Health Homes Administrative Component

Health Homes Administrative Component

Name of Health Homes Program:
RI Opioid Treatment Program Health Home Services

Monitoring

Provide an estimate of the number of individuals to be served by the Health Homes program during the first year of operation:

1250

Provide an estimate of the cost-savings that will be achieved from implementation of the Health Homes program during the first year of operation:

$ 1143375.00

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 opioid 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.		

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		

Health Homes Administrative Component: Core Measure Detail

Measure

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

Data Sources:

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized

Health Homes Administrative Component: Core Measure Detail

Measure
Adult Body Mass Index Assessment

Measure Specification, including a description of the numerator and denominator.
Percentage of Health Home enrollees who had their BMI documented during the measurement year.
Numerator is BMI documented during the measurement year.
The denominator is the number of OTP Health Home enrollees.

Data Sources:
Individual records/charts of the Opioid Treatment Programs.

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized
Each OTP has an Electronic Medical Record and will be expected to maintain this information in each individual record and report out on compliance.

Health Homes Administrative Component: Core Measure Detail

Measure
Ambulatory Care-Sensitive Admission.

Measure Specification, including a description of the numerator and denominator.
Age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital.
Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years.
Denominator: Number of OTP Health Home enrollees under age 75.

Data Sources:
Medicaid FFS data and Encounter data from MCOs on both hospitalization and use of appropriate ambulatory care.
Individual patient records at the OTPs identifying patients with ambulatory care sensitive conditions.

Frequency of Data Collection:

- ○ Monthly
- ● Quarterly
- ○ Annually
- ○ Continuously
- ○ 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.

Health Homes Administrative Component: Core Measure Detail

Measure
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.

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 Data Collection:

- ○ **Monthly**
- ◉ **Quarterly**
- ○ **Annually**
- ○ **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: 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:

- ○ **Monthly**
- ○ **Quarterly**
- ● **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized.
Information on readmission will be provided by Medicaid claims. MCOs will provide information to OTP Health Homes of all admissions and readmissions. Effective transition care planning and sharing of information using IT should impact readmission rate

Health Homes Administrative Component: Core Measure Detail

Measure
Screening for Clinical Depression and Follow-Up plan.

Measure Specification, including a description of the numerator and denominator.
Percentage of OTP Health Home patients screened for clinical depression using a standardized tool and follow-up documented.
Numerator: Total number of patients from the denominator who have follow-up documentation.
Denominator: All OTP Health Home patients screened for clinical depression using a standardized tool.

Data Sources:
Information regarding the measure will be maintained in the patient record and reported out quarterly.

Frequency of Data Collection:

- ○ **Monthly**
- ● **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized
Programs are all required to screen for depression annually and this screen is recorded in the EHR. Follow-up on positive screens will require documentation in the EHR and Direct

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.

Frequency of Data Collection:

- ○ **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

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.

Frequency of Data Collection:

- ○ **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

Measure
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:

Medicaid data will be used to identify those in the denominator who may not already be known to the OTPs as hypertensive.
Blood pressure measurements will be recorded in the EHR.

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized
BP measurements will be recorded in the EHR. OTP Health Homes may also access BP results from other practitioners by using CurrentCare.

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:

Health Homes Administrative Component: Goal Detail

Health Home Goal:
Improved Employment/wages earned.

Measure		
Number of OTP Health Home clients who begin employment or have increase in wagese.		

Health Homes Administrative Component: Measure Detail

Measure
Number of OTP Health Home clients who begin employment or have increase in wagese.

- ○ **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 OTP HH clients who begin employment or have increase in wages.
Denominator: 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 documented in EHR and change reported to client information database (RIBHOLD) of BHDDH.

Measure is related to:

- (●) **Clinical Outcomes**
- ( ) **Experience of Care**
- ( ) **Quality of Care**
- ( ) **Other**

Describe:

Health 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**
- (●) **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 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**
- ○ **Continuously**
- ○ **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 Homes Administrative Component: Goal Detail

Health Home Goal:
Reduction of illicit drug use.

Measure		

Measure		
Reduction in the number of urinalysis or saliva tests that demonstrate the presence of illicit subst...		

Health Homes Administrative Component: Measure Detail

Measure
Reduction in the number of urinalysis or saliva tests that demonstrate the presence of illicit substances.

- ○ **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 toxicology results that indicate the presence of illicit substances.
Denominator: The number of toxicology screens conducted on Health Home patients

Data Sources:
EHR.

Frequency of Data Collection:

- ○ **Monthly**
- ● **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized
Results of toxicology screens will be recorded in the EHR and reported out quarterly.

Measure is related to:

- ● **Clinical Outcomes**

- Experience of Care
- Quality of Care
- Other
  Describe:

Health Homes Administrative Component: Goal Detail

Health Home Goal:
Reduction of smoking rates

Measure		
Number of smokers referred to smoking cessation programs.		

Health Homes Administrative Component: Measure Detail

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:

- Monthly

- (●) Quarterly
- ( ) Annually
- ( ) Continuously
- ( ) Other

How Health IT will be utilized
Information will be recorded in EHR and reported to RIBHOLD>=.

Measure is related to:

- (●) Clinical Outcomes
- ( ) Experience of Care
- ( ) Quality of Care
- ( ) Other
  Describe: