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New York State Department of Health

Office of Quality and Patient Safety
Office of Health Insurance Programs
Office of Mental Health

HARP Behavioral Health Focused Clinical Study: Identification, Coordination, and Follow-up of Co-occurring Cardio-metabolic Conditions Among Individuals with Serious Mental Illness Admitted to Hospital Inpatient Mental Health Units

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March 2018

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I. Executive Summary

In 2017, IPRO, on behalf of the New York State Department of Health (NYSDOH) and the Office of Mental Health (OMH) conducted a focused clinical study to evaluate: 1) the identification of comorbid cardiometabolic conditions (defined as diabetes mellitus, hypertension, and cardiovascular disease) in members during inpatient psychiatric stays and 2) follow-up activities related to these conditions after discharge. Secondary analyses evaluated whether differences existed in the care delivered to members in the different product lines of the Medicaid Managed Care (MMC) program, including the mainstream MMC, Health and Recovery Plan (HARP), and HIV Special Needs Plan (SNP) in New York City (NYC), as well as, potential differences between NYC's public hospitals and other hospitals. At the time of this study, only NYC HARP plans had enrolled members; therefore, only NYC plan members were included in the study.

Methodology

The eligible population of the study included all MMC mainstream, HARP, and HIV Special Needs Plan (SNP) members in NYC MMC plans between the ages of 21 and 64 years. Members in the eligible population had an inpatient psychiatric admission between January 1, 2016 and June 30, 2016 with a minimum length of stay of seven days, were discharged between January 7, 2016 and July 7, 2016, and were not readmitted within 30 days of discharge.

A stratified random sample of 440 records (inclusive of a 10% oversample) was pulled per the following strata:

1. HARP or SNP HARP-like members with 2014 Diabetes mellitus, hypertension, and/or cardiovascular disease (113 records)
2. HARP or SNP HARP-like members without 2014 Diabetes mellitus, hypertension, and/or cardiovascular disease (113 records)
3. Mainstream MMC or SNP members with 2014 Diabetes mellitus, hypertension, and/or cardiovascular disease (102 records).
4. Mainstream MMC or SNP members without 2014 Diabetes mellitus, hypertension, and/or cardiovascular disease (113 records).

Data associated with three care settings defined as pre-inpatient, inpatient, and discharge, were collected through medical record review and augmented by MMC encounter data provided by the NYSDOH, as well as Managed Care Organization (MCO)-reported information regarding Health Home enrollment and care coordination. The MMC encounter data also allowed for the identification of co-morbid cardiometabolic conditions using Episode Disease Categories (EDCs)[1]. The final sample consisted of 406 records, which were reviewed to determine the extent to which inpatient behavioral health providers identify co-morbid conditions and arranged for ambulatory care follow-up for these conditions.

Results

All members in the sample received a comprehensive physical exam and medical history in at least one of the care settings (pre-inpatient, inpatient, and/or discharge). Testing for cardiometabolic conditions varied as follows: 76.1% of members had an electrocardiogram (EKG) performed, 59.5% had a diabetes screen (hemoglobin A1c (HbA1c), fasting glucose, and/or glucose tolerance test), and 38.4% had a fasting lipid profile documented in the medical record in at least one of the care settings.

Through medical record review of the inpatient stay, it was determined that cardiometabolic conditions were identified in 40.6% of members, while a significantly higher rate (48.3%) of members had a history of a

[1] Episode Disease Categories (EDCs) are defined using the 3M™ Clinical Risk Grouping Software. For detailed information on the 3M CRG software, refer to https://www.3m.com/3M/en_US/company-us/all-3m-products/~/3M-Clinical-Risk-Grouping-Software?N=5002385+3293081230&rt=rud

cardiometabolic condition based on 2014 Episode Disease Category data (p<.05). **Of those 48% (187) of members who had a history of a cardiometabolic condition documented by EDC, the inpatient behavioral health clinicians accurately identified a cardiometabolic condition in 122 (65%) members.** Multivariate analysis was conducted to identify factors associated with the identification of cardiometabolic conditions in the inpatient setting. Patient age was a statistically significant predictor of identification of co-morbid conditions with members ages 45-64 years more likely to have a cardiometabolic condition identified than members ages 21-44 years.

Once cardiometabolic conditions were identified, rates for monitoring also varied across care settings and conditions. Of the individuals identified with hypertension, 97.7% had documented blood pressure monitoring during the inpatient stay, whereas 25.6% of members identified with diabetes mellitus had documentation of fasting lipid profiles and 43.6% had HbA1c monitored. Additionally, 55.0% of members identified with cardiovascular disease had documented EKGs performed during the inpatient stay. Overall, between 28% and 35% of admissions, depending on the condition, had a medication initiated for a cardiometabolic condition during the inpatient stay. **Among the 157 admitted members with a documented cardiometabolic condition, 102 members (65%) had a referral to a medical provider noted in the discharge plan, 75 members (48%) had an appointment scheduled with a medical provider post-discharge, and 101 members (64%) attended an appointment with a medical provider within 45 days of discharge.**

Sub analyses, such as HARP vs. non-HARP and various demographic characteristics of the members were performed for several elements in the data collection tool. HARP members were found to have a significantly higher rate of *Any Identified Behavioral Risk* (includes tobacco use, drug use, and/or alcohol dependence), while Non-HARP members had a significantly higher rate of receiving *Counseling* as a follow-up to identified behavioral risks. HARP and Non-HARP members did not differ significantly for the remainder of the elements analyzed.

Male members were found to have significantly higher rates of *Tobacco Use, Drug Use (any drug(s)), Alcohol Dependence,* and *Any Identified Behavioral Risk*. However, men had significantly lower rates of the following: *Obesity, Elevated BMI, Abnormal Cardiac Exam, Any Abnormal Lab/Exam Findings*, and *Counseling* as a follow-up for abnormal lab/exam findings.

In terms of comparison analysis based on race/ethnicity, both Black and Hispanic members had a significantly higher rate than members identified as “Other” for *Any Identified Behavioral Risk*. Black members also had significantly higher rates than members identified as “Other” for *Drug Use (any drug(s))* and *Alcohol Dependence*. Conversely, members identified as “Other” had a significantly higher rate for *Any Abnormal Lab/Exam Follow-Up* than both White and Black members.

A comparison of members based on age group (21-44 years vs. 45-64 years) showed that members 45 to 64 years of age reported significantly higher rates for the following conditions: *Cardiovascular Disease, Hypertension, Diabetes, Pre-Diabetes,* and *Other Cardiometabolic Disease*. Additionally, this same age group had higher rates of the following abnormal lab/exam findings: *Any Abnormal Lab/Exam Findings, Elevated Blood Pressure, Diabetes Screen, Lipid Screen,* and *EKG.* Members aged 45-64 years also had higher rates for the following lab/exam follow-up actions: *Inpatient Testing Recommended, Pharmaceutical Therapy Initiation,* and *Pharmaceutical Therapy Titration.* Members ages 21-44 reported a significantly higher rate for a single indicator: *Drug Use (any drug(s))*.

The univariate analysis based on the facility type showed that, overall, the rates for both Health & Hospital Corporation (HHC) and non-HHC facilities did not differ significantly for most indicators. The rates were significantly higher for Health & Hospital facilities for *Obesity* and *Tobacco Use*, while the rate was higher for non-Health & Hospital facilities for the behavioral risk follow-up action *Quitline.*

Logistic regression analysis was performed among members identified with a cardiometabolic condition for two dependent variables: *Physical Health Visit Completed within 45 Days of Discharge* and *Follow-Up for*

Abnormal Lab/Exam Findings. Independent variables used in the regressions included plan type (HARP vs. Non-HARP), gender, age group, race/ethnicity, Health Home outreach/enrollment, MCO care coordination at discharge, and facility type (Health & Hospitals vs. non-Health & Hospitals). Members ages 45-64 were found to be more likely to complete physical health follow-up visits and have a follow-up activity for abnormal lab/exam findings than members ages 21-44. Additionally, women were more likely to have a follow-up activity for abnormal lab/exam findings than men.

For members who are eligible for Health Homes, additional analyses were performed to compare HARP to Non-HARP enrollment in Health Homes; enrollment rates were similar, approximately 40% despite the higher eligibility rates for HARP members (84.8% versus 64.8%). **HARP members experienced significantly higher rates of MCO outreach to Health Homes in which members were enrolled, as well as care coordination from the MCO during the inpatient stay, than Non-HARP members**. Rates of having a follow-up visit after discharge for both physical and behavioral health did not differ significantly between HARP and Non-HARP members. **However, when Health Home and/or MCO care management was offered, members were found more likely to attend an aftercare visit with behavioral and/or physical health providers.** Overall, 51% of HARP members and 58% of Non-HARP members attended a behavioral health appointment within 30 days of discharge, while 57% of HARP members and 64% of Non-HARP members attended a physical health appointment within 45 days of discharge. Both HARP and Non-HARP members demonstrated a higher rate of attendance for physical health appointments than for behavioral health appointments post-discharge.

Discussion

Members admitted to inpatient psychiatric care for mental illness that have co-occurring physical health conditions have complex health needs that must be addressed to ensure these members receive the care they need. The results of this study identified opportunities for improvement in the areas of identification of cardiometabolic conditions in inpatient psychiatric settings, follow-up care in the ambulatory care setting and coordination by the MCOs with ambulatory providers and Health Homes. Current processes for screening and diagnosis, monitoring of physical health conditions, communication with patients, and coordination of care demonstrate a need for improving the delivery of adequate medical care for inpatient mental health patients.

HARP plans had higher rates of care coordination both during the member's inpatient stay and in their direct outreach to the member's Health Home than non-HARP plans. However, there were no differences among the two plan types for members' compliance with follow-up visits. These results perhaps suggest that the HARP plans require more time to meaningfully improve care for their members.

Recommendations

Recommendations are made to improve the delivery of care for both Non-HARP and HARP members admitted to inpatient psychiatric units who have comorbid cardiometabolic conditions.

1. The MCOs should work with the NYSDOH, OMH, and OASAS to inform providers of the results of this study, notably the incidence of comorbid cardiometabolic conditions among individuals admitted to inpatient psychiatric units and the need for follow-up care in the ambulatory setting for both the mental and physical health conditions. Follow-up rates for patients with a hospitalization for a mental health condition continue to show room for improvement.
2. The MCOs should collaborate with providers to broaden the focus on care transition interventions to include post-discharge follow-up with medical providers when comorbid cardiometabolic conditions are present.
3. The MCOs should ensure that providers are aware that care management services (from Health Homes or MCOs) can improve rates of post-discharge follow-up with medical providers among individuals with comorbid cardiometabolic conditions. MCOs should work with providers to increase rates of care management services provided to these individuals.
4. The MCOs should routinely monitor their administrative data to identify gaps in care to help intervene when members are not receiving adequate care, services, and follow-up.

5. The MCOs and institutions should work with institutions (hospitals and inpatient facilities) to improve and implement the discharge process across the care continuum. MCOs should focus on communication of aftercare for high-risk physical health conditions, ensure inpatient providers schedule aftercare appointments with a date and time noted in the discharge plan, ensure care summaries are sent to aftercare providers, and confirm member attendance at follow-up appointments post-discharge, as well as conduct continuous outreach to the members. They should engage members with cardiometabolic conditions as a priority and ensure plans for care transitions are in place.
6. The MCOs should evaluate the study findings (using quality metrics) to identify cardiometabolic and mental health conditions and devise strategies to overcome barriers (i.e., transportation, flexibility of office hours, financial challenges) to care.
7. The MCOs should promote use of clinical practice guidelines (i.e., American Diabetes Association guidelines, etc.) to help guide providers with work-up and treatment protocols, as well as identify community resources for members with identified risks.
8. The workflow process should support a collaborative care model (CoCM), which is a data-driven process and requires active care teams to adopt ongoing surveillance methods to ensure early detection of cardiometabolic conditions.
9. The MCOs should ensure that their case management systems include follow-up alerts and reminders (for appointments and/or referrals), which function to track members' adherence to physical and mental health appointments and prompt case managers to routinely review whether appointments are kept. These reminders can be forwarded to the patients' provider(s) and health care team.
10. The MCOs should promote wellness strategies by incorporating lifestyle modifications into their education and treatment programs for members, including nutrition, exercise, and behavioral strategies.
11. Inpatient mental health institutions should promote the identification, documentation and treatment of physical health comorbidities during inpatient stays.

II. Introduction

Background

Individuals with serious behavioral health problems are more susceptible to chronic medical conditions, including diabetes mellitus, cardiovascular, and pulmonary disease. These co-occurring medical conditions are major risk factors contributing to heightened morbidity and mortality among this population.

In preparation for the integration of behavioral health benefits into Medicaid Managed Care, New York State (NYS) implemented a quality assurance readiness project in 2012-2013. In this Behavioral Health Organization (BHO) Phase I project, the Office of Mental Health (OMH) and the Office of Alcohol and Substance Abuse Services (OASAS) contracted with BHOs to review behavioral health inpatient admissions for the Medicaid fee-for-service population statewide. During the 2-year project period, over 50,000 psychiatric admissions were concurrently reviewed. The contracted BHOs were required to document patients' care coordination needs and establish benchmarks for routine provider discharge planning practices (e.g., scheduling outpatient appointments, forwarding aftercare summaries). BHOs were also asked to determine, for each admission, whether the patient had a general medical condition that required follow-up as part of the discharge plan. Inpatient behavioral health providers identified general medical conditions that required follow-up in 36% of all behavioral health discharges. However, upon discharge, only 18% of these individuals had an aftercare appointment for general medical care scheduled.

These findings suggest that hospital inpatient behavioral health providers can identify medical conditions requiring follow-up in individuals with behavioral health conditions, but that little effort is being made to ensure appropriate follow-up ambulatory care. However, these data were derived from provider self-reports and were independently validated. Therefore, the current study included a more rigorous medical record review to provide data on whether inpatient providers are identifying comorbid chronic medical conditions (including diabetes mellitus, hypertension, and cardiovascular disease) during an inpatient stay and whether there is adequate post-discharge follow-up for these conditions.

Objectives

The aim of this study is to describe patterns of assessment, identification, and coordination of follow-up care for hypertension, diabetes mellitus, and cardiovascular health (together referred to as cardiometabolic) conditions among NYS Medicaid Managed Care (MMC) members with a mental health inpatient admission. The results will be used to identify opportunities for improvement and inform quality improvement initiatives related to ensuring care for cardiometabolic conditions among MMC plan members. It is expected that the study findings will help inform opportunities for improvement that can be implemented by MMC plans, OMH, and OASAS.

Study questions included:

1. To what extent are cardiometabolic conditions identified by inpatient mental health providers?
    a. What processes are in place to screen for active general medical conditions among MMC members in mental health hospital settings before and during admission?
2. To what extent do inpatient mental health providers arrange for follow-up of active cardiometabolic conditions among members with a mental health inpatient admission?
3. How do MMC plans coordinate follow-up of cardiometabolic conditions for members with mental health hospitalizations?
4. What factors are associated with successful identification of follow-up of cardiometabolic conditions?
5. How does the general medical care delivered to HARP members differ from the care delivered to mainstream plan members admitted to mental health inpatient programs?

III. Methodology

The study included medical record review, augmented by a review of MMC encounter data to evaluate outpatient follow-up visits within forty-five (45) days after discharge.

Eligible Population

The eligible population for this study included all MMC Mainstream, HARP, and HIV SNP HARP-like members of Medicaid Managed Care Organizations (MCOs) in New York City whose lines of business included HARP and mainstream Medicaid plans. Eligible members had a mental health inpatient admission between January 1, 2016 and June 30, 2016 and met the following criteria:

1. Discharged from an inpatient mental health facility between January 7, 2016 and July 7, 2016
2. Minimum length of stay of seven (7) days for mental health inpatient admissions
3. Primary diagnosis of mental health diseases or disorders (ICD-10 CM F20-F60, F80-F99) for the admission
4. Discharged to home from inpatient stay and without a readmission to any inpatient setting within thirty (30) days following the mental health discharge

Eligible members had the following characteristics:

1. Medicaid (non-dual) adults ages 21-64 years as of the day of mental health admission and forty-five (45) days following discharge.
2. Using a stratified sampling approach (see *Sampling*), records were selected for review based upon the presence of diabetes mellitus, hypertension, and/or cardiovascular disease as determined by 2014 Episode Disease Categories (EDC).
3. Continuously enrolled in a New York City MCO with a mainstream, HARP, or SNP plan at the mental health admission and for forty-five (45) days following discharge.

Members who were "non-users"[2] in 2014, and therefore do not have 2014 EDC coded, were excluded from the sample. For members with multiple mental health admissions during the review period, only the first admission was included in the sample.

Sampling

A stratified random sample of 400 records, plus a 10% oversample, was pulled per the following strata:

1. HARP or SNP HARP-like members with 2014 Diabetes mellitus, hypertension, and/or cardiovascular disease (113 records)
2. HARP or SNP HARP-like members without 2014 Diabetes mellitus, hypertension, and/or cardiovascular disease (113 records)
3. Mainstream MMC or SNP members with 2014 Diabetes mellitus, hypertension, and/or cardiovascular disease (102 records).
4. Mainstream MMC or SNP members without 2014 Diabetes mellitus, hypertension, and/or cardiovascular disease (113 records).

Table 1 displays the disposition of the sample, stratified by plan and product line. The table includes the number of records in the eligible population, the number of records requested, the number of records received, the number of records reviewed, the number of records excluded (if any), and the total number of usable cases for the final sample.

[2] "Non-users" are defined as members for whom there were no claims for any encounters in Calendar Year 2014.

Table 1: Disposition of the Study Sample

MCO	Eligible Population	Records Requested	Records Received	Records Reviewed	Exclusions[1]	Final Sample Size
Medicaid MMC/HIV SNP						
Empire BCBS HealthPlus	177	32	28	28	0	28
Fidelis	273	32	31	31	1	30
Healthfirst	572	32	29	29	2	27
HIP	111	32	30	30	1	29
MetroPlus	309	32	32	32	1	31
United	150	32	32	32	2	30
Amida Care SNP	20	18	17	17	0	17
MetroPlus SNP	3	3	3	3	0	3
VNSNY Choice SNP	2	2	1	1	0	1
HARP/HIV SNP HARP-like						
Empire BCBS HealthPlus	170	32	30	30	0	30
Fidelis	223	32	31	31	0	31
Healthfirst	439	32	30	30	2	28
HIP	124	32	30	30	0	30
MetroPlus	247	32	31	31	1	30
United	117	32	32	32	1	31
Amida Care SNP	13	13	11	11	0	11
MetroPlus SNP	17	11	11	11	0	11
VNSNY Choice SNP	10	10	10	10	2	8
TOTAL	**2,977**	**441**	**419**	**419**	**13**	**406**

[1] Medical records were excluded if: (1) no record was received; (2) the medical record documented that the member was not discharged to the community; or (3) the medical record was incomplete, i.e., the medical record did not document both an inpatient mental health admission and a discharge plan so that items related to care during those periods could be abstracted/evaluated.

Data Collection

Encounter data, Clinical Risk Group (CRG)[3], and Episode Disease Categories (EDCs) were assessed to identify the eligible population and the study sample.

MCOs were queried for each member of the sample to gather information about the members' participation in the Health Home Program and the MCOs' involvement in outreach and coordination of care. MCOs answered each of the following questions for each case included in the sample:

1. Was the member already enrolled in a health home prior to admission?
2. Was the member eligible for enrollment in a health home prior to or during admission?
3. Was the member in outreach for health home enrollment?
4. If the member was in outreach or enrolled, what is the name of the care management agency/health home?
5. If the member was in outreach or enrolled, did the MCO outreach to the care management agency/health home during the inpatient stay?

[3] Clinical Risk Groups (CRG) are determined using the 3M™ Clinical Risk Grouping Software. For detailed information on the 3M CRG software, refer to https://www.3m.com/3M/en_US/company-us/all-3m-products/~/3M-Clinical-Risk-Grouping-Software?N=5002385+3293081230&rt=rud

6. Was there any MCO outreach/care coordination while inpatient?

IPRO prepared a medical record request to be sent to each MCO with the sample file and instructions. Each MCO was requested to provide medical records for each member selected for the sample for the inpatient stay. Documentation requested included:

1. Face sheet (see six items noted above)
2. Problem list
3. Admission history and physical exam, including medications
4. Emergency department evaluation (if applicable)
5. Inpatient transfer notes (if applicable)
6. Clinical progress notes—excluding therapy notes
7. Routine lab work and diagnostic test (e.g., EKG) results
8. Consultations
9. Discharge documentation (discharge plan, discharge instructions to the patient, medication reconciliation, scheduled outpatient testing or provider visits, referrals for behavioral risks, e.g., Smoking Quitline)

IPRO developed a Microsoft Access-based record abstraction tool and accompanying instructions to extract desired data elements in the medical record and care management record. All records were abstracted by IPRO nurse reviewers using the Access tool. Inter-rater reliability (IRR) testing was conducted to evaluate the performance of the nurse reviewers at the outset, and regular oversight was conducted throughout the review process through weekly over-reads of a minimum of 5% of reviewed charts. All nurse reviewers maintained a performance of at least 95% accuracy throughout the oversight process. The cumulative abstraction accuracy rate for the over-read was 99.1%.

Medical Record Study Domains

General demographic information and eight domains of inpatient mental health care were included in the review tool. Each domain is presented below, followed by the categories of indicators used to evaluate care. Specific indicators were suggested by NYSDOH and IPRO researchers, in addition to experts in the field of mental health care. The indicators selected represent evidence-based recommendations, particular areas of focus in NYS, and/or areas with opportunity for improvement based on results of the previous mental health inpatient study. A comprehensive list of indicators is provided with the data abstraction tool in **Appendix A**, and with instructions for abstraction in **Appendix B**.

A. General Member Information
1. Demographics
2. Health Home Involvement
3. MCO outreach/care coordination

B. General Health Evaluation Prior to Inpatient Stay
1. Medical History
2. Physical Exam
3. Lab testing

C. Selected Diagnoses, Findings, and Risks Identified During Pre-Inpatient Evaluation
1. Acute symptoms/diagnoses and follow-up
2. Behavioral risks and follow-up
3. Abnormal exam/lab findings and follow-up
4. Cardiometabolic risk medications
5. Recommendations made

D. General Health Evaluation During Inpatient Stay

1. Medical History
2. Physical Exam
3. Lab testing

E. Selected Diagnoses, Findings, and Risks Identified During Inpatient Stay

1. Acute symptoms/diagnoses and follow-up
2. Behavioral risks and follow-up
3. Abnormal exam/lab findings and follow-up
4. Cardiometabolic risk medications
5. Recommendations made

F. General Health Evaluation at Discharge

1. Medical History
2. Physical Exam
3. Lab testing

G. Selected Diagnoses, Findings, and Risks Identified at Discharge

1. Acute symptoms/diagnoses and follow-up
2. Behavioral risks and follow-up
3. Abnormal exam/lab findings and follow-up
4. Cardiometabolic risk medications
5. Recommendations made

H. Components of Discharge Plan

1. Elements in discharge plan
2. Potential barriers to care
3. Medication reconciliation

I. Care Coordination in Discharge Plan

1. PCP information
2. Communication with physical health providers
3. Non-Health Home Care Management

Data Analysis

Data from the abstraction tool were imported into SAS version 9.3 for compilation, cleaning, and analysis. Descriptive statistics (frequencies and proportions associated with care indicator values) were first calculated by aggregating data for all cases, with the resultant tables presented by domain, as noted above. For some indicators, descriptive statistics were also calculated for a subset of cases, such as those with known risk factors. The total number of cases upon which proportions are based varies for each indicator, depending on availability of information and applicability of the item to the case. The indicator-specific denominator is presented for each item, after excluding “Unable to Determine” (UTD) and “Not Applicable” (N/A) responses.

Multivariate analyses were performed to identify predictors of member behaviors and provider practices, and assess statistical significance after controlling for potentially confounding factors.

The purpose of the analyses was to determine the extent to which inpatient behavioral health providers arrange for physical health follow-up care for patients with identified physical health conditions. Additionally, a comparison of HARP (members enrolled in HARP plans *and* members enrolled in SNP plans with HARP enrollment) and Non-HARP (members in MMC and SNP plans *without* HARP enrollment) members was conducted. To test for differences in proportions, chi-square tests were used for all comparative analyses on dichotomous data (i.e., yes/no variables). Logistical regression analyses were also conducted to evaluate predictors of outcome data.

The **Results** section consists of multiple subsections which reflect the analyses conducted to address the study questions. The following subsections are included:

1. Identification of Cardiometabolic Conditions by Inpatient Mental Health Providers
2. Processes for Screening for Active Cardiometabolic Conditions
3. Follow-Up of Active Cardiometabolic Conditions
4. Factors Associated with the Identification of Follow-Up for Cardiometabolic Conditions
5. Predictors of selected outcome indicators
6. HARP members vs. Non-HARP members

Composite indicators were developed and analyzed. These composite indicators included, but were not limited to:

1. At least one documented cardiometabolic condition
2. At least two documented cardiometabolic conditions
3. Three or more documented cardiometabolic conditions
4. Documentation of at least one behavioral risk (i.e., tobacco use, drug abuse, alcohol dependence)
5. At least one abnormal lab/exam finding AND at least one follow-up action for that finding

Additionally, the frequencies for each individual indicator can be found in **Appendix A**.

IV. Results

Member Demographics

The majority of the study sample were Black or Hispanic (45.8% and 26.8%, respectively), while nearly nine out of ten members (88.7%) reported English as their primary language. The majority of members in the sample whose primary language was reported as "Other" had a primary language of Chinese/Mandarin or Russian (data not shown). Overall, 54% of the members in the sample were male, and 45% were between the ages of 45 and 64 years. Approximately 88% of the members in the sample were admitted through the Emergency Department. All members in the final sample were discharged to the community.

Table 2: Demographic Characteristics

Characteristics	N	%
Race/Ethnicity (n=406)		
White	59	14.5%
Black	186	45.8%
Hispanic	109	26.8%
Asian, Pacific Islander	21	5.2%
Other	19	4.7%
Unknown	12	3.0%
Primary Language (n=406)		
English	360	88.7%
Spanish	21	5.2%
Other	11	2.7%
Unknown	14	3.4%
Translator Services (n=392)[1]		
Yes	21	5.4%
No	6	1.5%
N/A	364	92.9%
UTD	1	0.2%
Gender (n=406)		
Male	219	53.9%
Female	187	46.1%
Age (n=406)[2]		
21-44 Years	225	55.4%
45-64 Years	181	44.6%
Admission Setting (n=406)		
Emergency Department	358	88.2%
Medical Unit Inpatient Transfer	12	3.0%
Outpatient Clinic/Office	1	0.2%
Direct Admission	15	3.7%
Other	20	4.9%
UTD	0	0.0%
Discharged to Community (n=406)		
Yes	406	100.0%
No	0	0.0%

N/A: Not applicable.
UTD: Unable to Determine.
[1] The denominator is based on the number of members in the sample for which the primary language could be determined.
[2] Age was calculated based on the date of discharge.

The MCOs were asked to include a face sheet with each medical record requested for review. On the face sheet, MCOs were asked to state member outreach/enrollment in a Health Home, member eligibility for Health Home enrollment, and if the MCO engaged in outreach and care coordination with the members during the episode of care. A Health Home is care management providers who together work to ensure members get the care and services needed through health care service providers. The MCOs were also queried regarding care coordination conducted through the MCO with members during the inpatient stay. As shown in **Table 3a**, MCOs reported that they conducted care coordination with the members in 48% of cases during inpatient stay.

Table 3a: MCO Care Coordination (Item From Face Sheet)[1]

	N	%
Was there any MCO outreach/care coordination while inpatient (n=406)[2]		
Yes	195	48.0%
HARP	129	66.2%
Non-HARP	66	33.8%
No	198	48.8%
Not documented	13	3.2%

[1] These data were derived from the face sheet each MCO filled out for each member in the sample, and not through medical record review.

[2] This indicator refers to MCO care coordination with the member while the member was in the inpatient care setting.

Table 3b shows items from the face sheet focusing on Health Home eligibility and enrollment. MCOs reported that 75% of the sample was eligible for Health Home enrollment. Of those members, 40% were in outreach with or enrolled in a Health Home; 58% were HARP members and 42% were Non-HARP members. In regard to MCO outreach to members eligible for Health Home enrollment, MCOs reported that they had conducted outreach to the Health Homes regarding the members for 42% of those eligible for Health Home enrollment. In regard to members who were not eligible for Health Home enrollment, only 32% were reported to have had MCO care coordination conducted during the inpatient stay.

Table 3b: Health Home Eligibility and Enrollment (Items From Face Sheet)[1]

	N	%
Was the member eligible for enrollment in a health home prior to or during admission? (n=406)		
Yes	305	75.1%
No	101	24.9%
Was the member already enrolled in a Health Home prior to admission? (n=305)		
Yes	122	40.0%
HARP	71	58.2%
Non-HARP	51	41.8%
No	183	60.0%
Was the member in outreach for Health Home enrollment? (n=305)		
Yes	133	43.6%
HARP	80	60.2%
Non-HARP	53	39.8%
No	161	52.8%
Not documented	11	3.6%
Did the MCO outreach to the care management agency/health home during the inpatient stay? (n=305)[2]		
Yes	128	42.0%
No	162	53.1%
Not documented	15	4.9%
Was there any MCO outreach/care coordination while inpatient for members not eligible for Health Homes? (n=101)		
Yes	32	31.7%
No	63	62.4%
Not documented	6	5.9%

[1] These data were derived from the face sheet each MCO filled out for each member in the sample, and not through medical record review.

[2] This indicator refers to MCO outreach to the Care Management Agency or Health Home in which a member was in outreach or enrolled; therefore, the denominator (n=305) includes only those members eligible for Health Home enrollment.

Identification of Cardiometabolic Conditions by Inpatient Mental Health Providers

Medical record review items pertaining to selected cardiometabolic diagnoses (cardiovascular disease, diabetes mellitus, and hypertension) are presented as raw frequencies in **Table 4a** for each of the three care settings: pre-inpatient, inpatient, and discharge. Composite scores were calculated to include only those members in the sample for which each indicator was identified in *at least one* of the three care settings (pre-inpatient, inpatient, and discharge). The denominators presented in the table for each care setting represent the number of members in the sample who had a physical exam conducted. Overall, across the three care settings, cardiometabolic conditions were identified at relatively similar rates. Notably, the most commonly identified condition across all three care settings was hypertension, followed by diabetes mellitus, and cardiovascular disease. Note that members may have been identified as having more than one of the three cardiometabolic conditions at any given time during the episode of care.

Table 4b displays the number of members in the sample who had at least one cardiometabolic condition identified during the inpatient care setting as compared to the number of members in the sample who had a history of any cardiometabolic condition, according to 2014 Episode Disease Category (EDC) information. EDC data represent members with a history of cardiovascular disease, diabetes mellitus, and/or hypertension. Note that of the 387 members in the sample who had an inpatient physical exam, 157 had at least one cardiometabolic condition identified, while 187 had a history of a cardiometabolic condition (according to EDC data). These data were compared using the McNemar test ($p<.05$). Of the 387 members, 48% had a history of a cardiometabolic condition based on 2014 EDC data. Among those same 387 members, cardiovascular disease, diabetes mellitus, and/or hypertension were identified in only 41% of cases, a significantly lower rate ($p<.05$).

Overall, 122 members had at least one cardiometabolic condition identified during the inpatient phase of the episode of care as well as a history of a cardiometabolic condition based on 2014 EDC data. Among the 187 members who had a history of a cardiometabolic condition (according to EDC 2014 data), 65 members were not identified with a cardiometabolic condition during inpatient stays of at least 7 days. Conversely, 35 members who did not have a history of a cardiometabolic condition were identified as having cardiovascular disease, diabetes mellitus, and/or hypertension.

Table 4a: Select Cardiometabolic Diagnoses Identified During Pre-Inpatient, Inpatient, and Discharge[1]

Indicator	Pre-Inpatient (n=369)		Inpatient (n=387)		Discharge (n=308)		Composite (n=406)	Composite Score
	N	%	N	%	N	%		
Cardiovascular Disease	22	6.0%	20	5.2%	22	7.1%	34	8.4%
Hypertension	113	30.6%	131	33.9%	99	32.1%	147	36.2%
Diabetes Mellitus	69	18.7%	78	20.2%	56	18.2%	85	20.9%
At least one of the above	135	36.6%	157	40.6%	124	40.3%	177	43.6%

[1] Note that the above indicators are not mutually exclusive; members may have had more than one of the above conditions identified during the same phase of the episode of care. For example, a member could have had both hypertension and cardiovascular disease identified during the inpatient phase.

Table 4b: Members with Identified Cardiometabolic Conditions and 2014 EDC Data[1]

Indicator	Cardiometabolic Condition(s) Identified at Inpatient[2] (n=387)		2014 EDC Data[2] (n=387)		P Value (p<.05)
	N	%	N	%	
Cardiovascular Disease, Diabetes, and Hypertension	157	40.6%	187	48.3%	.004
# of Members with 2014 EDC Identified at Inpatient	122		122		
# of Members without 2014 EDCs Identified at Inpatient	35				
# of Members with 2014 EDC Not Identified at Inpatient			65		

[1] These data are based on the number of members in the sample who had a physical exam documented in the medical record during the inpatient phase of the episode of care.

[2] Note that members may be included in both rates.

Multivariate Analysis—Predictors of Identification of Cardiometabolic Conditions

To determine factors associated with the identification of cardiometabolic conditions that are statistically significant after controlling for potential confounding factors, a multivariate analysis was performed using logistic regression. This regression analysis was performed based on members who had cardiovascular disease, hypertension, of diabetes mellitus identified at any time during the episode of care, as well as members who had a history of a cardiometabolic condition according to EDC 2014 data. Members who had at least one of those identified were included in the denominator.

The following data served as independent variables: plan type (HARP vs. Non-HARP), gender, age group, race, Health Home outreach/enrollment, MCO care coordination at discharge, and facility type (Health & Hospital facilities vs. Non-Health & Hospital facilities). **Table 4c** displays the dependent variable, the number of cases included in the analysis (with valid data on each variable of the equation), the independent variables, the corresponding odds ratios, and significant p values.

Older members (ages 45 to 64 years) were found more likely to have cardiometabolic conditions identified during the inpatient stage of the episode of care.

Table 4c: Logistic Regression Results—Identification of Cardiometabolic Conditions

Dependent Variable	N[1]	Independent Variables	Odds Ratios	P value (p<.05)
Identified Cardiometabolic Condition(s)[2]	242	Plan Type (HARP vs. Non-HARP)	1.492	n.s.
		Age Group (45-64 v. 21-44)	3.886	.000
		Gender (Men v. Women)	1.129	n.s.
		White v. all others	0.968	n.s.
		Health Home Outreach/Enrollment (Y v. N)	1.097	n.s.
		Facility Type (H&H vs. Non-H&H)	1.596	n.s.
		MCO Care Coordination (Y v. N)	1.726	n.s.

Notes for Odds Ratios:
Age Group: 0=21-44 Years; 1=45-64 Years.
Gender: 0=Female; 1=Male.
HARP/Non-HARP: 0=Non-HARP; 1=HARP.
Facility Type: 0=Non-H&H; 1= H&H.
White: 0=All other race/ethnicities; 1= White.
For all other indicators: 0=No; 1=Yes.
Items in bold face represent statistically significant results (p<.05).
[1] The denominator reflects the number of records that had valid data.
[2] Any cardiometabolic condition identified during the inpatient stage of the episode of care.

Processes for Screening for Active General Medical Conditions

Medical record review items pertaining to the physical health exams are presented as raw frequencies in **Table 5**. In order to categorize data for meaningful analysis, the information was organized into the following domains:

1. Physical exam conducted
2. Medical History
3. Documented tests

Table 5 depicts the items of the domains listed above for each of the three care settings: pre-inpatient, inpatient, and discharge. The table also presents composite scores for each indicator. Composite scores were calculated to include only those members in the sample for which each indicator was identified in *at least one* of the three care settings (pre-inpatient, inpatient, and discharge). In regard to the conduct of physical health exams, the rates were somewhat similar in all three care settings. Overall, 100% of the sample had a physical exam conducted in at least one of the three care settings. Additionally, 100% of the sample had their medical history taken in at least one of the three care settings. Individual rates for the medical history recorded during the physical exam were similar in both the pre-inpatient and inpatient care settings, but lower for the discharge care setting. Similar decreases were noted between the inpatient and discharge care settings for the documented lab testing indicators.

Table 5: Pre-Inpatient, Inpatient, and Discharge Findings—Components of Physical Exam

Indicator	Pre-Inpatient		Inpatient		Discharge		Composite (n=406)	Composite Score
	N	%	N	%	N	%		
Physical Evaluation Conducted (n=406)	369	90.9%	400	98.5%	385	94.8%	406	100.0%
Medical History	352	95.4%	387	96.8%	321	83.4%	406	100.0%
Physical Exam Conducted	369	100.0%	387	96.8%	308	80.0%	406	100.0%
Documented Diagnostic Tests/Lab Testing Ordered/Completed	**N=369**		**N=387**		**N=308**		**N=406**	
Electrocardiogram (EKG)	243	65.9%	130	33.6%	5	1.6%	309	76.1%
Cardiac enzymes	15	4.1%	14	3.6%	0	0.0%	25	6.2%
Hemoglobin A1c (HbA1c)	48	13.0%	96	24.8%	2	0.6%	132	32.5%
Fasting glucose	140	37.9%	128	33.1%	7	2.3%	201	49.5%
Glucose Tolerance Test (GTT)	1	0.3%	0	0.0%	0	0.0%	1	0.2%
Diabetes Tests[1]	167	45.3%	172	44.4%	9	2.9%	243	59.9%
Fasting lipid profile	57	15.4%	112	28.9%	3	1.0%	156	38.4%
Comprehensive metabolic screening[2]	302	81.8%	179	46.3%	6	1.9%	350	86.2%
Other cardiometabolic tests[3]	78	21.1%	41	10.6%	5	1.6%	113	27.8%
Study Profile Tests[4]	-	-	37	9.6%	-	-		
No lab testing	31	8.4%	93	24.0%	275	89.3%		

[1] This indicator is a composite measure that includes HbA1c, fasting glucose, and GTT. The rates include members who had at least one of these three tests.

[2] Comprehensive metabolic screenings can include the following: sugar (glucose) level, electrolyte and fluid balance, kidney function, and liver function, and can be documented as SMA16.

[3] These include: glomerular filtration rate (GFR), gamma-glutamyl transferase (GGT), basic metabolic panel, hepatic function panel, unspecified blood glucose “finger sticks”, and unspecified non-fasting lipid profile.

[4] Study Profile Tests include HbA1c tests and/or fasting glucose tests, plus fasting lipids tests and comprehensive metabolic screenings. The composite score includes members who had an HbA1c and/or fasting glucose test, a fasting lipids test, and a comprehensive metabolic screening during the inpatient phase.

Table 6 displays selected diagnostic and laboratory tests for selected cardiometabolic conditions. For members identified with cardiovascular disease documented by the mental health inpatient clinical team, EKG testing was conducted at a higher rate during the pre-inpatient phase, while BMI was recorded at a higher rate during the inpatient phase. In regard to members identified as having hypertension, blood pressure readings and pulse were reported at similar rates for the pre-inpatient and inpatient phases, while the rates are lower for the discharge phase. Members identified with diabetes mellitus saw a high rate of comprehensive metabolic screenings conducted in the pre-inpatient care setting. Notably, the rates for HbA1c, fasting glucose, and fasting lipids test increased from pre-inpatient to inpatient although they remained well below 100%, which is a reasonable target given that these were individuals with diagnosed diabetes mellitus (DM).

Table 6: Diagnostic Tests/Labs Ordered

	Pre-Inpatient		Inpatient		Discharge	
Indicator	**N**	**%**	**N**	**%**	**N**	**%**
Cardiovascular Disease	N=22		N=20		N=22	
Electrocardiogram (EKG)	16	72.7%	11	55.0%	0	0.0%
Cardiac Enzymes	1	4.5%	1	5.0%	0	0.0%
Body Mass Index (BMI)	13	59.1%	14	70.0%	-	-
Hypertension	N=113		N=131		N=99	
Blood Pressure	106	93.8%	128	97.7%	80	80.8%
Pulse	106	93.8%	125	95.4%	81	81.8%
Body Mass Index (BMI)	57	50.4%	82	62.6%	-	-
Diabetes Mellitus	N=69		N=78		N=56	
Hemoglobin A1c (HbA1c)	18	26.1%	34	43.6%	0	0.0%
Fasting Glucose	29	42.0%	47	60.3%	6	10.7%
Fasting Lipids	8	11.6%	20	25.6%	0	0.0%
Comprehensive Metabolic Screening	54	78.3%	40	51.3%	3	5.4%
Body Mass Index (BMI)	35	50.7%	50	64.1%	-	-

Note: The – symbol indicates that the item was not available for abstraction for that care setting.

Follow-Up of Active Cardiometabolic Conditions

Table 7 displays specific follow-up actions taken by inpatient mental health providers for cardiometabolic conditions identified in the inpatient care setting. The table also displays the rates for follow-up visits scheduled and attended for the members in the sample with a cardiometabolic condition identified in the inpatient care setting. Of the 157 members who had an identified cardiometabolic condition during the inpatient phase of care, only two-thirds (65.0%) had a referral for a physical health provider in their discharge plan, while less than half (47.8%) had an appointment scheduled as part of the discharge plan. Overall, 64.3% of members attended a physical health follow-up visit within forty-five days of discharge. Of the members who had a referral for a physical health provider documented in the discharge plan, 66% attended a physical health visit within forty-five days of discharge. Additionally, of the members who had a physical health visit scheduled prior to discharge documented in the discharge plan, 67% attended a physical health visit within forty-five days of discharge.

Table 7: Follow-Up for Cardiometabolic Conditions Identified in the Inpatient Care Setting

	Inpatient (n=157)	
Indicator	**N**	**%**
Cardiovascular Disease	N=20	
Inpatient Testing	9	45.0%
Inpatient Consultation	3	15.0%
Medication Initiation	7	35.0%
Medication Discontinuation	1	5.0%
Medication Titration	2	10.0%
Nutrition/Exercise Counseling	10	50.0%
None	2	10.0%
Hypertension	N=131	
Inpatient Testing	67	48.9%
Inpatient Consultation	15	11.5%
Medication Initiation	45	34.4%
Medication Discontinuation	7	5.3%
Medication Titration	22	16.8%
Nutrition/Exercise Counseling	66	50.4%
None	21	16.0%
Diabetes Mellitus	N=78	
Inpatient Testing	60	76.9%
Inpatient Consultation	21	26.9%
Medication Initiation	22	28.2%
Medication Discontinuation	4	5.1%
Medication Titration	25	32.1%
Nutrition/Exercise Counseling	60	76.9%
None	5	6.4%
Physical Health Referral Noted in Discharge Plan[1]	N=157	
Yes	102	65.0%
No	55	35.0%
Physical Health Appointment Scheduled[2]	N=157	
Yes	75	47.8%
No	82	52.2%
Physical Health Visit Completed[3]	N=157	
Yes	101	64.3%
No	56	35.7%

[1] This includes referrals to PCPs and specialists as documented in the discharge plan.

[2] This includes post-discharge appointments scheduled with PCPs and specialists as documented in the discharge plan.

[3] Administrative data were pulled for this indicator for members who attended a visit with a physical health provider within forty-five days of discharge.

MCO Care Coordination for Follow-Up for Cardiometabolic Conditions

Table 8 shows the rate of MCO care coordination for members who had a cardiometabolic condition identified during the inpatient care setting. According to data reported by the MCOs, 42.7% of these members were actively engaged in MCO Care Management/Coordination during the inpatient stay. However, only 30 (19.1%) of these members had communication with the MCO documented in the discharge plan. Of those 30 members, only 3 had documentation in the discharge plan that noted that the communication with the MCO did include discussion of cardiometabolic conditions.

Table 8: MCO Follow-Up for Cardiometabolic Conditions

	N	%
MCO Care Coordination (n=157)[1,2]		
Yes	67	42.7%
No	83	52.9%
Not documented	7	4.5%
Communication with MCO for Post-Discharge Needs[3] (n=157)		
Yes	30	19.1%
No	127	80.9%
Communication Concerning Cardiometabolic Conditions[3] (n=30)		
Yes	3	10.0%
No	27	90.0%

[1] These data were derived from the face sheet each MCO filled out for each member in the sample, and not through medical record review.
[2] This indicator refers to MCO care coordination with the member while the member was in the inpatient care setting.
[3] These data were derived from information abstracted from the members' discharge plans.

Factors Associated with the Identification of Follow-Up for Cardiometabolic Conditions

Tables 9-13 display comparisons of selected indicators based on selected demographic data. Demographic data included HARP vs. Non-HARP members, gender, race/ethnicity, age group, and Health & Hospitals facilities.

Table Notes for Tables 9-13[4]:
Note: Frequencies in **bold** type are statistically significantly higher.
n.s.: Not significant.

1 This item includes members who had at least one identified behavioral risk at any time.
2 This item includes members who were identified as using at least one drug at any time.
3 These items include members who were identified as having at least one of the following identified behavioral risks at any time during the episode of care: tobacco use/smoking, drugs use (any drug(s)), and/or alcohol dependence.
4 The denominator for this item includes only those members who were identified with the behavioral risk of tobacco use/smoking at any time during the episode of care (pre-inpatient, inpatient, discharge).
5 The denominator for this item includes only those members who were identified with the behavioral risk of tobacco use/smoking and/or drug use (any drugs) at any time during the episode of care.
6 The denominator for this item includes only those members who were identified with the behavioral risk of drug use (any drugs) and/or alcohol dependence at any time during the episode of care.
7 These items include members who were identified as having at least one of the following abnormal lab/exam findings at any time during the episode of care: elevated blood pressure, elevated BMI, abnormal lung sounds, abnormal cardiac exam, diabetes screen, lipid screen, and/or EKG.
8 This item includes only the following types of follow-up care/recommendations: counseling, inpatient consultation recommended, inpatient testing recommended, medication initiation, and medication titration. Note that inpatient consultation recommended and inpatient testing recommended were only available for review during the pre-inpatient and inpatient stages of the episode of care.

Comparison of HARP vs. Non-HARP Members

To determine whether overall care varied between Non-HARP and HARP members, comparison analyses were conducted on selected items (see **Table 9**). This comparison analysis was based on the composite scores calculated for each indicator. Overall, the rates for the HARP and Non-HARP populations did not differ statistically, with the exception of two indicators. The rate of members with *Any Identified Behavioral Risk* in at least one of the care settings was significantly higher for the HARP population, while the rate of *Counseling* for identified behavioral risks was significantly higher for the Non-HARP population.

[4] The following footnotes apply for Tables 9-13.

Table 9: Comparison of Members for Selected Medical Record Review Items—Non-HARP vs. HARP

	Non-HARP (n=196)		HARP (n=210)		P value
Indicator	**N**	**%**	**N**	**%**	**(p<.05)**
Physical Exam Conducted	196	100.0%	210	100.0%	n.s.
Presence of Cardiometabolic Conditions	N=196		N=210		
Cardiovascular Disease	13	6.6%	21	10.0%	n.s.
Stroke/Cerebral Vascular Accident (CVA)	2	1.0%	2	1.0%	n.s.
Hypertension	62	31.6%	85	40.5%	n.s.
Diabetes	35	17.9%	50	23.8%	n.s.
Pre-Diabetes	7	3.6%	8	3.8%	n.s.
Obesity	34	17.3%	45	21.4%	n.s.
Other Cardiometabolic Disease	36	18.4%	50	23.8%	n.s.
Behavioral Risks Identified	N=196		N=210		
Any identified behavioral risk[1]	142	72.4%	**170**	**81.0%**	.042
Tobacco Use	104	53.1%	130	61.9%	n.s.
Drug Use (any drug)[2]	102	52.0%	105	50.0%	n.s.
Alcohol Dependence	80	40.8%	81	38.6%	n.s.
Behavioral Risk Follow-Up Actions[3]					
Counseling (n=142, 170)	**115**	**81.0%**	121	71.2%	.044
Quitline Referral[4] (n=104, 130)	7	6.7%	10	7.7%	n.s.
Pharmaceutical Therapy/Cessation (n=137, 164)[5]	57	41.6%	71	43.3%	n.s.
Community-Based Organization Referral (n=142, 170)	22	15.5%	32	18.8%	n.s.
Behavioral Health Provider Referral[6] (n=125, 137)	68	54.4%	79	57.7%	n.s.
Treatment Center Referral[6] (n=125, 137)	34	27.2%	35	25.5%	n.s.
Abnormal Lab/Exam Findings	N=196		N=210		
Any abnormal lab/exam findings[7]	115	58.7%	134	63.8%	n.s.
Elevated Blood Pressure	30	15.3%	40	19.0%	n.s.
Elevated BMI	58	29.6%	77	36.7%	n.s.
Abnormal Lung Sounds	2	1.0%	1	0.5%	n.s.
Abnormal Cardiac Exam	3	1.5%	1	0.5%	n.s.
Diabetes Screen	48	24.5%	55	26.2%	n.s.
Lipid Screen	23	11.7%	33	15.7%	n.s.
EKG	36	18.4%	43	20.5%	n.s.
Lab/Exam Follow-Up Actions	N=115		N=134		
Any abnormal lab/exam follow-up[8]	69	60.0%	90	67.2%	n.s.
Counseling	34	29.6%	40	29.9%	n.s.
Inpatient Consultation Recommended	27	23.5%	26	19.4%	n.s.
Inpatient Testing Recommended	40	34.8%	50	37.3%	n.s.
Pharmaceutical Therapy Initiation	32	27.8%	35	26.1%	n.s.
Pharmaceutical Therapy Titration	16	13.9%	24	17.9%	n.s.

Comparison of Members by Gender

To determine whether overall care varied between male and female members, comparison analyses were conducted on selected items (see **Table 10**). This comparison analysis was based on the composite scores calculated for each indicator. Male members were found to have higher rates for the following indicators: *Any Behavioral Risk Identified, Tobacco Use, Drug Use (any drug(s)),* and *Alcohol Dependence.* Conversely, female members had higher rates for the following indicators: *Obesity, Any Abnormal Lab/Exam Findings, Elevated BMI,* and *Follow-Up for Abnormal Lab/Exam Findings—Counseling.*

Table 10: Comparison of Members for Selected Medical Record Review Items—Gender

Indicator	Male (n=219)		Female (n=187)		P value (p<.05)
	N	%	N	%	
Physical Exam Conducted	219	100.0%	187	100.0%	n.s.
Presence of Cardiometabolic Conditions	N=219		N=187		
Cardiovascular Disease	18	8.2%	16	8.6%	n.s.
Stroke/CVA	1	0.5%	3	1.6%	n.s.
Hypertension	85	38.8%	62	33.2%	n.s.
Diabetes	46	21.0%	39	20.9%	n.s.
Pre-Diabetes	10	4.6%	5	2.7%	n.s.
Obesity	29	13.2%	**50**	**26.7%**	.001
Other Cardiometabolic Disease	46	21.0%	40	21.4%	n.s.
Behavioral Risks Identified	N=219		N=187		
Any identified behavioral risk[1]	**188**	**85.8%**	124	66.3%	.000
Tobacco Use	**147**	**67.1%**	87	46.5%	.000
Drug Use (any drug)[2]	**135**	**61.6%**	72	38.5%	.000
Alcohol Dependence	**104**	**47.5%**	57	30.5%	.000
Behavioral Risk Follow-Up Actions[3]					
Counseling (n=188, 124)	148	78.7%	88	71.0%	n.s.
Quitline Referral[4] (n=147, 87)	11	7.5%	6	6.9%	n.s.
Pharmaceutical Therapy/Cessation[5] (n=184, 117)	79	42.9%	49	41.9%	n.s.
Community-Based Organization Referral (n=188, 124)	38	20.2%	16	12.9%	n.s.
Behavioral Health Provider Referral[6] (n=165, 97)	92	55.8%	55	56.7%	n.s.
Treatment Center Referral[6] (n=165, 97)	46	27.9%	23	23.7%	n.s.
Abnormal Lab/Exam Findings	N=219		N=187		
Any abnormal lab/exam findings[7]	122	55.7%	**127**	**67.9%**	.012
Elevated Blood Pressure	42	19.2%	28	15.0%	n.s.
Elevated BMI	61	27.9%	**74**	**39.6%**	.012
Abnormal Lung Sounds	1	0.5%	2	1.1%	n.s.
Abnormal Cardiac Exam	0	0.0%	**4**	**2.1%**	.030
Diabetes Screen	51	23.3%	52	27.8%	n.s.
Lipid Screen	24	11.0%	32	17.1%	n.s.
EKG	42	19.2%	37	19.8%	n.s.
Lab/Exam Follow-Up Actions	N=122		N=127		
Any abnormal lab/exam follow-up[8]	71	58.2%	88	69.3%	n.s.
Counseling	29	23.8%	**45**	**35.4%**	.044
Inpatient Consultation Recommended	22	18.0%	31	24.4%	n.s.
Inpatient Testing Recommended	46	37.7%	44	34.6%	n.s.
Pharmaceutical Therapy Initiation	33	27.0%	34	26.8%	n.s.
Pharmaceutical Therapy Titration	21	17.2%	19	15.0%	n.s.

Note: please refer to the notes on page 22 of this report.

Comparison of Members by Race/Ethnicity

To determine whether overall care varied among members of different race/ethnicities, comparison analyses were conducted on selected items (see **Table 11**). This comparison analysis was based on the composite scores calculated for each indicator. Both Black and Hispanic members had a significantly higher rate than members identified as “Other” for *Any Behavioral Risk Identified*. Black members also had significantly higher rates than members identified as “Other” for *Drug Use (any drug(s))* and *Alcohol Dependence*. Conversely, members identified as “Other” had a significantly higher rate for *Any Abnormal Lab/Exam Follow-Up* than both White and Black members.

Table 11: Comparison of Members for Selected Medical Record Review Items—Race/Ethnicity

Indicator	White (n=59)		Black (n=186)		Hispanic (n=109)		Other (n=52)		P value (p<.05)
	N	%	N	%	N	%	N	%	
Physical Exam Conducted	59	100.0%	186	100.0%	109	100.0%	52	100.0%	n.s.
Presence of Cardiometabolic Conditions	N=59		N=186		N=109		N=52		
Cardiovascular Disease	4	6.8%	19	10.2%	5	4.6%	6	11.5%	n.s.
Stroke/CVA	1	1.7%	1	0.5%	0	0.0%	2	3.8%	n.s.
Hypertension	20	33.9%	71	38.2%	32	29.4%	24	46.2%	n.s.
Diabetes	8	13.6%	39	21.0%	23	21.1%	15	28.8%	n.s.
Pre-Diabetes	0	0.0%	6	3.2%	7	6.4%	2	3.8%	n.s.
Obesity	14	23.7%	36	19.4%	21	19.3%	8	15.4%	n.s.
Other Cardiometabolic Disease	18	30.5%	32	17.2%	25	22.9%	11	21.2%	n.s.
Behavioral Risks Identified	N=59		N=186		N=109		N=52		
Any identified behavioral risk[1]	44	74.6%	**153**	**82.3%**	**87**	**79.8%**	28	53.8%	.000
Tobacco Use	32	54.2%	117	62.9%	62	56.9%	23	44.2%	n.s.
Drug Use (any drug)[2]	27	45.8%	**107**	**57.5%**	56	51.4%	17	32.7%	.013
Alcohol Dependence	21	35.6%	**88**	**47.3%**	42	38.5%	10	19.2%	.003
Behavioral Risk Follow-Up Actions[3]									
Counseling (n=44, 153, 87, 28)	30	68.2%	123	80.4%	66	75.9%	17	60.7%	n.s.
Quitline Referral[4] (n=32, 117, 62, 23)	2	6.3%	6	5.1%	7	11.3%	2	8.7%	n.s.
Pharmaceutical Therapy/Cessation[5] (n=43, 147, 85, 26)	23	53.5%	65	44.2%	34	40.0%	6	23.1%	n.s.
Community-Based Organization Referral (n=44, 153, 87, 28)	5	11.4%	33	21.6%	11	12.6%	5	17.9%	n.s.
Behavioral Health Provider Referral[6] (n=33, 133, 74, 22)	16	48.5%	76	57.1%	45	60.8%	10	45.5%	n.s.
Treatment Center Referral[6] (n=33, 133, 74, 22)	6	18.2%	35	26.3%	24	32.4%	4	18.2%	n.s.
Abnormal Lab/Exam Findings	N=59		N=186		N=109		N=52		
Any abnormal lab/exam findings[7]	34	57.6%	117	62.9%	66	60.6%	32	61.5%	n.s.
Elevated Blood Pressure	13	22.0%	33	17.7%	12	11.0%	12	23.1%	n.s.
Elevated BMI	16	27.1%	72	38.7%	34	31.2%	13	25.0%	n.s.
Abnormal Lung Sounds	2	3.4%	1	0.5%	0	0.0%	0	0.0%	n.s.
Abnormal Cardiac Exam	0	0.0%	2	1.1%	1	0.9%	1	1.9%	n.s.
Diabetes Screen	14	23.7%	46	24.7%	27	24.8%	16	30.8%	n.s.
Lipid Screen	11	18.6%	17	9.1%	22	20.2%	6	11.5%	n.s.
EKG	9	15.3%	45	24.2%	17	15.6%	8	15.4%	n.s.
Lab/Exam Follow-Up Actions	N=34		N=117		N=66		N=32		
Any abnormal lab/exam follow-up[8]	18	52.9%	71	60.7%	43	65.2%	**27**	**84.4%**	.043
Counseling	5	14.7%	35	29.9%	21	31.8%	13	40.6%	n.s.
Inpatient Consultation Recommended	9	26.5%	20	17.1%	17	25.8%	7	21.9%	n.s.
Inpatient Testing Recommended	13	38.2%	36	30.8%	25	37.9%	16	50.0%	n.s.
Pharmaceutical Therapy Initiation	9	26.5%	32	27.4%	14	21.2%	12	37.5%	n.s.
Pharmaceutical Therapy Titration	5	14.7%	19	16.2%	10	15.2%	6	18.8%	n.s.

Note: please refer to the notes on page 22 of this report.

Comparison of Members by Age Group

To determine whether overall care varied among members of different ages, comparison analyses were conducted on selected items (see **Table 12**). This comparison analysis was based on the composite scores calculated for each indicator. Across the two age groups, 21-44 years and 45-64 years, many of the rates varied significantly. In regard to presence of cardiometabolic conditions, members aged 45-64 years reported significantly higher rates for the following conditions: *Cardiovascular Disease, Hypertension, Diabetes, Pre-Diabetes,* and *Other Cardiometabolic Disease*. Additionally, members aged 45-64 years had higher rates of the following abnormal lab/exam findings: *Any Abnormal Lab/Exam Findings, Elevated Blood Pressure, Diabetes Screen, Lipid Screen,* and *EKG.* Members aged 45-64 years also had higher rates for the following lab/exam follow-up actions: *Inpatient Testing Recommended, Pharmaceutical Therapy Initiation,* and *Pharmaceutical Therapy Titration.* Members aged 21-44 years reported a significantly higher rate for a single indicator: *Drug Use (any drug(s))*.

Table 12: Comparison of Members for Selected Medical Record Review Items—Age

Indicator	21-44 Years (n=225) N	21-44 Years (n=225) %	45-64 Years (n=181) N	45-64 Years (n=181) %	P value (p<.05)
Physical Exam Conducted (n=406)	225	100.0%	181	100.0%	n.s.
Presence of Cardiometabolic Conditions	N=225		N=181		
Cardiovascular Disease	9	4.0%	**25**	**13.8%**	.000
Stroke/CVA	1	0.4%	3	1.7%	n.s.
Hypertension	45	20.0%	**102**	**56.4%**	.000
Diabetes	27	12.0%	**58**	**32.0%**	.000
Pre-Diabetes	4	1.8%	**11**	**6.1%**	.022
Obesity	47	20.9%	32	17.7%	n.s.
Other Cardiometabolic Disease	28	12.4%	**58**	**32.0%**	.000
Behavioral Risks Identified	N=225		N=181		
Any identified behavioral risk[1]	174	77.3%	138	76.2%	n.s.
Tobacco Use	128	56.9%	106	58.6%	n.s.
Drug Use (any drug)[2]	**128**	**56.9%**	79	43.6%	.008
Alcohol Dependence	95	42.2%	66	36.5%	n.s.
Behavioral Risk Follow-Up Actions[3]					
Counseling (n=174, 138)	136	78.2%	100	72.5%	n.s.
Quitline Referral[4] (n=128, 106)	9	7.0%	8	7.5%	n.s.
Pharmaceutical Therapy/Cessation[5] (n=168, 133)	69	41.1%	59	44.4%	n.s.
Community-Based Organization Referral (n=174, 138)	30	17.2%	24	17.4%	n.s.
Behavioral Health Provider Referral[6] (n=151, 111)	86	57.0%	61	55.0%	n.s.
Treatment Center Referral[6] (n=151, 111)	34	22.5%	35	31.5%	n.s.
Abnormal Lab/Exam Findings	N=225		N=181		
Any abnormal lab/exam findings[7]	127	56.4%	**122**	**67.4%**	.024
Elevated Blood Pressure	25	11.1%	**45**	**24.9%**	.000
Elevated BMI	78	34.7%	57	31.5%	n.s.
Abnormal Lung Sounds	1	0.4%	2	1.1%	n.s.
Abnormal Cardiac Exam	2	0.9%	2	1.1%	n.s.
Diabetes Screen	42	18.7%	**61**	**33.7%**	.001
Lipid Screen	23	10.2%	**33**	**18.2%**	.020
EKG	35	15.6%	**44**	**24.3%**	.027
Lab/Exam Follow-Up Actions	N=127		N=122		
Any abnormal lab/exam follow-up[8]	76	59.8%	83	68.0%	n.s.
Counseling	34	26.8%	40	32.8%	n.s.
Inpatient Consultation Recommended	23	18.1%	30	24.6%	n.s.
Inpatient Testing Recommended	37	29.1%	**53**	**43.4%**	.019
Pharmaceutical Therapy Initiation	20	15.7%	**47**	**38.5%**	.000
Pharmaceutical Therapy Titration	13	10.2%	**27**	**22.1%**	.011

Note: please refer to the notes on page 22 of this report.

Comparison of Members by Provider Type (Health and Hospitals Facilities)

To determine whether overall care differed between members in New York City Health and Hospital (H&H) Facilities and members not in New York City Health and Hospital facilities, comparison analyses were conducted on selected items (see **Table 13**). This comparison analysis was based on the composite scores calculated for each indicator. Overall, the rates for both H&H and non-H&H facilities were similar for most indicators. The rates were significantly higher for H&H facilities for *Obesity* and *Tobacco Use*, while the rate was higher for non-H&H facilities for the behavioral risk follow-up action *Quitline.*

Table 13: Comparison of Members for Selected Medical Record Review Items—Health & Hospitals Facilities

Indicator	H&H (n=157)		Non-H&H (n=249)		P value (p<.05)
	N	%	N	%	
Physical Exam Conducted (n=406)	157	100.0%	249	100.0%	n.s.
Presence of Cardiometabolic Conditions	N=157		N=249		
Cardiovascular Disease	8	5.1%	26	10.4%	n.s.
Stroke/CVA	0	0.0%	4	1.6%	n.s.
Hypertension	55	35.0%	92	36.9%	n.s.
Diabetes	34	21.7%	51	20.5%	n.s.
Pre-Diabetes	7	4.5%	8	3.2%	n.s.
Obesity	**42**	**26.8%**	37	14.9%	.003
Other Cardiometabolic Disease	30	19.1%	56	22.5%	n.s.
Behavioral Risks Identified	N=157		N=249		
Any identified behavioral risk[1]	125	79.6%	187	75.1%	n.s.
Tobacco Use	**100**	**63.7%**	134	53.8%	.050
Drug Use (any drug)[2]	76	48.4%	131	52.6%	n.s.
Alcohol Dependence	66	42.0%	95	38.2%	n.s.
Behavioral Risk Follow-Up Actions[3]					
Counseling (n=125, 187)	99	79.2%	137	73.3%	n.s.
Quitline Referral[4] (n=100, 134)	3	3.0%	**14**	**10.4%**	.030
Pharmaceutical Therapy/Cessation[5] (n=122, 179)	56	45.9%	72	40.2%	n.s.
Community-Based Organization Referral (n=125, 187)	27	21.6%	27	14.4%	n.s.
Behavioral Health Provider Referral[6] (n=102, 160)	57	55.9%	90	56.3%	n.s.
Treatment Center Referral[6] (n=102, 160)	28	27.5%	41	25.6%	n.s.
Abnormal Lab/Exam Findings	N=157		N=249		
Any abnormal lab/exam findings[7]	99	63.1%	150	60.2%	n.s.
Elevated Blood Pressure	22	14.0%	48	19.3%	n.s.
Elevated BMI	60	38.2%	75	30.1%	n.s.
Abnormal Lung Sounds	1	0.6%	2	0.8%	n.s.
Abnormal Cardiac Exam	1	0.6%	3	1.2%	n.s.
Diabetes Screen	39	24.8%	64	25.7%	n.s.
Lipid Screen	19	12.1%	37	14.9%	n.s.
EKG	31	19.7%	48	19.3%	n.s.
Lab/Exam Follow-Up Actions	N=99		N=150		
Any abnormal lab/exam follow-up[8]	68	68.7%	91	60.7%	n.s.
Counseling	35	35.4%	39	26.0%	n.s.
Inpatient Consultation Recommended	20	20.2%	33	22.0%	n.s.
Inpatient Testing Recommended	32	32.3%	58	38.7%	n.s.
Pharmaceutical Therapy Initiation	22	22.2%	45	30.0%	n.s.
Pharmaceutical Therapy Titration	18	18.2%	22	14.7%	n.s.

Note: please refer to the notes on page 22 of this report.

Predictors of Selected Outcome Indicators

Multivariate Analysis—Follow-Up for Identified Cardiometabolic Conditions

To determine factors associated with the identification of follow-up of cardiometabolic conditions that are statistically significant after controlling for potential confounding characteristics, multivariate analyses were performed using logistic regressions.

Two logistic regressions were performed based on the 242 members (specified in Table 4c) who were identified with a diagnosis of a cardiometabolic disease and/or Episode Disease Category (EDC) 2014 information. Plan type (Non-HARP vs. HARP), gender, age group, race/ethnicity, Health Home outreach/enrollment, MCO care coordination at discharge, and facility type (Health & Hospital facilities) data served as the independent variables. **Table 14** displays the dependent variables, the number of cases included in the analyses (with valid data on each variable of the equation), the independent variables, the corresponding odds ratios, and p values.

One regression was performed for each of the following outcome variables:

1. Physical Health Visit Completed within 45 days of discharge
2. Follow-Up for Abnormal Lab/Exam Findings[5]

Members between the ages of 45 and 64 years were found more likely to have completed a physical health follow-up visit and to have a follow-up for abnormal lab/exam findings. Additionally, women were more likely than men to have a follow-up for abnormal lab/exam findings.

[5] Follow-Up for Abnormal Lab/Exam Findings refers to actions recommended or taken by behavioral health providers in response to abnormal diagnostic tests and laboratory testing, including, but not limited to, abnormal EKGs, abnormal cardiac exams, elevated blood pressure, etc.

Table 14: Logistic Regression Results—Follow-Up for Identified Cardiometabolic Conditions

Dependent Variable	N[1]	Independent Variables	Odds Ratios	P value (p<.05)
Physical Health Visit Completed[2]	242	Plan Type (HARP vs. Non-HARP)	0.737	n.s.
		Age Group (45-64 v. 21-44)	2.106	.008
		Gender (Men v. Women)	0.798	n.s.
		White v. all others	1.882	n.s.
		Health Home Outreach/Enrollment (Y v. N)	1.501	n.s.
		Facility Type (H&H vs. Non-H&H)	1.235	n.s.
		MCO Care Coordination (Y v. N)	1.078	n.s.
Follow-up for Abnormal Lab/Exam Findings[3]	117	Plan Type (HARP vs. Non-HARP)	1.465	n.s.
		Age Group (45-64 v. 21-44)	1.766	.041
		Gender (Men v. Women)	0.541	.023
		White v. all others	0.815	n.s.
		Health Home Outreach/Enrollment (Y v. N)	1.070	n.s.
		Facility Type (H&H vs. Non-H&H)	1.608	n.s.
		MCO Care Coordination (Y v. N)	1.930	n.s.

Notes for Odds Ratios:
Age Group: 0=21-44 Years; 1=45-64 Years.
Gender: 0=Female; 1=Male.
HARP/Non-HARP: 0=Non-HARP; 1=HARP.
Facility Type: 0=Non-H&H; 1= H&H.
White: 0=All other race/ethnicities; 1= White.
For all other indicators: 0=No; 1=Yes.
Items in bold face represent statistically significant results (p<.05).
[1] The denominator reflects the number of records that had valid data.
[2] Administrative data were pulled for this indicator.
[3] Any follow-up identified in *at least one* of the three care settings.

HARP vs. Non-HARP Members

Table 15a displays a comparison of HARP and Non-HARP members for selected indicators regarding care coordination and follow-up care. HARP members were more likely to have MCO outreach to the Health Homes in which members were enrolled or engaged with than Non-HARP members (p<.05). Additionally, HARP members were more likely to have MCO Care Coordination conducted than Non-HARP members (p<.05). Although Non-HARP members had higher percentage rates for both physical and behavioral health visits within 45 days post-discharge than HARP members, the rates did not differ statistically.

Table 15a: HARP vs. Non-HARP Members—Care Coordination and Follow-Up Care

	Non-HARP		HARP		Total	
	N	%[1]	N	%[1]	N	%[1]
Health Home Eligibility[2]	N=196		N=210		N=406	
Yes	127	64.8%	178	84.8%	305	75.1%
No	69	35.2%	32	15.2%	101	24.9%
Health Home Enrollment[2]	N=127		N=178		N=305	
Yes	51	40.2%	71	39.9%	122	40.0%
No	76	59.8%	107	60.1%	183	60.0%
MCO Outreach[2,3]	N=127		N=178		N=305	
Yes	36	28.3%	**92**	**51.7%**	128	42.0%
No	87	68.5%	75	42.1%	162	53.1%
Not documented	4	3.1%	11	6.2%	15	4.9%
MCO Care Coordination[2,4]	N=196		N=210		N=406	
Yes	66	33.7%	**129**	**61.4%**	195	48.0%
No	121	61.7%	77	36.7%	198	48.8%
Not documented	9	4.6%	4	1.9%	13	3.2%
Medical Health Follow-Up Visit[5]	N=196		N=210		N=406	
Yes	125	63.8%	120	57.1%	245	60.3%
No	71	36.2%	90	42.9%	161	39.7%
Behavioral Health Follow-Up Visit[5]	N=196		N=210		N=406	
Yes	113	57.7%	108	51.4%	221	54.4%
No	83	42.3%	102	48.6%	185	45.6%

[1] Percentages may not equal 100% due to rounding.
[2] These data were derived from the face sheet each MCO filled out for each member in the sample, and not through medical record review.
[3] This indicator refers to MCO outreach to the Care Management Agency or Health Home in which a member was in outreach or enrolled; therefore, the denominator (n=305) includes only those members eligible for Health Home enrollment.
[4] This indicator refers to MCO care coordination with the member while the member was in the inpatient care setting.
[5] Administrative data were pulled for this indicator.

Table 15b displays a comparison of HARP members and Non-HARP members among the 157 members who had a cardiometabolic condition identified during the inpatient phase of the episode of care. Only one indicator was found to be statistically significant: *Lipid Screens* was higher for the HARP members than the Non-HARP members.

