

Texas DSRIP

# Measure Bundle Protocol

Demonstration Years 7-10

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## Introduction

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The Delivery System Reform Incentive Payment (DSRIP) program is designed to provide incentive payments to Texas hospitals, physician practices, Community Mental Health Centers (CMHCs), and Local Health Departments (LHDs) for investments in delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients and families they serve. This Measure Bundle Protocol for the DSRIP program is effective for Demonstration Years (DYs) 7-10 beginning October 1, 2017 [contingent on negotiations with the Centers for Medicare and Medicaid Services (CMS)].

The DY7-10 Measure Bundle Protocol reflects the evolution of the DSRIP program from project-level reporting to provider-level outcome reporting to measure the continued transformation of the Texas healthcare system. In DY7-10, DSRIP Performing Providers will report on required reporting categories at their provider system level.

### Category A

Required reporting for Category A in DY7-10 includes progress on Core Activities, Alternative Payment Model (APM) arrangements, Costs and Savings, and Collaborative Activities. The Category A requirements were developed to serve as an opportunity for Performing Providers to move further towards sustainability of their transformed systems, including development of APMs to continue services for Medicaid and Low-Income or Uninsured (MLIU) individuals after DSRIP ends. The listing of Core Activities in the Measure Bundle Protocol reflects those project areas that have been determined to be the most transformational and will support continuation of the work begun by Performing Providers during the first years of DSRIP. These Core Activities will be continued or implemented by a Performing Provider to support achievement of its Category C measure goals.

### Category B

As DSRIP shifts from project-level reporting to system-level reporting, the Texas Health and Human Services Commission (HHSC) wants to ensure that Performing Providers maintain a focus on serving the DSRIP target population: MLIU individuals. To that end, Category B will require each Performing Provider to report the total number of individuals and the number of MLIU individuals served by its system during each DY. **In addition, Performing Providers will also report a breakout of MLIU individuals served by its system during DY9-10.** The Measure Bundle Protocol sets out parameters for a Performing Provider to define its “system” to reflect the Performing Provider’s current care landscape that is striving to advance the Triple Aim: improving the patient experience of care; improving the health of populations; and reducing the per capita cost of health care.

### Category C

For Category C, targeted Measure Bundles have been developed for hospitals and physician practices and lists of measures are available for CMHCs and LHDs. Measure Bundles consist of measures that share a unified theme, apply to a similar population, and are impacted by similar activities. Bundling measures for DY7-10 allows for ease in measure selection and approval, increases standardization of measures across the state for hospitals and physician practices with similar activities, facilitates the use of regional networks to identify best practices and share innovative ideas, and continues to build on the foundation set in the initial waiver period while providing additional opportunities for transforming the healthcare system and bending the cost curve.

The menu of available Measure Bundles for hospitals and physician practices and measures for CMHCs and LHDs were built with measures from common DY2-6 Category 3 pay-for-performance (P4P) measures; new P4P measures added from authoritative sources, with a preference for measures endorsed by the National Quality Forum; and innovative measures as needed, which will be pay-for-reporting (P4R) for DY7-8 and function as a measure testing process.

Additionally, in DY9-10, Category C includes required reporting on lists of Related Strategies associated with Measure Bundle selection for hospitals and physicians or measure selection for CMHCs and LHDs. The list of Related Strategies represent strategies Performing Providers may have implemented to achieve improvements in Category C measures for the MLIU patient populations.

Related Strategies (Category C) and Core Activities (Category A) both involve better understanding what kinds of strategies Performing Providers are implementing to meet Category C achievement goals. In fact, the list of Related Strategies was informed by Core Activity descriptions. However, the list of Related Strategies includes strategies a Performing Provider may have implemented, even apart from DSRIP, which may not be included in Core Activities reporting, and unlike Core Activities reporting, Related Strategies reporting does not include a qualitative reporting component.

Moreover, even if multiple Category C measures are selected, Performing Providers are only required to report on at least one Core Activity, leaving a gap in understanding what strategies were implemented across all selected Category C measures for a given Performing Provider or across Performing Providers selecting shared measures. HHSC aims to examine the relationship between Related Strategies and Performing Providers demonstrating higher Category C performance achievement.

### **Measure Development Process**

HHSC formed a DSRIP Clinical Champions stakeholder group in 2015 to provide clinical expertise for development of DSRIP processes. The Clinical Champions consist of clinical, health quality, and operational professionals in Texas. In 2015, the Clinical Champions reviewed Performing Provider-submitted Transformational Impact Summaries—brief, structured project descriptions and evaluations—and identified DSRIP projects' high impact practices. HHSC used these high impact practices to inform the initial selection of the Category C Measure Bundle topics. The Clinical Champions also helped HHSC refine the DSRIP project menu to include only the most transformational project areas.

In 2017, Texas HHSC began a new process with the Clinical Champions to seek their input on the meaningfulness, improvability, and clinical appropriateness of proposed measures to include in the Hospital and Physician Practice Measure Bundles, as well as any identified gaps in measurement. HHSC implemented a multi-round process with the Clinical Champions to choose the draft measures for each of the Category C Measure Bundles. The process entailed three rounds of anonymous voting by Measure Bundle topic subgroups—termed Bundle Advisory Teams—via online surveys. Each round was followed by an advisory team conference call to discuss the survey results.

HHSC assigned Clinical Champions to 11 Bundle Advisory Teams based on their areas of clinical expertise and interest. Additionally, some Clinical Champions with operational expertise were assigned to a Technical Advisory Team, which provided feedback to the Bundle Advisory Teams and HHSC about the feasibility of implementing suggested quality measures in a variety of settings.

The Bundle Advisory Teams rated each potential measure using a 5-point Likert scale, based on the measure's importance according to the member's clinical judgement. During the second and third survey rounds, participants reviewed the anonymous results of previous rounds, including both numerical ratings for each measure and qualitative comments submitted on the surveys and during conference calls. Each round resulted in the exclusion of measures with limited support. Additionally, Bundle Advisory Team members had the opportunity to suggest new and innovative measures, and those were included in the last round of voting.

CMHCs and the Texas Council of Community Centers provided recommendations for measures related to behavioral health, and LHDs were engaged in the development of measures for those Performing Providers.

Points were assigned to measures as outlined in the Measure Bundle Protocol.

HHSC will submit an updated Measure Bundle Protocol for DY7-10 to CMS (including a review of innovative measures tested in DY7 and DY8 for possible inclusion as P4P in the DY9-10 menu) no later than July 31, 2019.

### Category D

For DY7-10, the Category D Statewide Reporting Measure Bundles have replaced the former Category 4 reporting on population-focused measures. While Category 4 was only for hospitals, all Performing Provider types can report on Category D in DY7-10. The Statewide Reporting Measure Bundles align with the MLIU population, are identified as high priority given the health care needs and issues of the patient population served, and are viewed as valid health care indicators to inform and identify areas for improvement in population health within the health care system. These bundles refine the hospital measures from the former Category 4 and add measures for physician practices, CMHCs, and LHDs. The emphasis of Category D is on the reporting of population health measures to gain information on and understanding of the health status of key populations and to build the capacity for reporting on a comprehensive set of population health metrics.

## Category A

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Each Performing Provider is required to report on the following for Category A:

- Core Activities;
- APMs;
- Costs and Savings; and
- Collaborative Activities.

Category A is designed to support DSRIP sustainability through Performing Providers' reporting on progress on the four key areas outlined above. Performing Providers design the structure of their next-step initiatives based on the foundation of quality improvements from DY2-6 projects and the experience from implementing Core Activities in DY7-8. This approach offers Performing Providers the flexibility to choose the elements for these four key areas with the goal to continue improvement in health care access and coordination. Category A reporting is required for all Performing Providers; its structure allows the flexibility for continuous quality improvement for the P4P in quality measurement in Category C.

### Core Activities

With the transition from project-level to Performing Provider-level reporting, Performing Providers no longer report on projects; instead, they report on achievement of the goals for the Category C measures they select. To understand what enables Performing Providers to achieve these goals, Performing Providers report the Core Activities they implement to meet their Category C goals.

As defined in the Program Funding and Mechanics Protocol (PFM), a Core Activity is an activity implemented by a Performing Provider to achieve its Category C measure goals. A Core Activity can be an activity implemented by a Performing Provider as part of a DY2-6 DSRIP project that the Performing Provider chooses to continue in DY7-10, or it can be a new activity that the Performing Provider is implementing in DY7-10.

Core Activities included in this Measure Bundle Protocol are connected to the Transformational Extension Menu (TEM) that HHSC and the Clinical Champions developed in 2015-2016. In the TEM, HHSC and the Clinical Champions identified the most transformative initiatives from the initial waiver period, many of which are based on effective models that can be implemented by Performing Providers in the transition from project-level reporting to Performing Provider-level, quality-based reporting. In addition to activities learned through Texas DSRIP, Performing Providers can also propose activities from other national quality initiatives such as the MACRA Merit-based Incentive Payment System.

There are certain activities that Performing Providers can incorporate in any Core Activity as a sub-activity if it contributes to improving quality of care, such as technology improvements (e.g., Electronic Medical Records or Health Information Exchange connectivity) and continuous quality improvement (CQI), but the technological advances activities or the CQI should not be the only activity that Performing Providers choose to report on.

### Core Activities Selection and Reporting

A Performing Provider needs to select and report on at least one Core Activity that supports the achievement of its Category C measure goals for the selected Measure Bundle(s) or measures. There is no maximum number of Core Activities that the Performing Provider may select.

Performing Providers can select Core Activities from the list created by HHSC, and they can include their own Core Activity by using the *Other* option and providing a description. In addition to reporting on Core Activities supporting Category C measures, a Performing Provider may include a Core Activity tied to the mission of the Performing Provider's organization, even if the activity does not have a strong connection to the selected measures. Selection of a Core Activity not tied to the Measure Bundles or measures cannot be the only selection but can be chosen as an additional Core Activity that the Performing Provider is reporting.

Requirement of at least one Core Activity was designed to increase the flexibility for Performing Providers and to lessen the reporting commitment by the Performing Providers. It is reasonable to assume that some Performing Providers will have just one main activity and requiring them to report on many initiatives would not benefit the Performing Provider or state and federal entities. However, Performing Providers with many initiatives can benefit from sharing what activities they are implementing. If some Performing Providers are successful at achieving the goals for the measures they are working on, understanding the main drivers for this success is beneficial to the state and federal government as well as other Performing Providers who are working on similar quality initiatives. In addition, sharing information on Core Activities can lead to further collaboration among Performing Providers within and across the regions.

In the RHP Plan Update for DY7-8, Performing Providers indicated which DY2-6 projects had Core Activities that continued in DY7-8 and which projects have been completed. The template for the RHP Plan Update for DY7-8 allowed Performing Providers to select Core Activities that continued from DY2-6 projects and new Core Activities that Performing Providers selected for implementation. **In DY9-10, Performing Providers can continue working on the Core Activities from DY7-8 if they contribute to the Performing Providers' goals, or new Core Activities can be selected if Performing Providers need to adjust their initiatives based on their experience.**

For example, a Performing Provider that expanded its primary care clinic in DSRIP DY2-6 decided to continue that expansion in DY7-8 (e.g., space expansion, increase in hours that clinic is in operation, or additional staffing) and selected *Provision of coordinated services for patients under Patient Centered Medical Home (PCMH) model* as a Core Activity that assisted the Performing Provider in achieving the goals for Improved Chronic Disease Management: Diabetes Care Measure Bundle in DY7-8. **This Performing Provider can continue with the same Core Activity in DY9-10 but adjust it if needed. The Performing Provider may also decide to add a new Core Activity to reflect additional work that currently takes place or will be done in DY9-10.**

As another example, a Performing Provider who increased access to different types of specialty care during DY2-6 could then decide in DY7-8 to maintain the same level of specialty care only in some areas but provide telemedicine services to other areas of specialty care. This Performing Provider may have selected *Use telehealth to deliver specialty services* as a Core Activity for DY7-8. **In DY9-10, this Performing Provider may decide to continue with the existing Core Activity and adjust it as needed and select a new Core Activity, *Implementation of remote patient monitoring programs for diagnosis and/or management of care*, that will reflect additional plans that the Performing Provider is selecting to further promote its goals tied to quality measures selected under Category C.**

In general, Performing Providers can select Core Activities from various groupings as long as it reflects what the Performing Provider is carrying out. Performing Providers working on quality initiatives in the



area of behavioral health are not limited to areas directly related to behavioral health Core Activities and can select items in other areas.

During the second reporting period of each DY, Performing Providers report on all Core Activities selected, both continuing and those that are newly added. If adjustments are needed, Performing Providers can revise their strategies used in achieving Category C goals and update their selection of Core Activities at any time without HHSC approval. During the second reporting period of each DY, Performing Providers provide a description of any newly selected Core Activity and the reason for selecting it along with reporting progress on previously selected Core Activities. If a Performing Provider has more than one Core Activity in the initial selection, and the Performing Provider needs to delete one of these activities due to the changes, then the Performing Provider is not required to choose a replacement activity to report on. Performing Providers may also add new Core Activities and discontinue those that are not showing results. It is recommended that Performing Providers use continuous quality improvement to monitor their progress. Providers report on Core Activities using the DSRIP online reporting system.

## Menu of Core Activities

### **Access to Primary Care Services**

- Increase in utilization of mobile clinics
- Increase in capacity and access to services by utilizing Community Health Workers (CHWs)/promoters, health coaches, peer specialists and other alternative clinical staff working in primary care
- Expanded Practice Access (e.g., increased hours, telemedicine, etc.)
- Establishment of care coordination and active referral management that integrates information from referrals into the plan of care
- Provision of screening and follow up services
- Provision of vaccinations to target population
- Integrated physical and behavioral health care services
- Use telemedicine/telehealth to deliver specialty services
- Provision of services to individuals that address social determinants of health
- Other

### **Access to Specialty Care Services**

- Improvement in access to specialty care services with the concentration on underserved areas, so Performing Providers can continue to increase access to specialty care in the areas with limited access to services
- Use telemedicine/telehealth to deliver specialty services
- Implementation of remote patient monitoring programs for diagnosis and/or management of care
- Provision of services to individuals that address social determinants of health
- Other

### **Expansion or Enhancement of Oral Health Services**

- Utilization of targeted dental intervention for vulnerable and underserved population in alternate setting (e.g., mobile clinics, teledentistry, Federally Qualified Health Centers (FQHCs), etc.)
- Expanded use of existing dental clinics for underserved population
- Expansion of school-based sealant and/or fluoride varnish initiatives to otherwise unserved school-aged children by enhancing dental workforce capacity through partnerships with dental and dental hygiene schools, LHDs, FQHCs, and/or local dental providers
- Other

### **Maternal and Infant Health Care**

- Implementation of evidence-based strategies to reduce low birth weight and preterm birth (Evidence-based strategies include Nurse Family Partnership, Centering Pregnancy, IMPLICIT: Interventions to Minimize Preterm and Low birth weight Infants through Continuous Improvement Techniques among others)
- Develop and implement standard protocols for the leading causes of preventable death and complications for mothers and infants (Early Elective Delivery, Hemorrhage, Preeclampsia, and Supporting Vaginal Birth and Reducing Primary Cesareans)
- **Provision of coordinated prenatal and postpartum care**
- Use telemedicine/telehealth to deliver specialty services
- Provision of services to individuals that address social determinants of health
- Other

### **Patient Centered Medical Home**

- Provision of coordinated services for patients under Patient Centered Medical Home (PCMH) model, which incorporates empanelment of patients to physicians, and management of chronic conditions and preventive care
- Integration of care management and coordination for high-risk patients based on the best practices (Agency for Healthcare Research and Quality (AHRQ) PCMH framework; Risk Stratified Care Management — High Risk, Rising Risk, and Low Risk designations; ACP PCMH model Safety Net Medical Home Initiative — Change Concepts for Practice Transformation, etc.)
- Enhancement in data exchange between hospitals and affiliated medical home sites
- Utilization of care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; etc.
- Provision of services to individuals that address social determinants of health
- Other

