# **Health Homes Administrative Component**

### **Health Homes Administrative Component**

Name of Health Homes I RI Opioid Treatment Pr	gram: am Health Home Services
Monitoring	
Provide an estimate of the	umber of individuals to be served by the Health Homes program during the fi
1250	The state of the s
Provide an estimate of the program during the first \$1143375.00	ost-savings that will be achieved from implementation of the Health Homes ir of operation:

Describe how this cost-saving estimate was calculated, whether it accounted for savings associated with dual eligibles, and if Medicare data was available to the State to utilize in arriving at its cost-savings estimates: Savings achieved through this program will most likely not be realized in the first year of implementation or perhaps even in the second. Health Home interventions for this population are designed to create lifestyle changes that will benefit health outcomes in years to come.

We did however establish the above number as an estimate of potential savings attached to OTP Health Homes. In 2011, Medicaid spent 1.3 million dollars on Emergency room visits for individuals enrolled (at some point) in opicid treatment programs. The total population was 1813, though it is likely that there were many in that cohort that did not utilize the ER and that those numbers are reflective of a smaller group. In 2011, 4 millions dollars was spent in pharmacy for this same population. If we eliminate ER visits for the 1250 engaged in Health Home services in six months, at a rate of \$60.45 per member per month, than we will save \$453,375. If we reduce pharmacy expenses of the 1250 by half for six months, at a per member per month cost of \$184.16, then we will save \$690,000. It is expected that Health Home services will provide greater incentive to remain in treatment and stay connected to not only a substance abuse treatment provider, but also to other healthcare professionals, limiting the need for multiple medications and ED visits.

### **Quality Measurement**

CMS Recommended Core Measures

For each Health Homes core measure, indicate the data source, the measure specification, and how HIT will be utilized in reporting on the measure.

Health Homes Core Measure	
Adult Body Mass Index Assessment	
Ambulatory Care-Sensitive Admission.	
Care Transition - Transition Record Transmitted to Health Care Professional	
Follow-Up After Hospitalization for Mental Illness.	
Plan - All Cause Readmissions.	
Screening for Clinical Depression and Follow-Up plan.	



Effective Date: 7/1/13

Health Homes Core Measure	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.	
Controlling High Blood Pressure	

Aeasure	
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Measure Specification, i	including a description of the numerator and denominate
Data Sources:	
Frequency of Data Co	ollection:
Monthly  Quarterly	
Annually	
Continuously Other	
How Health IT will be	
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Effective Date: 7/1/13

Hom	es Administrative Component: Core Measure Detail
Mea Adu	asure alt Body Mass Index Assessment
Pero	asure Specification, including a description of the numerator and denominator. centage of Health Home enrollees who had their BMI documented during the isurement year.
Nur	nerator is BMI documented during the measurement year. denominator is the number of OTP Health Home enrollees.
Dat Ind	a Sources: ividual records/charts of the Opioid Treatment Programs.
Fre	equency of Data Collection:
0	Monthly
0	Quarterly
•	Annually
Č	Continuously
•	Other
Ea	w Health IT will be utilized ch OTP has an Electronic Medical Record and will be expected to maintain this formation in each individual record and report out on compliance.
lor	nes Administrative Component: Core Measure Detail
	easure nbulatory Care-Sensitive Admission.
Ag an Nu	easure Specification, including a description of the numerator and denominator, ge-standardized acute care hospitalization rate for conditions where appropriate abulatory care prevents or reduces the need for admission to the hospital.  Imperator: Total number of acute care hospitalizations for ambulatory care sensitive acute acresses.
De	nditions under age 75 years. enominator: Number of OTP Health Home enrollees under age 75.
Da M	ata Sources: edicaid FFS data and Encounter data from MCOs on both hospitalization and use
ap In	propriate ambulatory care. dividual patient records at the OTPs identifying patients with ambulatory care se anditions.
F	requency of Data Collection:



Approval Date: 11/6/13 Rhode Island

justi. Lista e di Lista e di	Monthly-
	Quarterly
	D Annually
	© Centinuously
	(b) Other
	How Health IT will be utilized Each OPT will be required to track ambulatory care sensitive conditions along with hospitalizations on Health Home clients in teh Electronic Medical Record. The Project Coordinator will be responsible for tracking data from Medicaid expenditures.
ealth I	Iomes Administrative Component: Core Measure Detail
	Manus
	Care Transition - Transition Record Transmitted to Health Care Professional
	Measure Specification, including a description of the numerator and denominator. Percentage of OTP Health Home enrollees 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 care physician or other health care professional designated for follow-up care within 24 hours of discharge. Numerator: Patients for whom a transition record was transmitted to the OTP Health Home provider for follow-up care within 24 hours of discharge. Denominator: All OTP Health Home patients discharged from an inpatient facility to home/self-care or any other site of care.
	Data Sources:  Medicaid and plan data will inform as to inpatient stay. Transition plans will be expected to be incorporated into the patient record at the OTP.
	Frequency of Data Collection:
	© Monthly
	Quarterly
	Annually
	© Continuously
	Other
	How Health IT will be utilized  Transition plans will be incorporated into the EHR at the OTP. The goal is to establish automatic transfer of this information into the EHR using Direct Messaging through CurrentCare, or sharing of the CCD using the viewer function of CurrentCare.



### Health Homes Administrative Component: Core Measure Detail

Measure

Follow-Up After Hospitalization for Mental Illness. 4

Measure Specification, including a description of the numerator and denominator. Percentage of discharges for OTP Health Home patients 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.

Numerator: An outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days after discharge.

Denominator: OTP Health Home patients who are discharged alive from an acute inpatient

setting with a principal mental health diagnosis.

Data Sources:

Medicaid claims data for information on both the numerator and denominator. EHR of the OTP should contain documentation of the same.

Frequency	of Bata	Collection	•
rieducucy	ui Dala	COMPERMENT	۰

Monthly

Quarterly

Annually

**O** Continuously

Other

How Health IT will be utilized

OTP Health Homes will be notified by Managed Care plans within 24 hours of an inpatient admission. OTP Health Homes will use Direct Messaging through CurrentCare to securely send and receive information on follow-up.

### Health Homes Administrative Component: Core Measure Detail

Measure

Plan - All Cause Readmissions.

Measure Specification, including a description of the numerator and denominator. For OTP Health Home patients, 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: Court the number of Index Hospital Stays with a readmission within 30 days.

Numerator: Count the number of Index Hospital Stays with a readmission within 30 days. Denominator: Count the number of Index Hospital Stays.

Data Sources:

Medicaid claims data.



Frequency of Data Collection:

<b>0</b> :	Monthly
•	Quarterly
<b>©</b>	Annually
0	Continuously
0	Other
Info	Health IT will be utilized.  The state of th
ealth Hom	es Administrative Component: Core Measure Detail
Mes	asure sening for Clinical Depression and Follow-Up plan.
Pero star Nui doc Der	asure Specification, including a description of the numerator and denominator. centage of OTP Health Home patients screened for clinical depression using a adardized tool and follow-up documented. merator: Total number of patients from the denominator who have follow-up sumentation. nominator: All OTP Health Home patients screened for clinical depression using a adardized tool.
Inf	ta Sources: formation regarding the measure will be maintained in the patient record and reported ou arterly.
Fr	equency of Data Collection:
. 6	Monthly
•	Quarterly
	Annually
	Continuously
ľ,	Other
	A CONTRACTOR OF THE PROPERTY O
	ow Health IT will be utilized ograms are all required to screen for depression annually and this screen is recorded in eEHR. Follow-up on positive screens will require documentation in the EHR and Direct the EHR.



Messaging can be used to facilitate referrals. Programs can access both CurrentCare and quarterly utilization reports from MCOs to assess patient follow through with referrals.

### Health Homes Administrative Component: Core Measure Detail

Measure

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.

Measure Specification, including a description of the numerator and denominator. Percentage of OTP Health Home clients with a new episode of alcohol or other drug dependence who received the following: - Initiation of AOD treatment - Engagement of AOD treatment.

Numerator: Initiation of AOD Dependence treatment: OTP HH patients with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.

Engagement of AOD treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalization with any AOD diagnosis within 30 days after the date of the Initiation encounter Denominator: OTP Health Home patients with a new episode of AOD during the intake period.

Data Sources:

EHR. This measure is less relevant for this particular Health Home setting as the provider is an AOD Dependence Treatment provider and every new intake will have a new episode of AOD dependence and will initiate and engage in treatment. Relevant however, will be those patients diagnosed with dependence other than opioid dependence needing a higher level of care, and the initiation and engagement of those individuals in the appropriate level of care.

Monthly					
Quarterly			*		
Annually	.!	.•		٧,	
Continuously					
Other					

## Health Homes Administrative Component: Core Measure Detail

Measur

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.

Measure Specification, including a description of the numerator and denominator.

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OFTERS

Percentage of OTP Health Home clients with a new episode of alcohol or other drug dependence who received the following: - Initiation of AOD treatment - Engagement of

Numerator: Initiation of AOD Dependence treatment: OTP HH patients with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. Engagement of AOD treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalization with

any AOD diagnosis within 30 days after the date of the Initiation encounter Denominator: OTP Health Home patients with a new episode of AOD during the intake

Data Sources:

Data Sources:

EHR. This measure is less relevant for this particular Health Home setting as the provider is an AOD Dependence Treatment provider and every new intake will have a new episode of AOD dependence and will initiate and engage in treatment. Relevant however, will be those patients diagnosed with dependence other than opioid dependence needing a higher level of care, and the initiation and engagement of those individuals in the appropriate level of care.

Frequency	Λf	Data	Collection:
rreduency	OΙ	Data	Concentions

Monthly

Quarterly

🖲 Annually

Continuously

🛡 Other

How Health IT will be utilized Information will be recorded in the EHR and reported out quarterly.

# Health Homes Administrative Component: Core Measure Detail

Controlling High Blood Pressure

Measure Specification, including a description of the numerator and denominator. The percentage of patients who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.

Numerator: The number of patients in the denominator whose most recent, representative

BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must by <140/90mm Hg.

Denominator: Patients with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.

Data Sources:

Ostanulal

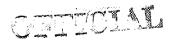
Fre	quency of Data Collection:
0	Monthly
0	Quarterly
•	Annually
0	Continuously
(2)	Other
-	•

State Goals and Quality Measures

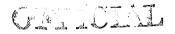
In addition to the CMS recommended core measures, identify the goals and define the measures the State will use to assess its Health Homes model of service delivery:

Health Home Goal	
Housing stability	
Improved Employment/wages earned.	
Reduce rates of arrest and incarceration.	
Reduction of illicit drug use.	
Reduction of smoking rates	

# Health Homes Administrative Component: Goal Detail Health Home Goal: Housing stability Measure The number of OTP HH clients reporting housing stability. Health Homes Administrative Component: Measure Detail Measure The number of OTP HH clients reporting housing stability.

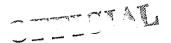


The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:	
🖰 Hospital Admissions	
Emergency Room Visits	
Skilled Nursing Facility Admissions	
The measure is not included in the Health Homes State Plan	
Measure Specification, including a description of the numerator and denominator.  Numerator: The number of OTP HH clients reporting housing stability.  Denominator: The number of OTP HH clients.	
Data Sources: EHR.	
Frequency of Data Collection:	
Monthly	
Quarterly	
Annually	
© Continuously	
Other	
How Health IT will be utilized Will be recorded in EHR and reported quarterly.	
Measure is related to:	
Clinical Outcomes	
Experience of Care	
🖑 Quality of Care	
Other Describe:	
DOM TOU.	

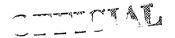


Effective Date: 7/1/13

	Home Goal:				
Improv	ed Employment/v	vages earned.			
		Measure			
	er of OTP Healt ncrease in wages	n Home clients who begin employment e.	or		
Heal	th Homes Ad	ministrative Component: Me	asuı	re Deta	il
	Measure Number of increase in	OTP Health Home clients who begin em	ployn	nent or h	ave
	State l	easure is an Evaluation Measure from Plan for purposes of determining the e ucing one of the following:			
	Ø	Hospital Admissions			
	0	Emergency Room Visits			
	•	Skilled Nursing Facility Admissions			
	The m	easure is not included in the Health H	omes	State Pl	an
		sure Specification, including a description	on of	the nume	erator a
		ominator. nerator: Number of OTP HH clients who	o begi	in emplo	yment
		e increase in wages. ominator: Number of OTP HH clients.			
	Dat EHI	a Sources: R			
	Fre	quency of Data Collection:			
	O	Monthly	i.		
	•	Quarterly			
	•	Annually			
	0	Continuously			
	Ø	Other			



