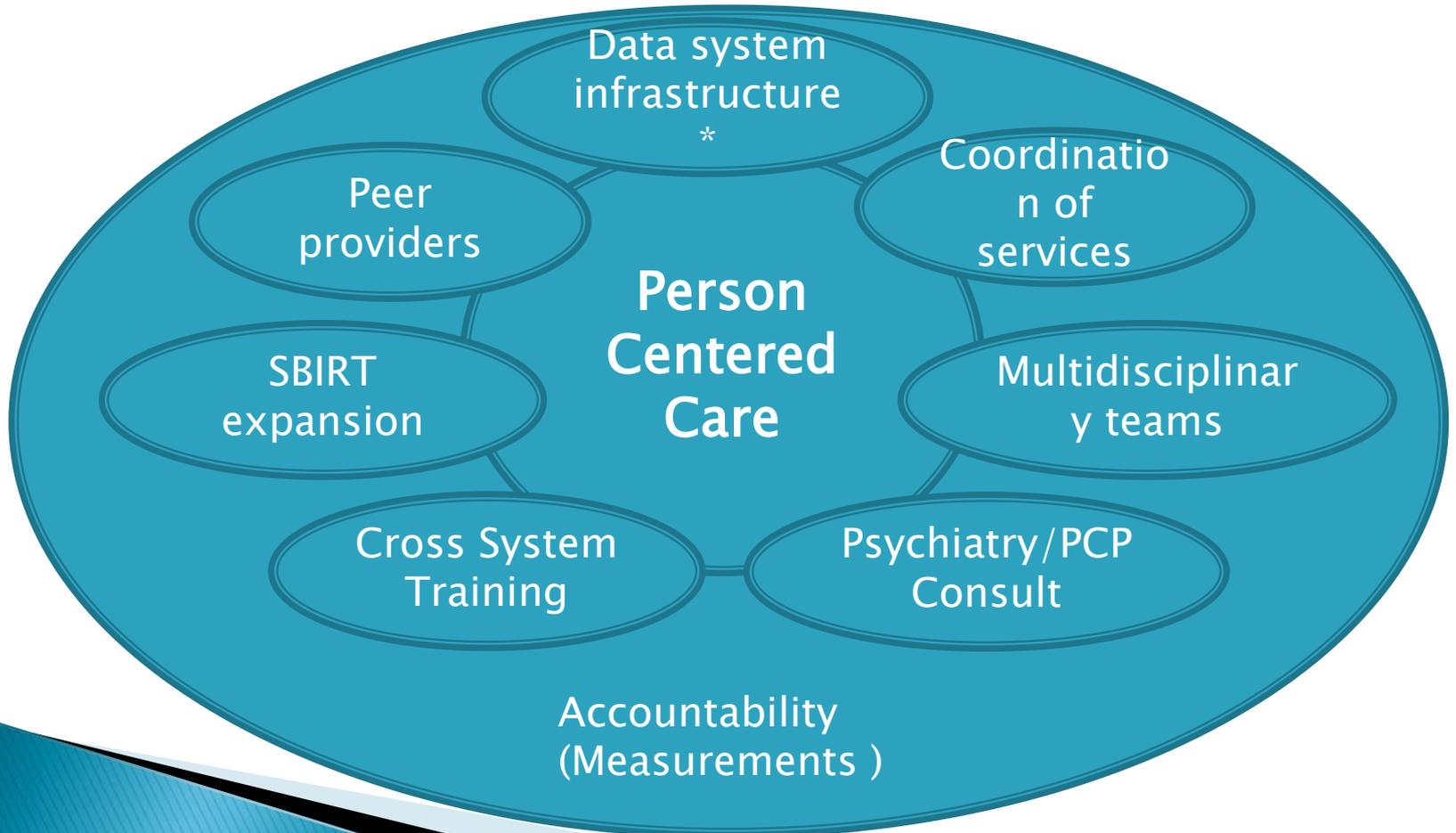
Measures for Whole Person Care

Presentation before
DSRIP 2 Expert Workgroup
Section 1115 Medicaid Waiver Renewal
January 13, 2015

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Building blocks for Integration



Potential Measures

Condition/Area	Performance Measure *
Asthma	<ul style="list-style-type: none"> • Use of appropriate medications for people with asthma
Cardiovascular Care	<ul style="list-style-type: none"> • Cholesterol management for patients with cardiovascular condition (LDL-C <100 mg/dL) • Controlling high blood pressure (<140/90)*
Diabetes Care	<ul style="list-style-type: none"> • Comprehensive Diabetes Care (HbA1c level below 7) • Comprehensive Diabetes Care: Cholesterol management (LDL-C <100 mg/dL)
Management of Behavioral Health Conditions	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none">• Annual assessment of weight/BMI• Glycemic Control• Lipids
Bipolar Disorder	<ul style="list-style-type: none">• Annual assessment of weight/BMI• Glycemic Control• Lipids
Clinical Depression	<ul style="list-style-type: none">• Screening• Follow-up plan*
Obesity	<ul style="list-style-type: none">• BMI Assessment*

Potential Measures – cont.

Condition/Area	Performance Measure *
Utilization and Access	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • All-cause readmission (number of acute 30-day readmissions for any diagnosis)

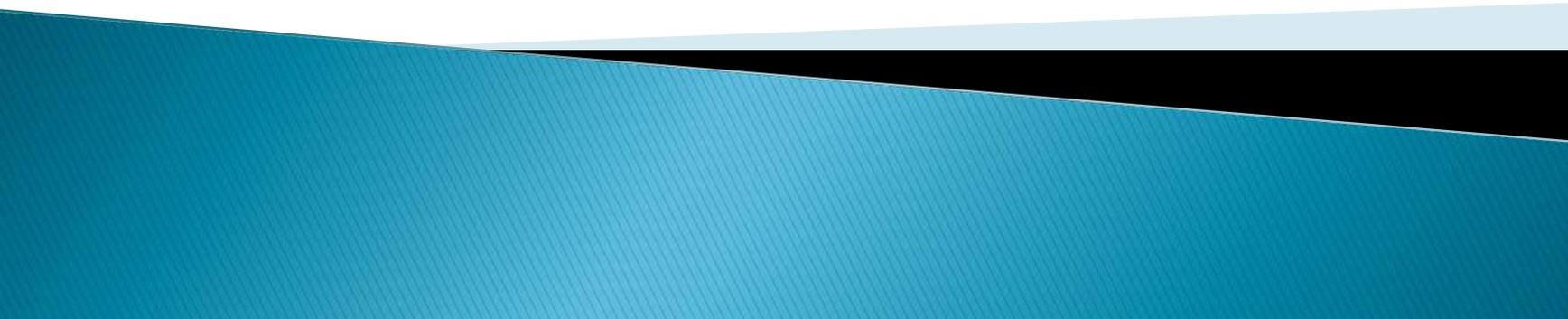
Potential Measures – cont.

Condition/Area	Performance Measure
Care Coordination	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• Screening• SBIRT• Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
Patient Experience	<ul style="list-style-type: none">• Client experience with care• Client confidence• Satisfaction with coordination of care
Recovery	<ul style="list-style-type: none">• Milestones of Recovery Scale (Improved mental health outcomes)• Housing stability• Employment• Food Access

Thank you!

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