Crosswalk of All RI OHIC Aligned Measure Sets

This spreadsheet includes all five RI OHIC Aligned Measure Sets in aggregate, specifically the ACO, Acute Care Hospital, Behavioral Health Hospital, Behavioral Health, Maternity, and Primary Care Measure Sets.

Updated 7-16-2021

#	Measure Name	NQF Number	NQF Endorsement Status as of 7/8/2021	Steward	Description	Domain	Condition	Measure Type	Populations	Data Source	Facility-based or Practitioner-based	Rationale	Special Notes	Link to Measure Specifications *(note: Referred to HEDIS MY 2020 specifications, then to CMS specifications (first MPS 2020 then eCQM 2021) before other sources. CTC-M specifications are provided for all measures in the PCMH Measure Set.)*	Equity Assessment *Is there evidence of disparities in performance as it relates to race, ethnicity, language, disability status, and/or social determinants of health?* *See "Equity Assessment Sources" tab for sources.*	Summary of Changes for MY 2021 / MY 2022	Degree of Change and Progress of Action	In Aligned Measure Set?	OHIC Aligned Measure Sets for 2021 *Maternity Care, Acute Care Hospital, and Behavioral Health Hospital Measure Sets Updated for 2022, others are not*						
																			ACO	Primary Care	Acute Care Hospital	Behavioral Health Hospital	Maternity Care	Outpatient Behavioral Health - Mental Health	Outpatient Behavioral Health - Substance Use Treatment
7	Antidepressant Medication Management	0105	Endorsed	National Committee for Quality Assurance	Adults 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported. 1. Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). 2. Effective Continuation Phase Treatment. The percentage of members who remained	Medication Management	Mental Health	Process	Adult	Claims	Professional-based	2016 Annual Review • The Work Group did not have interest in adding this measure back to the Primary Care Set. 2017 Annual Review • Measure requires pharmacy claims data and look-back period is misaligned, so remove from primary care and ACO • Medicaid currently requires reporting for this measure, but Medicaid will align recommendations with the Work Group 2015-2016 Work Group Discussions • Concern that claims data may not pick up a drug that is available from discount		For Contractual Use: HEDIS®: AMM	Buying Value identified this to be a "disparities-sensitive measure" using NQF's 2017 Disparities Project Final Report (NQF, 2017). An a study using nationally representative data, among persons with depression and private coverage, **racial-ethnic minority groups were significantly less likely than non-Hispanic whites to use antidepressant medication** (OR=0.79, 95% confidence interval [CI]=0.62-0.99) for Blacks, **no significant racial-ethnic disparity in the use of antidepressants was found in Medicare** (N=1,944), **Medicaid** (N=2,126), and **uninsured populations** (N=1,670). **For all racial-ethnic groups, persons with no insurance coverage had much lower rates of antidepressant use than their insured counterparts** (Jung et al., 2014). African American and Latino users said they felt less likely to fill an antidepressant prescription than	Clarified that members in hospice or using hospice services are a required exclusion.	Minor edits - no change required	Yes						Menu	
25	Depression Remission or Response for Adolescents and Adults	NA	NA	National Committee for Quality Assurance	The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 5 to 7 months of the elevated score. Four rates are reported. 1. CCDS Coverage. The percentage of members 12 and older with a diagnosis of major depression or dysthymia, for whom a health plan can receive any electronic clinical quality data. 2. Initial PHQ-9. The percentage of members who have a follow-up PHQ-9 score documented within the five to seven months after the initial elevated PHQ-9 score. 3. Depression Remission. The percentage of members who achieved remission within five to seven months after the initial elevated PHQ-9 score. 4. Depression Response. The percentage of members who showed response within five to seven months after the initial elevated PHQ-9 score.	Acute Care	Mental Health	Outcome	All Ages	Electronic Clinical Data System s	Professional-based	2016 Annual Review • Recommended moving from Menu to Developmental since plans cannot yet implement. 