	Will be documented in EHR and change reported to client information database (RIBHOLD) of BHDDH.
	Measure is related to:
	Clinical Outcomes
	Experience of Care
	Ouality of Care
	Other Describe:
Health 1	Homes Administrative Component: Goal Detail
	Health Home Goal: Reduce rates of arrest and incarceration.
	Measure
	The percentage of OTP Health Home clients who are arrested and/or become incarcerated.
	Health Homes Administrative Component: Measure Detail
	Measure The percentage of OTP Health Home clients who are arrested and/or become incarcerated.
	The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:
	Hospital Admissions
	🕏 Emergency Room Visits
	Skilled Nursing Facility Admissions
	Skilled Nursing Facility Admissions  The measure is not included in the Health Homes State Plan



	Numerator: The number of clients in OTP Health Homes who are arrested and/or incarcerated.  Denominator: The number of OTP Health Home clients.
	Data Sources: DOC database and EHR of OTPs.
	Frequency of Data Collection:
	Monthly
	Quarterly
	Annually
	6 Continuously
	Ø Other
	How Health IT will be utilized DOC arrest and incarceration data is shared daily with OTPs by comparing DOC database with BHDDH database. OTPs are informed when clients are incarcerated to arrange for continued care.
	Measure is related to:
	Clinical Outcomes
	Experience of Care
	Quality of Care
	Other Describe:
	:
Health H	omes Administrative Component: Goal Detail
	Health Home Goal:  Reduction of illicit drug use.
	Measure



Effective Date: 7/1/13

Measure		
eduction in the number of urinalysis or saliva tests that		1
monstrate the presence of illicit subst		ليسيا
ealth Homes Administrative Component: Meas	ure Det	ail
Measure	t damons	rate the
Reduction in the number of urinalysis or saliva tests the	tt ucinons	I die me
presence of illicit substances.		
The measure is an Evaluation Measure from th	e Health	Homes
State Plan for purposes of determining the effe	ct of the p	rogram
on reducing one of the following:		
disk war of the tentance		
O Hospital Admissions		
Emergency Room Visits		
Skilled Nursing Facility Admissions		
The measure is not included in the Health Hon	es State l	Plan
Measure Specification, including a description denominator.	of the nur	nerator and
Numerator: The number of toxicology results	that indica	te the
presence of illicit substances.		
Denominator: The number of toxicology scree	ns conduc	ted on
Health Home patients		
Data Sources:		
EHR.		
Frequency of Data Collection:		

How Health IT will be utilized

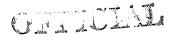
Results of toxicology screens will be recorded in the EHR and reported out quarterly.

Measure is related to:

Monthly Quarterly Annually Continuously

Other 0

Clinical Outcomes



1	Experience of Care
	Ouality of Care
	Other
	Describe:
Ì	
<b>L</b> -,	
rr	Administrative Commonwett Coal Detail
Health Hol	mes Administrative Component: Goal Detail
	ealth Home Goal: eduction of smoking rates
100	addition of amounting three
	, Measure
N	umber of smokers referred to smoking cessation programs.
E	Measure Number of smokers referred to smoking cessation programs.
	The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:
	Hospital Admissions
	© Emergency Room Visits
	Skilled Nursing Facility Admissions
	The measure is not included in the Health Homes State Plan
	Measure Specification, including a description of the numerator and denominator.
	Numerator: Number of identified smokers referred to smoking
	cessation programs.  Denominator: Number of OTP HH clients identified as smokers.
	Data Sources: EHR and RIBHOLD.
	Frequency of Data Collection:



Effective Date: 7/1/13

Monthly

	Quarterly
	Annually
· · · · · · · · · · · · · · · · · · ·	Continuously
1	Other
9	Other
Hov Info	w Health IT will be utilized ormation will be recorded in EHR and reported to RIBHOLD>=.
Me	asure is related to:
	Clinical Outcomes
, C	Experience of Care
•	Quality of Care
•	Other Describe:

