HHSC requests comments on the proposed measures and associated performance requirements for the Comprehensive Hospital Increased Reimbursement Program. HHSC will require reporting on all measures for which a hospital is eligible to report for the hospital to be eligible for payment. HHSC does not intend to require all identified measures in this proposal but encourages stakeholders to provide comments on the potential impact of proposed measures on improving Medicaid quality and comments about which measures should be prioritized for inclusion in the final measure set. Stakeholders may also suggest alternative, evidenced-based measures for the program that they believe would be more impactful on improving Medicaid quality.

Program	Comprehensive Hospital Increased Reimbursement Program (CHIRP)
Target Beneficiaries	Adults and children enrolled in STAR and STAR+PLUS

Intended Quality Outcomes

1. Advance at least one of the goals and objectives in the managed care quality strategy.
2. Maintain access to care for Medicaid managed care members.
3. Monitor the adoption of successful innovations from DSRIP by a broader base of hospitals across the state.

Program Overview

- In Year 1, the program would include the two components: Uniform Hospital Rate Increase Program (UHRIP) and Average Commercial Incentive Award (ACIA).
- Hospitals apply for participation in the program and can opt into the ACIA component.
- Participating hospitals are required to report program measures as a condition of participation for CHIRP, including for both the UHRIP and ACIA components.

Reporting Requirements

- UHRIP includes three structure measures applicable to all participating hospitals and requires quarterly submission of status updates for all measures.
- ACIA includes structure, outcome, and process measures and requires quarterly submission of status updates for structure measures, and twice-yearly submission of data for outcome and process measures.
- ACIA includes seven modules which are groupings of measures around a similar hospital service type. Providers must report on all modules for which they are eligible. Eligibility for a module is determined by the hospital's provider class as defined in program enrollment and historic volume and type of services provided. This data will be used to monitor provider-level progress toward state quality objectives.
- Reporting is tentatively planned to take place during Quarter 1 (Sep-Nov 2021), Quarter 2 (Dec 2021-Feb 2022), Quarter 3 (Mar-May 2022), and Quarter 4 (Jun-Aug 2022)
    - Quarter 1 and Quarter 3: report progress on structure measures and report data for outcome and process measures.
    - Quarter 2 and Quarter 4: report progress on structure measures
- For outcome and process measures, hospitals must report performance rates stratified by Medicaid managed care program population (i.e. STAR, STAR+PLUS), other Medicaid, uninsured, and other payer-types.
- Reporting and module eligibility will follow the detailed specifications for measures found in the "CHIRP DPP Specs 20210112" excel file.

Achievement Requirements

- As a condition of participation in the program, a hospital must report data for all measures for which it is eligible. If a hospital fails to report required information, the hospital may not participate in the program and any funds received by the hospital may be subject to recoupment.
- For a structure measure, a provider must submit responses to qualitative reporting questions that summarize a hospitals progress towards implementing a structure measure.

- For outcome and process measures, a provider must submit specified numerator and denominator rates as specified by HHSC, and for structure measures in ACIA, submit responses to associated qualitative reporting questions that summarize a hospitals progress towards reporting a measure and any improvement efforts tied to a measure.

Program Component	Measure ID	Measure Name	Measure Type	NQF #	Measure Steward
C1 - UHRIP	C1-101	HIE Participation	Structure	NA	NA
	C1-102	Data Quality Review	Structure	NA	NA
	C1-103	SDA Learning Collaborative Participation	Structure	NA	NA
C2 – ACIA Maternal Care	C2-104	AIM Collaborative Participation	Structure	NA	NA
	C2-105	Severe Maternal Morbidity	Outcome	NA	AIM
	C2-106	PC-02 Cesarean Section	Outcome	0471	TJC
	C2-107	PC-03 Antenatal Steroids	Process	0476	TJC
C2 - ACIA Hospital Safety	C2-108	Hospital Safety Collaborative Participation	Structure	NA	NA
	C2-109	Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Outcome	0138	CDC
	C2-110	Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure	Outcome	0139	CDC
	C2-111	Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Outcome	1717	CDC
	C2-112	Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Outcome	0753	CDC
C2 - ACIA Pediatric Hospital Safety	C2-113	Hospital Safety Collaborative Participation	Structure	NA	NA
	C2-114	Pediatric Adverse Drug Events	Outcome	NA	CHSPS
	C2-115	Pediatric CLABSI	Outcome	NA	CHSPS
	C2-116	Pediatric CAUTI	Outcome	NA	CHSPS
	C2-117	Pediatric SSI	Outcome	NA	CHSPS
C2 - ACIA Psychiatric Care Transitions	C2-118	Written transition procedures that include formal MCO relationship or EDEN notification/ADT Feed	Structure	NA	NA
	C2-119	Post-discharge appointment for behavioral health	Process	2455	Texas HHSC
	C2-120	Rate of 30-day readmissions for BH Conditions	Outcome	NA	3M
	C2-121	Follow-Up After Hospitalization for Mental Illness - 7-Day	Outcome	0576	NCQA
C2 - ACIA Care Transitions	C2-122	Transition Plan that Includes formal MCO relationship or ADT Feed	Structure	NA	NA
	C2-123	Post-discharge appointment for heart failure	Process	2455	AHA/ASA
	C2-124	Transition Record with Specified Elements Received by Discharged Patients	Process	NA	AMA-PCPI
C2 - ACIA ED Best Practices	C2-125	Use of validated screening tool for food insecurity	Structure	NA	NA
	C2-126	Food Insecurity Screening	Process	NA	Texas HHSC
	C2-127	Adult Major Depressive Disorder: Suicide Risk Assessment	Process	0104	PCPI
	C2-128	Follow-Up After ED Visits for Mental Illness - 7-Day	Outcome	0576	NCQA
C2 - ACIA Rural Hospital Best Practices	C2-129	Use of validated screening tool for food insecurity and suicide risk	Structure	NA	NA
	C2-130	Food Insecurity Screening	Process	NA	Texas HHSC
	C2-131	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	P4R	0028	NCQA
	C2-132	Inpatient Influenza Immunization IMM-2	Process	NA	TJC
	C2-133	Preventive Care and Screening: Influenza Immunization	Process	0041	AMA-PCPI

Program Measures and Rationales

Measure ID	Measure Name	Rationale
C1-101	HIE Participation	Strategy 1 of the Texas Health IT Strategic Plan calls for facilitating connections among local HIEs and ambulatory care providers and hospitals. This strategy will build the critical mass of connected providers needed to create meaningful exchange of clinical data across Texas.[i] Lack of interoperability and care coordination have resulted in duplication of care, increased error rates, adverse drug-drug interactions, reduced safety, and increased costs. It has been argued that investments in health information technologies will radically transform the healthcare sector by increasing efficiencies, decreasing expenditures and increasing quality. Prevalence of chronic diseases, and the need for improved quality of care and patient outcomes necessitates the application of Health Information Technology (HIT) and Health Information Exchange (HIE) to streamline patient care, eliminate waste, and improve care coordination, with the goal of ultimately improving patient health outcomes. A study found that those institutions with the highest HIT scores for specific measures of clinical decision support, continuity of care documentation and clinical discharge and summary care documentation showed modest and statistically significant levels of improvement in health care quality outcomes for the 3 key outcome metrics of over the study period. Overall, more intensive use of HIT/HIE in the long run could help providers achieve better quality outcomes.[ii]
C1-102	Data Quality Review	Data accuracy in encounters is critical, as this source is used for many monitoring and performance measurement purposes. Providers should have a quality review process to ensure encounter data are complete and valid. Specifically, valid coding of "Present on Admission" (POA) for reported diagnoses is critical to the External Quality Review Organization's (EQRO) efforts to calculate the 3M™ potentially preventable complications (PPC) measure. When POA codes are missing or invalid, the PPC rate calculations may misclassify or exclude these encounters, hindering the EQRO in its ability to provide HHSC with accurate and complete information about Texas Medicaid and CHIP. For many hospitals, data inconsistency leads to data exclusion from PPC calculations; total exclusions have been as high as 40 percent of all admissions. [iii]
C1-103	SDA Learning Collaborative Participation	As part of the DSRIP Transition, DSRIP providers were surveyed regarding the benefits of having a formal regional structure to advance regional collaboration and continued delivery system reform. Most respondents agreed the structure and Anchoring entities had a positive impact on their organizations and regions. They indicated the formal regional structure made it easier to coordinate or collaborate with other providers, develop best practices, standardize processes for continuous quality improvement (CQI), and improve decision making for patient outcomes. The formal structure also helped facilitate the regional learning collaboratives, where providers shared lessons learned/best practices, helped each other navigate DSRIP and reporting, provided opportunities for networking, and in some cases, acted as a neutral resource to clarify processes between the provider organization and IGT entity. [iv]
C2-101	TexasAIM Participation	The Department of State Health Services (DSHS) has teamed up with the Alliance for Innovation on Maternal Health (AIM) and the Texas Hospital Association (THA) to create the TexasAIM initiative. TexasAIM will help hospitals and clinics in Texas carry out maternal safety projects. AIM is a program used by hospitals and communities across the country. AIM helps hospitals and communities improve maternal safety through implementing best-practices. They work with state teams and health systems to achieve these goals. An AIM Maternal Safety Bundle is a collection of best-practices for improving maternal care. Experts in the field have vetted these practices to ensure their effectiveness. Each bundle focuses on a specific maternal health and safety topic.[v]

Measure ID	Measure Name	Rationale
C2-102	Severe Maternal Morbidity	CDC defines SMM as unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. SMM is closely related to maternal mortality because it involves conditions that, if left untreated, could result in death.[vi]
C2-103	PC-02 Cesarean Section	The removal of any pressure to not perform a cesarean birth has led to a skyrocketing of hospital, state and national cesarean birth (CB) rates. Some hospitals now have CB rates over 50%. Hospitals with CB rates at 15-20% have infant outcomes that are just as good and better maternal outcomes (Gould et al., 2004). There are no data that higher rates improve any outcomes, yet the CB rates continue to rise. This measure seeks to focus attention on the most variable portion of the CB epidemic, the term labor CB in nulliparous women. This population segment accounts for the large majority of the variable portion of the CB rate, and is the area most affected by subjectivity. As compared to other CB measures, what is different about NTSV CB rate (Low-risk Primary CB in first births) is that there are clear cut quality improvement activities that can be done to address the differences. Main et al. (2006) found that over 60% of the variation among hospitals can be attributed to first birth labor induction rates and first birth early labor admission rates. The results showed if labor was forced when the cervix was not ready the outcomes were poorer. Alfirevic et al. (2004) also showed that labor and delivery guidelines can make a difference in labor outcomes. Many authors have shown that physician factors, rather than patient characteristics or obstetric diagnoses are the major driver for the difference in rates within a hospital (Berkowitz, et al., 1989; Goyert et al., 1989; Luthy et al., 2003). The dramatic variation in NTSV rates seen in all populations studied is striking according to Menacker (2006). Hospitals within a state (Coonrod et al., 2008; California Office of Statewide Hospital Planning and Development [OSHPD], 2007) and physicians within a hospital (Main, 1999) have rates with a 3-5 fold variation.[vii]
C2-104	PC-03 Antenatal Steroids	The National Institutes of Health 1994 recommendation is to give a full course of corticosteroids to all pregnant women between 24 weeks and 34 weeks of gestation who are at risk of preterm delivery. Repeated corticosteroid courses should not be used routinely, because clinical trials show decreased brain size, decreased birth weight, and adrenal insufficiency in newborns exposed to repeated doses. Treatment should consist of two doses of 12 mg of betamethasone given intramuscularly 24 hours apart or four doses of 6 mg dexamethasone given intramuscularly every 12 hours. A single course of corticosteroids should be given at 24 0/7 to 33 6/7 weeks gestation (NIH, 2000). A Cochrane meta-analysis reinforces the beneficial effect of this therapy regardless of membrane status and further concludes for all preterm deliveries the single course of corticosteroids should be routinely administered (Roberts & Dalziel, 2006). [viii]
C2-105	Hospital Safety Collaborative Participation	Learning collaboratives can facilitate the sharing of best practices and accelerate improvement in patient care. According to research recently published in the Journal of the American Medical Association, participation in a comprehensive, multicomponent, statewide surgical quality improvement collaborative was associated with positive changes in hospital safety culture, particularly for hospitals with the poorest baseline culture.[ix]

Measure ID	Measure Name	Rationale
C2-106	Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Urinary tract infections (UTIs) are the fifth most common type of healthcare-associated infection, with an estimated 62,700 UTIs in acute care hospitals in 2015. UTIs additionally account for more than 9.5% of infections reported by acute care hospitals. Virtually all healthcare-associated UTIs are caused by instrumentation of the urinary tract. Approximately 12%-16% of adult hospital inpatients will have an indwelling urinary catheter (IUC) at some time during their hospitalization, and each day the indwelling urinary catheter remains, a patient has a 3%-7% increased risk of acquiring a catheter-associated urinary tract infection (CAUTI). CAUTI can lead to such complications as prostatitis, epididymitis, and orchitis in males, and cystitis, pyelonephritis, gram-negative bacteremia, endocarditis, vertebral osteomyelitis, septic arthritis, endophthalmitis, and meningitis in patients. Complications associated with CAUTI cause discomfort to the patient, prolonged hospital stay, and increased cost and mortality. It has been estimated that each year, more than 13,000 deaths are associated with UTIs.[x]
C2-107	Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure	Although a 46% decrease in CLABSIs has occurred in hospitals across the U.S. from 2008-2013, an estimated 30,100 central line-associated bloodstream infections (CLABSI) still occur in intensive care units and wards of U.S. acute care facilities each year.1 CLABSIs are serious infections typically causing a prolongation of hospital stay and increased cost and risk of mortality. CLABSI can be prevented through proper insertion techniques and management of the central line. These techniques are addressed in the CDC's Healthcare Infection Control Practices Advisory Committee (CDC/HICPAC) Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011. [xi]
C2-108	Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Clostridium difficile is responsible for a spectrum of C. difficile infection (CDI) complications, including uncomplicated diarrhea, pseudomembranous colitis, and toxic megacolon which can, in some instances, lead to sepsis and even death. In recent years, a previously unrecognized strain of C. difficile with increased virulence and high levels of antimicrobial resistance has resulted in outbreaks in health care facilities in the United States. Additionally, CDI has become more common in the community setting, with increased risk in those with a recent inpatient stay in a health care facility. Significant increases in the cost of inpatient care and post-hospitalization care have been seen in cases of CDI.[xii]
C2-109	Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	It is envisioned the use of this measure will promote SSI prevention activities which will lead to improved patient outcomes including reduction of avoidable medical costs, and patient morbidity and mortality. When SIRs are compared over time, assessment of performance can be made. In separate analyses, CDC and ACS have demonstrated a significant performance gaps in SIRs across facilities.[xiii]
C2-110	Hospital Safety Collaborative Participation	Learning collaboratives can facilitate the sharing of best practices and accelerate improvement in patient care. According to research recently published in the Journal of the American Medical Association, participation in a comprehensive, multicomponent, statewide surgical quality improvement collaborative was associated with positive changes in hospital safety culture, particularly for hospitals with the poorest baseline culture.[xiv]
C2-111	Pediatric Adverse Drug Events	ADEs result in a substantial number of health care visits, particularly in outpatient clinics. The incidence of ADEs and medications implicated vary by age, indicating that age-specific approaches for monitoring and preventing ADEs may be most effective.[xv]
C2-112	Pediatric CLABSI	Central Line-Associated Bloodstream Infections (CLABSIs) are a significant cause of mortality and morbidity in hospital neonatal intensive care units (NICUs). Premature infants in NICUs are particularly susceptible to infection because of their immature immune systems.[xvi]

Measure ID	Measure Name	Rationale
C2-113	Pediatric CAUTI	According to the Association for Professionals in Infection Control, urinary tract infections are among the most common of healthcare-associated infections (HAIs), accounting for 25.6 percent of all hospital HAIs. 70%–80% of healthcare-associated UTIs are caused by indwelling urethral catheters. Catheter-associated urinary tract infections (CAUTIs) are associated with increased morbidity, mortality, hospital cost, length of stay, and antimicrobial use.[xvii]
C2-114	Pediatric SSI	While advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical technique, and availability of antimicrobial prophylaxis, SSIs remain a substantial cause of morbidity, prolonged hospitalization, and death. SSI is associated with a mortality rate of 3%, and 75% of SSI associated deaths are directly attributable to the SSI. SSI is the most costly HAI. Surveillance of SSI with feedback of appropriate data to surgeons has been shown to be an important component of strategies to reduce SSI risk. A successful surveillance program includes the use of epidemiologically-sound infection definitions and effective surveillance methods, stratification of SSI rates according to risk factors associated with SSI development, and data feedback.[xviii]
C2-115	Written transition procedures that include formal MCO relationship or EDEN notification/ADT Feed	As part of Texas's Health IT Strategic Plan, the Emergency Department Encounter Notification (EDEN) system was established to provides the ADT processing infrastructure to be used by hospital systems to exchange ADT data between Health Information Exchanges (HIEs) connected to each other via THSA. Using EDEN, Medicaid clients' admission, discharge or transfer status will be transmitted to Texas Medicaid and MCOs. EDEN will evolve to support the exchange of patient information with primary care physicians (PCPs) and other care team members.[xix] ADT messages are the vehicle for communicating updates about a patient's care transitions. The alerts are triggered by an admission, discharge, or transfer (ADT) event in a hospital information system that sends a message to the HIE system. The HIE system processes the message and transforms it into an alert sent to the primary care practice or community-based care manager. This communication notifies the physician, care manager or care management team to initiate an intervention, improving the post-discharge transition, and supports management of patients with chronic conditions.[xx] Current emergency department information systems do not always allow ADT messages/notifications to be exchanged outside the hospital's system (i.e., with MCOs or with a patient's primary care provider). Diagnosis and admissions data is valuable to care coordination and can be used by MCOs to automate prior authorizations, which is a key benefit for both MCOs and hospitals. [xxi]
C2-116	Post-discharge appointment for behavioral health	Scheduling timely appointments for outpatient follow-up care is a discharge planning practice widely accepted as a standard of care for inpatient treatment. Despite these endorsements, however, rates of hospital providers completing these practices vary widely. Scheduling an outpatient mental health appointment increases aftercare attendance following a psychiatric discharge. This effect was noted across all 5 propensity strata, indicating that discharge planning has a positive impact regardless of the presence of other factors highly predictive of failure to attend aftercare appointments.[xxii]
C2-117	Rate of 30-day readmissions for BH Conditions	According to the EQRO, three of the top ten potentially preventable readmission (PPR) conditions overall in 2017 were related to mental health (bipolar disorders, schizophrenia, and major depressive disorders), suggesting a need to improve the management of mental health conditions. PPRs are an indicator of quality of care because they reflect poor clinical care and poor coordination of services, either during hospitalization or in the immediate period following hospital discharge. [xxiii]

Measure ID	Measure Name	Rationale
C2-118	Follow-Up After Hospitalization for Mental Illness - 7-Day	Follow-up care following an acute event, such as hospitalization, reduces the risk of negative outcomes (e.g., medication errors, re-admission, emergency department use). Efforts to facilitate treatment following a hospital discharge also lead to less attrition in the initial post-acute period of treatment. Thus, this time period may be an important opportunity for health plans to implement strategies aimed at establishing strong relationships between patients and mental health providers and facilitate long-term engagement in treatment. Evidence suggests that brief, low-intensity case management interventions are effective in bridging the gap between inpatient and outpatient treatment (Dixon 2009). Low-intensity interventions are typically implemented at periods of high risk for treatment dropout, such as following an emergency room or hospital discharge or the time of entry into outpatient treatment (Kreyenbuhl 2009). For example, Boyer et al evaluated strategies aimed at increasing attendance at outpatient appointments following hospital discharge. They found that the most common factor in a patient s medical history that was linked to a patient having a follow-up visit was a discussion about the discharge plan between the inpatient staff and outpatient clinicians. Other strategies they found that increased attendance at appointments included having the patient meet with outpatient staff and visit the outpatient program prior to discharge (Boyer 2000). Other studies suggest that repeated follow-up outreach and in-person visits with patients can reduce the rate of subsequent suicide attempts (Luxton, 2013) or psychiatric readmissions (Barekatain, 2014).[xxiv]
C2-119	Written transition procedures that include formal MCO relationship or EDEN notification/ADT Feed	ADT messages are the vehicle for communicating updates about a patient's care transitions. The alerts are triggered by an admission, discharge, or transfer (ADT) event in a hospital information system that sends a message to the health information exchange (HIE) system. The HIE system processes the message and transforms it into an alert sent to the primary care practice or community-based care manager. This communication notifies the physician, care manager or care management team to initiate an intervention, improving the post-discharge transition, and supports management of patients with chronic conditions.[xxv] Current emergency department (ED) information systems do not always allow ADT messages/notifications to be exchanged outside the hospital's system (i.e., with MCOs or with a patient's primary care provider). Diagnosis and admissions data is valuable to care coordination and can be used by MCOs to automate prior authorizations, which is a key benefit for both MCOs and hospitals. As part of Texas's Health IT Strategic Plan, the Emergency Department Encounter Notification (EDEN) system was established to provides the ADT processing infrastructure to be used by hospital systems to exchange ADT data between HIEs connected to each other via THSA. Using EDEN, Medicaid clients' admission, discharge or transfer status will be transmitted to Texas Medicaid and MCOs. EDEN will evolve to support the exchange of patient information with primary care physicians (PCPs) and other care team members.[xxvi]

Measure ID	Measure Name	Rationale
C2-120	Post-discharge appointment for heart failure	Care coordination is important for all patients, but especially for vulnerable populations, such as patients with heart failure and other chronic diseases. Today, the average Medicare patient sees two primary care and five specialists per year (NQF, 2010). For patients with multiple chronic conditions, the number of healthcare providers involved in the care of the patient is even higher. The exchange of information from one healthcare provider to another should smooth the transition of care from the inpatient to outpatient setting. According to Bell and colleagues (2008), the separation of hospital and ambulatory care may result in significant care discontinuities after discharge. Therefore, it is paramount that discussions between providers summarize the patient's history and communicate the plan for follow-up care after discharge in order to be effective. When done well, this exchange of information can avoid conflicting plans of care; overuse, underuse, and misuse of medications, tests and therapies; reduce costs and potentially adverse events.[xxvii]
C2-120	Transition Record with Specified Elements Received by Discharged Patients (Discharges from Inpatient Facility)	Sabogal and colleagues found that uncoordinated transitions between sites of care, even within the same institution, and between caregivers increase hospital readmissions, medical errors, duplication of services, and waste of resources. Moore and colleagues examined three types of discontinuity of care among older patients transferred from the hospital: medication, test result follow-up, and initiation of a recommended work-up. They found that nearly 50 percent of hospitalized patients experienced at least one discontinuity and that patients who did not have a recommended work-up initiated were six times more likely to be re-hospitalized. A prospective, cross-sectional study by Roy and colleagues found that approximately 40 percent of patients have pending test results at the time of discharge and that 10 percent of these require some ac Emergency Department Visits. The 2008 National Health Statistics Report determined that 2.3 million (2 percent) emergency department visits are from patients who were discharged from the hospital within the previous 7 days. The report also cited the following: Ten percent of the 2.3 million emergency department visits were for complications related to their recent hospitalization, and the uninsured are 3 times more likely to visit the emergency department. An estimated 60 percent of medication errors occur during times of transition: upon admission, transfer, or discharge of a patient. During care transitions, patients receive medications from different prescribers who rarely have access to patients' comprehensive medication list. Forster and colleagues found that 19 percent of discharged patients experienced an associated adverse event within three weeks of leaving the hospital; 66 percent of these were adverse drug events.[xxviii]
C2-121	Use of validated screening tool for food insecurity	Food insecurity, a condition of "limited or uncertain availability of nutritionally adequate and safe foods," has been widely identified as a modifiable health-related social need. To address food insecurity in the health care setting, health care providers need an efficient and valid strategy to identify and support individuals living in food-insecure households.[xxix]
C2-122	Food Insecurity Screening	The Hunger Vital SignTM (HVS) is a validated 2-question food insecurity screening tool that allows clinicians to accurately identify households at risk of food insecurity and address patient needs appropriately. Endorsed by the American Academy of Pediatrics, the tool is being used by hundreds of clinicians in the US and is being incorporated into electronic health record systems. As use increases, it is critical to identify best practices for screening appropriately and intervening effectively.[xxx]

Measure ID	Measure Name	Rationale
C2-123	Adult Major Depressive Disorder: Suicide Risk Assessment	Research has shown that more than 90% of people who kill themselves have depression or another diagnosable mental or substance abuse disorder. Depression is the cause of over two-thirds of the reported suicides in the U.S. each year. The intent of this measure is for a clinician to assess suicide risk at initial intake or at the visit in which depression was diagnosed. As the guidelines state, it is important to assess for additional factors which may increase or decrease suicide risk, such as presence of additional symptoms (eg, psychosis, severe anxiety, hopelessness, severe chronic pain); presence of substance abuse, history and seriousness of previous attempts, particularly, recent suicidal behavior, current stressors and potential protective factors (eg, positive reasons for living, strong social support), family history of suicide or mental illness or recent exposure to suicide, impulsivity and potential for risk to others, including history of violence or violent or homicidal ideas, plans, or intentions, and putting one's affairs in order (eg, giving away possessions, writing a will). In addition, although the measure focuses on the initial visit, it is critical that suicide risk be monitored especially for the 90 days following the initial visit and throughout MDD treatment.[xxxi]
C2-125	Follow-Up After ED Visits for Mental Illness - 7-Day	Follow-up care following an acute event, such as hospitalization, reduces the risk of negative outcomes (e.g., medication errors, re-admission, emergency department use). Efforts to facilitate treatment following a hospital discharge also lead to less attrition in the initial post-acute period of treatment. Thus, this time period may be an important opportunity for health plans to implement strategies aimed at establishing strong relationships between patients and mental health providers and facilitate long-term engagement in treatment. Evidence suggests that brief, low-intensity case management interventions are effective in bridging the gap between inpatient and outpatient treatment (Dixon 2009). Low-intensity interventions are typically implemented at periods of high risk for treatment dropout, such as following an emergency room or hospital discharge or the time of entry into outpatient treatment (Kreyenbuhl 2009). For example, Boyer et al evaluated strategies aimed at increasing attendance at outpatient appointments following hospital discharge. They found that the most common factor in a patient s medical history that was linked to a patient having a follow-up visit was a discussion about the discharge plan between the inpatient staff and outpatient clinicians. Other strategies they found that increased attendance at appointments included having the patient meet with outpatient staff and visit the outpatient program prior to discharge (Boyer 2000). Other studies suggest that repeated follow-up outreach and in-person visits with patients can reduce the rate of subsequent suicide attempts (Luxton, 2013) or psychiatric readmissions (Barekatain, 2014).[xxxii]
C2-126	Use of validated screening tool for food insecurity and suicide risk	Food insecurity, a condition of "limited or uncertain availability of nutritionally adequate and safe foods," has been widely identified as a modifiable health-related social need. To address food insecurity in the health care setting, health care providers need an efficient and valid strategy to identify and support individuals living in food-insecure households.[xxxiii] The majority of people who die by suicide visit a healthcare provider within months before their death. Yet, most healthcare settings do not screen for suicide risk. In February 2016, the Joint Commission, the accrediting organization for health care programs in hospitals throughout the United States, issued a Sentinel Event Alert recommending that all medical patients in all medical settings (inpatient hospital units, outpatient practices, emergency departments) be screened for suicide risk. Using valid suicide risk screening tools that have been tested in the medical setting and with youth, will help clinicians accurately detect who is at risk and who needs further intervention.[xxxiv]

Measure ID	Measure Name	Rationale
C2-127	Food Insecurity Screening	The Hunger Vital SignTM (HVS) is a validated 2-question food insecurity screening tool that allows clinicians to accurately identify households at risk of food insecurity and address patient needs appropriately. Endorsed by the American Academy of Pediatrics, the tool is being used by hundreds of clinicians in the US and is being incorporated into electronic health record systems.1 As use increases, it is critical to identify best practices for screening appropriately and intervening effectively.[xxxv]
C2-128	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.[xxxvi]
C2-129	Inpatient Influenza Immunization IMM-2	Up to 1 in 5 people in the United States get influenza every season (CDC, Key Facts 2015). Each year an average of approximately 226,000 people in the US are hospitalized with complications from influenza and between 3,000 and 49,000 die from the disease and its complications (Thompson 2003). Combined with pneumonia, influenza is the nation's 8th leading cause of death (Heron 2012). Up to two-thirds of all deaths attributable to pneumonia and influenza occur in the population of patients that have been hospitalized during flu season regardless of age (Fedson 2000). The Advisory Committee on Immunization Practices (ACIP) recommends seasonal influenza vaccination for all persons 6 months of age and older to highlight the importance of preventing influenza. Vaccination is associated with reductions in influenza among all age groups (Kostova 2013). The influenza vaccination is the most effective method for preventing influenza virus infection and its potentially severe complications. Screening and vaccination of inpatients is recommended, but hospitalization is an underutilized opportunity to provide vaccination to persons 6 months of age or older.[xxxvii]
C2-130	Preventive Care and Screening: Influenza Immunization	Influenza vaccination is the most effective protection against influenza virus infection (Centers for Disease Control and Prevention [CDC], 2018). Influenza may lead to serious complications including hospitalization or death (CDC, 2018). Influenza vaccine is recommended for all persons aged >=6 months who do not have contraindications to vaccination. However, data indicate that less than half of all eligible individuals receive an influenza vaccination (CDC, 2015). This measure promotes annual influenza vaccination for all persons aged >= 6 months.[xxxviii]

[i] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/health-it-strategic-plan.pdf
[ii] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4765664/
[iii] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/eqro-summary-of-activites-report-contract-yr-2018.pdf
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