## **Expansion of Patient Care Navigation and Transition Services**

- Provision of navigation services to targeted patients (e.g., patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, the uninsured, those with low health literacy, frequent visitors to the Emergency Department (ED), and others)
- Enhancement in coordination between primary care, urgent care, and EDs to increase communication and improve care transitions for patients
- Identification of frequent ED users and use of care navigators as part of a preventable ED reduction program, which includes a connection of ED patients to primary and preventive care
- Implementation of a care transition and/or a discharge planning program and post discharge support program. This could include a development of a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.
- Utilization of a comprehensive, multidisciplinary intervention to address the needs of high-risk patients
- Expansion of access to medical advice and direction to the appropriate level of care to reduce ED use for non-emergent conditions
- Provision of services to individuals that address social determinants of health
- Other

## **Prevention and Wellness**

- Self-management programs and wellness programs using evidence-based designs (e.g., Stanford Small-Group Self-Management Programs for people with arthritis, diabetes, HIV, cancer, chronic pain, and other chronic diseases; and SAMHSA's Whole Health Action Management among others)
- Implementation of strategies to reduce tobacco use (Example of evidence-based models: 5R's (Relevance, Risks, Rewards, Roadblocks, Repetition) for patients not ready to quit; Ottawa Model; Freedom From Smoking Curriculum- American Lung Association among others)
- Implementation of evidence-based strategies to reduce and prevent obesity in children and adolescents (e.g., Technology Supported Multi Component Coaching or Counseling Interventions to Reduce Weight and Maintain Weight Loss; Coordinated Approach to Child Health - CATCH; and SPARK among others)
- Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions
- Utilization of whole health peer support, which could include conducting health risk assessments, setting SMART goals, providing educational and supportive services to targeted individuals with specific disorders (e.g., hypertension, diabetes, and health risks such as obesity, tobacco use, and physical inactivity)
- Use of CHWs to improve prevention efforts
- Implementation of evidence-based strategies to reduce sexually transmitted diseases
- Implementation of interventions focusing on social determinants of health that can lead to improvement in well-being of an individual
- Other

## **Chronic Care Management**

- Utilization of evidence-based care management models for patients identified as having high-risk health care needs and/or individuals with complex needs (e.g., Primary care–integrated complex care management (CCM), Complex Patient Care Model Redesign- enhanced multidisciplinary care teams, The Transitional Care Model, etc.)
- Utilization of care management and/or chronic care management services, including education in chronic disease self-management
- Management of targeted patient populations (e.g., chronic disease patient populations that are at high risk for developing complications, co-morbidities, and/or utilizing acute and emergency care services)
- Implementation of a medication management program that serves patients across the continuum of care
- Utilization of pharmacist-led chronic disease medication management services in collaboration with primary care and other health care providers
- Utilization of enhanced patient portal that provides up-to-date information related to relevant chronic disease health or blood pressure control and allows patients to enter health information and/or enables bidirectional communication about medication changes and adherence
- Use telemedicine/telehealth to deliver specialty services
- Education and alternatives designed to curb prescriptions of narcotic drugs to patients
- Provision of services to individuals that address social determinants of health
- Other

## **Availability of Appropriate Levels of Behavioral Health Care Services**

- Utilization of mobile clinics that can provide access to behavioral health care in very remote, inaccessible, or impoverished areas of Texas
- Utilization of telehealth/telemedicine in delivering behavioral services
- Increasing access to services by utilizing staff with the following qualifications: Wellness and Health Navigation: Bachelors level professional with experience in mental health and/or wellness initiatives or a peer specialist who has successfully completed the DSHS certification program for peer specialists
- Provision of care aligned with Certified Community Behavioral Health Clinic (CCBHC) model
- Utilization of Care Management function that integrates primary and behavioral health needs of individuals
- Provision of services to individuals that address social determinants of health and/or family support services.
- Other

## **Substance Use Disorder**

- Provision of Medication Assisted Treatment
- Education of primary care practitioners on preventive treatment option
- Utilization of telehealth/telemedicine in delivering behavioral health services
- Utilization of Prescription Drug Monitoring program (can include targeted communications campaign)
- Supported employment services for individuals in recovery

- Office-based additional treatment for uninsured individuals
- Peer recovery support
- Provision of services to individuals that address social determinants of health including housing navigation services
- Utilization of telehealth/telemedicine in delivering behavioral services

### **Behavioral Health Crisis Stabilization Services**

- Provision of crisis stabilization services based on the best practices (e.g., Critical Time Intervention, Critical Intervention Team, START model)
- Implementation of community-based crisis stabilization alternatives that meet the behavioral health needs of the patients
- Implement models supporting recovery of individuals with behavioral health needs
- Provision of services to individuals that address social determinants of health
- Other

### **Palliative Care**

- Provision of coordinated palliative care to address patients with end-of-life decisions and care needs
- Provision of palliative care services in outpatient setting
- Transitioning of palliative care patients from acute hospital care into home care, hospice, or a skilled nursing facility and management of patients' needs
- Provision of services to individuals that address social determinants of health
- Utilization of services assisting individuals with pain management
- Other

### **Hospital Safety and Quality**

- Development and implementation of standard protocols and/or evidence-based practices to address leading causes of hospital infections and injuries (e.g., CLABSI, CAUTI, SSI, Sepsis, and Falls)
- Implementation of evidence-based practices to improve quality of care (e.g., Quality Departments, monitoring and evaluation, etc.)
- Other

### **Other**

If a Core Activity is not on this list, a Performing Provider can include a Core Activity and provide a description. As stated previously, Performing Providers may not add activities such as continuous quality improvement or a technology improvement as a stand-alone Core Activity. HHSC reserves the right to determine the appropriateness of "other" Core Activities chosen by a Performing Provider.

### **Alternative Payment Models**

Based on numerous studies and research articles related to categories of healthcare spending and opportunities for increased efficiencies, there is a widespread trend towards linking health care payments to measures of quality and/or efficiency (aka "value"). Texas Medicaid and Children's Health Insurance Program programs are following this trend and have developed a Value-Based Purchasing Roadmap. Through its managed care contracting model, HHSC is making progress on a multiyear

transformation of provider reimbursement models that have been historically volume based (i.e., fee-for-service) toward models that are structured to reward patient access, care coordination and/or integration, and improved healthcare outcomes and efficiency.

Because the initial DSRIP program has been a very effective incubator for testing how alternative, value-based payment models can support patient centered care and clinical innovation, HHSC continues to work with Managed Care Organizations (MCOs) and DSRIP Performing Providers on ways to incorporate promising clinical models as Value-Based Purchasing (VBP) arrangements in the Medicaid MCO provision of care. Performing Providers will report on progress in building the capacity to participate in a VBP model with MCOs through better utilization of Health Information Technologies and better measurement processes.

### Costs and Savings Analysis

Based on the requirement included in the PFM for DY7-8, Performing Providers with a total valuation of \$1 million or more per DY are required to submit information related to the costs of at least one Core Activity of their choice and the forecasted or generated savings of that Core Activity. In DY9-10, Performing Providers will continue with the Costs and Savings review and must analyze: 1) a different Core Activity than was used for the Costs and Savings analysis in DY7-8; or 2) a different aspect of the same Core Activity for the Costs and Savings analysis than was used for the Costs and Savings analysis in DY7-8. Along with other required information, Performing Providers will submit a short narrative including Core Activity chosen, methodologies, and assumptions made for the analysis. Information related to Costs and Savings analysis will be submitted in a template approved by HHSC or a comparable template. Performing Providers may use the *Return on Investment Forecasting Calculator for Quality Initiatives* by the Center for Health Care Strategies, Inc. or a comparable template that includes information such as the duration of the initiative, target population, costs, utilization changes, and/or savings.

Performing Providers will include costs and savings specific to their organization and other contracted providers if that information is available. If the Core Activity selected for the analysis is broad in scope, Performing Providers can concentrate their analysis on a component of this Core Activity and provide an explanation for such selection during reporting. In DY7-8, Performing Providers submitted a progress update on the analysis during the second reporting period of DY7, and the final report of costs and savings will be submitted during the second reporting period of DY8. For DY9-10, Performing Providers will submit a progress update for the new analysis to HHSC during the second reporting period of DY9, and a final report of costs and savings will be submitted during the second reporting period of DY10. This information is key to assist Performing Providers to work with Medicaid MCOs and other health care payers for sustainability.

## Collaborative Activities

To continue to foster growth of collaboration within and among regions, all Performing Providers are required to attend at least one learning collaborative, stakeholder forum, or other stakeholder meeting each DY and report on participation during the second reporting period of each DY. A Performing Provider's participation in the learning collaborative, stakeholder forum, or other stakeholder meeting in DY7-10 can be done in person, via conference call, or via other telecommunications applications, and individuals invited to the learning collaborative, stakeholder forum, or other stakeholder meeting should include individuals from other entities in this region or other regions. Lessons learned from these meetings should be relevant at the Performing Provider level or applicable to some of the Performing Provider's Core Activities. Performing Providers will report on Collaborative Activities via the DSRIP online reporting system.

## Category B

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### System Definition

DSRIP is shifting from project-based reporting to system-level reporting and a focus on system-wide changes and quality outcomes for DY7-10. As such, each Performing Provider will be required to define its system in the RHP Plan Update for its RHP.

In the broadest sense, the system is defined by the location(s) where patients are served by the Performing Provider and the types of services patients are receiving. The system definition will provide a broad structure in which Performing Providers work to improve care and transform the way healthcare is delivered in the state of Texas. While DSRIP will maintain its overall emphasis of improving care and access for the MLIU population in Texas, DSRIP reporting will no longer be limited by project-specific interventions or project-defined target populations.

A Performing Provider's system definition should capture all aspects of the Performing Provider's patient services. The Patient Population by Provider (PPP) (reported in Category B) is intended to reflect the universe of patients served by the Performing Provider's system; and, therefore, the Performing Provider's system definition should incorporate all aspects of its organization that serve patients. The system definition may not exclude certain populations (with the exception of incarcerated populations served by hospital systems under contract with a government entity). The system definition should include all of a Performing Provider's service areas that will be measured in its Category C measures but may not be limited to those populations or locations if other services are provided by the Performing Provider. In DY9-10, Performing Providers report a breakout of Medicaid and low-income or uninsured (LIU) served by their systems. In DY7-8 MLIU was reported as one number.

Systems may be limited by geographic location. For example, a Performing Provider that operates one hospital in one RHP and another hospital in a separate RHP will have two systems if the separate hospitals were each DSRIP Performing Providers in DY2-6, though they are technically owned by the same company. System is not exclusively defined by ownership. Alternatively, the system may cross geographic locations. For example, a Performing Provider that operates a variety of clinics in one RHP and multiple clinics in another RHP may be one system. DSRIP Performing Providers with the same ownership may not combine two currently separate DSRIP Performing Providers into one system for DY7-10, unless this has been previously approved. A Performing Provider's delineation of system should consider data systems and the extent to which the various components are coordinating to improve health of the patients served.

There are required and optional components of a Performing Provider's system definition for each Performing-Provider type. The required components are elements of a system that, through discussion with stakeholders and the technical advisory team, should be included as a Performing Provider's "base unit"; it has been determined that these components are essential functions and/or departments of the Performing Provider type. Therefore, the required components must be included in a Performing Provider's system definition if the Performing Provider's organization has that business component. A Performing Provider may then include optional components in its system definition and patient count, including contracted partners for certain services. Unless otherwise granted permission from HHSC, a Performing Provider should not count within its system definition or patient population another DSRIP



Performing Provider’s **required** components. There may be overlap in system definition for contracted partners; for example, System A that contracts with FQHC A and System B that contracts with FQHC A may both count the FQHC A as part of their system definition.

As indicated in the PFM, Performing Providers may add contracted entities to their system definition. Certain options will be specified by HHSC, but Performing Providers will also have the option to add an “other” category. Performing Providers will be required to explain any “other” optional component of the system definition. Inclusion of the population served in the optional components may be disallowed by HHSC. Performing Providers should include optional components in their system definition only if the Performing Provider will have access to all data necessary for reporting. Performing Providers should be mindful of data arrangements when contracting with entities that they intend to include in their system definition.

### Required and Optional System Components

The following table displays the required and optional components of the system definition by Performing Provider type.

	<b>Required*</b>	<b>Optional</b>
<b>Hospitals</b>	Inpatient Services	Contracted Specialty Clinics
	Emergency Department	Contracted Primary Care Clinics
	Owned or Operated Outpatient Clinics	School-based Clinics
	Maternal Department	Contracted Palliative Care Programs
	Owned or Operated Urgent Care Clinics	Contracted Mobile Health Programs
		Other
<b>Physician Practices</b>	Owned or Operated Primary Care Clinics	Contracted Specialty Clinics
	Owned or Operated Specialty Care Clinics	Contracted Primary Care Clinics
	Owned or Operated Hospital	Contracted Community-based Programs
	Owned or Operated Urgent Care Clinics	Other
<b>Community Mental Health Centers</b>	Home-based services	Hospital
	Office/Clinic	Contracted Clinic

		School-based Clinic
		Contracted Inpatient Beds
		State-funded Community Hospital
		Community Institution for Mental Disease (IMD)
		General Medical Hospital
		State Mental Health Facility
		State Mental Retardation Facility
		Other
<b>Local Health Departments</b>	Clinics	Mobile Outreach
	Immunization Locations	Other

\*Required only if the Performing Provider has this business component.

Once the Performing Provider has defined its system and the definition has been approved by HHSC, then the Performing Provider will focus its system population according to the measure denominators for Category C reporting. Denominators for Category C will be naturally limited by the encounter types defined in the measure specifications.

## Category C

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Each Performing Provider must select Category C Measure Bundles or measures from the following menus included in this section based on Performing Provider type: 1) Hospital and Physician Practice Measure Bundle Menu; 2) Local Health Department Measure Menu; or 3) Community Mental Health Center Measure Menu. These menus include the number of points that each Measure Bundle or measure is worth.

Each Performing Provider is assigned a minimum point threshold (MPT) for Measure Bundle or measure selection as described in the PFM. Each Performing Provider must select Measure Bundles or measures worth enough points to meet its MPT in order to maintain its valuation for DY7 and DY8, and in DY9 and DY10.

Additionally, in DY9-10, Performing Providers will report on lists of Related Strategies as determined by Measure Bundle selection for hospitals and physician practices or by measure selection for LHDs and CMHCs. For each Related Strategy within a list, Performing Providers will make two reporting indications regarding the strategy's implementation (e.g., Implementation Date and Implementation Status). Performing Providers are required to report on lists of Related Strategies in the DY9-10 RHP Plan Update and as part of the DY9 and DY10 Category C reporting milestones.

### 1. Measure Points

- a. Each measure is assigned a point value based on the following classifications:
  - i. Clinical Outcome: Patient clinical measures for which improvement in the measure represents an improvement in patient health outcomes or utilization patterns are valued at 3 points.
  - ii. Population Based Clinical Outcome (PBCO): Clinical Outcomes that measures ED utilization or admissions for selected conditions for all individuals in the target population of a Measure Bundle are valued at 4 points.
  - iii. Cancer Screening: Cancer screening measures are valued at 2 points.
  - iv. Hospital Safety: Hospital safety and infection measures are valued at 2 points.
  - v. Process Measure: Measures of clinical practice are valued at 1 point.
  - vi. Immunization: Immunization rates are valued at 1 point.
  - vii. Quality of Life: Measures related to quality of life or functional assessment are valued at 1 point.
  - viii. Innovative Measure: Innovative measures are P4R and valued at 0 points.
  - ix. Quality Improvement Collaborative Activity: Participation in quality improvement activities is valued at 0 points.
- b. Measure classification is specified for each measure in Appendix A Category C Specifications Document.
- c. All measures are designated as P4P except for Innovative Measures and Quality Improvement Collaborative Activities which are P4R in DY7 and DY8 and P4P if selected or continued in DY9 and DY10. Measures that are P4R are noted in Measure Bundles for Hospital & Physician Practices section.

## 2. Hospital and Physician Practice Measure Bundle Points & Selection Requirements

- a. The base point value of a Measure Bundle is equal to the sum of the points for the required measures in the Measure Bundle **during the initial selection period**. The base point value of a Measure Bundle designated as High State Priority is then multiplied by 2, and the base point value of a Measure Bundle designated as State Priority is then multiplied by 1.5.
  - i. High State Priority Measure Bundles (sum of the required measures' points multiplied by 2)
    1. E1: Improved Maternal Care
    2. E2: Maternal Safety
    3. H3: Chronic Non-Malignant Pain Management
  - ii. State Priority Measure Bundles (sum of the required measures' points multiplied by 1.5)
    1. A1: Chronic Disease Management: Diabetes
    2. A2: Chronic Disease Management: Heart Disease
    3. C1: Healthy Texans
    4. D1: Pediatric Primary Care
    5. D4: Pediatric Chronic Disease Management: Asthma
    6. D5: Pediatric Chronic Disease Management: Diabetes
    7. H1: Behavioral Health in a Primary Care Setting
    8. H2: Behavioral Health & Appropriate Utilization
    9. H4: Integrated Care for People with Serious Mental Illness
- b. Optional measures in a Measure Bundle, if selected, add points to the Measure Bundle.
  - i. Optional measures that add points, if selected, are not impacted by a high state priority or a state priority multiplier.

EXAMPLE: Measure Bundle A1 - Chronic Disease Management: Diabetes is a State Priority Measure Bundle with required measures equaling 7 points and a multiplier of 1.5 for a base point value of 11 points. If a hospital selects Measure Bundle A1 and selects measures A1-500 Diabetes Composite and A1-508 Rate of ED Visits for Diabetes as P4P (A1-500 and A1-508 PBCOs worth an additional four points each and are required as P4P for Performing Providers with an MPT of 75 and optional as P4P for Performing Providers with an MPT less than 75), 8 points will be added to the Measure Bundle for a total of 19 points towards the hospital's MPT.

- c. Limitations on Hospital and Physician Practice Measure Bundle Selections and Optional Measure Selections
  - i. Measure Bundles K1 Rural Preventive Care and K2 Rural Emergency Care can only be selected in DY7-8 by hospitals with a valuation less than or equal to \$2,500,000 per DY. Performing Providers that select Measure Bundle K1 cannot also select Measure Bundles A1, A2, B1, C1, D1, E1, or H1. Measure K2-285 cannot be selected if Measure Bundle K1 is selected.

- ii. In DY7 and DY8, each hospital or physician practice with an MPT of 75 must select at least one Measure Bundle with a PBCO. In DY9 and DY10, each hospital or physician practice with an MPT of 75 must select Measure Bundles that result in a minimum of two PBCOs.
- iii. For Measure Bundles A1, A2, B1, C1, D1, and H2, Population Based Clinical Outcomes are required for Performing Providers with an MPT of 75 and optional as P4P with 4 additional points for Performing Providers with an MPT below 75. Providers that do not opt to select a PBCO as P4P but have a measurable numerator greater than 0 are required to report the PBCO as P4R following the requirements for a measure with insignificant volume.
- iv. For Measure Bundles D4 and D5, the PBCO is a required measure for any Performing Provider that selects that Measure Bundle as the PBCO in each Measure Bundle is essential to the Measure Bundle objective.
- v. Each hospital or physician practice with a valuation of more than \$2,500,000 per DY in DY7-8 or \$2,000,000 in DY10 must either: 1) select at least one Measure Bundle with at least one required 3 point clinical outcome measure; or 2) select at least one Measure Bundle with at least one optional 3 point clinical outcome measure selected. Three-point clinical measures must have significant volume and be P4P to qualify as the required 3 point measure.
- vi. If bundles D3 Pediatric Hospital Safety and J1 Hospital Safety are both selected, the points of each bundle will be reduced by 50%.

### 3. Community Mental Health Center and Local Health Department Measure Points & Selection Requirements

- a. Certain measures designated as a state priority, if selected, add an additional point.
- b. CMHCs and LHDs must select and report on at least two unique measures.
- c. Each CMHC or LHD with a valuation of more than \$2,500,000 per DY in DY7-8 or \$2,000,000 in DY10 must select at least one 3 point clinical outcome measure.
- d. If a CMHC selects more than one of the depression response measures M1-165, M1-181, or M1-286, only 4 points will be counted towards the Performing Provider's MPT.

### 4. Minimum Volume Definitions & Requirements

- a. Minimum Volume Definitions
  - i. *Significant volume* is defined, for most outcome measures, as an MLIU denominator for the measurement period that is greater than or equal to 30, unless an exception has been granted by HHSC to use an all-payer denominator as defined in the PFM.
  - ii. *Insignificant volume* is defined, for most outcome measures, as an MLIU denominator for the measurement period that is less than 30, but greater than 0, unless an exception has been granted by HHSC to use an all-payer denominator.
  - iii. *No volume* is defined as an MLIU denominator for the measurement period that is 0. For a PBCO, no volume is defined as a numerator for the 12 month measurement period that is 0.

b. Hospital and Physician Practice Minimum Volume Requirements

- i. A hospital or physician practice may only select a Measure Bundle for which the hospital’s or physician practice’s MLIU denominator for the baseline measurement period for at least half of the required measures in the Measure Bundle has *significant volume*.
- ii. A hospital or physician practice may only select an optional measure in a selected Measure Bundle for which the hospital or physician practice’s MLIU denominator for the baseline measurement period has *significant volume*.
- iii. **Insignificant Volume:** If a hospital or physician practice selects a Measure Bundle with a required measure for which the hospital or physician practice has *insignificant volume*, the valuations of the measure’s reporting milestones will remain the same, but the valuations of the measure’s achievement milestones will be redistributed proportionally among the achievement milestones for the other measures in the Measure Bundle with *significant volume*.

EXAMPLE: A physician practice selects a Measure Bundle with four required measures, selects one optional measure in the Measure Bundle, and has *insignificant volume* for one required measure. The selected Measure Bundle is assigned a valuation of \$1,000,000. The milestone valuations for DY7 and DY8 are as follows:

Measure	Volume	DY7 Measure Bundle Valuation: \$1,000,000			DY8 Measure Bundle Valuation: \$1,000,000	
		DY7 Baseline Milestone (\$250,000)	DY7 PY1 Reporting Milestone (\$250,000)	DY7 Achievement Milestone (\$500,000)	DY8 PY2 Reporting Milestone (\$250,000)	DY8 Achievement Milestone (\$750,000)
1 (required)	Significant	\$62,500	\$62,500	\$166,667	\$62,500	\$250,000
2 (required)	Significant	\$62,500	\$62,500	\$166,667	\$62,500	\$250,000
3 (required)	Insignificant	\$62,500	\$62,500	-	\$62,500	-
4 (optional)	Significant	\$62,500	\$62,500	\$166,667	\$62,500	\$250,000

- 1. If a hospital or physician practice has *insignificant volume* for the baseline measurement period for a required measure in a selected Measure Bundle at the time of RHP Plan Update submission, the hospital or physician practice will notify HHSC in the RHP Plan Update that it has *insignificant volume* for the measure.
- 2. If a hospital or physician practice reports the baseline or performance for a required measure in a selected Measure Bundle with *insignificant volume* for the measurement period, the measure’s achievement milestone valuation may be redistributed as described in this subsection.
- iv. **No Volume:** Required measures with *no volume* because the hospital or physician practice does not serve the population measured will be removed from the Measure Bundle and the valuations of the associated reporting and achievement milestones

will be redistributed proportionally among the remaining measures in the Measure Bundle.

EXAMPLE: A physician practice selects a Measure Bundle with four required measures, selects one optional measure in the Measure Bundle, and has *no volume* for one required measure. The selected Measure Bundle is assigned a valuation of \$1,000,000. The valuations for DY7 and DY8 are as follows:

Measure	Volume	DY7 Measure Bundle Valuation: \$1,000,000			DY8 Measure Bundle Valuation: \$1,000,000	
		DY7 Baseline Milestone (\$250,000)	DY7 PY1 Reporting Milestone (\$250,000)	DY7 Achievement Milestone (\$500,000)	DY8 PY2 Reporting Milestone (\$250,000)	DY8 Achievement Milestone (\$750,000)
1 (required)	Significant	\$83,333	\$83,333	\$166,667	\$83,333	\$250,000
2 (required)	Significant	\$83,333	\$83,333	\$166,667	\$83,333	\$250,000
3 (required)	None	-	-	-	-	-
4 (optional)	Significant	\$83,333	\$83,333	\$166,667	\$83,333	\$250,000

1. If a hospital or physician practice has *no volume* for the baseline measurement period for a required measure in a selected Measure Bundle at the time of RHP Plan Update submission, the hospital or physician practice will notify HHSC in the RHP Plan Update that it has *no volume* for the measure.
2. If a hospital or physician practice reports the baseline or performance for a required measure in a selected Measure Bundle with *no volume* for the measurement period, the measure’s reporting and achievement milestone valuation may be redistributed as described in this subsection.

c. CMHC and LHD Minimum Volume Requirements

- i. A CMHC or LHD may only select measures for which it has *significant volume*.

## 5. Eligible Denominator Population

All Measure Bundles will be based on the DSRIP attributed population defined below. Each Measure Bundle has a target population (or pool of people) for which the Performing Provider system is accountable for improvement under the DSRIP incentive arrangements. The target population identifies all individuals in the DSRIP attributed population for each Performing Provider system, which then serves as the starting point for all the measures within the Measure Bundle and includes all individuals that would fall into the measure specifications for the included measure.

When reporting data for measures in a Measure Bundle, the eligible denominator population for each measure will be determined by the following process:

- Step 1: Determine the DSRIP attributed population using the prescribed attribution methodology defined below.

Step 2: Determine the individuals from step one that are included in the Measure Bundle or measure target population

Step 3: Determine the individuals from the Measure Bundle target population that meet the measure specific denominator inclusion criteria.

Step 4: Determine payer type for individuals or encounters in the denominator following standardized specifications to determine the all payer, Medicaid, and LIU rate for each measure.

**Step 1: Determine the DSRIP attributed population using the prescribed retroactive attribution methodology defined below based on the Performing Provider type indicated in the RHP Plan Submission:**

1. For hospital organizations and physician practices, the DSRIP attributed population includes individuals from the DSRIP system defined in Category B that meet at least one of the criteria below. Individuals do not need to meet all or multiple criteria to be included.
  - a. Medicaid beneficiary attributed to the Performing Provider during the measurement period as determined by assignment to a primary care provider (PCP), medical home, or clinic in the Performing Providers DSRIP defined system OR
  - b. Individuals enrolled in a local coverage program (for example, a county-based indigent care program) assigned to a PCP, medical home, or clinic in the Performing Providers DSRIP defined system OR
  - c. One preventive service provided during the measurement period (Includes value sets of visit type codes for annual wellness visit, preventive care services - initial office visit, preventive care services - established office visit, and preventive care individual counseling) OR
  - d. One ambulatory encounter during the measurement year and one ambulatory encounter during the year prior to the measurement year OR
  - e. Two ambulatory encounters during the measurement year OR
  - f. Other populations managed with chronic disease in specialty care clinics in the Performing Providers DSRIP defined system
  - g. One ED visit during the measurement year OR
  - h. One admission for inpatient or observation status during the measurement year OR
  - i. One prenatal or postnatal visit during the measurement year OR
  - j. One delivery during the measurement year OR
  - k. One dental encounter during the measurement year OR
  - l. Enrolled in a palliative care or hospice program during the measurement year OR
  - m. Other populations not included above that should be included in a Measure Bundle target population included in the RHP plan submission and approved by HHSC (for example, individuals enrolled in community-based education programs)
2. For CMHCs, the DSRIP attributed population includes:
  - a. All individuals from the DSRIP system defined in Category B that meet one of the following criteria during the measurement period:



- i. One encounter with the Performing Providers system during the measurement year and one encounter during the year prior to the measurement year OR
  - ii. Two encounters with the Performing Providers system during the measurement year OR
  - iii. Other populations defined by the CMHC in the RHP Plan Submission and approved by HHSC
  
- 3. For LHDs, the DSRIP attributed population includes:
  - a. Individuals with one eligible encounter during the measurement period OR
  - b. Other populations defined by the LHD in the RHP Plan Submission and approved by HHSC
  
- 4. Allowable Exclusions for all Performing Provider types:
  - a. Performing Providers may remove from the DSRIP attributed population any individual for which the Performing Provider has documentation of any one of the following during the measurement year:
    - i. The individual that was previously assigned a PCP, medical home, or clinic with the Performing Provider but has changed their care to a PCP, medical home, or clinic that is not with the Performing Providers DSRIP system.
    - ii. The patient has had a total time of incarceration during the measurement period that exceeded 45 days.

For Steps 2 - 4, refer to the introduction section of Appendix A Category C Measure Specifications.

## 6. Exceptions to MPTs and Measure Bundle Selection for Hospital and Physician Practices with a Limited Scope of Practice

- a. Certain Performing Providers have a limited scope of practice. These Performing Providers may include children's hospitals and specialty hospitals such as infectious disease hospitals and Institutions for Mental Disease.
  - i. If such a Performing Provider is not able to reasonably report on enough Measure Bundles to meet its MPT based on its limited scope of practice and available community partnerships, the Performing Provider may request a lowered MPT equal to the sum of all Measure Bundles that the Performing Provider could reasonably report. The Performing Provider must request a lowered MPT prior to the RHP Plan Update submission, by a date determined by HHSC.
  - ii. If such a Performing Provider is not able to reasonably report on at least half of the required measures in Measure Bundles needed to meet its MPT based on its limited scope of practice and available community partnerships, the Performing Provider may request approval to select measures outside of the Measure Bundle structure prior to the RHP Plan Update submission, by a date determined by HHSC.
    - 1. The hospital or physician practice must select measures from the Hospital and Physician Practice Measure Bundle Menu, the Local Health Department Measure Menu, or the Community Mental Health Center Measure Menu in accordance with the measure selection requirements for LHDs and CMHCs.

- iii. A hospital's or physician practice's request to lower the MPT or to select measures outside of the Measure Bundle structure may be subject to review by CMS. If HHSC and CMS, as appropriate, approve the request, the hospital's or physician practice's total valuation may be reduced.

## 7. Exceptions to Measure Selection for Local Health Departments

- a. LHDs may continue to report measures that an LHD reported for Category 3 in DY6 that are P4P in DY6 and not otherwise included in the L1 Local Health Department Menu.
  - i. Grandfathered measures that are classified as standalone measures in DY2-6 will be valued at 3 points. Grandfathered measures that are non-standalone in DY2-6 will be valued at 1 point unless a measure has been given a categorization with a valuation of 2 points in the Measure Bundle Protocol.
  - ii. Grandfathered measures will use DY6 (10/01/2016 - 09/30/2017) as the baseline measurement period for determining DY7 and DY8 goal achievement milestones and standard performance measurement periods so that PY1 is CY2018, PY2 is CY2019, and PY3 is CY2020.
  - iii. Duplicated measures will only count once towards a Performing Providers MPT. For example, if an LHD has two non-standalone measures that are the same measure selection in DY6 but report different rates for different facilities, the Performing Provider may continue to report both measures, but both measures will only contribute 3 points towards the MPT.
- b. LHDs may use a combination of grandfathered DY6 Category 3 measures and new measures selected from the L1 Local Health Department Menu in the Measure Bundle Protocol. New measures cannot duplicate grandfathered measures.
- c. LHDs may continue to report as P4P in DY9 and DY10 grandfathered measures that were approved for use in DY7 and DY8.
- d. LHDs may not select new grandfathered measures for use in DY9 and DY10.

## Hospital & Physician Practice Measure Bundle Menu DYs 7-10

Hospital & Physician Practice Measure Bundles	Any PBCO (4 points)	Any Clinical Outcome (3 points)	Base Points	Additional Points	Max Points	
A1: Chronic Disease Management: Diabetes [SP]	Required <sup>1</sup>	Required	11	9	20	
A2: Chronic Disease Management: Heart Disease [SP]	Required <sup>1</sup>	Required	8	11	19	
B1: Care Transitions & Hospital Readmissions	None	Required	11	0	11	
B2: Patient Navigation & ED Diversion	None	Required	3	9	12	
C1: Primary Care Prevention - Healthy Texans [SP]	Required <sup>1</sup>	None	12	4	16	
C2: Primary Care Prevention - Cancer Screening	None	None	6	0	6	
C3: Hepatitis C	None	None	4	0	4	
D1: Pediatric Primary Care [SP]	Required <sup>1</sup>	Required	14	6	20	
D3: Pediatric Hospital Safety	None	None	10	0	10	
D4: Pediatric Chronic Disease Management: Asthma [SP]	Required	None	9	0	9	
D5: Pediatric Chronic Disease Management: Diabetes [SP]	Required	None	8	0	8	
E1: Improved Maternal Care [HSP]	None	Required	10	1 <sup>5</sup>	11	
E2: Maternal Safety [HSP]	DY7/8	None	Required	8	0	8
	DY9/10	None	Required	12	0	12
F1: Improved Access to Adult Dental Care	None	Required	7	0	7	
F2: Preventive Pediatric Dental	None	None	2	0	2	
G1: Palliative Care	None	None <sup>2</sup>	6	0	6	
H1: Integration of Behavioral Health in a Primary or Specialty Care Setting [SP]	None	Required	12	0	12	
H2: Behavioral Health and Appropriate Utilization [SP]	Required <sup>1</sup>	Optional	8	11	19	
H3: Chronic Non-Malignant Pain Management [HSP]	None	None	10	0	10	
H4: Integrated Care for People with Serious Mental Illness [SP]	None	None	5	0	5	
I1: Specialty Care <sup>3</sup>	None	None	2	0	2	
J1: Hospital Safety	None	None	10	0	10	
K1: Rural Preventive Care <sup>4</sup>	Optional	None	3	10	13	
K2: Rural Emergency Care <sup>4</sup>	None	None	3	1	4	
<b>Total Possible Points</b>			187	62	244	

[SP] Measure Bundle Designated as a State Priority

[HSP] Measure Bundle Designated as a High State Priority

<sup>1</sup> One or more PBCOs are required as P4P for Performing Providers with an MPT Of 75 that select bundle, optional as P4P for others

<sup>2</sup> Clinical outcome included for cancer hospital only

<sup>3</sup> Requires prior authorization

<sup>4</sup> Can only be selected by hospitals with a valuation at or below \$2,500,000 per DY

<sup>5</sup> Additional point (E1-193) cannot be continued or newly selected in DY9/10

## A1: Improved Chronic Disease Management: Diabetes Care

*This bundle is a State Priority.*

### Objective:

Develop and implement chronic disease management interventions that are geared toward improving management of diabetes and comorbidities, improving health outcomes and quality of life, preventing disease complications, and reducing unnecessary acute and emergency care utilization.

### Target Population:

Adults with diabetes

**Base Points:** 7\*1.5 (state priority) = 11

**Possible Additional Points:** 9

**Maximum Total Possible Points:** 20

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY9/10	Required if Continued in DY9/10	Measure Points
A1-111	Comprehensive Diabetes Care: Eye Exam (retinal) performed	NCQA	0055	No	No	No	+1
A1-112	Comprehensive Diabetes Care: Foot Exam	NCQA	0056	Yes	Yes	No	1
A1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	Yes	Yes	Yes	3
A1-207	Diabetes care: BP control (<140/90mm Hg)	NCQA	0061	Yes	Yes	Yes	3
A1-500	PQI 93 Diabetes Composite (Adult short-term complications, long-term complications, uncontrolled diabetes, lower-extremity amputation admission rates)	AHRQ	N/A	Yes*	Yes*	Yes*	+4/+0
A1-508	Reduce Rate of Emergency Department visits for Diabetes	N/A	N/A	Yes*	Yes*	Yes*	+4/+0

\*For Performing Providers that select Measure Bundle A1:

- Measures A1-500 AND A1-508 are PBCOs and are required P4P measures for Performing Providers with an MPT of 75.
- Performing Providers with an MPT less than 75 may opt to report measures as P4P.
- Performing Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the Measure Bundle's point value and do not contribute towards a Performing Provider's MPT.

## A2: Improved Chronic Disease Management: Heart Disease

*This bundle is a State Priority.*

### Objective:

Develop and implement chronic disease management interventions that are geared toward improving management of heart disease and comorbidities, improving health outcomes and quality of life, preventing disease complications, and reducing unnecessary acute and emergency care utilization.

### Target Population:

Adults with heart disease

**Base Points:** 5\*1.5 (state priority) = 8

**Possible Additional Points:** 11

**Maximum Total Possible Points:** 19

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
A2-103	Controlling High Blood Pressure	NCQA	0018	Yes	Yes	Yes	3
A2-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS	N/A	Yes	No	No	1
A2-384	Risk Adjusted CHF 30-Day Readmission Rate	N/A	N/A	No	Yes	Yes	+3
A2-404	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS	N/A	Yes	Yes	Yes	1
A2-501	PQI 08 Heart Failure Admission Rate (Adult)	AHRQ	N/A	Yes*	Yes*	Yes*	+4/+0
A2-509	Reduce Rate of Emergency Department visits for CHF, Angina, and Hypertension	N/A	N/A	Yes*	Yes*	Yes*	+4/+0

\*For Performing Providers that select Measure Bundle A2:

- Measures A2-501 and A2-509 are PBCOs and are required P4P measures for Performing Providers with an MPT of 75.
- Performing Providers with an MPT less than 75 may opt to report measures as P4P.
- Performing Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the Measure Bundle's point value and do not contribute towards a Performing Provider's MPT.

## B1: Care Transitions & Hospital Readmissions

### Objective:

Implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to improve health outcomes and prevent increased health care costs and hospital readmissions.

### Target Population:

Individuals transitioning out of inpatient care

**Base Points:** 11

**Possible Additional Points:** N/A

**Maximum Total Possible Points:** 11

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
B1-124	Medication Reconciliation Post-Discharge	NCQA	0097	Yes	Yes	Yes	1
B1-141	Risk Adjusted All-Cause 30-Day Readmission for Targeted Conditions: coronary artery bypass graft (CABG) surgery, CHF, Diabetes, AMI, Stroke, COPD, Behavioral Health, Substance Use	N/A	N/A	Yes	Yes	Yes	3
B1-217	Risk Adjusted All-Cause 30-Day Readmission	N/A	N/A	Yes	Yes	Yes	3
B1-252	Care Transition: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	AMA	0649	Yes	Yes	No	1
B1-253	Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	AMA	0647	Yes	Yes	No	1
B1-287	Documentation of Current Medications in the Medical Record	CMS	0419	Yes	Yes	Yes	1
B1-352	Post-Discharge Appointment	AHA/ASA, TJC	2455/2439	Yes	Yes	Yes	1

## B2: Patient Navigation & ED Diversion

### Objective:

Utilize patient navigators (CHWs, case managers, or other types of professionals) and/or develop other strategies to provide enhanced social support and culturally competent care to connect high risk patients to primary care or medical home sites, improve patient outcomes, and divert patients needing non-urgent care to appropriate settings.

### Target Population:

Adults utilizing the emergency department

**Base Points:** 3

**Possible Additional Points:** 9

**Maximum Total Possible Points:** 12

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
B2-242	Reduce Emergency Department (ED) visits for Chronic Ambulatory Care Sensitive Conditions (ACSC)	N/A	N/A	Yes**	Yes**	Yes**	(+3)
B2-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	Yes**	Yes**	Yes**	(+3)
B2-392	Reduce Emergency Department visits for Acute Ambulatory Care Sensitive Conditions (ACSC)	N/A	N/A	Yes	Yes	Yes	3
B2-393	Reduce Emergency Department visits for Dental Conditions	N/A	N/A	Yes**	Yes**	Yes**	(+3)

\*\*Must select one of either B2-242, B2-387, B2-393

May select one or more additional from B2-242, B2-387, B2-393 for up to an additional 6 points.

## C1: Primary Care Prevention - Healthy Texans

*This bundle is a State Priority.*

### Objective:

Provide comprehensive, integrated primary care services that are focused on person-centered preventive care and chronic disease screening.

### Target Population:

Adults

**Base Points:** 8\*1.5 (state priority) = 12

**Possible Additional Points:** 4

**Maximum Total Possible Points:** 16

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
C1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	Yes	Yes	No	1
C1-113	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	NCQA	0057	Yes	Yes	Yes	1
C1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421 / 2828	Yes	Yes	Yes	1
C1-268	Pneumonia vaccination status for older adults	CMS	0043	Yes	Yes	Yes	1
C1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041 / 3070	Yes	Yes	Yes	1
C1-272	Adults (18+ years) Immunization status	ICSI	N/A	Yes	Yes	Yes	1
C1-280	Chlamydia Screening in Women (CHL)	NCQA	0033	Yes	Yes	Yes	1
C1-389	Human Papillomavirus Vaccine (age 18 -26)	N/A	N/A	Yes	Yes	Yes	1
C1-502	PQI 91 Acute Composite (Adult Dehydration, Bacterial Pneumonia, Urinary Tract Infection Admission Rates)	AHRQ	N/A	Yes*	Yes*	Yes*	+4/+0

\*For Performing Providers that select Measure Bundle C1:

- Measure C1-502 is a PBCOs and is a required P4P measures for Performing Providers with an MPT of 75.
- Performing Providers with an MPT less than 75 may opt to report measure as P4P.
- Performing Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the Measure Bundle's point value and do not contribute towards a Performing Provider's MPT.



## C2: Primary Care Prevention - Cancer Screening

**Objective:**

Increase access to cancer screening in the primary care setting.

**Target Population:**

Adults

**Base Points:** 6

**Possible Additional Points:** N/A

**Maximum Total Possible Points:** 6

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
C2-106	Cervical Cancer Screening	NCQA	0032	Yes	Yes	Yes	2
C2-107	Colorectal Cancer Screening	NCQA	0034	Yes	Yes	Yes	2
C2-186	Breast Cancer Screening	NCQA	2372	Yes	Yes	Yes	2

### C3: Hepatitis C

**Objective:**

Implement screening program in high risk populations to detect and treat Hepatitis C infections.

**Target Population:**

Adults

**Base Points:** 4

**Possible Additional Points:** N/A

**Maximum Total Possible Points:** 4

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
C3-203	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	AMA-PCPI	3059	Yes	Yes	Yes	1
C3-328	Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection	PCPI	3061	Yes	Yes	Yes	1
C3-368	Hepatitis C: Hepatitis A Vaccination	American Gastroenterological Association	0399	Yes	Yes	Yes	1
C3-369	Hepatitis C: Hepatitis B Vaccination	American Gastroenterological Association	0400	Yes	Yes	Yes	1

## D1: Pediatric Primary Care

*This bundle is a State Priority.*

### Objective:

Increase access to comprehensive, coordinated primary care & preventive services focused on accountable, child-centered care that improves quality of life and health outcomes.

### Target Population:

Children

**Base Points:** 9\*1.5 (state priority) = 14

**Possible Additional Points:** 5

**Maximum Total Possible Points:** 20

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
D1-108	Childhood Immunization Status (CIS)	NCQA	0038	Yes	Yes	Yes	1
D1-211	Weight Assessment and Counseling for Nutrition and Physical Activity	NCQA	0024	Rate 1: Yes Rate 2: Yes Rate 3: Yes	Rate 1: Yes Rate 2: Yes Rate 3: Yes	Rate 1: No Rate 2: Yes Rate 3: Yes	1
D1-212	Appropriate Testing for Children With Pharyngitis	AHRQ	0002	Yes	Yes	Yes	3
D1-237	Well-Child Visits in the First 15 Months of Life	NCQA	1392	Yes	Yes	Yes	1
D1-271	Immunization for Adolescents	NCQA	1407	Yes	Yes	Yes	1
D1-284	Appropriate Treatment for Children with URI	NCQA	0069	Yes	Yes	Yes	1
D1-301	Maternal Depression Screening	NCQA	1401	No	No	No	+1
D1-389	Human Papillomavirus Vaccine (age 15-18)	N/A	N/A	No	No	No	+1
D1-400	Tobacco Use and Help with Quitting Among Adolescents	CMS	N/A	Yes	Yes	No	1
D1-503	PDI 97 Acute Composite (Gastroenteritis, Urinary Tract Infection Admission Rate)	AHRQ	N/A	Yes*	Yes*	Yes*	*+4/*+0
D1-T01	<i>Innovative Measure:</i> Behavioral Health Counselling for Childhood Obesity (DY7/8: P4R, DY9/10: P4P)	Meadows	N/A	No	No	No	0 / +1

\*For Performing Providers that select Measure Bundle D1:

- Measure D-503 is a PBCOs and is a required P4P measures for Performing Providers with an MPT of 75.
- Performing Providers with an MPT less than 75 may opt to report measure as P4P.
- Performing Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the Measure Bundle's point value and do not contribute towards a Performing Provider's MPT.

### D3: Pediatric Hospital Safety

**Objective:**

Reduce hospital errors, improve effectiveness of staff communication (both internally and with patients and their caregivers), improve medication management, and reduce the risk of health-care associated infections.

**Target Population:**

Children receiving inpatient care

**Base Points:** 10

**Possible Additional Points:** N/A

**Maximum Total Possible Points:** 10

*If D3 and J1 are both selected, the points of each bundle will be reduced by 50%.*

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
D3-330	Pediatric CLABSI	Children's Hospitals' Solutions for Patient Safety National Children's Network	N/A	Yes	Yes	Yes	2
D3-331	Pediatric CAUTI		N/A	Yes	Yes	Yes	2
D3-333	Pediatric Surgical site infections (SSI)		N/A	Yes	Yes	Yes	2
D3-334	Pediatric Adverse Drug Events		N/A	Yes	Yes	Yes	2
D3-335	Pediatric Pressure Injuries		N/A	Yes	Yes	Yes	2

## D4: Pediatric Chronic Disease Management: Asthma

*This bundle is a State Priority.*

**Objective:**

Develop and implement chronic disease management interventions that are geared toward improving management of asthma to improve patient health outcomes and quality of life and reduce unnecessary acute and emergency care utilization.

**Target Population:**

Children with asthma

**Base Points:** 6\*1.5 (state priority) = 9

**Possible Additional Points:** N/A

**Maximum Total Possible Points:** 9

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
D4-139	Asthma Admission Rate (PDI 14)	AHRQ	0728	Yes	Yes	Yes	4
D4-353	Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit	University Hospitals Cleveland Medical Center	3170	Yes	Yes	Yes	1
D4-375	Asthma: Pharmacologic Therapy for Persistent Asthma (Rate 3 only)	The American Academy of Asthma Allergy and Immunology	0047	Yes	Yes	Yes	1

## D5: Pediatric Chronic Disease Management: Diabetes

**Objective:**

Develop and implement diabetes management interventions that improve patient health outcomes and quality of life, prevent onset or progression of comorbidities, and reduce unnecessary acute and emergency care utilization.

**Target Population:**

Children with Type 1 and Type 2 Diabetes

**Base Points:** 5\*1.5 (state priority) = 8

**Possible Additional Points:** N/A

**Maximum Total Possible Points:** 8

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
D5-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	NCQA	0024	Rate 1: Yes Rate 2: Yes Rate 3: Yes	Rate 1: Yes Rate 2: Yes Rate 3: Yes	Rate 1: No Rate 2: Yes Rate 3: Yes	1
D5-406	Diabetes Short-term Complications Admission Rate (PDI 15)	AHRQ	N/A	Yes	Yes	Yes	4
D5-T07	<i>Innovative Measure:</i> Diabetes Care Coordination (DY7/8: P4R, DY9/10: P4P)	TBD	N/A	No	No	No	0 / +1

## E1: Improved Maternal Care

*This bundle is a High State Priority.*

### Objective:

Improve maternal health outcomes by implementing evidence-based practices to provide pre-conception, prenatal, and postpartum care including early detection and management of comorbidities like hypertension, diabetes, and depression.

### Target Population:

Pregnant and postpartum women

**Base Points:** 5\*2 (high state priority) = 10

**Possible Additional Points:** 1

**Maximum Total Possible Points:** 11

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
E1-193	Contraceptive Care – Postpartum Women Ages 15–44	US Office of Population Affairs	2902	No	Discontinued	Discontinued	+1
E1-232	Timeliness of Prenatal Care	NCQA	1517	Yes	Yes	Yes	1
E1-235	Post-Partum Follow-Up and Care Coordination	CMS	N/A	Yes	Yes	Yes	3
E1-300	Behavioral Health Risk Assessment for Pregnant Women	AMA-PCPI	N/A	Yes	Yes	Yes	1

## E2: Maternal Safety

*This bundle is a High State Priority.*

**Objective:** Improve maternal safety and reduce maternal morbidity through data driven interventions to prevent and manage obstetric hemorrhage.

**Target Population:**

Women with preterm or full-term deliveries

**Base Points:** 4\*2 (high state priority) = 8

**Possible Additional Points:** N/A

**Maximum Total Possible Points:** 8

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
E2-150	PC-02 Cesarean Section	The Joint Commission	0471	Yes	Yes	Yes	3
E2-151	PC-03 Antenatal Steroids	The Joint Commission	0476	Yes	No	No	1
E2-A01	Quality Improvement Collaborative Activity: Participation in OB Hemorrhage Safety Bundle Collaborative (TexasAIM Plus) through the Texas Department of State Health Services ( <i>P4R for participation in collaborative and implementation of recommended practices in DY7-8</i> )	N/A	N/A	Yes	Discontinued	Discontinued	0
E2-601	Hemorrhage Risk Assessment ( <i>Requires participating in TexasAIM Plus</i> )	Alliance for Innovation in Maternal Care Data Collection Plan	N/A	No	Yes	Yes	1
E2-602	Quantified Blood Loss ( <i>Requires participating in TexasAIM Plus</i> )	Alliance for Innovation in Maternal Care Data Collection Plan	N/A	No	Yes	Yes	1



## F1: Improved Access to Adult Dental Care

**Objective:**

Increase access to timely, appropriate dental care.

**Target Population:**

Adults

**Base Points: 7**

**Possible Additional Points: N/A**

**Maximum Total Possible Points: 7**

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
F1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	Yes	Yes	Yes	1
F1-226	Chronic Disease Patients Accessing Dental Services	N/A	N/A	Yes	Yes	Yes	3
F1-227	Dental Caries: Adults	Healthy People 2020	N/A	Yes	Yes	Yes	3
F1-T03	<i>Innovative Measure: Oral Cancer Screening</i> (DY7/8: P4R, DY9/10: P4P)	A&M College of Dentistry	N/A	No	No	No	0 / +1

## F2: Preventive Pediatric Dental Care

**Objective:**

Expand access to dental care including screening and preventive dental services to improve long term oral health and quality of life and reduce costs by preventing the need for more intensive treatments.

**Target Population:**

Children

**Base Points: 2**

**Possible Additional Points: N/A**

**Maximum Total Possible Points: 2**

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
F2-224	Dental Sealant: Children	Healthy People 2020	N/A	Yes	Yes	Yes	1
F2-229	Oral Evaluation: Children	American Dental Association	2517	Yes	Yes	Yes	1

## G1: Palliative Care

### Objective:

Provide palliative care services to patients and their families and/or caregivers to improve patient outcomes and quality of life with a focus on relief from symptoms, stress, and pain related to serious, debilitating, or terminal illness.

### Target Population:

Individuals with serious or terminal illness enrolled in a hospice or palliative care program

**Base Points:** 6

**Possible Additional Points:** N/A or 6\*

**Maximum Total Possible Points:** 6 or 12\*

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
G1-276	Hospice and Palliative Care – Pain assessment	University of North Carolina-Chapel Hill	1637	Yes	Yes	Yes	1
G1-277	Hospice and Palliative Care – Treatment Preferences	University of North Carolina-Chapel Hill	1641	Yes	Yes	Yes	1
G1-278	Beliefs and Values	University of North Carolina-Chapel Hill	1647	Yes	Yes	Yes	1
G1-361	Patients Treated with an Opioid who are Given a Bowel Regimen	RAND Corporation/UCLA	1617	Yes	Yes	Yes	1
G1-362	Hospice and Palliative Care - - Dyspnea Treatment	University of North Carolina-Chapel Hill	1638	Yes	Yes	Yes	1
G1-363	Hospice and Palliative Care - - Dyspnea Screening	University of North Carolina-Chapel Hill	1639	Yes	Yes	Yes	1
G1-505	Proportion Admitted to Hospice for less than 3 day	American Society of Clinical Oncology	0216	No*	No*	No*	+3
G1-507	Proportion not Admitted to Hospice	American Society of Clinical Oncology	0215	No*	No*	No*	+3

\*Measures G1-505 and G1-507 may only be selected by a cancer hospital in DY7/8, and may be selected by any performing provider with a cancer hospital as a part of their system definition in DY9/10

## H1: Integration of Behavioral Health in a Primary or Specialty Care Setting

*This bundle is a State Priority.*

### Objective:

Implement depression, substance use disorder, and behavioral health screening and multi-modal treatment in a primary or non-psychiatric specialty care setting.

### Target Population:

Individuals receiving primary care services or specialty care services

**Base Points:** 8\*1.5 (state priority) = 12

**Additional Points:** N/A

**Maximum Total Possible Points:** 12

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
H1-146	Screening for Clinical Depression and Follow-Up Plan	CMS	0418	Yes	Yes	Yes	1
H1-255	Follow-up Care for Children Prescribed ADHD Medication	NCQA	0108	Yes	Yes	Yes	3
H1-286	Depression Remission at Six Months	MN Community Measurement	0711	Yes	Yes	Yes	3
H1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	AMA-PCPI	2152	Yes	Yes	Yes	1
H1-T04	<i>Innovative Measure:</i> Engagement in Integrated Behavioral Health (DY7/8: P4R, DY9/10: P4P)	Meadows	N/A	No	No	No	0 / +1

## H2: Behavioral Health and Appropriate Utilization

*This bundle is a State Priority.*

### Objective:

Provide specialized and coordinated services to individuals with serious mental illness and/or a combination of behavioral health and physical health issues to reduce emergency department utilization and avoidable inpatient admission and readmissions.

### Target Population:

Individuals with serious mental illness

**Base Points:** 5\*1.5 (state priority) = 8

**Possible Additional Points:** 11

**Maximum Total Possible Points:** 19

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
H2-160	Follow-Up After Hospitalization for Mental Illness	NCQA	0576	(Yes)*	(Yes)*	(Yes)*	+3
H2-216	Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate	N/A	N/A	(Yes)*	(Yes)*	(Yes)*	+3
H2-259	Assignment of Primary Care Physician to Individuals with Schizophrenia	CQAIMH	N/A	Yes	Yes	Yes	1
H2-265	Housing Assessment for Individuals with Schizophrenia	CQAIMH	N/A	No	No	No	+1
H2-266	Independent Living Skills Assessment for Individuals with Schizophrenia	CQAIMH	N/A	Yes	Yes	Yes	1
H2-305	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	AMA-PCPI	1365	Yes	Yes	Yes	1
H2-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	0104	Yes	Yes	Yes	1
H2-510	Reduce Rate of Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	Yes * †	Yes * †	Yes * †	+4/+0
H2-405	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	CMS	N/A	Y	Y	Y	1

† For Performing Providers that select Measure Bundle H2 and have an MPT of 75:

Measure H2-510 is a PBCO and is a required P4P measure for Performing Providers with an MPT of 75.

† \* For Performing Providers that select Measure Bundle H2 and have an MPT of less than 75:

Performing Providers with an MPT less than 75 must select one of either H2-160, H2-216, or H2-510 as P4P.

Performing Providers that do not opt to report H2-510 as P4P that have any numerator volume must report as P4R and select one of either H2-160 or H2-216. Measures reported as P4R will not count towards the Measure Bundle's point value and do not contribute towards a Performing Provider's MPT.

### H3: Chronic Non-Malignant Pain Management

*This bundle is a High State Priority.*

**Objective:**

Improve individuals' quality of life and reduce pain through lifestyle modification, psychological approaches, interventional pain management, and/or pharmacotherapy while recognizing current or potential substance abuse disorders. Improve providers' ability to identify and manage chronic, non-malignant pain using a function-based multimodal approach and ability to screen for substance use disorder and connect individuals to appropriate treatment.

**Target Population:**

Adults with chronic pain or on long-term opioid therapy

**Base Points:** 5\*2 (high state priority) = 10

**Possible Additional Points:** N/A

**Maximum Total Possible Points:** 10

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
H3-144	Screening for Clinical Depression and Follow-Up Plan (CDF-AD) for individuals with a diagnosis of chronic pain	CMS	0418	Yes	Yes	Yes	1
H3-287	Documentation of Current Medications in the Medical Record	CMS	0419	Yes	Yes	Yes	1
H3-288	Pain Assessment and Follow-up	CMS	0420	Yes	Yes	Yes	1
H3-401	Opioid Therapy Follow-up Evaluation	N/A	N/A	Yes	Yes	Yes	1
H3-403	Evaluation or Interview for Risk of Opioid Misuse	N/A	N/A	Yes	Yes	Yes	1
H3-T05	<i>Innovative Measure:</i> Treatment of Chronic Non-Malignant Pain Management with Multi-Modal Therapy (DY7/8: P4R)	San Francisco Health Network, Alameda Health Systems, UC San Diego	N/A	No	Discontinued	Discontinued	0
H3-T06	<i>Innovative Measure:</i> Patients on long-term opioid therapy checked in prescription drug monitoring programs (PDMPs) (DY7/8: P4R)	AHRQ/ San Francisco Health Network, Alameda Health Systems, UC San Diego	N/A	No	Discontinued	Discontinued	0

#### H4: Integrated Care for People with Serious Mental Illness

*This bundle is a State Priority.*

**Objective:**

Improve physical health outcomes for individuals with serious mental illness.

**Target Population:**

Individuals with Serious Mental Illness

**Base Points:** 3\*1.5 (state priority) = 5

**Possible Additional Points:** N/A

**Maximum Total Possible Points:** 5

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
H4-182	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	NCQA	1932	Yes	Yes	Yes	1
H4-258	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NCQA	1933	Yes	Yes	Yes	1
H4-260	Annual Physical Exam for Persons with Mental Illness	CQAIMH	N/A	Yes	Yes	Yes	1

## I1: Specialty Care

**Objective:**

Improve quality of life and functional status for individuals with chronic and life impacting conditions receiving services in an outpatient specialty care setting.

**Target Population:**

Adults & Children with chronic and life impacting conditions

**Base Points: 2**

**Possible Additional Points: N/A**

**Maximum Total Possible Points: 2**

*Requires prior authorization and can only be selected once by hospital and physician practices with a specialty care project in DY6. Cannot be newly selected in DY9/10.*

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
I1-385	Assessment of Functional Status or QoL	N/A	N/A	Yes	N/A	Yes	1
I1-386	Improvement in Functional Status or QoL	N/A	N/A	Yes	N/A	Yes	1



## J1: Hospital Safety

**Objective:**

Improve patient health outcomes and experience of care by reducing the risk of health-care associated infections and reducing hospital errors.

**Target Population:**

Individuals receiving inpatient care

**Base Points:** 10

**Possible Additional Points:** N/A

**Maximum Total Possible Points:** 10

*If D3 and J1 are both selected, the points of each bundle will be reduced by 50%.*

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
J1-218	Central line-associated bloodstream infections (CLABSI) rates	CDC	0139	Yes	Yes	Yes	2
J1-219	Catheter-associated Urinary Tract Infections (CAUTI) rates	CDC	0138	Yes	Yes	Yes	2
J1-220	Surgical site infections (SSI) rates	CDC	0299	Yes	Yes	Yes	2
J1-221	Patient Fall Rate	American Nurses Association	0141	Yes	Yes	Yes	2
J1-506	PSI 13 Post-Operative Sepsis Rate	AHRQ	N/A	Yes	Yes	Yes	2

## K1: Rural Preventive Care

This bundle is only available to hospitals with a valuation less than or equal to \$2,500,000 per DY in DY7-8. This bundle may not be Newly-Selected for DY9-10.

### Objective:

Improve provision of preventive care in rural and critical access hospitals to improve patient health.

### Target Population:

Adults and Children in Rural Areas

**Base Points:** 3

**Possible Additional Points:** 10

**Maximum Total Possible Points:** 13

Measure Bundles A1, A2, C1, D1, E1, and H1 cannot be selected if Measure Bundle K1 is selected.

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
K1-103	Controlling High Blood Pressure	NCQA	0018	No	No	No	+3
K1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	Yes	Yes	Yes	1
K1-112	Comprehensive Diabetes Care: Foot Exam	NCQA	0056	No	No	No	+1
K1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	No	No	No	+3
K1-146	Screening for Clinical Depression and Follow-Up Plan	CMS	0418	No	No	No	+1
K1-268	Pneumonia vaccination status for older adults	CMS	0043	Yes	Yes	Yes	1
K1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041/ 3070	No	No	No	+1
K1-285	Advance Care Plan	NCQA	0326	Yes	Yes	Yes	1
K1-300	Behavioral Health Risk Assessment for Pregnant Women	AMA-PCPI	N/A	No	No	No	+1

## K2: Rural Emergency Care

This bundle is only available to hospitals with a valuation less than or equal to \$2,500,000 per DY in DY7-8. This bundle may not be Newly-Selected for DY9-10.

### Objective:

Improve quality of emergency care in rural and critical access hospital to improve patient health.

### Target Population:

Adults and Children receiving emergency services in rural areas

**Base Points:** 3

**Possible Additional Points:** 1

**Maximum Total Possible Points:** 4

ID	Measure	Steward	NQF #	Required if Newly-Selected in DY7/8	Required if Newly-Selected in DY 9/10	Required if Continued in DY9/10	Measure Points
K2-285	Advance Care Plan	NCQA	0326	No*	No*	No*	+1
K2-287	Documentation of Current Medications in the Medical Record	CMS	0419	Yes	Yes	Yes	1
K2-355	Admit Decision Time to ED Departure Time for Admitted Patients	CMS	0497	Yes	Yes	Yes	1
K2-359	Emergency Transfer Communication Measure	University of Minnesota Rural Health Research Center	0291	Yes	Yes	Yes	1

\*K2-285 cannot be selected if Measure Bundle K1 is selected.

## Local Health Department Measure Menu

LHD Measures				
ID	Measure	Steward	NQF #	Points
L1-103	Controlling High Blood Pressure	NCQA	0018	3
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	1
L1-107	Colorectal Cancer Screening	NCQA	0034	2
L1-108	Childhood Immunization Status (CIS)	NCQA	0038	1
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	3
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421 / 2828	1
L1-160	Follow-Up After Hospitalization for Mental Illness	NCQA	0576	3
L1-186	Breast Cancer Screening	NCQA	2372	2
L1-205	Third next available appointment	Wisconsin Collaborative for Healthcare Quality	N/A	1
L1-207	Diabetes care: BP control (<140/90mm Hg)	NCQA	0061	3
L1-210	317 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS	N/A	1
L1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	0024	1
L1-224	Dental Sealant: Children	Healthy People 2020	N/A	1
L1-225	Dental Caries - Children	Healthy People 2020	N/A	3
L1-227	Dental Caries - Adults	Healthy People 2020	N/A	3
L1-231	Preventive Services for Children at Elevated Caries Risk - Modified Denominator	American Dental Association	N/A	1
L1-235	Post-Partum Follow-Up and Care Coordination	CMS	N/A	3
L1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)	NCQA	1392	1
L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	None	N/A	3
L1-242	Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)	None	N/A	3
L1-268	Pneumonia vaccination status for older adults	CMS	0043	1
L1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041 / 3070	1

LHD Measures				
ID	Measure	Steward	NQF #	Points
L1-271	Immunization for Adolescents- Tdap/TD and MCV	NCQA	1407	1
L1-272	Adults (18+ years) Immunization status	Institute for Clinical Systems Improvement	N/A	1
L1-280	Chlamydia Screening in Women	NCQA	0033	1
L1-343	Syphilis positive screening rates	CDC	N/A	1
L1-344	Follow-up after Treatment for Primary or Secondary Syphilis	CDC	N/A	3
L1-345	Gonorrhea Positive Screening Rates	CDC	N/A	1
L1-346	Follow-up testing for N. gonorrhoeae among recently infected men and women	CDC	N/A	3
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	CDC	N/A	3
L1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	3
L1-400	Tobacco Use and Help with Quitting Among Adolescents	CMS	N/A	1

## Community Mental Health Center Measure Menu

CMHC Measures					
ID	Measure	Steward	NQF #	Points	Additional Points for State Priority Measures
M1-100	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA	0004	3	+1
M1-103	Controlling High Blood Pressure	NCQA	0018	3	+1
M1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	1	+1
M1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	3	
M1-124	Medication Reconciliation Post-Discharge	NCQA	0097	1	
M1-125	Antidepressant Medication Management (AMM-AD)	NCQA	0105	3	
M1-146	Screening for Clinical Depression and Follow-Up Plan (CDF-AD)	CMS	0418	1	
M1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421 / 2828	1	
M1-160	Follow-Up After Hospitalization for Mental Illness	NCQA	0576	3	
M1-165	Depression Remission at 12 Months	MN Community Measurement	0710	(3)*	+1
M1-180	Adherence to Antipsychotics for Individuals with Schizophrenia	CMS	1879	3	
M1-181	Depression Response at Twelve Months-Progress Towards Remission	MN Community Measurement	1885	(3)*	+1
M1-182	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA	1932	1	+1
M1-203	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	AMA-PCPI	N/A / 3059	1	+1

CMHC Measures					
ID	Measure	Steward	NQF #	Points	Additional Points for State Priority Measures
M1-205	Third next available appointment	Wisconsin Collaborative for Healthcare Quality	N/A	1	
M1-207	Diabetes care: BP control (<140/90mm Hg)	NCQA	0061	3	
M1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS	N/A	1	
M1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	0024	1	+1
M1-216	Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate	N/A	N/A	3	
M1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	None	N/A	3	
M1-255	Follow-up Care for Children Prescribed ADHD Medication	NCQA	0108	3	
M1-256	Initiation of Depression Treatment	CQAIMH	N/A	1	
M1-257	Care Planning for Dual Diagnosis	CQAIMH	N/A	1	
M1-259	Assignment of Primary Care Physician to Individuals with Schizophrenia	CQAIMH	N/A	1	
M1-260	Annual Physical Exam for Persons with Mental Illness	CQAIMH	N/A	1	+1
M1-261	Assessment for Substance Abuse Problems of Psychiatric Patients	CQAIMH	N/A	1	+1
M1-262	Assessment of Risk to Self/Others	CQAIMH	N/A	1	
M1-263	Assessment for Psychosocial Issues of Psychiatric Patients	CQAIMH	N/A	1	
M1-264	Vocational Rehabilitation for Schizophrenia	CQAIMH	N/A	1	
M1-265	Housing Assessment for Individuals with Schizophrenia	CQAIMH	N/A	1	+1
M1-266	Independent Living Skills Assessment for Individuals with Schizophrenia	CQAIMH	N/A	1	
M1-280	Chlamydia Screening in Women	NCQA	0033	1	+1
M1-286	Depression Remission at Six Months	MN Community Measurement	0711	(3)*	+1

CMHC Measures					
ID	Measure	Steward	NQF #	Points	Additional Points for State Priority Measures
M1-287	Documentation of Current Medications in the Medical Record	CMS	0419	1	+1
M1-305	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	AMA-PCPI	1365	1	+1
M1-306	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	2801	1	
M1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	AMA-PCPI	2152	1	+1
M1-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	0104	1	+1
M1-339	Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge	The Joint Commission	1664	1	+1
M1-340	Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period.	APA/ NCQA/ PCPI	N/A	1	+1
M1-341	Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period	APA/ NCQA/ PCPI	N/A	1	+1
M1-342	Time to Initial Evaluation: Evaluation within 10 Business Days	SAMHSA/ CCBHC	N/A	1	
M1-385	Assessment of Functional Status or QoL <i>Specific to IDD Services</i>	N/A	N/A	1	
M1-386	Improvement in Functional Status or QoL <i>Specific to IDD Services</i>	N/A	N/A	1	
M1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	3	+1
M1-390	Time to Initial Evaluation: Mean Days to Evaluation	SAMHSA/ CCBHC	NA	1	



CMHC Measures					
ID	Measure	Steward	NQF #	Points	Additional Points for State Priority Measures
M1-400	Tobacco Use and Help with Quitting Among Adolescents	CMS		1	+1
M1-405	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	CMS/CQAIMH	NA	1	+1

*\*If more than one of M1-165, M1-181, and/or M1-286 are selected, only 4 points will be added to meet MPT.*

## Related Strategies Reporting for Hospitals & Physician Practices

In DY9-10, Performing Providers will report on lists of Related Strategies by indicating which individual Related Strategies were implemented to achieve improvements in Category C measures for the MLIU patient populations. Hospitals and physician practices will report on Related Strategies Lists as determined by Measure Bundle selection.

As identified in the table below, Measure Bundles with similar interventions, care settings, and/or populations may be associated with a single Related Strategies List so that Performing Providers will report only once on the implementation of Related Strategies within that Related Strategies List.

Within each Related Strategies List, the individual Related Strategies are organized into the following Themes: *Access to Care, Care Coordination, Data Analytics, Disease Management, and Social Determinants of Health*. As identified in the tables below for each Theme, individual Related Strategies may be limited to specific Related Strategies Lists.

Hospitals & Physician Practices Measure Bundles and associated Related Strategies Lists		
Measure Bundle		Related Strategies List
A1	Chronic Disease Management: Diabetes	Adult Primary Care and Chronic Disease Management
A2	Chronic Disease Management: Heart Disease	
C1	Primary Care Prevention - Healthy Texans	
C2	Primary Care Prevention - Cancer Screening	
C3	Hepatitis C	
B1	Care Transitions and Hospital Readmissions	Hospital Readmissions and Emergency Department Utilization
B2	Patient Navigation & ED Diversion	
D1	Pediatric Primary Care	Pediatric Primary Care and Chronic Disease Management
D4	Pediatric Chronic Disease Management: Asthma	
D5	Pediatric Chronic Disease Management: Diabetes	
E1	Improved Maternal Care	Maternal Care and Safety
E2	Maternal Safety	
F1	Improved Access to Adult Dental Care	Dental Care
F2	Preventive Pediatric Dental	
G1	Palliative Care	Palliative Care and Specialty Care (Chronic and Life Impacting Conditions)
I1	Specialty Care	
H1	Mental Health Comorbidities	Behavioral Health Integration
H2	Behavioral Health and Appropriate Utilization	
H3	Chronic Non-Malignant Pain Management	
H4	Integrated Care for People with Serious Mental Illness	
J1	Hospital Safety	Hospital Safety
D3	Pediatric Hospital Safety	
K1	Rural Primary Care	Rural Primary Care
K2	Rural Emergency Care	Rural Emergency Care

### Example:

In DY9-10, a hospital or physician practice has selected seven Measure Bundles: A1, A2, C1, C2, D1, F2, and J1.

The Performing Provider will report on the Related Strategies included in the following four Related Strategies Lists associated with those seven Measure Bundle selections:

- Adult Primary Care Prevention and Chronic Disease Management

- *Pediatric Primary Care Prevention and Chronic Disease Management*
- *Dental Care*
- *Hospital Safety*

**H/PP Theme: Access to Care**

Related Strategies in the Access to Care theme are included in the following Related Strategies Lists:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Behavioral Health Integration
- Rural Primary Care
- Rural Emergency Care

RS-ID	Related Strategies Description
1.00	Same-day and/or walk-in appointments in the outpatient setting
1.01	Night and/or weekend appointments in the outpatient setting
1.10	Integration or co-location of primary care and specialty care services (not including behavioral health) in the outpatient setting
1.11	Integration or co-location of primary care and psychiatric services in the outpatient setting
1.12	Telehealth to provide virtual medical appointments and/or consultations with a primary care provider
1.20	Telehealth to provide virtual medical appointments and/or consultations with a specialty care physician (physical health only)
1.21	Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist
1.30	Mobile clinic or other community-based delivery model to provide care outside of the traditional office
1.31	Mobile clinic or other community-based delivery model to provide care at school(s) <i>(Limited to: Pediatric Primary Care and Chronic Disease Management; Dental Care)</i>
1.40	Integration or co-location of primary care and dental services in the outpatient setting <i>(Limited to: Hospital Readmissions and ED Utilization; Dental Care)</i>
1.41	Telehealth to provide virtual appointments and/or consultations with a dentist <i>(Limited to: Hospital Readmissions and ED Utilization; Dental Care)</i>

## H/PP Theme: Care Coordination

Related Strategies from the Care Coordination Theme are included in the following Related Strategies Lists:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Palliative/Specialty Care
- Behavioral Health Integration
- Rural Primary Care
- Rural Emergency Care

RS-ID	Related Strategies Description
2.00	Culturally and linguistically appropriate care planning for patients
2.01	Pre-visit planning and/or standing order protocols (e.g. for screenings/assessments, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.02	Automated reminders/flags within the E.H.R. or other electronic care platform (e.g. for screenings/assessments, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.10	Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)
2.11	Care team includes personnel in a care coordination role requiring clinical licensure (e.g. registered nurse, licensed clinical social worker, etc.)
2.12	Hotline, call center, or other similar programming staffed by personnel with clinical licensure to answer questions for patients (and their families) related to medications, clinical triage, care transitions, etc.
2.20	Formal closed loop process for scheduling a follow-up visit with a primary care provider and/or assigning a primary care provider when none is identified
2.30	Formal closed loop process for scheduling referral visits as needed
2.40	Data sharing connectivity or arrangement with Medicaid Managed Care Organization(s) for patient claims data
2.50	Data sharing connectivity across care settings within provider's integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.51	Data sharing connectivity or Health Information Exchange (HIE) arrangement across care settings external to provider's office/integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.60	Formal closed loop process for coordinating the transition from pediatric to adult care <i>(Limited to: Pediatric Primary Care and Chronic Disease Management)</i>

## H/PP Theme: Data Analytics

Related Strategies from the Data Analytics Theme are included in the following Related Strategies Lists:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Palliative/Specialty Care
- Behavioral Health Integration
- Hospital Safety
- Rural Primary Care
- Rural Emergency Care

RS-ID	Related Strategies Description
3.00	Panel management and/or proactive outreach of patients using a gap analysis method (i.e. strategically targeting patients with missing or overdue screenings, assessments, lab work, etc.)
3.01	Panel management and/or proactive outreach of patients using a risk-stratification method (i.e. strategically targeting patients based on risk factors associated with worsening disease states)
3.10	Database or registry to track quality and clinical outcomes data on patients
3.20	Analysis of appointment "no-show" rates
3.30	Formal partnership or arrangement with post-acute care facilities (e.g. skilled nursing facility, inpatient rehabilitation facility, long-term acute care hospital, home health agency, hospice, etc.) to track/share quality measures such as length of stay and readmission rates, etc. <i>(Limited to: Hospital Readmissions and ED Utilization; Palliative/Specialty Care; Rural Emergency Care)</i>
3.40	Formal partnership or arrangement with schools/school districts to track/share data such as absenteeism, classroom behaviors, etc. <i>(Limited to: Pediatric Primary Care and Chronic Disease Management; Dental Care)</i>

## H/PP Theme: Disease Management

Related Strategies from the Disease Management Theme are included in the following Related Strategies Lists:

- Adult Primary Care and Chronic Disease Management
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Palliative/Specialty Care
- Behavioral Health Integration
- Hospital Safety \*\*
- Rural Primary Care
- Rural Emergency Care

RS-ID	Related Strategies Description
4.00	Care team includes a clinical pharmacist(s)
4.01	Care team includes a behavioral health professional such as a psychologist, licensed clinical social worker, licensed counselor (LPC, LMHC), etc.
4.02	Care team includes a registered dietician(s)
4.10	Group visit model
4.20	Home visit model
4.30	Classes for patients focused on disease self-management (e.g. lifestyle changes, symptom recognition, clinical triage guidance, etc.)
4.31	Classes for patients focused on diet, nutrition counseling, and/or cooking
4.32	Classes for patients focused on physical activity
4.40	Peer-based programming (includes support groups, peer coaching/mentoring, etc.)
4.50	Telehealth to provide remote monitoring of patient biometric data (e.g. HbA1c levels, blood pressure, etc.) and/or medication adherence
4.60	Patient educational materials or campaigns about preventive care (e.g. immunization, preventive screenings, etc.)
4.61	Patient educational materials or campaigns about advance care planning/directives (Limited to: Adult Primary Care and Chronic Disease Management; Palliative/Specialty Care; Rural Primary Care; Rural Emergency Care)
4.70	SBIRT (Screening, Brief Intervention, Referral, and Treatment) workflow (Limited to: Maternal Care and Safety; Palliative/Specialty Care; Behavioral Health Integration; Rural Primary Care)
4.71	Medication-Assisted Treatment (MAT) services (Limited to: Behavioral Health Integration)
4.80	Hospital hand hygiene protocol/programming (Limited to: Hospital Safety)
4.81	Checklist(s) (or similar standardized protocol) tailored to prevent hospital safety-related events (Limited to: Hospital Safety)
4.82	Formal process for monitoring compliance with hospital safety-related protocols (includes reviews, "secret shopper" approaches, etc.) (Limited to: Hospital Safety)
4.83	Formal process for analyzing and addressing hospital safety-related events (includes root-cause analyses, remediation policies, etc.) (Limited to: Hospital Safety)

\*\*The Hospital Safety List will include only RS-4.80, RS-4.81, RS-4.82, and RS-4.83 for this theme

## H/PP Theme: Social Determinants of Health

Related Strategies from the Social Determinants of Health Theme are included in the following Related Strategies Lists:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Palliative/Specialty Care
- Behavioral Health Integration
- Rural Primary Care
- Rural Emergency Care

RS-ID	Related Strategies Description
5.00	Screening patients for food insecurity
5.01	Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)
5.10	Screening patients for housing needs
5.11	Formal partnership or arrangement with housing resources to support patient health status (e.g. affordable housing units, transitional housing, rental assistance, etc.)
5.12	Screening patients for housing quality needs
5.13	Formal partnership or arrangement with housing quality resources to support patient health status (e.g. housing inspections, pest control management, heating and other utility services, etc.)
5.20	Screening patients for transportation needs
5.21	Formal partnership or arrangement with transportation resources to support patient access to care (e.g. public or private transit, etc.)
5.30	Formal partnership or arrangement with schools/school districts to collaborate on health-promoting initiatives (e.g. addressing environmental triggers, healthy lunch options, field day activities, etc.) (Limited to: Pediatric Primary Care and Chronic Disease Management; Dental Care)



## Related Strategies Reporting for Local Health Departments

In DY9-10, Performing Providers will report on lists of Related Strategies by indicating which individual Related Strategies were implemented to achieve improvements in Category C measures for the MLIU patient populations. Local Health Departments will report on Related Strategies Lists as determined by measure selection.

As identified in the table below, measures with similar interventions, care settings, and/or populations may be associated with a single Related Strategies List so that Performing Providers will report only once on the implementation of Related Strategies within that Related Strategies List.

Within each Related Strategies List, the individual Related Strategies are organized into the following Themes: *Access to Care, Care Coordination, Data Analytics, Disease Management, and Social Determinants of Health*. As identified in the tables below for each Theme, individual Related Strategies may be limited to specific Related Strategies Lists.

