

Department of Health Services

Behavioral Health Integrated Care

Health Home Certification Application

(Langlade, Lincoln, and Marathon Counties)

December 18, 2013

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(Langlade, Lincoln, and Marathon Counties)

1. INTRODUCTION

Approximately one-third of the Medicaid population in Wisconsin is not enrolled in managed care. Within the non-managed care Medicaid population, the Department of Health Services (DHS) has identified a population of approximately 17,000 individuals in the state on an annual basis with one or more mental health or substance abuse conditions who would likely benefit from participation in a Behavioral Health Integrated Care (BHIC) health home model.

The BHIC health home will focus on preventive services, wellness, and chronic and acute care for both behavioral and physical health needs. BHIC is being developed to achieve the following goals:

- Improve the quality of health care for individuals eligible for BHIC.
- Provide additional care coordination and care management resources for individuals eligible for BHIC.
- Provide access to dental services for individuals eligible for BHIC.
- Reduce costs over time compared to fee-for-service Medicaid.

2. INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

Interested applicants should complete the attached contact sheet and indicate how the requirements of this application will be met. The BHIC health home applicant must be the lead administrative agency.

Completed applications should be submitted to Jami Crespo by **January 31, 2014**. Email applications are preferred. Questions about the application should also be directed to Jami Crespo.

Jami Crespo
Wisconsin Department of Health Services
Division of Health Care Access and Accountability
1 West Wilson Street, Room 350
PO Box 309
Madison, WI 53701-0309
608-267-9697
jami.crespo@wisconsin.gov

3. ADMINISTRATIVE REQUIREMENTS

- Organizational Capacity

The BHIC health home must be a Medicaid certified provider with the capability to:

- Serve as the lead administrative agency among multiple Medicaid certified primary and behavioral health care providers.
- Provide comprehensive team-based health care services to a population with mental health, substance abuse, and chronic medical health conditions.
- Provide the Medicaid Standard Plan array of services or have the ability to coordinate those services with other health care providers in the community.
- Demonstrate the core competencies in this application upon certification.
- Administer and adhere to the quality improvement requirements in this application.
- Serve Medicaid members in the following three counties: Langelade, Lincoln, and Marathon.
- Contract with DHS to provide the care coordination services in this application.

- Personnel

The health home must employ or contract with a medical team of professionals that meet the requirements in this application.

- Electronic Medical Records

The health home must have an electronic medical records system and must demonstrate how health care information will be shared with other health care providers and key personnel to meet the care coordination and quality improvement requirements in this application.

The health home must document its policies and procedures for safeguarding member health care information in its electronic medical records' system and in its manual files.

4. MEMORANDA OF UNDERSTANDING (MOUs)/CONTRACTS

- Required Agreements/Contracts

The BHIC health home must have a memorandum of understanding or a contract with the other participating health care providers in the three counties.

- Basic Contract Requirements: The MOU or contract must contain the following required information:
 - Contact information for the health home and other health care provider(s) responsible for executing the agreement or contract.

- Dated signatures by the directors of the health home and other health care provider(s).
- Referral procedures for services to the health home and other health care provider(s).
- Clearly defined responsibilities between the health home and the other health care provider(s) with respect to the BHIC health home members, their peers, families and others as appropriate.
- Procedures for the coordination of assessment and care plan information between the health home and other relevant health care providers.
- A clearly defined process for communication between the other health care provider(s) on behalf of enrolled members, their peers, families, and others as appropriate.
- A process for resolving conflicts between health care providers regarding areas of mutual responsibility on behalf of enrolled members.
- Relevant language regarding HIPAA and protected health information or a separate agreement covering these requirements.

5. COMPREHENSIVE TEAM-BASED HEALTH CARE

The BHIC health home must have a core team of professionals that include the following personnel:

- Primary care physician or nurse practitioner
- Medical case manager
- Mental health and/or substance abuse professional
- Care coordinator (could be one of the other members of the core team)
- Pharmacist
- Others professionals as needed and appropriate. Examples include:
 - Nutritionist
 - Additional mental health or substance abuse professionals or providers
 - Social services support staff
 - Peer specialists

Each team will have a lead to ensure that there is communication, coordination, and consultation among the team. The team lead and the care coordinator can be the same individual.

6. CARE COORDINATION SERVICES

The team must provide the following health home services to enrolled individuals in accordance with the identified needs of each person:

- **Comprehensive care management**-Comprehensive care management involves the use of evidence-based guidelines to provide systematic, responsive and coordinated management of all aspects of primary and specialty care (physical and behavioral needs) for individuals with a mental illness and/or substance abuse issues.
- **Care coordination**-Care coordination is the ongoing management of the patient's medical, behavioral, pharmacological, dental, and community care needs by a designated team lead (usually the team lead is the care coordinator). The team lead will ensure that the patient has a current, written, individualized, multidisciplinary care and treatment plan that addresses all aspects of the patient's care (including preventive care needs, all medical subspecialties, institutional care, home and community care).
- **Health promotion**-Health promotion services include all activities aimed at prevention and assisting the patient in better understanding their mental illness, substance abuse, and chronic health conditions. Enhanced patient education and active promotion of self-management and self-care are part of health promotion.
- **Comprehensive transitional care**-Comprehensive transitional care, including appropriate follow-up from inpatient to other settings, involves the establishment of an automatic referral arrangement between institutional care providers and the health home provider to ensure that there is immediate communication and/or referrals of patients with mental illness who are admitted to an institution or are seen in the emergency room. Automatic referrals include the establishment of policies and procedures to assure that there is systematic and timely sharing of information related to the patient's institutional or emergency room care.

Transitional care will include timely face-to-face or telephone contacts with the patient (or the patient's authorized representative) after an emergency room visit or an institutional discharge. Institutions include hospitals and nursing homes. Transitional care includes reviewing the discharge summary with the patient and assisting them in receiving the recommended care, including scheduling follow-up appointments and filling prescriptions.

- **Individual, family and peer supports (including authorized representatives)**- These include activities related to advocating on the member's behalf and mobilizing services and support for the member. It includes contacts with anyone identified as instrumental to the member's day-to-day support and care. Peer-to-peer information

sharing and support are included in these support services. Individual and family support services include providing information in a manner that is simple, clear, straightforward and culturally appropriate.

- **Referral to community and social support services**-Referral to community and social support services includes activities related to providing assistance to members to ensure they have access to social support services identified in the care plan.

To the extent feasible, the health home provider should establish meaningful working relationships with community-based organizations that provide support services to individuals with mental illness.

- **Use of information technology to link services, as feasible and appropriate**-The health home should coordinate relevant clinical information in the member's electronic medical records from multiple health care providers and share that information electronically as much as feasible in a timely enough manner to affect clinical decision-making.

7. CORE HEALTH HOME PROVIDER COMPETENCIES

The BHIC health home must demonstrate the ability to meet the following requirements as a condition of certification:

- Co-locate behavioral health services within the medical clinic or have the ability to move medical staff to where the behavioral health services are located in a manner that facilitates the coordination of individual member services.
- Implement strategies to engage members in the assessment, care planning and care coordination processes used by the health home.
- Establish a consumer advisory committee or a process that involves consumers in advising the BHIC health home on policies and procedures affecting members.
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical physical and behavioral health care related needs and services. The plan must be based on a comprehensive assessment conducted at least annually by the health home team and updated along with the plan as needed throughout the year.
- Provide access to chronic disease management, including self-management support, to individuals and their families as appropriate.

- Coordinate and provide quality-driven, cost effective, culturally appropriate, person-centered services.
- Coordinate and provide access to high quality health care and preventive health services informed by evidence-based guidelines.
- Coordinate and provide access to quality behavioral health services, including treatment for substance abuse disorders, informed by evidence-based guidelines.
- Follow evidence-based clinical practice guidelines in providing mental health and substance abuse treatment.
- Provide access to preventative, diagnostic, and restorative dental care.
- Demonstrate a capacity to use health information technology to: link services; and facilitate communication among health home team members, between the team and individual and family caregivers, and between other relevant health care providers as appropriate to ensure continuity of care for the member.
- Demonstrate the capacity to use a population management tool (such as a patient registry) and the ability to evaluate results from patient data to implement interventions that improve patient outcomes.
- Demonstrate the capacity to implement a prescription drug monitoring program that routinely reviews prescribed medications across the population of enrolled members and recommends practice-level and individual-level changes in prescribing practices, individual prescriptions, and monitoring procedures as needed.
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from an inpatient stay to community care.
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.

Some of these requirements may be deemed if the designated provider is accredited as a health home by the National Committee on Quality Assurance (NCQA), or another nationally recognized accreditation organization.

8. QUALITY IMPROVEMENT

To be certified, the BHIC health home must meet the following quality improvement requirements:

- A continuous quality improvement program must be established. This involves collecting and reporting on data to evaluate: (a) increased coordination of care and chronic disease management on the individual level; and (b) clinical, experience of care, and quality of care outcomes at the population level.
- There must be a medical director responsible for oversight of the quality improvement program.
- The health home will need to submit data and cooperate with the State in reporting on federally-mandated performance indicators and other indicators that the State requires.

The initial 18 months of the program are dedicated, in part, to getting baseline data and focusing on ensuring that the care management processes being initiated are completed timely and comprehensively. Details of the quality indicators to be monitored by the State and BHIC health home over the first couple of years of the program are provided in Attachment A.

9. PROPOSED BHIC HEALTH HOME PROVIDER RATES

The BHIC health home rate proposal consists of three components. The first rate is an annual assessment rate for the development of an annual care plan. The second rate is a rate for monthly care coordination activities that can be billed in 15 minute increments. The third rate is a rate for certified peer specialists that can be billed in 15 minutes increments. The annual assessment rate and the monthly rate were calculated using a survey tool completed by interested BHIC health home providers which estimated the time each provider type within the care coordination team would spend either directly or indirectly with each individual member on care coordination activities. An hourly blended provider type rate based on Medicaid payment rates was applied in proportion to the percentage of time allotted for each type. Care coordination activities for the purpose of BHIC cannot include services covered under Fee for Service (FFS). Please see section six of this document for more information on what services are included and excluded from BHIC. Note that the proposed rates presented below are for care coordination only.

- Proposed Annual Assessment Rate

Initial Assessment Payment Calculation (based on provider survey results)					
Provider Type	Time recommended by providers (min)	Proportion of total time	Medicaid hourly rate	Medicaid minute rate	Cost by provider type
Primary care physician or nurse practitioner	30	5.04%	\$69.83	\$1.16	\$34.92
Medical case manager (RN)	420	70.59%	\$45.39	\$0.76	\$317.73
Mental health and substance abuse professional	75	12.61%	\$44.42	\$0.74	\$55.53
Other care coordinator (social worker)	30	5.04%	\$43.28	\$0.72	\$21.64
Pharmacist	30	5.04%	\$75.00	\$1.25	\$37.50
Other: Nutritionist	10	1.68%	\$37.95	\$0.63	\$6.33
Total	595	100%			\$473.64
	Total in hours				Cost per hour
	9.92				\$47.76

The annual assessment allows the selected BHIC health home provider to coordinate a comprehensive review of each member, including face-to-face time to assess all aspects of the member’s life for developing the initial care plan. This rate was developed considering the needs for an initial assessment upon entry into the health home. Given that we anticipate that ongoing annual assessments will be less resource intensive, we expect to develop a two-tier annual assessment rate for year two of the program; one rate for the initial assessment and one rate for the ongoing assessments. As part of the certification process, the BHIC provider is required to identify their time-reporting methodology for tracking direct and indirect time spent by each provider within the care coordination team with each member. This data will be used in updating rates and establishing the tiered annual assessment rate structure. Please include a methodology for tracking time with your proposal.

- Proposed Monthly Care Coordination Activities Rate

Monthly Medicaid Minute Calculation (based on provider survey results)					
Provider Type	Time recommended by providers (min)	Proportion of total time	Medicaid hourly rate	Medicaid minute rate	Rate per minute
Primary care physician, physician assistant, or nurse practitioner	30	8.70%	\$69.83	\$1.16	\$0.10
Medical case manager (RN)	150	43.48%	\$45.39	\$0.76	\$0.33
Mental health and substance abuse professional	60	17.39%	\$44.42	\$0.74	\$0.13
Other care coordinator (social worker)	45	13.04%	\$43.28	\$0.72	\$0.09
Pharmacist	15	4.35%	\$75.00	\$1.25	\$0.05
Other: Dentist	5	1.45%	\$45.51	\$0.76	\$0.01
Other: Psychiatrist	30	8.70%	\$96.16	\$1.60	\$0.14
Other: Nutritionist	10	2.90%	\$37.95	\$0.63	\$0.02
Total	345	100%			\$0.88
	Total in hours				Cost per hour
	5.75				\$52.26
	Cost per member per month (PMPM)				Cost per minute
	\$302.22				\$13.14

Monthly care coordination allows the RN case manager and other professionals to spend face-to-face time with the member and also allows for consultation with specialists. This rate is expressed in 15 minute increments that can be billed for in fractions as outlined

below:

Accumulated Time	Unit(s) Billed
1-5 minutes	.3
6-10 minutes	.7
11-15 minutes	1.0

While the per member per month (PMPM) rate calculated above is \$302.22, we would expect that some members would need less time and other members would require additional care coordination initially. Therefore, we are asking the BHIC health home provider to identify the units of time spent per month with each member and submit accordingly. Billing by time increments will allow the selected BHIC provider flexibility in coordinating the care of a wider mix of members. As with the annual assessment, the selected BHIC provider will need to track the actual direct and indirect time each provider within the care coordination team spends with each member. This data will be used in updating rates. Over time, DHS may calculate a monthly PMPM rate which would be set and adjusted annually. Please include a methodology for tracking time with your proposal.

- **Proposed Certified Peer Specialist Rate**

This rate allows certified peer specialists to provide mental health and substance abuse peer specialist services to enrolled members that the BHIC team determines could benefit from these services. Peer specialists must be certified and trained by the Division of Mental Health and Substance Abuse Services (DMHSAS) within DHS. DMHSAS maintains oversight of the training, certification and supervision requirements for peer specialist providers. Certified peer specialists must be supervised by a qualified mental health professional that is part of the BHIC team. The BHIC supervisor must bill for the certified peer specialist services.

The proposed rate for certified peer specialists is \$5.75 per 15 minutes. One unit is equal to 15 minutes and up to 16 units may be billed per week.

10. ASSESSMENT, CARE PLANNING, and CARE COORDINATION REQUIREMENTS

Each member should receive the assessment, care planning, and care coordination services at a level consistent with their medical and behavioral health needs and the level of natural supports available to the member. Not all of the assessments noted below need to be performed on every individual, nor does every individual need the same intensity level or amount of care coordination and monitoring. The services and requirements noted in this application are intended to be a guide to the health home for serving the enrolled populations.

- Required Assessments

The BHIC health home is expected to provide an initial comprehensive assessment of members' health care needs, including their needs for behavioral health. The initial assessment must be completed within 30 days of the member's enrollment into the BHIC health home. The health home provider is also expected to assess and monitor all members' health care needs through ongoing assessments and screenings as needed.

- Screening and Assessment Information

The U. S. Preventive Services Task Force has recommended screenings for alcohol, drugs, tobacco, and depression. Other alcohol and drug screening instruments include: AUDIT (Alcohol Use Disorder Identification Test), DAST (Drug Abuse Screening Test), ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test), SIP-AD (Short Index of Problems-Alcohol and Drugs), and SDS (Severity of Dependence Scale). The Wisconsin Medicaid Screening Brief Intervention and Referral to Treatment (SBIRT) benefit allows reimbursement for the annual administration of these substance abuse screenings and brief interventions (for more information, please see <https://www.forwardhealth.wi.gov/kw/pdf/2009-96.pdf>). Brief intervention services should be delivered as soon as possible to individuals that demonstrate a need for these services based on the SBIRT screening. Ideally, the services should be provided during the same clinic encounter using a motivational interviewing approach.

The BHIC health home will be expected to incorporate trauma screening as appropriate into their comprehensive assessment process and implement trauma-informed care throughout their health home services.

- Care Planning Requirements

The BHIC health home must have procedures to direct the development and updating of an individualized, comprehensive, coordinated services plan for each member enrolled in the BHIC health home. The plan must include clear lines of responsibility for all health care providers and the BHIC health home. The member and, as applicable, the member's peer, family, and other natural supports should participate in treatment planning.

