VII. Data Collection

Implementation of integrated, whole person services through the BHH initiative will require a change to existing service delivery, and may result in necessary changes to service documentation and reporting requirements. The additional data collected and reported on through various means, will prove beneficial in better informing service delivery and improving outcomes.

BHH provider performance is directly linked to the reporting of data and to being in compliance with contract requirements. Therefore, to be successful and to help Connecticut achieve the goals of improving the quality, cost effectiveness, and satisfaction of care, it is imperative that BHH designated provider agencies collect and report data that is timely and accurate. For up to date information on the DDaP/WITS reporting requirements, and to ensure your agency is in compliance with deadlines for uploading data, visit www.ct.gov/dmhas/cwp/view.asp?q=334736.

Service Reporting:

Generally, the levels of care (LOC) where BHH services are expected to occur include:

MH Outpatient
MH Case Management
Community Support
MH Residential Support
MH Supportive Housing
MH Supervised Apartments
Assertive Community Treatment
BHH Adult NAE
BHH Children Program

In some cases, other programs have been added to the list if the agency is prepared to meet billing/documentation requirements. If you have questions about your agency's specific program listing for BHH please contact Lauren Staiger at lauren.staiger@ct.gov.

If a BHH enrollee is being served in a LOC that is not on the list for billing, the person must be enrolled in the BHH Adult NAE program, which exists to capture services provided to those individuals. The other purpose for this LOC is to allow for enrollment of individuals who are only being served by the BHH and do not have other open agency programs. BHH NAE is a billable program so chart and billing requirements must be met for individuals enrolled in that program.

The BHH Children's Program exists to capture children and services being provided by those designated provider agencies that provide care to children.

Direct care service reporting will build off the existing service codes used in DDaP/WITS, with the addition of a few new services codes. For a complete list of the codes that count towards BHH visit https://www.ctintegratedcare.com/providers/prv-materials.html

It is expected all BHH enrollees will receive at least 1 hour a month of BHH services. Any combination of BHH services can be provided. For BHH, phone and collateral contacts count towards the 1 hour of services provided per month. Staff should document those services using existing TCM or CM, by phone or with collateral codes.

VII. Data Collection

Service Reporting (continued):

Staff will use the service codes typically used to document the targeted case management (TCM) and/or other case management service(s) provided, when they are documenting BHH services. To report which specific BHH service(s) are provided during the intervention, staff will enter the name(s) of the BHH service(s) provided in the note section of the client's record. Some EHRs have been updated to allow staff to select which BHH service(s) were provided when entering a note, but if your EHR does not have that feature, staff should indicate the BHH service in their notes.

BHH documentation should comply with DMHAS targeted case management (TCM) guidelines. In addition, BHH staff providing BHH services to BHH eligible clients, should be included on the agency's staff list for the Random Moment Time Study (RMTS). The BHH Director and BHH Administrative Support Specialist should also be included in the RMTS as they are providing billable services that support BHH. Each BHH designated provider agency has a RMTS coordinator who can answer questions about how to ensure BHH staff are included in the Study.

In addition, BHH Primary Care Physician Consultants will use the PC Tracker to document the indirect services they provide. For a copy of the form, and/or instructions on completing or submitting the form, contact Lauren Staiger, lauren.staiger@ct.gov, or Vanessa O'Neal-Campbell, vanessa.o'neal-campbell@ct.gov.

Meeting these requirements will ensure appropriate BHH rate setting and billing practices.

Outcome Data:

Each of the DMHAS BHH core quality measures will be collected and reported using claims, designated provider agency data, or a combination of both. The DMHAS BHH core quality measures, the related data sources, and BHH designated provider agencies responsibilities (referred to below as provider responsibilities), are as follows:

A. **IU-HH (Inpatient Hospitalization)-**the rate of all inpatient care and services per 1,000 enrollee months among health home enrollees.
    - Data Source: Claims
    - Provider Responsibilities: None at the time, but review available reports to improve service delivery

B. **AMB-HH (Ambulatory Care-Emergency Department visits)-**the rate of emergency department visits per 1,000 enrollee months among health home enrollees.
    - Data Source: Claims
    - Provider Responsibilities: None at the time, but review available reports to improve service delivery

C. **CDF-HH (Screening for Clinical Depression and Follow-Up Plan)-**percentage of patients age 12 years and older screened for clinical depression using a standardized tool, and if positive, a follow-up plan is documented on the date of positive screen.
    - Data Source: Claims, DDaP/WITS, and ProviderConnect
    - Provider Responsibilities: Enter into DDaP/WITS G8431 code for positive screen and G8510 for negative screens, with the date screening was done, and with referral to follow-up care on the same day for positive screens; or entry into ProviderConnect. See Health Assessment Practice Guidelines at www.ctintegratedcare.com/providers/2017/Practice-Guideline-5-Health-Assessments.pdf for details.

