Medicaid Innovation Accelerator Program

Physical and Mental Health Integration

Measures that Matter: State Measurement Strategies that Drive Integration

National Dissemination Webinar
October 30, 2017, 3:00pm-4:30pm ET
Logistics for the Webinar

• All lines will be muted during the presentation
• You may use the chat box on your screen to ask a question or leave a comment
  – Note: chat box will not be seen if you are in “full screen” mode
• To participate in a polling question, you will need to exit out of full screen mode
• Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience
Agenda

• Welcome and Introductions
• Medicaid Innovation Accelerator Program’s (IAP) Physical and Mental Health (PMH) Integration initiative
• Emerging Themes and Strategies
• Measures that Drive Integration
• Quality Measurement in Colorado
• Questions and Discussion
Facilitator

• Kitty Purington, Senior Program Director, National Academy for State Health Policy
Presenters

• **Karen LLanos**, Director, Medicaid Innovation Accelerator Program

• **Dr. Harold Pincus**, MD, Professor and Vice Chair, Department of Psychiatry, Columbia University, Director of Quality and Outcomes Research, New York-Presbyterian Hospital

• **Leilani Russell**, Data Coordinator/Analyst, Colorado State Innovation Model (SIM) Office
Medicaid Innovation Accelerator Program’s (IAP) Physical and Mental Health (PMH) Integration Initiative

Karen Llanos
Director, Medicaid Innovation Accelerator Program
Background

• IAP worked with nine states over twelve months to enhance or expand diverse integration approaches by providing technical support on issues such as:
  – Administrative alignment
  – Payment and delivery system reform
  – Quality measurement

• This webinar is the second in a series of four national dissemination webinars for the IAP Physical and Mental Health Integration program area
Teams Participating in the IAP PMH Program Area

- Idaho
- Illinois
- Hawaii
- Massachusetts
- New Hampshire
- New Jersey
- Nevada
- Puerto Rico
- Washington
Poll Question

What is your biggest challenge in designing and implementing strategies that measure integrated care?

• Identifying measures that support state’s goals
• Understanding what to measure regarding integration: care coordination, practice transformation, etc.
• Accessing the necessary data
• Incorporating integrated care measures into alternative payment methodologies
• Other (type in chat box)
Measuring PMH Integration: Themes and Strategies

Kitty Purington, JD
Senior Program Director, National Academy for State Health Policy
Themes and Strategies

• Define state goals and vision:
  – Engage stakeholders
  – Review models and definitions
  – Leverage best practices

• Create a measurement strategy
  – Align with existing state measurement activities
  – Inventory measures in use
  – Prioritize
  – Determine feasibility

• Use a combination of structure, process, and outcome measures to understand how PMH integration efforts are changing and improving care
Measures that Drive Integration

Dr. Harold Pincus
Professor and Vice Chair, Department of Psychiatry
Co-Director, Irving Institute for Clinical and Translational Research, Columbia University

Director of Quality and Outcomes Research Research, NewYork-Presbyterian Hospital
Behavioral Health/General Health Integration: Top Issues

1. Understanding the Interface of physical and behavioral health
2. “Measurement-Based Care” as a core clinical concept
3. Key Organizational Principles in a “continuum-based framework”
4. Creating a balanced portfolio across types of measures
5. Key strategies at policy levels
6. Challenges to measurement
7. “Shared Accountability” as a core concept
8. Creating a measurement agenda

– Commonwealth Fund Project
A Reality Check

• How do YOU choose a doctor for yourself, your children, your parents?
• How do YOU choose a mental health provider for your children or suggest one for a friend or a family member?
• How do YOU determine whether your children are receiving high quality medical care?
• High quality mental health care?
• What DATA do you examine to answer these questions? What data do you WISH you had?
Clinical Examples at the Interface

• 35 year old male with schizophrenia, diabetes, and tobacco dependence
  – Can expect up to 25 year shortened life span, increased medical costs

• 25 year old HIV+ female IV drug user with post traumatic stress syndrome
  – Frequent emergency department visits, non adherence to meds, increased medical costs

• 60 year old female with diabetes, congestive heart failure and depression
  – Frequent (re-) hospitalizations, poor self management and adherence, early candidate for long term care
Assessing Both Sides of the Interface

• Patients primarily in contact with the general medical sector with co-morbid behavioral health conditions, e.g., depression, substance use disorders (SUD)
  – Not identified, or treated as acute problems with little follow-up

• Patients with severe and persistent behavioral health conditions (e.g., schizophrenia, bipolar disorder) and treated in behavioral health specialty settings
  – Poor self-care, medications worsen general medical conditions
  – Limited provider capacity and incentives

• Medical and behavioral health providers operate in silos
Measurement-Based Care

- Systematically apply appropriate clinical measures
  - e.g. Hemoglobin A1c, PHQ-9, Vanderbilt Assessment Scales
  - Create a measurement toolkit
- Assure consistent, longitudinal assessment
  - “Ruthless” follow-up/care management
- Use action-oriented menu of evidence-based options
  - Treatment intensification/“stepped care”
- Establish practice-based infrastructure
  - Build information technology/registry capacity
- Enhance Connectivity among Systems
  - Mental health/primary care/SUD/social services/education
- Incentivize structures that produce outcomes
10 Key Organizational Practices

1. Formalized partnerships (co-location?)*
2. Population management /predictive modeling*
3. Effective communication*
4. Care management with relentless follow-up*
5. Clinical registries for tracking and coordination*
6. Decision support for measurement-based/stepped care*
7. Access to evidence-based psychosocial services
8. Self-management as part of a recovery framework*
9. Link with community services/resources*
10. Data-driven quality measurement and improvement*

* = Health Information Technology (HIT)-sensitive practice
### Key Principles: Continuum-Based Framework

#### Key components of integrated care

<table>
<thead>
<tr>
<th>Case finding, screening, and referral to care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening, initial assessment, and follow-up</td>
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<tr>
<td>Referral facilitation and tracking</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Ongoing care management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination, communication, and longitudinal assessment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information tracking and exchange among providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical registries for tracking and coordination</td>
</tr>
<tr>
<td>Sharing of treatment information</td>
</tr>
</tbody>
</table>

#### Integration Continuum

- **Preliminary**:
  - Patient/clinician identification of those with symptoms—not systematic
  - Referral to external BH specialist/psychiatrist
  - Limited follow-up of patients provided by office staff

- **Intermediate**:
  - Systematic screening of target populations (e.g., diabetes, CAD), with follow-up for assessment
  - Enhanced referral to outside BH specialist/psychiatrist through a formal agreement, with engagement and feedback strategies employed
  - Proactive follow-up to assure engagement or early response to care
  - Patients referred to outside BH specialist/psychiatrist with clear expectations for shared communication and follow-up

- **Advanced**:
  - Population stratification/analysis as part of outreach and screening, with follow-up for assessment and engagement
  - Referral and tracking through EHR or alternate data-sharing mechanism, with engagement and accountability mechanisms
  - Registry plus BH activation and relapse prevention, with assertive outreach to patients (including field-based visits) when necessary
  - Registry integrated into EHR, including severity measurement, attendance at visits, and care management interventions; selected medical measures tracked when appropriate
  - Routine sharing of information through electronic means (registry, shared EHR, and shared care plans)

(H. Chung, et al, UHF, 2016)
Creating a Balanced Portfolio Across Types of Measures

• Structure:
  – Are adequate personnel, training, facilities, Quality Improvement (QI) infrastructure, information technology resources, policies, etc. available for providing care?
  – Structures that support use and reporting of outcomes
  – The Joint Commission, Patient-Centered Medical Homes, Certified Community Behavioral Health Clinics (Protecting Access to Medicare Act, Section 223)
  – “Continuum Model”
Creating a Balanced Portfolio

• Process:
  – Are evidence-based processes of care delivered?
  – Behavioral health AND general medical care
  – Screening/follow-up, preventive care, acute care, maintenance care
  – Underuse, overuse, appropriateness, fidelity
  – Monitoring of depression symptoms and monitoring of hemoglobin A1c
Creating a Balanced Portfolio

• Outcome:
  – Does care improve clinical outcomes?
  – Clinical/symptoms, function/health-related quality of life
  – Behavioral health AND general medical outcomes
  – E.g. PHQ-9 for depression and blood pressure for hypertension
Creating a Balanced Portfolio

• Patient Experience:
  – What do users and other stakeholders think about the system’s structure, the care they have received, and their outcomes?
  – Access, communication, engagement, etc.
Creating a Balanced Portfolio

• Resource Use:
  – What/how much resources are expended for providing care?
  – Are resources being used in an efficient way?
  – Readmissions (both behavioral health and general medical), total costs of care
Key Strategies at Policy Levels

• Realign financial and non-financial incentives
  – At patient, provider, practice, plan, purchaser, policy levels
• Incentivize structures that produce outcomes
• Establish national quality integrated care measures
  – Structure, Process, Outcomes – Commonwealth Fund Study
• Alter contractual/organizational arrangements between/among Providers and Payers
• Develop health information technology infrastructure/policies supporting effective communication and measurement
• Build bridges to “non-health” services
  – Transportation, Housing, SUD, Dental, Criminal Justice, Social Security
• Establish “Shared Accountability”
Shared Accountability
Breaking Down Silos

- Relatively simple concept
- Applies to all participants caring for a patient;
- For example, the primary care physician is jointly responsible for assuring quality for both physical and behavioral health (BH) care
- BH provider is responsible for assuring quality for both BH and physical health care;
- The same applies to Med/Surg Health Plan and BH carve out
- Instantiated in training, practice, contracts, performance incentives, and ultimately, culture
Challenges to Measurement

- Adequacy/specificity of evidence base!
- Agreement/development/health information technology integration of clinical measures for “Measurement-Based Care”
- Codifying psychosocial interventions in administrative data (psychotherapy/“90806” v. Cognitive Behavioral Therapy v. Cognitive Behavioral Therapy with fidelity)
- Adequacy of data sources - documentation or reality
- Determining benchmarks/risk adjustment
Challenges to Measurement

- Linking structure-process-outcome measures (e.g. Action to Control Cardiovascular Risk in Diabetes outcomes)
- Who is stewarding/funding measure development?
- Behavioral health providers far behind in implementation of health information technology (exclusion from the Health Information Technology for Economic and Clinical Health Act)
- Heterogeneity of providers/training/certification
Creating a Measurement Agenda: Commonwealth Fund Project

- Reviews of potential
  - Process
  - Structure
  - Access
  - Outcome/patient perceptions
  - Costs/efficiency
- Expert/Delphi panel process
- Serious Mental Illness (SMI) as a “Disparities Category”
- Engaging the QMIC (“Quality Measurement Industrial Complex”)
Prioritizing quality measure concepts at the interface of behavioral and physical healthcare

HAROLD ALAN PINCUS\textsuperscript{1,2}, MINGJIE LI\textsuperscript{3}, DEBORAH M. SCHARF\textsuperscript{4}, BRIGITTA SPAETH-RUBLEE\textsuperscript{3}, MATTHEW L. GOLDMAN\textsuperscript{3,5}, PARASHAR P. RAMANUJ\textsuperscript{6}, and ERIN K. FERENCHICK\textsuperscript{7}
Domain Framework: Measurement Development for Integrated Care

• Overall Strategic Framework: Structure, Process and Outcomes
  – Domain 1: Stratification/disparities for preventive/chronic disease care in populations with serious mental illness

• Section A: General medical care for individuals with behavioral health conditions
  – Domain 2: General medical screening or diagnostic assessment and prevention
  – Domain 3: Outcomes and patient perception of care
  – Domain 4: Continuity and coordination of care
  – Domain 5: Access to general medical care
Domain Framework: Measurement Development for Integrated Care

• Section B: Behavioral health care in general medical settings
  – Domain 6: Mental health screening or assessment
  – Domain 7: Behavioral health evidence-based treatment
  – Domain 8: Behavioral health patient-centered care
  – Domain 9: Continuity and coordination of care
  – Domain 10: Access to behavioral health care

• Section C: Concepts applying to both general medical and behavioral health settings
  – Domain 11: Continuity and coordination of care
  – Domain 12: Social service access
  – Domain 13: Cost and efficiency
Serious Mental Illness as a “Disparities Category”

- High level of general medical co-morbidity
- Lack of access to primary/preventive care
- Poor quality of care
- Reduced life span
- Potentially easily implemented measurement strategy
- Report existing endorsed measures for this population segment, for example:
  - Receipt of preventive health interventions, screening, immunizations
  - Process and outcomes measures for common general medical comorbidities such as smoking, diabetes, hypertension, cardiovascular
- Include in national disparity reports
## Quality Measurement SMI Segmentation

### National Quality Forum (NQF) Endorsed Measures

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>NQF Endorsed Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1927</td>
<td>Cardiovascular screening for Schizophrenia or Bipolar patients on antipsych meds</td>
</tr>
<tr>
<td>1932</td>
<td>Diabetes screening for Schizophrenia or Bipolar patients on antipsych meds</td>
</tr>
<tr>
<td>1933</td>
<td>Cardiovascular monitoring for people with cardiovascular disease and schizophrenia</td>
</tr>
<tr>
<td>1934</td>
<td>Diabetes mellitus monitoring for people with diabetes mellitus and schizophrenia</td>
</tr>
<tr>
<td>2601</td>
<td>Body Mass Index screening and follow-up for SMI population</td>
</tr>
<tr>
<td>2602</td>
<td>Blood Pressure control for SMI population with hypertension</td>
</tr>
<tr>
<td>2603</td>
<td>Hemoglobin A1c testing for SMI population with diabetes mellitus</td>
</tr>
<tr>
<td>2604</td>
<td>Nephropathy screening for SMI population with diabetes mellitus</td>
</tr>
<tr>
<td>2606</td>
<td>Blood pressure control for SMI population with diabetes mellitus</td>
</tr>
<tr>
<td>2607</td>
<td>Hemoglobin A1c control for SMI population with diabetes mellitus</td>
</tr>
<tr>
<td>2608</td>
<td>Hemoglobin A1c control for SMI population with diabetes mellitus</td>
</tr>
<tr>
<td>2609</td>
<td>Eye exam for SMI population with diabetes mellitus</td>
</tr>
<tr>
<td>2600</td>
<td>Screen (and follow-up) for tobacco use in SMI or alcohol or other drug use population</td>
</tr>
<tr>
<td>2599</td>
<td>Screening (and counseling) for alcohol use in SMI population</td>
</tr>
</tbody>
</table>
Questions?
Measuring PMH Integration: Colorado

Leilani Russell
Data Coordinator/Analyst, Colorado State Innovation Model (SIM) Office

SIM celebrates one year of practice implementation and plans for future success.
Colorado State Innovation Model (SIM) Approach

80% of Coloradans have Access to Integrated Care

**Payment Reform**
- Development and implementation of value-based payment models that incentivize integration and improve quality of care.

**Practice Transformation**
- Support for practices as they accept new payment models and integrate behavioral and physical healthcare.

**Population Health**
- Engaging communities in prevention, education, and improving access to integrated care.

**HIT**
- Secure and efficient use of technology across health and non-health sectors in order to advance integration and improving health.
Measuring Success
CO SIM Overarching Goal:

Improve the health of Coloradans by providing access to integrated physical and behavioral healthcare services in coordinated systems with value-based payment structures for 80% of Colorado residents by 2019.
# Measuring Impact

### Clinical Quality Measures
- Depression Screening
- Diabetes: Hemoglobin A1c
- Hypertension
- Obesity: Adult & Adolescent
- Developmental Screening
- Maternal Depression
- Substance Use Disorder: Alcohol and Other Drug Dependence, Tobacco
- Asthma
- Fall Safety

### Population Health
- Anxiety disorders among adults
- Adults being treated for mental health
- Prenatal care counseling about maternal depression
- Adults who are currently depressed
- Suicide death rate
- Developmental screening for children
- Binge Drinking
- Current smoking among adults
- Heavy Alcohol Consumption
- Non-medical opioid use

### Cost & Utilization
- Total Cost of Care
- Out of Pocket Expenditures for Consumers
- Admissions
- Psychiatric Admissions
- Readmissions
- Psychiatric Readmissions
- Emergency Department (ED) Rate
- Psychiatric ED Rate
- Follow-up after Hospitalization for Mental Illness
- Actuarial calculations

### Model participation (process)
- Payment reform (practices/beneficiaries in APMs)
- Practice transformation (practices, providers, beneficiaries in cohort)
- Population health (LPHAs, RHCs, provider education)
- HIT (broadband, CQM reporting)

### Access to care
- Prevention Quality Chronic Composite
- Prevention Quality Acute Composite
- Pediatric Quality Overall Composite
- Prevention Quality Overall Composite

### Additional Evaluation Measures
- Access to integrated care (IPAT, milestones, CHAS)
- Client experience of care
- Payer/provider ROI
- Community System Coordination Index
- Collaboration, stakeholder engagement
- Workforce and policy efforts
- SPLIT assessment data (performance improvement plans, data quality, field notes)
- Key informant interviews (challenges, successes, lessons learned)
Measuring Prioritization

• Center for Medicare & Medicaid Innovation reporting requirements
  – Model participation (process measures)
  – Model performance (outcomes measures)
  – Payer participation (APM/payment measures)

• Seven SIM stakeholder workgroups
  – Practice Transformation
  – Healthcare Information Technology
  – Population Health
  – Evaluation
  – Consumer Engagement
  – Policy
  – Workforce Development
Measuring Prioritization

• Alignment with existing initiatives
  – Comprehensive Primary Care Plus, Quality Payment Program/Merit Based Incentive Payment System
  – Medicaid primary care alternative payment model

• Multi-payer Collaborative
  – Alignment with national Health Care Payment and Learning Action Network data collection efforts
  – Priorities for value-based payment models

• Leverage existing data and infrastructure where possible
  – Reduce reporting burden for practices and other partners
Data Sources & Systems
## Shared Practice Learning and Improvement Tool (SPLIT) Assessments

<table>
<thead>
<tr>
<th>Assessment Name</th>
<th>Purpose</th>
<th>Who Fills it Out</th>
<th>Responsible for Reporting</th>
<th>Timing</th>
<th>Expected Time to Complete (Minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Home Practice Monitor</td>
<td>Practice self-assessment of level of implementation of core aspects of advanced primary care.</td>
<td>Practice Team led by PF</td>
<td>Practice Champion or PF</td>
<td>Baseline &amp; Annually</td>
<td>60</td>
</tr>
<tr>
<td>IPAT (Integrated Practice Assessment Tool)</td>
<td>Assesses current behavioral health integration (BHI) methods along levels of coordination, co-location, and integration.</td>
<td>Practice Champion</td>
<td>Practice Champion or PF</td>
<td>Baseline &amp; Annually</td>
<td>10</td>
</tr>
<tr>
<td>Clinician and Staff Experience Survey</td>
<td>Individual provider and staff survey that assesses two subscales - Clinician and Staff Experience, and Burnout.</td>
<td>All members of Practice</td>
<td>Each practice member</td>
<td>Baseline &amp; Annually</td>
<td>15</td>
</tr>
<tr>
<td>SIM Milestone Activity Inventory</td>
<td>Assesses practice’s current implementation of SIM milestone activities, helps identify gaps and prioritizes practice’s next steps.</td>
<td>Practice Team led by PF</td>
<td>Practice Champion or PF</td>
<td>Baseline &amp; Every 6 Months</td>
<td>60</td>
</tr>
<tr>
<td>Data Quality Assessment</td>
<td>Assesses practice’s current state of data quality including accuracy of data element capture, validity of CQM reports and desired next steps for HIT.</td>
<td>Practice HIT Champion led by CHITA</td>
<td>CHITA</td>
<td>Baseline &amp; Annually</td>
<td>60</td>
</tr>
<tr>
<td>Practice Improvement Plan</td>
<td>SMART goals related to practice transformation as it relates to milestone activities (can be done at same time as SIM Milestone Activity Inventory).</td>
<td>Practice Team led by PF</td>
<td>PF</td>
<td>Baseline &amp; Every 6 Months</td>
<td>15</td>
</tr>
<tr>
<td>Clinical Quality Measures</td>
<td>Track patient and process outcomes achieved by practices.</td>
<td>Practice Champion</td>
<td>Practice Champion or CHITA</td>
<td>Every calendar quarter</td>
<td>Variable</td>
</tr>
</tbody>
</table>
## Clinical Quality Measures: Adults

<table>
<thead>
<tr>
<th>Measure Condition</th>
<th>SIM Metric Title</th>
<th>Citation</th>
<th>CPC+</th>
<th>QPP</th>
<th>TCPI</th>
<th>HCPF APM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary CQMs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Depression</td>
<td>Preventive Care and Screening for Clinical Depression and Follow-up Plan</td>
<td>NQF 0418 CMS 2v6</td>
<td>Depression Remission at 12 Months</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Diabetes: Hemoglobin A1c</td>
<td>Diabetes: Hemoglobin A1c Poor Control</td>
<td>NQF 0059 CMS 122v5</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Controlling High Blood Pressure</td>
<td>NQF 0018 CMS 165v5</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Obesity: Adult</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan</td>
<td>NQF 0421 CMS 69v5</td>
<td>No obesity measure (not required for SIM if in CPC+)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Substance Use Disorder: Alcohol and Other Drug Dependence</td>
<td>Initiation &amp; Engagement of Alcohol &amp; Other Drug Dependence Treatment</td>
<td>NQF 0004 CMS 137v5</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Substance Use Disorder: Tobacco</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>NQF 0028 CMS 138v5</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td><strong>Secondary CQM</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Asthma</td>
<td>Medication Management for People with Asthma (replaced to align with QPP)</td>
<td>NQF 1799 CMS n/a</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Fall Safety</td>
<td>Falls: Screening for Future Fall Risk</td>
<td>NQF 0101 CMS 139v5</td>
<td>✔️</td>
<td>✔️</td>
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<td>✔️</td>
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<tr>
<td>Maternal Depression</td>
<td>Maternal Depression Screening</td>
<td>NQF 1401 CMS 82v4</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Substance Use Disorder: Alcohol</td>
<td>Preventive Care and Screening: Unhealthy Alcohol Use: Screening &amp; Brief Counseling</td>
<td>NQF 2152 CMS n/a</td>
<td>Alcohol &amp; Other Drug Dependence measure (above)</td>
<td>✔️</td>
<td>✔️</td>
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</tr>
<tr>
<td><strong>Measures reported via APCD claims data automatically</strong></td>
<td></td>
<td></td>
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<tr>
<td>Breast Cancer</td>
<td>Breast Cancer Screening</td>
<td>NQF 2372 CMS 125v5</td>
<td>(clinical)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Colorectal Cancer</td>
<td>Colorectal Cancer Screening</td>
<td>NQF 0034 CMS 130v5</td>
<td>(clinical)</td>
<td>✔️</td>
<td>✔️</td>
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</table>
# Clinical Quality Measures: Pediatrics

<table>
<thead>
<tr>
<th>Measure Condition</th>
<th>Metric Title</th>
<th>Citation</th>
<th>QPP</th>
<th>TCPI</th>
<th>APM</th>
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</tr>
<tr>
<td>Depression</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan</td>
<td>NQF 0418 CMS 2v6</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Development Screening</td>
<td>Developmental Screening in the First Three Years of Life (<em>developed by Mathematica</em>)</td>
<td>NQF 1448 CMS – under development</td>
<td>No developmental screening measure</td>
<td>✓</td>
<td>blank</td>
</tr>
<tr>
<td>Maternal Depression</td>
<td>Maternal Depression Screening</td>
<td>NQF 1401 CMS 82v4</td>
<td>✓</td>
<td>✓</td>
<td>blank</td>
</tr>
<tr>
<td>Obesity: Adolescent</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>NQF 0024 CMS 155v5</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Secondary CQM</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Asthma</td>
<td>Medication Management for People with Asthma (<em>replaced to align with QPP</em>)</td>
<td>NQF 1799 CMS n/a</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

[CQM Reporting Requirements Summary](#)
[Updated CQM Guidebook](#)
Measurement: Access to Care

- All Payer Claims Database (APCD) data using standardized Agency for Healthcare Research and Quality Access to Care metrics
- Shared Practice Learning and Improvement Tool data: Integrated Practice Assessment Tool (IPAT), Medical Home Practice Monitor, Milestone Activity Inventory
- Number of patients served by providers scoring a specific integration threshold level on the IPAT, Milestone Inventory, and access estimates from APCD data analysis
- Colorado Health Access Survey
Challenges

• No one data source or measure for estimating access to integrated care

• Piecing together a puzzle from various data points:
  – Access to care (not necessarily integrated care)
  – Behavioral health outcomes
  – Primary care outcomes
  – Clinical data
  – Claims data
  – Statewide data
  – SIM cohort practice specific data
  – Assessment data on milestones (interim process achievements)
Return on Investment

- SIM is expected to save or avoid $126.6 million in healthcare costs and have a 1.95 return-on-investment (ROI) by the end of the program.
- Cost, cost savings/avoidance, return on investment projections (proposal, baseline, annually)
- SIM cost and utilization measures (quarterly)
  - Aggregate cohort
  - Individual reports for each participating practice
- Actuarial cost and utilization measures (semi-annually)
  - Aggregate cohort
  - Individual reports for each participating practice
- Cost savings/avoidance and return on investment analyses (annually)
Questions?
Key Takeaways

• A robust quality measurement strategy for PMH integration can include a diversity of measure types, such as:
  – Structure, process, outcome, cost, access

• There are emerging frameworks for structuring and measuring integrated care that states can use in developing their measurement strategy

• States can build infrastructure for data collection using diverse sources, including:
  – Existing data, EHRs, practice assessments and reporting, etc.
Upcoming IAP PMH Integration Webinars

Coming Winter 2018!

• Building Provider Capacity National Learning Webinar
• Administrative Alignment National Learning Webinar
Thank you for joining!

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