2017 Annual Review • ECDS measures will become a standard for HEDIS in the future, and is one of the few outcome-based measures in the set 2016 Annual Review • PCMH and other SIM measure. MSSP uses a similar measure. • New HEDIS measure that should be a part of multi-payer contracts to improve scores and create progress		For Contractual Use: HEDIS®: DRR	Buying Value identified this to be a "disparities-sensitive measure" using NQF's 2017 Disparities Project Final Report (NQF, 2017). In RI, 19.6% of adults are depressed. Rates are **highest among multiracial individuals (28.8%), followed by Whites (21.2%), Hispanics (17.1%), Other (14.4%) and Blacks (11.1%).** Depression is **most common among individuals who are low-income** (36.4% among adults making <$20k compared to 13.0% among adults making >$75k) and **have a lower education level** (23.5% among adults with less than high school degree vs. 16.0% among college graduates) (America's Health Rankings, 2020). According to 2013-2014 BRFSS data, non-Hispanic, **Black Rhode Islanders reported slightly higher rates of being diagnosed with depression (20.1%) than non-Hispanic, White (20.3%) and Hispanic (26.2%) residents** (RI State Innovation Model Health Assessment, 2017). In a study of nationally representative data, for persons with past-year depressive disorder, 63.7% of Latinos, 58.7% of Asians, and 58.8% of African Americans, compared with 45.2% of non-Latino whites, did not access any past-year mental health treatment. Disparities in the likelihood of both having access to and receiving adequate care for depression were significantly different for Asians and African Americans in contrast to non-Latino whites. Among non-Latino whites with depression, about 33 percent are predicted to access treatment and receive quality depression care, compared to about 20 percent of Latinos, 18.9 percent of Asians, and 16.4 percent of African-Americans (Alegria et al., 2008). Medicaid-covered Latino, Asian/Pacific Islander, and Black youth were **less likely to have a depression diagnosis** than white counterparts. After a new diagnosis, Native American and Latino youth were **less likely than white youth to have received an antidepressant or a mental health specialty visit** (Richardson et al., 2003). Black and Asian adults were **less likely to be screened for depression** than white adults. Latino adults were **more likely to be screened for depression**. Post-screening, Black adults, Latino males, and Asian	Updated measure logic to be expressed in FHIR.	Minor edits - no change required	Yes	Develop priority	Develop priority				Development	
29	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications	1932	Endorsed	National Committee for Quality Assurance	Percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year	Chronic Illness Care	Mental Health	Process	Adult	Claims	Professional-based	2016 Behavioral Health Measures Work Group Discussions • State performance goal measure for Medicaid contracts • Best practice measure		For Contractual Use: HEDIS®: SSD	Buying Value identified this to be a "disparities-sensitive measure" using NQF's 2017 Disparities Project Final Report (NQF, 2017). **Blacks were less likely to be monitored on all metabolic components**, whereas **Hispanics were less likely to have glucose and high-density-lipoprotein cholesterol monitored** but more likely to have triglycerides tested (Phillips et al., 2016). **People with schizophrenia have higher rates of hyperglycemia and type 2 diabetes than the general population**, and diabetes is a leading cause of illness and death for people affected by schizophrenia-related disorders. Antipsychotic medications used to treat schizophrenia and, increasingly, nonpsychotic emotional disorders, are associated with increased risk for type 2 diabetes (SAMSA, 2015). In RI, diabetes prevalence is **increasing mostly among Black non-Hispanic adults.** RI adults whose **primary language is Spanish are diagnosed with diabetes 2x more often** than those whose first language is English (RIDOH, 2014). In RI, diabetes is **nearly 2x more common in lower income adults and adults with less education** (14.8% of adults with annual income <$20k are diagnosed with diabetes compared to 7.8% of adults with incomes of >$75k and 12.0% of adults without a high school diploma compared to 6.4% of adults with at least some college education) (RIDOH, 2014). In RI, individuals with **disabilities are disproportionally represented among the diabetic population** (roughly 16% of RIs have disabilities, but 42% of adult diabetes have disabilities). (RIDOH, 2014). •Compared to adults without disability, **those with physical disabilities and those with cognitive limitations experienced more diabetes** (Reichard et al., 2010).	Clarified that members in hospice or using hospice services are a required exclusion.	Minor edits - no change required	Yes						Menu	
34	Follow-Up After Emergency Department Visit for Mental Illness	3489	Endorsed	National Committee for Quality Assurance	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm and for mental illness. Two rates are reported. 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. 2. The percentage of ED visits for which the member received follow-up within 7 days of	Hospital	Emergency Care	Process	All Ages	Claims	Professional-based	2021 Annual Review •Flagged as a topical out measure because of high RI performance for 30-day rate •Retained but moved from Core to Menu because participant pointed out that high cross-state emergency performance is being driven by high performers and there are still low performers in RI, indicating an opportunity for improvement. 2017 Annual Review • Discussion of moving to the menu set because there are issues with small denominators	For Contractual Use: HEDIS®: Florida Varnish Release Specification	Buying Value identified this to be a "disparities-sensitive measure" using NQF's 2017 Disparities Project Final Report (NQF, 2017). In a study of Medicaid fee-for-service claims from 15 states in 2008 (not including RI), the odds of seven- and 30-day follow-up after mental health ED discharges were lower among males, African Americans versus whites, and beneficiaries who qualified for Medicaid on the basis of income rather than disability, and beneficiaries with depression and other mood disorders compared with other psychiatric diagnoses. (Crosse et al., 2017).	Clarified that members in hospice or using hospice services are a required exclusion.	Minor edits - no change required	Yes	Menu		Menu			Menu	
35	Follow-Up After Hospitalization for Mental Illness (7-Day)	576	Endorsed	National Committee for Quality Assurance	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or disorders and who had an ER visit, an intensive OP encounter, or partial hospitalization with a mental health practitioner. Two rates are reported. 1) the percentage of members who received follow-up within 30 days of discharge, 2) the percent of members who received follow-up within 7 days of discharge	Hospital	Mental Health	Process	Adult and Pediatric	Claims	Professional-based	2021 Annual Review •Participant pointed out that RI performance relative to national average is being driven by high performers and there are still low performers in RI. Retained due to opportunity for improvement. 2016 Annual Review Include as a Core Measure for behavioral health hospitals. • Participants recommended this measure be included to provide incentive for communication between inpatient and outpatient behavioral health providers. 2017 Annual Review • Not applicable for primary care because (1) specifications do not accept a follow-up visit with a PCP and (2) PCP is not necessarily notified if a follow-up is performed by a behavioral health provider 2015-2016 Work Group Discussions • The plans are looking at 7 days or less. For some 7 days seemed too short, while 30 days seemed too long	Use if the facility has an adequate payer-specific denominator size.	For Contractual Use: HEDIS®: FUH (7-day rate)	Buying Value identified this to be a "disparities-sensitive measure" using NQF's 2017 Disparities Project Final Report (NQF, 2017). A study using data from the Medical Expenditure Panel Survey (2006-2010) assessed the quality of outpatient treatment episodes following inpatient psychiatric treatment among Blacks, Whites, and Latinos in the United States. Rates of follow-up were generally low, particularly rates of adequate treatment (<26%). After adjustment for need and sociodemographic status, the analyses showed that Blacks were less likely than Whites to receive any treatment or begin adequate follow-up within 30 days of discharge (Carson et al., 2014). People with developmental disability had a mean of 1.74 (SD 1.64) hospitalizations in 2005/06, compared with 1.32 (SD 0.80) hospitalizations for people without developmental disability. The proportion of people without developmental disability having only one hospitalization was greater than the proportion for those with developmental disability. In contrast, people with developmental disability were more likely to have multiple hospitalizations in that time frame (Lunsky et al, 2010).	Updated the steps for identifying acute readmission or direct transfer in the denominator. Clarified that members in hospice or using hospice services are a required exclusion. Added psychiatric collaborative care management to the numerator.	Minor edits - no change required	Yes	Core		Core	Core		Menu	
47	Metabolic Monitoring for Children and Adolescents on Antipsychotics	2859	NA	National Committee for Quality Assurance	The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.	Chronic Illness Care	Mental Health	Process	Pediatric	Claims	Professional-based	2016 Behavioral Health Measures Work Group Discussions • Relate for improvement • Best practice measure		For Contractual Use: HEDIS®: APM CTC	Buying Value identified this to be a "disparities-sensitive measure" using NQF's 2017 Disparities Project Final Report (NQF, 2017). There is little research on potential disparities in metabolic monitoring for youth prescribed antipsychotics. One study found that race/ethnicity was not associated with glucose or lipid screening rates (Morrato, et al., 2010). However, among adults, in general, **minorities are at much greater risk for diabetes than whites** (CDC, 2020) (NHRQ, 2018). **Black adults were less likely to be monitored on all metabolic components**, whereas **Hispanics were less likely to have glucose and high-density-lipoprotein cholesterol monitored** but more likely to have triglycerides tested (Phillips et al., 2016). •**Children with intellectual difficulties** were **more likely to be prescribed antipsychotics** (2.8% have been prescribed an antipsychotic [70% with autism] compared with 0.10% of children without intellectual difficulty). Those with intellectual disabilities/autism were **prescribed antipsychotics at a younger age and for a longer period**. Antipsychotic use was associated with a higher rate of respiratory illness for all (PSRR of hospital admission: 1.55 [95% CI: 1.51–1.598] or increase in rate of 2 per 100 per year in those treated) (Brophy et al., 2018).	Clarified that members in hospice or using hospice services are a required exclusion.	Minor edits - no change required	Yes						Menu	
69	Unhealthy Alcohol Use Screening and Follow-Up	NA	NA	National Committee for Quality Assurance	Percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized tool and, if screened positive, received appropriate follow-up care. • Unhealthy Alcohol Use Screening. The percentage of members who had a systematic screening for unhealthy alcohol use. • Counseling or Other Follow-up. The percentage of members who screened positive for unhealthy alcohol use and received brief counseling or other follow-up care within 2 months of a positive screening.	Prevention/ Early Detection	Substance Abuse	Process	Adult	Clinical Data		2016 Annual Review •The Work Group expressed interest in revisiting this topic when the ECDS version of the measure is available. •The measure is not used in any value-based contracts and requires clinician documentation in EHRs. •One participant noted that there is good clinical rationale for the measure and data collection may be more feasible given ongoing state initiatives. 2016 Annual Review • Metrics will lead measure development, but this is of lower priority than the three depression measures. The group decided to move towards ECDS measures and prioritized this measure over SBIRT.		For Developmental Work: HEDIS®: ASF	Buying Value identified this to be a "disparities-sensitive measure" using NQF's 2017 Disparities Project Final Report (NQF, 2017). In RI, **rates of alcohol use among both adults and teens, alcohol use disorder, and unmet treatment needs are all well above national levels** (Rhode Island Department of Behavioral Healthcare Developmental Disabilities & Hospitals, 2019). In RI in 2019, **excessive drinking** (percentage of adults who reported binge drinking (four or more [women] or five or more [men] drinks on one occasion in the past 30 days) or **chronic drinking** (eight or more [women] or 15 or more [men] drinks per week) was **31.8% for Multiracial category, 31.4% for Blacks, 28.9% for Whites, and 19.8% for Hispanics** (America's Health Rankings, 2020). In an analysis of BRFSS data from 13 states and the District of Columbia, a **higher percentage of persons with a household income <200% of the federal poverty level were asked about binge drinking** than were persons with an income >400% of the federal poverty level. **Hispanic adults reported being asked about binge drinking more than other racial/ethnic groups** (McKnight-Eily et al., 2008). In a study using national data, compared to Whites, **racial/ethnic minorities had two-thirds the odds of receiving an alcohol intervention** over the three-year period (OR=0.62, 95%CI: 0.39-0.98). This disparity increased after adjusting for socioeconomic and clinical confounders (AOR=0.47, 95%CI: 0.28-0.80). The most pronounced disparities were observed among U.S.-born and foreign-born Hispanics (vs. Whites) (Wallace et al., 2016). In a study using national data, **Blacks and Hispanics were 3.9-4.1 percentages points less likely than whites to complete treatment for alcohol and drugs**, and **Native Americans were 4.7 percentage points less likely to complete treatment for alcohol and drugs.** Only **Asian Americans** fared better than whites for both types of treatment. Completion disparities for Blacks and Hispanics were largely explained by differences in socioeconomic status and, in particular, great unemployment and housing instability. However, the six-month treatment discrepancy for Native Americans was not explained by	Updated measure logic to be expressed in FHIR.	Minor edits - no change required	Yes	Develop priority	Develop priority				Development	
63	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	NA	NA	National Committee for Quality Assurance	The percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia, who have a PHQ-9 tool administered at least once during a four-month period. Two rates are reported. 1. CCDS Coverage. The percentage of members 12 and older with a diagnosis of major depression or dysthymia for whom a health plan can receive any electronic clinical quality data. 2. Utilization of PHQ-9. The percentage of PHQ-9 utilization. Members with a diagnosis of major depression or dysthymia for whom measure data are reportable using ECDS and, had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter.	Acute Care	Mental Health	Process	All Ages	Electronic Clinical Data System s	Professional-based	2016 Annual Review •Recommended moving to Developmental since plans cannot yet implement. 2017 Annual Review • ECDS measures will become a standard for HEDIS in the future • Reconsider removal in future years once the group officially adopts "Depression Screening and Follow-Up for Adolescents and Adults" 2016 Behavioral Health Measures Discussion • Would almost serve as a supplement or introductory measure for the DRR measure. • New HEDIS measure that should be a part of multi-payer contracts to improve scores		For Contractual Use: HEDIS®: DMS	Buying Value identified this to be a "disparities-sensitive measure" using NQF's 2017 Disparities Project Final Report (NQF, 2017). In RI, 19.6% of adults are depressed. Rates are **highest among multiracial individuals (28.8%), followed by Whites (21.2%), Hispanics (17.1%), Other (14.4%) and Blacks (11.1%).** Depression is **most common among individuals who are low-income** (36.4% among adults making <$20k compared to 13.0% among adults making >$75k) and **have a lower education level** (23.5% among adults with less than high school degree vs. 16.0% among college graduates) (America's Health Rankings, 2020). According to 2013-2014 BRFSS data, non-Hispanic, **Black Rhode Islanders reported slightly higher rates of being diagnosed with depression (20.1%) than non-Hispanic, White (20.3%) and Hispanic (26.2%) residents** (RI State Innovation Model Health Assessment, 2017). In a study of nationally representative data, for persons with past-year depressive disorder, **63.7% of Latinos, 58.7% of Asians, and 58.8% of African Americans, compared with 45.2% of non-Latino whites, did not access any past-year mental health treatment.** Disparities in the likelihood of both having access to and receiving adequate care for depression were significantly different for Asians and African Americans in contrast to non-Latino Whites (Alegria et al., 2008). Medicaid-covered Latino, Asian/Pacific Islander, and Black youth were **less likely to have a depression diagnosis** than white counterparts. After a new diagnosis, Native American and Latino youth were **less likely than white youth to have received an antidepressant or a mental health specialty visit** (Richardson et al., 2003). Black and Asian adults were **less likely to be screened for depression** than white adults. Latino adults were **more likely to be screened for depression**. Post-screening, Black adults, Latino males, and Asian adults were less likely to receive mental health care than their white counterparts (Hahn et al., 2015).	Updated measure logic to be expressed in FHIR.	Minor edits - no change required	Yes	Develop priority	Develop priority				Development	

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