D. **PCR-HH (Plan All-Cause Readmission Rate)-**for individuals 18 years of age 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.
    - Date Source: Claims
    - Provider Responsibilities: None at the time, but review available reports to improve service delivery

VII. Data Collection Continued

Outcome Data (continued):

E. **FUH-HH (Follow-Up after Hospitalization for Mental Illness)-**percentage of discharges for individuals 6 years of age 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.
- Data Source: Claims
- Provider Responsibilities: None at the time, but review available reports to improve service delivery

F. **FUA-HH (Follow-Up After Hospitalization for Substance Use Disorder)**-percentage of discharges for individuals 6 years of age or older who were hospitalized for treatment of selected substance use disorders and who had an outpatient visit, intensive outpatient encounter, or partial hospitalization with a substance abuse practitioner within 7 days
- Data Source: Claims
- Provider Responsibilities: None at this time, but review available reports to improve service delivery

G. **AIF-HH (Admission to an Institution from the Community)**-percentage of admissions to an institutional facility among individuals 18 and older residing the community for at least one month.
- Data Source: Claims
- Provider Responsibilities: None at the time, but review available reports to improve service delivery

H. **CBP-HH (Controlling High Blood Pressure)-**percentage of Health Home Enrollees ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (140/90) during the measurement year.
- Data Source: Claims, DDaP Health Assessment, Excel spreadsheets, and ProviderConnect Health Assessment
- Provider Responsibilities: Collect and enter blood pressure at least 1x/year

I. **IET-HH (Initiation and Engagement of Alcohol and Other Drug Dependence Treatment)-**percentage of Health Home enrollees age 13 and older with a new episode of alcohol or other drug (AOD) dependence who received the following:
   i. Initiation of AOD Treatment: The percentage of Health Home enrollees who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.
   ii. Engagement of AOD Treatment: The percentage of Health Home enrollees who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
- Data Source: Claims
- Provider Responsibilities: None at the time, but review available reports to improve service delivery

J. **PQI92-HH (Chronic Condition Hospital Admission Composite – Prevention Quality Indicator)-**the total number of hospital admissions for ambulatory care sensitive chronic conditions per 100,000 Health Home enrollees age 18 and older. This measure includes adult hospital admissions for diabetes with short-term complications; diabetes with long-term complications; uncontrolled diabetes without complications; diabetes with lower-extremity amputation; chronic obstructive pulmonary disease; asthma; hypertension; heart failure; or angina without a cardiac procedure.
- Data Source: Claims
- Provider Responsibilities: None at the time, but review available reports to improve service delivery

K. **Tobacco Cessation Intervention (Connecticut-specific)-**current smokers or tobacco users who have been offered tobacco use cessation counseling.
- Data Source: DDaP Health Assessment, Excel spreadsheets, and ProviderConnect Health Assessment
- Provider Responsibilities: Complete health assessment question related to tobacco cessation at least 1x/year

Outcome Data (continued):

K. **OUD-HH (Use of Pharmacotherapy for Opioid Use Disorder)**- Numerator: Number of individuals in the denominator that utilize pharmacotherapy as treatment for opioid use disorder. Denominator: Total number of individuals with an opioid use disorder.
- Data Source: Claims
- Provider Responsibility: None at this time, but review available reports to monitor effectiveness of treatment

L. **HbA1c Level Screening (Medicaid Adult Core Set, NQF) (Connecticut-specific)-**individuals ages 18-75 with a diagnosis of diabetes (type 1 and type 2), who had a hemoglobin A1c (HbA1c) test.
- Data Source: Claims
- Provider Responsibilities: Awareness of BHH Participants' diagnosis and Hb1Ac testing

M. **Measure LDL-AD: Comprehensive Diabetes Care: LDL-C Screening (Connecticut-specific)-**the percentage of enrollees ages 18-75 with diabetes (type 1 and type 2) who had an LDL-C screening test.
- Data Source: Claims
- Provider Responsibilities: Awareness of BHH Participants' diagnosis and LDL testing

N. **General Satisfaction with Care, Access, Quality and Appropriateness (Connecticut-specific)-**Numerator: Number of individuals in the denominator who report scores of 2.5 or higher on each of the instrument's sub-scales. Denominator: The total number of survey responses.
- Data Source: DMHAS Consumer Survey or other specified survey tool
- Provider Responsibilities: Administer DMHAS designated satisfaction survey and report results

O. **Decrease Homelessness (Connecticut-specific)-**Numerator: Number of individuals in the denominator who had stable housing during the measurement period. Denominator: The number of individuals in the program.
- Data Source: DDaP/ WITS Periodic Assessment
- Provider Responsibilities: Enter Living Situation data

P. **Increase Employment and Education Opportunities (Connecticut-specific)-**Numerator: Number of individuals in the denominator involved in employment and or educational activities. Denominator: Total number of individuals in the program.
- Data Source: DDaP/ WITS Periodic Assessment
- Provider Responsibilities: Enter Employment Status data