The procedures for care planning must include a requirement that the initial coordinated services plan must be completed within 60 days of the member's enrollment into the BHIC health home. The plan must be updated at least once every 6 months or more as medically indicated.

There must be a crisis plan which includes a list of progressive interventions to resolve/de-escalate an emotional crisis/safety situation. The plan must be developed with input from relevant health care providers, peers, and other persons who know the member best, as well as the member as much as possible. The plan could be included as part of the overall comprehensive coordinated services plan or be a separate document.

- Care Coordination Requirements

The BHIC health home care management system must have procedures to assure that each member is assigned:

- A Medicaid certified primary care provider who is board eligible or board certified in general or family practice or as an internist.
- A care coordinator to coordinate access to medical and non-medical services who is responsible for the development of the comprehensive coordinated services plan and ongoing monitoring of that plan for each enrolled member.

The health home must have a protocol to assess the care management service coordination needs of BHIC members at initial enrollment and as the members' needs change over time. The health system must have processes and procedures for prioritizing the care management/service coordination needs of BHIC members. For example, members have differing levels of service needs that often change over time. Levels of care could be used to prioritize the initial and ongoing care management needs of members. Levels of care could include:

- Level 1-Minimal care management which includes short-term information sharing, technical assistance and/or referrals.
- Level 2-Moderate care management which includes significant, but not necessarily long-term assistance in planning and coordinating multiple services.
- Level 3-Intensive care management which includes long-term assistance in planning and coordinating multiple services. Members needing intensive care include members at risk of hospitalization or institutionalization, members with immediate mental health or substance abuse problems, and members who are recovering from significant physical health problems or conditions.

The health home should specify in its application how it will triage and prioritize the care management needs of members to ensure that an appropriate level of resources is devoted to managing the population.

ATTACHMENT A

Behavioral Health Integrated Care Quality Indicators

These are quality indicators that the state and the BHIC provider will develop as the BHIC health home program is implemented. These measures may be revised based on future discussions with the Centers for Medicaid and Medicare Services (CMS) and the BHIC health home provider.

CMS Recommended Measures

1. ADULT BODY MASS INDEX (BMI) ASSESMENT

Description: Percentage of members age 18-74 who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year.

Numerator: BMI documented during the measurement year or the year prior to the measurement year.

Denominator: Members age 18-74 who had an outpatient visit

Data Source: interChange claims; DHS/MetaStar chart reviews; provider reporting.

2. AMBULATORY CARE-SENSITIVE CONDITION ADMISSION

Description: Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 populations under age 75.

Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions for members under age 75.

Denominator: Total mid-year population under age 75.

Data Source: interChange claims

3. CARE TRANSITION-TRANSITION RECORD TRANSMITTED TO HEALTH CARE PROFESSIONAL

Description: Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

Numerator: Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

Denominator: All patients, regardless of age, discharged from an inpatient facility (e.g. hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care.

Data Source Options: Provider reporting

4. FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Description: Percentage of discharges for members age 6 and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.

Numerator: An outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Denominator: Members age 6 and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year.

Data Source: interChange claims

5. PLAN-ALL CAUSE READMISSION

Description: For members age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Numerator: Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination.

Denominator: Count the number of Index Hospital Stays for each age, gender, and total combination.

Data Source: interChange claims

6. SCREENING FOR CLINICAL DEPRESSION AND FOLLOW-UP PLAN

Description: Percentage of patients age 18 and older screened for clinical depression using a standardized tool and follow-up documented.

Numerator: Total number of patients from the denominator who have follow-up documentation.

Denominator: All patients age 18 and older screened for clinical depression using a standardized tool.

Data Source Options: Provider self-reporting and/or have DHS/MetaStar do chart reviews.

7. INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

Description: Percentage of adolescents and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following:

- Initiation of AOD treatment
- Engagement of AOD treatment

Numerators:

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

Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.

Denominator: Members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.

Data Source: interChange claims

8. CONTROLLING HIGH BLOOD PRESSURE

Description: The percentage of patients age 18-85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Numerator: The number of patients in the denominator whose most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be <140/90mm Hg.

Denominator: Patients age 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.

Data Source: Provider reporting; DHS/MetaStar chart reviews.

Care Management Measures

9. INITIAL CARE PLAN AND ASSESSMENT COMPLETED TIMELY AND COMPREHENSIVELY.

Description: Ensuring that the care management process being funded is being done timely and comprehensively.

Measures:

- The initial assessment is completed within 30 days of enrollment
- The care plan should be completed within 60 days of enrollment.
- The care plans must include particular core elements (e.g. recommendations for future care giving results of assessment) as well as other elements that may vary by individual (e.g. follow-up with individual to ensure particular condition is being treated).

Data Source Options: Provider reporting; DHS/MetaStar chart reviews.

Additional Behavioral Health Measures

10. ANTIDEPRESSANT MEDICATION MANAGEMENT–ACUTE

Description: Percentage of members age 18 or older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and remained on an antidepressant medication for at least 12 weeks.

Numerator: Number of members from the denominator with at least 84 days (12 weeks) of continuous treatment with antidepressant medication.

Denominator: Members age 18 years and older as of the beginning of a measurement year who were diagnosed with a new episode of major depression during the intake period and were treated with antidepressant medication.

Source: interChange claims

11. ANTIDEPRESSANT MEDICATION MANAGEMENT–CONTINUATION

Description: Percentage of members 18 and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and remained on an antidepressant medication for at least six months.

Numerator: Number of members from the denominator with at least 180 days (6 months) of continuous treatment with antidepressant medication.

Denominator: Members age 18 years and older as of the beginning of the measurement year who were diagnosed with a new episode of major depression during the intake period and were treated with antidepressant medication.

Source: interChange claims

12. TOBACCO CESSATION (18 AND OLDER, COUNSELING AND PHARMACOTHERAPY)

Description: Utilizes CAHPS survey to get response rates to three questions:

- In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health care provider in your plan?
- In the last 6 months, how often was medication recommended or discussed by a doctor or health care provider to assist you with quitting smoking or using tobacco?
- In the last 6 months, how often did your doctor or health care provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco?

Source: CAHPS survey

Additional Chronic Physical Condition Measure

13. COMPREHENSIVE DIABETES CARE–HbA1c

Background: Percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose most recent hemoglobin A1c (HbA1c) level is greater than 9.0% (poorly controlled).

Numerator: Use codes to identify the most recent hemoglobin A1c (HbA1c) test during the measurement year. The member is numerator compliant if the most recent automated HbA1c level is greater than 9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

Denominator: Members 18 to 75 years of age as of a certain date of the measurement year with diabetes (type 1 and type 2)

Data Source Options: Provider reporting; DHS/MetaStar chart reviews

Other Measures

14. DENTAL CARE

Background: The number and percentage of adults age 18-64 receiving dental services, including:

- Preventive dental services
- Diagnostic dental services
- Restorative dental services

Numerator: Number of individuals receiving preventive, diagnostic, and/or restorative dental services during measurement year.

Denominator: Number of individuals enrolled in BHIC during measurement year.

Source: interChange claims

15. PATIENT SATISFACTION

Background: Measurement of patient satisfaction of the BHIC program and provider.

Source: CAHPS Survey

16. COST OF CARE

Background: The cost of the BHIC Program will be calculated, and will include all Medicaid claims as well as the county share. Baseline costs will be calculated prior to initiation of the program and will be done annually after the program is initiated.

Data Source Options: interChange claims; TBD.

BEHAVIORAL HEALTH INTEGRATED CARE HEALTH HOME CONTACT SHEET
 (Langlade, Lincoln, and Marathon Counties)

Name of BHIC Health Home			
Administrative Office Address (Street)	City	State	Zip Code

Name of Primary Contact for the Health Home			
Telephone Number		Fax Number	
Email			
Address (Street)			
City		State	Zip Code

OTHER BHIC HEALTH HOME CONTACTS

Title/Area	Name/Email	Telephone Number
Chief Executive Officer		
Medical Director		
Contract Administrator		
Lead Care Coordinator		
Enrollment		
Quality Improvement		
Systems/Security		
Finance		