Local Health Department Measures and associated Related Strategies Lists		
Measure		Related Strategies List
L1-103	Controlling High Blood Pressure	Adult Primary Care Prevention and Chronic Disease Management
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	
L1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	
L1-107	Colorectal Cancer Screening	
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	
L1-186	Breast Cancer Screening	
L1-268	Pneumonia vaccination status for older adults	
L1-269	Preventive Care and Screening: Influenza Immunization	
L1-272	Adults (18+ years) Immunization status	
L1-280	Chlamydia Screening in Women (CHL)	
L1-343	Syphilis positive screening rates	
L1-344	Follow-up after Treatment for Primary or Secondary Syphilis	
L1-345	Gonorrhea Positive Screening Rates	
L1-346	Follow-up testing for N. gonorrhoeae among recently infected men and women	
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	
L1-207	Diabetes care: BP control (<140/90mm Hg)	
L1-160	Follow-Up After Hospitalization for Mental Illness	
L1-242	Reduce Emergency Department visits for Chronic Ambulatory Care Sensitive Conditions (ACSC)	
L1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)	
L1-108	Childhood Immunization Status (CIS)	Pediatric Primary Care
L1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	
L1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)	
L1-271	Immunization for Adolescents	
L1-400	Tobacco Use and Help with Quitting Among Adolescents	

Local Health Department Measures and associated Related Strategies Lists		
Measure		Related Strategies List
L1-235	Post-Partum Follow-Up and Care Coordination	Maternal Care and Safety
L1-224	Dental Sealant: Children	Dental Care
L1-225	Dental Caries: Children	
L1-227	Dental Caries: Adults	
L1-231	Preventive Services for Children at Elevated Caries Risk	
L1-205	Third next available appointment	Access to Care
L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	Criminal Justice

**Example:**

In DY9-10, an LHD has selected five measures: L1-103 Controlling High Blood Pressure, L1-105 Tobacco Screening & Cessation, L1-115 HbA1C Poor Control, L1-225 Dental Caries: Children, and L1-227 Dental Caries: Adult.

The Performing Provider will report on the Related Strategies included in the following two Related Strategies Lists associated with those five measure selections:

- Primary Care Prevention and Chronic Disease Management
- Dental Care

**LHD Theme: Access to Care**

Related Strategies from the Access to Care Theme are included in the following Related Strategies Lists:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Access to Care
- Criminal Justice

<b>RS-ID</b>	<b>Related Strategies Description</b>
1.00	Same-day and/or walk-in appointments in the outpatient setting
1.01	Night and/or weekend appointments in the outpatient setting
1.10	Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting
1.11	Integration or co-location of primary care and psychiatric services in the outpatient setting
1.12	Telehealth to provide virtual medical appointments and/or consultations with a primary care provider
1.20	Telehealth to provide virtual medical appointments and/or consultations with a specialty care physician (physical health only)
1.21	Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist
1.30	Mobile clinic or other community-based delivery model to provide care outside of the traditional office
1.31	Mobile clinic or other community-based delivery model to provide care at school(s) <i>(Limited to: Pediatric Primary Care and Chronic Disease Management; Dental Care)</i>
1.40	Integration or co-location of primary care and dental services in the outpatient setting <i>(Limited to: Dental Care)</i>
1.41	Telehealth to provide virtual appointments and/or consultations with a dentist <i>(Limited to: Dental Care)</i>

## LHD Theme: Care Coordination

Related Strategies from the Care Coordination Theme are included in the following Related Strategies Lists:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Criminal Justice

RS-ID	Related Strategies Description
2.00	Culturally and linguistically appropriate care planning for patients
2.01	Pre-visit planning and/or standing order protocols (e.g. for screenings/assessments, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.02	Automated reminders/flags within the E.H.R. or other electronic care platform (e.g. for screenings/assessments, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.10	Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)
2.11	Care team includes personnel in a care coordination role requiring clinical licensure (e.g. registered nurse, licensed clinical social worker, etc.)
2.12	Hotline, call center, or other similar programming staffed by personnel with clinical licensure to answer questions for patients (and their families) related to medications, clinical triage, care transitions, etc.
2.20	Formal closed loop process for scheduling a follow-up visit with a primary care provider and/or assigning a primary care provider when none is identified
2.30	Formal closed loop process for scheduling referral visits as needed
2.40	Data sharing connectivity or arrangement with Medicaid Managed Care Organization(s) for patient claims data
2.50	Data sharing connectivity across care settings within provider's integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.51	Data sharing connectivity or Health Information Exchange (HIE) arrangement across care settings external to provider's office/integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.60	Formal closed loop process for coordinating the transition from pediatric to adult care (Limited to: Pediatric Primary Care and Chronic Disease Management)

**LHD Theme: Data Analytics**

Related Strategies from the Data Analytics Theme are included in the following Related Strategies Lists:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Access to Care
- Criminal Justice

RS-ID	Related Strategies Description
3.00	Panel management and/or proactive outreach of patients using a gap analysis method (i.e. strategically targeting patients with missing or overdue screenings, assessments, lab work, etc.)
3.01	Panel management and/or proactive outreach of patients using a risk-stratification method (i.e. strategically targeting patients based on risk factors associated with worsening disease states)
3.10	Database or registry to track quality and clinical outcomes data on patients
3.20	Analysis of appointment "no-show" rates
3.30	Formal partnership or arrangement with post-acute care facilities (e.g. skilled nursing facility, inpatient rehabilitation facility, long-term acute care hospital, home health agency, hospice, etc.) to track/share quality measures such as length of stay and readmission rates, etc. <i>(Limited to: Hospital Readmissions and ED Utilization)</i>
3.40	Formal partnership or arrangement with schools/school districts to track/share data such as absenteeism, classroom behaviors, etc. <i>(Limited to: Pediatric Primary Care and Chronic Disease Management; Dental Care)</i>

**LHD Theme: Disease Management**

Related Strategies from the Disease Management Theme are included in the following Related Strategies Lists:

- Adult Primary Care and Chronic Disease Management
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Criminal Justice

**RS-ID Related Strategies Description**

4.00	Care team includes a clinical pharmacist(s)
4.01	Care team includes a behavioral health professional such as a psychologist, licensed clinical social worker, licensed counselor (LPC, LMHC), etc.
4.02	Care team includes a registered dietician(s)
4.10	Group visit model
4.20	Home visit model
4.30	Classes for patients focused on disease self-management (e.g. lifestyle changes, symptom recognition, clinical triage guidance, etc.)
4.31	Classes for patients focused on diet, nutrition counseling, and/or cooking
4.32	Classes for patients focused on physical activity
4.40	Peer-based programming (includes support groups, peer coaching/mentoring, etc.)
4.50	Telehealth to provide remote monitoring of patient biometric data (e.g. HbA1c levels, blood pressure, etc.) and/or medication adherence
4.60	Patient educational materials or campaigns about preventive care (e.g. immunization, preventive screenings, etc.)
4.70	SBIRT (Screening, Brief Intervention, Referral, and Treatment) workflow (Limited to: Maternal Care and Safety; Criminal Justice)
4.71	Medication-Assisted Treatment (MAT) services (Limited to: Criminal Justice)

## LHD Theme: Social Determinants of Health

Related Strategies from the Social Determinants of Health Theme are included in the following Related Strategies Lists:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Access to Care \*\*
- Criminal Justice

RS-ID	Related Strategies Description
5.00	Screening patients for food insecurity
5.01	Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)
5.10	Screening patients for housing needs
5.11	Formal partnership or arrangement with housing resources to support patient health status (e.g. affordable housing units, transitional housing, rental assistance, etc.)
5.12	Screening patients for housing quality needs
5.13	Formal partnership or arrangement with housing quality resources to support patient health status (e.g. housing inspections, pest control management, heating and other utility services, etc.)
5.20	Screening patients for transportation needs
5.21	Formal partnership or arrangement with transportation resources to support patient access to care (e.g. public or private transit, etc.)
5.30	Formal partnership or arrangement with schools/school districts to collaborate on health-promoting initiatives (e.g. addressing environmental triggers, healthy lunch options, field day activities, etc.) (Limited to: Pediatric Primary Care and Chronic Disease Management; Dental Care)
**The Access to Care List will include only RS-5.20 and RS-5.21 for this theme	

## Related Strategies Reporting for Community Mental Health Centers

In DY9-10, Performing Providers will report on lists of Related Strategies by indicating which individual Related Strategies were implemented to achieve improvements in Category C measures for the MLIU patient populations. Community Mental Health Centers will report on Related Strategies Lists as determined by measure selection.

As identified in the table below, measures with similar interventions, care settings, and/or populations may be associated with a single Related Strategies List so that Performing Providers will report only once on the implementation of Related Strategies within that Related Strategies List.

Within each Related Strategies List, the individual Related Strategies are organized into the following Themes: *Access to Care*, *Care Coordination*, *Data Analytics*, *Disease Management*, and *Social Determinants of Health*. As identified in the tables below for each Theme, individual Related Strategies may be limited to specific Related Strategies Lists.

Community Mental Health Centers Measures and associated Related Strategies Lists			
Measure		Related Strategies List	
M1-103	Controlling High Blood Pressure	Physical Health Comorbidities	
M1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention		
M1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)		
M1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up		
M1-182	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)		
M1-203	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk		
M1-207	Diabetes care: BP control (<140/90mm Hg)		
M1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented		
M1-259	Assignment of Primary Care Physician to Individuals with Schizophrenia		
M1-260	Annual Physical Exam for Persons with Mental Illness		
M1-280	Chlamydia Screening in Women (CHL)		
M1-124	Medication Reconciliation Post-Discharge		Hospital Readmissions and Emergency Department Utilization
M1-160	Follow-Up After Hospitalization for Mental Illness		
M1-216	Risk Adjusted Behavioral Health/ Substance Abuse 30-Day Readmission Rate		
M1-287	Documentation of Current Medications in the Medical Record		
M1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)		
M1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	Children and Adolescents	
M1-255	Follow-up Care for Children Prescribed ADHD Medication (ADD)		
M1-305	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-CH)		
M1-306	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)*		
M1-400	Tobacco Use and Help with Quitting Among Adolescents		



Community Mental Health Centers Measures and associated Related Strategies Lists			
Measure		Related Strategies List	
M1-385	Assessment of Functional Status or QoL (Modified from NQF# 0260/2624)	Specialty Care (Chronic and Life Impacting Conditions)	
M1-386	Improvement in Functional Status or QoL (Modified from PQRS #435)		
M1-125	Antidepressant Medication Management (AMM-AD)	Serious Mental Illness (SMI): Depression	
M1-146	Screening for Clinical Depression and Follow-Up Plan (CDF-AD)		
M1-165	Depression Remission at Twelve Months		
M1-181	Depression Response at Twelve Months- Progress Towards Remission		
M1-256	Initiation of Depression Treatment		
M1-262	Assessment of Risk to Self/ Others		
M1-286	Depression Remission at Six Months		
M1-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (eMeasure)		
M1-180	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD)		Serious Mental Illness: Schizophrenia
M1-263	Assessment for Psychosocial Issues of Psychiatric Patients		
M1-264	Vocational Rehabilitation for Schizophrenia		
M1-265	Housing Assessment for Individuals with Schizophrenia		
M1-266	Independent Living Skills Assessment for Individuals with Schizophrenia		
M1-100	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Dual Diagnosis and Substance Use Disorder (SUD) Treatment	
M1-257	Care Planning for Dual Diagnosis		
M1-261	Assessment for Substance Abuse Problems of Psychiatric Patients		
M1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling		
M1-339	Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge SUB-3 / Alcohol and Other Drug Use Disorder Treatment at Discharge SUB-3a		
M1-340	Substance use disorders: Percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12-month reporting period		
M1-341	Substance use disorders: Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period		
M1-405	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use		
M1-205	Third next available appointment		Access to Care
M1-342	Time to Initial Evaluation: Evaluation within 10 Business Days		
M1-390	Time to Initial Evaluation: Mean Days to Evaluation		
M1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	Criminal Justice	

*Example:*

*In DY9-10, a CMHC has selected five measures: M1-103 Controlling High Blood Pressure, M1-115 HbA1c Poor Control, M1-147 BMI Screening and Follow-Up, M1-125 Antidepressant Medication Management, and M1-146 Screening for Clinical Depression and Follow Up Plan.*

*The Performing Provider will report on the Related Strategies included in the following two Related Strategies Lists associated with those five measure selections:*

- *Physical Health Comorbidities*
- *Serious Mental Illness: Depression*

**CMHC Theme: Access to Care**

Related Strategies from the Access to Care Theme are included in the following Related Strategies Lists:

- Physical Health Comorbidities
- Hospital Readmissions and ED Utilization
- Children and Adolescents
- SMI: Depression
- SMI: Schizophrenia
- Dual Diagnosis/SUD Treatment
- Access to Care
- Criminal Justice

RS-ID	Related Strategies Description
1.00	Same-day and/or walk-in appointments in the outpatient setting
1.01	Night and/or weekend appointments in the outpatient setting
1.10	Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting
1.11	Integration or co-location of primary care and psychiatric services in the outpatient setting
1.12	Telehealth to provide virtual medical appointments and/or consultations with a primary care provider
1.20	Telehealth to provide virtual medical appointments and/or consultations with a specialty care physician (physical health only)
1.21	Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist
1.22	Integration or co-location of psychiatry and substance use disorder treatment services in the outpatient setting
1.30	Mobile clinic or other community-based delivery model to provide care outside of the traditional office
1.31	Mobile clinic or other community-based delivery model to provide care at school(s) (Limited to: Children and Adolescents)

## CMHC Theme: Care Coordination

Related Strategies from the Care Coordination Theme are included in the following Related Strategies Lists:

- Physical Health Comorbidities
- Hospital Readmissions and ED Utilization
- Children and Adolescents
- Specialty Care
- SMI: Depression
- SMI: Schizophrenia
- Dual Diagnosis/SUD Treatment
- Criminal Justice

RS-ID	Related Strategies Description
2.00	Culturally and linguistically appropriate care planning for patients
2.01	Pre-visit planning and/or standing order protocols (e.g. for screenings/assessments, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.02	Automated reminders/flags within the E.H.R. or other electronic care platform (e.g. for screenings/assessments, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.10	Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)
2.11	Care team includes personnel in a care coordination role requiring clinical licensure (e.g. registered nurse, licensed clinical social worker, etc.)
2.12	Hotline, call center, or other similar programming staffed by personnel with clinical licensure to answer questions for patients (and their families) related to medications, clinical triage, care transitions, etc.
2.20	Formal closed loop process for scheduling a follow-up visit with a primary care provider and/or assigning a primary care provider when none is identified
2.30	Formal closed loop process for scheduling referral visits as needed
2.40	Data sharing connectivity or arrangement with Medicaid Managed Care Organization(s) for patient claims data
2.50	Data sharing connectivity across care settings within provider's integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.51	Data sharing connectivity or Health Information Exchange (HIE) arrangement across care settings external to provider's office/integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.60	Formal closed loop process for coordinating the transition from pediatric to adult care (Limited to: Children and Adolescents)

## CMHC Theme: Data Analytics

Related Strategies from the Data Analytics Theme are included in the following Related Strategies Lists:

- Physical Health Comorbidities
- Hospital Readmissions and ED Utilization
- Children and Adolescents
- Specialty Care
- SMI: Depression
- SMI: Schizophrenia
- Dual Diagnosis/SUD Treatment
- Access to Care
- Criminal Justice

RS-ID	Related Strategies Description
3.00	Panel management and/or proactive outreach of patients using a gap analysis method (i.e. strategically targeting patients with missing or overdue screenings, assessments, lab work, etc.)
3.01	Panel management and/or proactive outreach of patients using a risk-stratification method (i.e. strategically targeting patients based on risk factors associated with worsening disease states)
3.10	Database or registry to track quality and clinical outcomes data on patients
3.20	Analysis of appointment "no-show" rates
3.30	Formal partnership or arrangement with post-acute care facilities (e.g. skilled nursing facility, inpatient rehabilitation facility, long-term acute care hospital, home health agency, hospice, etc.) to track/share quality measures such as length of stay and readmission rates, etc. <i>(Limited to: Hospital Readmissions &amp; ED Utilization; Specialty Care)</i>
3.40	Formal partnership or arrangement with schools/school districts to track/share data such as absenteeism, classroom behaviors, etc. <i>(Limited to: Children and Adolescents)</i>

## CMHC Theme: Disease Management

Related Strategies from the Disease Management Theme are included in the following Related Strategies Lists:

- Physical Health Comorbidities
- Children and Adolescents
- Specialty Care
- SMI: Depression
- SMI: Schizophrenia
- Dual Diagnosis/SUD Treatment
- Criminal Justice

RS-ID	Related Strategies Description
4.00	Care team includes a clinical pharmacist(s)
4.01	Care team includes a behavioral health professional such as a psychologist, licensed clinical social worker, licensed counselor (LPC, LMHC), etc.
4.02	Care team includes a registered dietician(s)
4.10	Group visit model
4.20	Home visit model
4.30	Classes for patients focused on disease self-management (e.g. lifestyle changes, symptom recognition, clinical triage guidance, etc.)
4.31	Classes for patients focused on diet, nutrition counseling, and/or cooking
4.32	Classes for patients focused on physical activity
4.40	Peer-based programming (includes support groups, peer coaching/mentoring, etc.)
4.50	Telehealth to provide remote monitoring of patient biometric data (e.g. HbA1c levels, blood pressure, etc.) and/or medication adherence
4.60	Patient educational materials or campaigns about preventive care (e.g. immunization, preventive screenings, etc.)
4.70	SBIRT (Screening, Brief Intervention, Referral, and Treatment) workflow
4.71	Medication-Assisted Treatment (MAT) services <i>(Limited to: Dual Diagnosis/SUD Treatment; Criminal Justice)</i>

## CMHC Theme: Social Determinants of Health

Related Strategies from the Social Determinants of Health Theme are included in the following Related Strategies Lists:

- Physical Health Comorbidities
- Hospital Readmissions and ED Utilization
- Children and Adolescents
- Specialty Care
- SMI: Depression
- SMI: Schizophrenia
- Dual Diagnosis/SUD Treatment
- Access to Care\*\*
- Criminal Justice

RS-ID	Related Strategies Description
5.00	Screening patients for food insecurity
5.01	Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)
5.10	Screening patients for housing needs
5.11	Formal partnership or arrangement with housing resources to support patient health status (e.g. affordable housing units, transitional housing, rental assistance, etc.)
5.12	Screening patients for housing quality needs
5.13	Formal partnership or arrangement with housing quality resources to support patient health status (e.g. housing inspections, pest control management, heating and other utility services, etc.)
5.20	Screening patients for transportation needs
5.21	Formal partnership or arrangement with transportation resources to support patient access to care (e.g. public or private transit, etc.)
5.30	Formal partnership or arrangement with schools/school districts to collaborate on health-promoting initiatives (e.g. addressing environmental triggers, healthy lunch options, field day activities, etc.) (Limited to: Children and Adolescents)
**The Access to Care List will include only RS-5.20 and RS-5.21 for this theme	

## Category D

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Category D represents a population health perspective for all DSRIP Performing Providers. Whereas the initial waiver period included Category 4 statewide reporting for hospitals, Category D includes measures for all DSRIP Performing Provider types including hospitals, CMHCs, physician practices, and LHDs. This reporting is designed to assist Performing Providers, MCOs, Regional Healthcare Partnerships (RHP), and state and federal agencies to have regional and statewide views of important health care trends. The Category D reporting Measure Bundles are:

- Aligned with Medicaid and LIU populations;
- Identified as high priority given the health care needs and issues of the patient population served; and
- Viewed as valid health care indicators to inform and identify areas for improvement in population health within the health care system.

### **Category D Structure:**

Required Statewide Reporting Measure Bundles for each of the Performing Provider types:

- Hospitals
- CMHCs
- Physician practices
- LHDs

The Category D emphasis is on the reporting of population health measures to gain information on and understanding of the health status of key populations and to build the capacity for reporting on a comprehensive set of population health metrics; therefore, Performing Providers will not be required to achieve improvement in Category D. All measures are required and may be reported in the first or second reporting period of each DY. Performing Providers will also submit qualitative information describing Performing Providers' activities impacting measures. Measure reporting and qualitative information will be submitted in the form prescribed by HHSC.

### Hospital Statewide Reporting Measure Bundle

As specified in the PFM, hospital Performing Providers must report on all measures included in this bundle:

- Potentially preventable admissions (PPAs)
- Potentially Preventable 30-day readmissions (PPRs)
- Potentially preventable complications (PPCs)
- Potentially Preventable ED visits (PPVs)
- Patient satisfaction

Hospital Performing Providers report on the Category D Statewide Hospital Reporting Measure Bundle, including hospitals that were previously exempt from the reporting on population health measures during DY2-6. Each hospital Performing Provider subject to required Category D reporting must report on all measures.



For PPAs, PPRs, PPCs and PPVs, hospitals with low volume are still required to respond to qualitative questions.

## Hospital Reporting Measures

### Potentially Preventable Admissions (PPAs)

PPAs are facility admissions that may have resulted from the lack of adequate access to care or ambulatory care coordination. Circumstances associated with PPAs are ambulatory sensitive conditions (e.g., asthma) for which adequate patient monitoring and follow-up (e.g., medication management) can often avoid the need for admission. The occurrence of high rates of PPAs may represent a failure of the ambulatory care provided to the patient. In addition to a significant quality problem, excess PPAs result in unnecessary increases in cost. From the perspective of care providers, one way to improve efficiency and quality and to generate greater value is to better identify and avoid unnecessary hospitalizations.

#### PPA by Category

CHF (Congestive Heart Failure)
DM (Diabetes)
BH/SA (Behavioral Health/Substance Abuse)
COPD (Chronic Obstructive Pulmonary Disease)
Adult Asthma
Pediatric Asthma
CP & CAD (Angina and Coronary Artery Disease)
HTN (Hypertension)
Cellulitis
Bacterial PNA (Respiratory Infection)
PE & RF (Pulmonary Edema and Respiratory Failure)
Others

### Potentially Preventable Readmissions (PPRs)

Readmissions have potential value as an indicator of quality of care because they may reflect poor clinical care and poor coordination of services either during hospitalization or in the immediate post discharge period. A potentially preventable readmission is a readmission (return hospitalization within the specified readmission time interval) that is clinically related to the initial hospital admission. “Clinically related” is defined as a requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following a prior hospital admission. A readmission is defined as a return hospitalization to an acute care hospital that follows a prior acute care admission within a specified time interval, called the readmission time interval. The readmission time interval is the

maximum number of days allowed between the discharge date of a prior admission and the admitting date of a subsequent admission. If a subsequent admission occurs within the readmission time interval and is clinically related to a prior admission, it is considered a PPR. The hospitalization triggering a PPR is called an Initial Admission. Subsequent PPRs relate back to the care rendered during or following the Initial Admission.

**PPR by Category**

CHF (Congestive Heart Failure)
DM (Diabetes)
BH/SA (Behavioral Health or Substance Abuse)
COPD (Chronic Obstructive Pulmonary Disease)
CVA (Cerebrovascular Accident)
Adult Asthma
Pediatric Asthma
AMI (Acute Myocardial Infarction)
CP & CAD (Angina and Coronary Artery Disease)
HTN (Hypertension)
Cellulitis
Renal Failure
C Section (Cesarean delivery)
Sepsis
Others

**Potentially Preventable Complications (PPCs)**

PPCs are in-hospital complications that are not present on admission but result from treatment during the inpatient stay. As indicators of quality of care, PPCs represent harmful events or negative outcomes that might result from processes of care and treatment rather than from natural progression of the underlying disease. Increased costs resulting from complications are passed on to payers because the diagnosis codes linked to complications frequently increase Diagnosis Related Group (DRG) payment.

The 3M PPC methodology identifies PPCs based on risk at admission, using information from inpatient encounters, such as diagnosis codes, procedure codes, procedure dates, present on admission (POA) indicators, patient age, sex, and discharge status. Accurate coding of the POA indicators is particularly important as it serves two primary purposes: (1) to identify potentially preventable complications from among diagnoses not present on admission and (2) to allow only those diagnoses designated as present on admission to be used for assessing the risk of incurring complications.

### PPC by Category

Renal Failure without Dialysis
Urinary Tract Infection
Clostridium Difficile Colitis
Encephalopathy
Shock
Pneumonia & Other Lung Infections
Acute Pulmonary Edema and Respiratory Failure without Ventilation
Stroke and Intracranial Hemorrhage
Post Hemorrhagic & Other Acute Anemia with Transfusion
Venous Thrombosis
Ventricular Fibrillation/Cardiac Arrest
Major Gastrointestinal Complications without Transfusion or Significant Bleeding
Other Complications of Medical Care
Moderate Infections
Inflammation & Other Complications of Devices, Implants or Grafts except Vascular Infection
Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Procedure
Septicemia & Severe Infections
Acute Pulmonary Edema and Respiratory Failure with Ventilation
Post-Operative Infection & Deep Wound Disruption without Procedure
Infections due to Central Venous Catheters

**Potentially Preventable ED visits (PPVs)**

A PPV is an emergency treatment for a condition that could have been treated or prevented by a physician or other health care provider in a nonemergency setting. Because some visits are preventable, they may indicate poor care management, inadequate access to care, or poor choices on the part of the patient. ED visits for conditions that are preventable or treatable with appropriate primary care lower health system efficiency and raise costs.

**PPV by Category**

Skin and Integumentary System
Breast
Musculoskeletal System
Respiratory System
Cardiovascular System
Hematologic, Lymphatic and Endocrine
Gastrointestinal
Genitourinary System
Male Reproductive System
Female Reproductive System
Neurologic System
Ophthalmologic System
Otolaryngologic System
Radiologic Procedures
Rehabilitation
Mental Illness and Substance Abuse Therapies
Nuclear Medicine
Radiation Oncology
Dental Procedures

## Patient Satisfaction

Reporting on Patient Satisfaction is limited to the inpatient setting.

For Patient Satisfaction, Performing Providers will report the percentage of survey respondents who choose the most positive, or "top-box," response for the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Reporting Measures:

- Percent of patients who reported that their doctors "Always" communicated well
- Percent of patients who reported that their nurses "Always" communicated well
- Percent of patients who reported that their pain was "Always" well controlled <sup>1</sup>
- Percent of patients who reported that staff "Always" explained about medicines before giving it to them
- Percent of patients who reported that YES, they were given information about what to do during their recovery at home
- Percent of patients who reported that their room and bathroom were "Always" clean
- Percent of patients who reported that the area around their room was "Always" quiet at night
- Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)
- Percent of patients who reported YES, they would definitely recommend the hospital.

Hospitals that do not report HCAHPS as part of Medicare Inpatient Prospective Payment System due to low volume or other exempt status may use an alternative hospital patient satisfaction survey.

## Community Mental Health Center Statewide Reporting Measure Bundle

CMHCs will report on their activities being carried out to impact rates on the following measures and provide qualitative reporting as required by HHSC<sup>2</sup>:

### 1. Effective Crisis Response

This measure is the percent of individuals receiving crisis services who avoid inpatient admission after the crisis episode.

### 2. Crisis Follow up

This measure is the percent of individuals receiving crisis services who receive a crisis follow up services within a defined time period.

### 3. Community Tenure (Adult and Child/Youth)

This measure is the percent of individuals who successfully avoid psychiatric inpatient care.

### 4. Reduction in Juvenile Justice Involvement

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<sup>1</sup> This question will most likely be substituted for DY9-10 reporting.

<sup>2</sup> Some measures may be modified at the end of DY9-10. CMHCs will report based on the modified measure specifications once approved by HHSC.

This measure is the percent of children and youth who demonstrate improvement on indicators of juvenile justice involvement.

## 5. Adult Jail Diversion

This measure is the percent adults who demonstrate improvement on indicators of criminal justice involvement.

## Physician Practices Statewide Reporting Measure Bundle

Physician practices report on their activities being carried out to impact rates measured by Prevention Quality Indicators (PQIs). Based on the description by the AHRQ, PQIs are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

Even though these indicators are based on hospital inpatient data, they provide insight into the community health care system or services outside the hospital setting. For example, patients with diabetes may be hospitalized for diabetic complications if their conditions are not adequately monitored or if they do not receive the patient education needed for appropriate self-management.

Based on the regional summary of the PQIs that HHSC will make available to the Performing Providers, each physician practice will provide qualitative information on their efforts to impact these rates.

1. Diabetes Short-term Complications Admission Rate
2. Perforated Appendix Admission Rate
3. Diabetes Long-term Complications Admission Rate
4. Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
5. Hypertension Admission Rate
6. Heart Failure Admission Rate
7. Low Birth Weight Rate
8. Dehydration Admission Rate
9. Bacterial Pneumonia Admission Rate
10. Urinary Tract Infection Admission Rate
11. Uncontrolled Diabetes Admission Rate
12. Asthma in Younger Adults Admission Rate
13. Lower-Extremity Amputation among Patients with Diabetes Rate

## Local Health Departments Statewide Reporting Measure Bundle

Based on the information available via Texas Behavioral Risk Factor Surveillance System (BRFSS)<sup>3</sup>, HHS agencies will provide a RHP specific summary for the following areas:

- Access to health care services
- Health status of the population
- Selected immunizations
- Prevention of sexually transmitted diseases

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<sup>3</sup> Additional information on BRFSS is available in Appendix B

Each LHD will provide a qualitative description of what is carried out by that LHD in its region to impact the rates and trends of the following measures:

- 1. Time Since Routine Checkup**
  - BRFSS Questionnaire: About how long has it been since you last visited a doctor for a routine checkup?
- 2. High Blood Pressure Status**
  - BRFSS Calculated Variable: Doctor diagnosed high blood pressure
- 3. Diabetes Status**
  - BRFSS Calculated Variable: Doctor diagnosed diabetes
- 4. Overweight or Obese**
  - BRFSS Calculated Variable: Overweight or obese
- 5. Smoker Status**
  - BRFSS Calculated Variable: Four-level smoker status (Current Smoker - Every Day; Current Smoker - Some Days; Former Smoker; and Never Smoker)
- 6. Selected Immunizations**
  - **Flu Shot Past Year**
    - BRFSS Questionnaire: During the past 12 months, have you had either a seasonal flu shot or a seasonal flu vaccine that was sprayed in your nose?
  - **Ever Had Pneumonia Shot**
    - BRFSS Questionnaire: Have you ever had a pneumonia shot?
  - **Received Tetanus Shot Since 2005**
    - BRFSS Questionnaire: Since 2005, have you had a tetanus shot? Was this Tdap, the tetanus shot that also has pertussis or whooping cough vaccine?
  - **Ever Had MMR Vaccine**
    - BRFSS Questionnaire: Have you ever received the MMR vaccine?
  - **Had All HPV Shots**
    - Calculated Variable: Received all 3 HPV shots
- 7. Prevention of Sexually Transmitted Diseases**
  - **Ever Had HIV Test**
    - BRFSS Questionnaire: Have you ever been tested for HIV?

## Appendix B

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Regional summaries with selected health information are generated based on the data collected by the Department of State Health Services via BRFSS. BRFSS, initiated in 1987, is a federally supported landline and cellular telephone survey that collects data about Texas residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Texas BRFSS is an important tool for decision-making throughout the Texas Health and Human Services, Texas Department of State Health Services and the public health community. Public and private health officials at the federal, state, and local levels rely on the BRFSS to identify public health problems, set priorities and goals, design policies and interventions, as well as evaluate the long-term impact of these efforts.

This surveillance can be used to monitor the Healthy People 2020 Objectives for current smoking, obesity, high blood pressure, exercise and physical activity, flu and pneumonia vaccinations, cholesterol and cancer screenings, seat belt use, as well as other risk factors.

The BRFSS is administered under the direction of the Centers for Disease Control and Prevention (CDC) so that survey methods and much of the questionnaire are standardized across all BRFSS surveys in the 50 states, three territories, and the District of Columbia. As a result, comparisons can be made among states and to the nation.