Table 15b: HARP vs. Non-HARP Members with Cardiometabolic Conditions Identified During Inpatient Care Setting

Indicator	Non-HARP (n=72)		HARP (n=85)		P value (p<.05)
	N	%	N	%	
Physical Exam Conducted	72	100.0%	85	100.0%	n.s.
Presence of Cardiometabolic Conditions	N=72		N=85		
Cardiovascular Disease	10	13.9%	16	18.8%	n.s.
Hypertension	15	20.8%	9	10.6%	n.s.
Diabetes	33	45.8%	45	52.9%	n.s.
Behavioral Risks Identified	N=72		N=85		
Any identified behavioral risk[1]	48	66.7%	67	78.8%	n.s.
Tobacco Use	39	54.2%	58	68.2%	n.s.
Drug Use (any drug)[2]	28	38.9%	31	36.5%	n.s.
Alcohol Dependence	30	41.7%	37	43.5%	n.s.
Behavioral Risk Follow-Up Actions[3]					
Counseling (n=48, 67)	39	81.3%	50	74.6%	n.s.
Quitline Referral[4] (n=39, 58)	3	7.7%	5	8.6%	n.s.
Pharmaceutical Therapy/Cessation(n=46, 65)[5]	24	52.2%	36	55.4%	n.s.
Community-Based Organization Referral (n=48, 67)	6	12.5%	17	25.4%	n.s.
Behavioral Health Provider Referral[6] (n=40, 50)	25	62.5%	30	60.0%	n.s.
Treatment Center Referral[6] (n=40, 50)	8	20.0%	16	32.0%	n.s.
Abnormal Lab/Exam Findings	N=72		N=85		
Any abnormal lab/exam findings[7]	45	62.5%	57	67.1%	n.s.
Elevated Blood Pressure	25	34.7%	32	37.6%	n.s.
Elevated BMI	24	33.3%	40	47.1%	n.s.
Abnormal Lung Sounds	1	1.4%	1	1.2%	n.s.
Abnormal Cardiac Exam	1	1.4%	1	1.2%	n.s.
Diabetes Screen	31	43.1%	37	43.5%	n.s.
Lipid Screen	8	11.1%	**21**	**24.7%**	.029
EKG	17	23.6%	21	24.7%	n.s.
Lab/Exam Follow-Up Actions	N=45		N=57		
Any abnormal lab/exam follow-up[8]	36	80.0%	47	82.5%	n.s.
Counseling	18	40.0%	18	31.6%	n.s.
Inpatient Consultation Recommended	14	31.1%	14	24.6%	n.s.
Inpatient Testing Recommended	26	57.8%	30	52.6%	n.s.
Pharmaceutical Therapy Initiation	24	53.3%	25	43.9%	n.s.
Pharmaceutical Therapy Titration	13	28.9%	19	33.3%	n.s.

[1] This item includes members who had at least one identified behavioral risk at any time.
[2] This item includes members who were identified as using at least one drug at any time.
[3] These items include members who were identified as having at least one of the following identified behavioral risks at any time during the episode of care: tobacco use/smoking, drugs use (any drug(s)), and/or alcohol dependence.
[4] The denominator for this item includes only those members who were identified with the behavioral risk of tobacco use/smoking at any time during the episode of care (pre-inpatient, inpatient, discharge).
[5] The denominator for this item includes only those members who were identified with the behavioral risk of tobacco use/smoking and/or drug use (any drugs) at any time during the episode of care.
[6] The denominator for this item includes only those members who were identified with the behavioral risk of drug use (any drugs) and/or alcohol dependence at any time during the episode of care.
[7] These items include members who were identified as having at least one of the following abnormal lab/exam findings at any time during the episode of care: elevated blood pressure, elevated BMI, abnormal lung sounds, abnormal cardiac exam, diabetes screen, lipid screen, and/or EKG.
[8] This item includes only the following types of follow-up care/recommendations: counseling, inpatient consultation recommended, inpatient testing recommended, medication initiation, and medication titration. Note that inpatient consultation recommended and inpatient testing recommended were only available for review during the pre-inpatient and inpatient stages of the episode of care.

Relationships of Clinical Interest

Other specific analyses were performed to determine relationships among selected items. Due to the high number of items included in the medical record review, the indicators for these analyses were chosen according to clinical relevance and significance. The following relationships were evaluated:

1. Health Home outreach or enrollment and/or MCO Case Management during the inpatient stay associated with adherence to the follow-up physical health visit (as per administrative claims data).
2. At least one, two, or three or more documented cardiometabolic condition(s) associated with adherence to the follow-up physical health visit (as per administrative claims data).
3. Documentation of at least one behavioral risk (i.e., tobacco use, drug abuse, alcohol dependence) associated with adherence to the follow-up physical health and behavioral health visits (as per administrative claims data).

Table 16 displays the rates for selected indicators, as well as the percentage of those members for each indicator who had a physical health follow-up visit within 45 days of discharge. In regard to physical health follow-up adherence, members with more documented cardiometabolic conditions had a higher rate of follow-up visit adherence. Of the members with three or more documented conditions, 73% attended a physical health follow-up visit. Additionally, two-thirds of the sample who had contact with either the Health Home (64.8%) or the MCO (63.1%) documented in the discharge plan attended a physical health follow-up visit. Over half of the members identified as having a behavioral risk (59.3%) attended a physical health follow-up visit.

Table 16 also displays the rates for selected indicators, the percentage of those members for each indicator who had a behavioral health follow-up visit within 45 days of discharge. Less than half of the members in the sample (46.2%) with at least one identified behavioral risk attended a behavioral health follow-up visit. Additionally, about two-thirds of the sample who had outreach/enrollment with the Health Home documented in the discharge plan attended a behavioral health follow-up visit, while just over half of the sample who had MCO care coordination documented in the discharge plan attended a behavioral health follow-up visit. Notably, the rates for members with at least one, at least two, or three or more identified cardiometabolic conditions who attended a behavioral health follow-up visit were similar.

Table 16: Clinical Indicators Associated with Adherence to a Physical and Behavioral Health Follow-Up Visit

Indicator[1]	Percent for which Indicator is Present		Percent that had a Physical Health follow-up visit[2]		Percent that had a Behavioral Health follow-up visit[2]	
	N	%	N	%	N	%
At least one identified behavioral risk (n=406)	312	76.8%	185	59.3%	144	46.2%
Health Home Outreach/Enrollment[3,4] (n=406)	142	35.0%	92	64.8%	91	64.1%
MCO Care Coordination[3,5] (n=406)	195	48.0%	123	63.1%	105	53.8%
At least one cardiometabolic condition (n=406)	233	57.4%	146	62.7%	126	54.1%
At least two cardiometabolic conditions (n=406)	121	29.8%	84	69.4%	67	55.4%
At least three cardiometabolic conditions (n=406)	69	17.0%	50	72.5%	38	55.1%

1 The indicators presented in this table are not mutually exclusive.
2 The denominators for these rates are the numerators of the "Indicator is Present" section of the table.
3 These rates are derived from information abstracted from the discharge plans.
4 The rate for this indicator represents the percentage of the sample who had communication with a Health Home Care Manager documented in the discharge plan. Note that not all members in the sample are eligible for Health Home.
5 The rate for this indicator represents the percentage of the sample who had communication with the Health Plan documented in the discharge plan.

V. Discussion

Given the prevalence of mental illness and co-occurring physical illness among New York State (NYS) Medicaid enrollees, this study was designed to evaluate practice patterns among inpatient mental health providers regarding identification, assessment, referral practices, and coordination of follow-up care for NYS Medicaid Managed Care (MMC) members. Cardiometabolic conditions and behavioral risk factors (tobacco use/smoking, drug use/abuse, alcohol abuse/dependence) were identified and follow-up activity, particularly in three hospital settings (pre-inpatient, inpatient and discharge), explored.

In this study, IPRO analyzed the extent to which cardiometabolic conditions are identified by inpatient mental health providers and whether coordination of follow-up care for patients with diabetes mellitus, hypertension and cardiovascular health occurs after discharge from a mental health inpatient admission. Further investigation involved the types of surveillance and screenings conducted for physical health conditions of patients hospitalized for a mental health condition during the episode of care (defined as the pre-inpatient, inpatient and post discharge settings). The impact of selected risk factors on members' health outcomes as seen in the medical records and administrative data were also explored.

For this study, IPRO sampled patients hospitalized for a mental health condition, approximately half of whom had a claim in 2014 for a comorbid cardiometabolic condition. Of these, a total of 40.6% (N=157) were verified to have the condition in the medical record, while 2014 EDC data showed 187 members (48.3%) out of 387 admissions were identified to have a cardiometabolic condition(s), suggesting that such conditions may not be adequately assessed during the episode of care. Further analysis, through logistic regression (Table 4c), found that older members (ages 45 to 64 years old) were more likely to have cardiometabolic conditions identified during the inpatient stage of the episode of care.

The study indicated that individuals admitted to the mental health inpatient unit do receive comprehensive medical histories and physical examinations (Table 5). In fact, every admitted individual (N=406) received a medical history and physical examination in at least one of the three episodes of care (pre-admission, inpatient, or discharge setting). However, the rates of screening for cardiometabolic conditions were low given the high comorbidity of these cardiometabolic condition(s). For example, 76.1% (N=309) of individuals had an electrocardiogram (EKG), 59.9% (N=243) of individuals were screened for diabetes, and 38.4% (N=156) of individuals had a fasting lipid profile.

Monitoring and follow-up for identified cardiometabolic conditions was variable throughout the care settings. For example, 97.7% of individuals with hypertension documented during the inpatient stay had routine monitoring of their blood pressure (Table 6), whereas only 43.6% of individuals with diabetes mellitus had an HbA1c lab test during their inpatient stay, although 60.3% did have fasting blood glucose monitored. Only 25.6% of individuals with diabetes mellitus had fasting lipids monitored during their inpatient stay. Depending on the condition, between 28-35% of individuals had a medication initiated for their cardiometabolic condition during the mental health inpatient stay (Table 7).

Among the 157 admitted individuals with documented comorbid cardiometabolic conditions, 102 individuals (65%) had a referral to a medical provider noted in the discharge plan. Only 75 individuals (47.8%) had an appointment scheduled with a medical provider following discharge from an inpatient care setting as part of the discharge plan and 101 individuals (64.3%) attended an aftercare appointment with a medical care provider in the 45 days following discharge from the mental health inpatient unit (Table 7). The rates of medication initiation, discontinuation, and titration for these members suggests in many cases the conditions were not controlled/stable, which underscores need for follow-up and for plans to facilitate follow-up for cardiometabolic conditions.

Comparison of HARP and Non-HARP members
Similar rates of comorbid cardiometabolic conditions and follow-up practices were noted among HARP and Non-HARP members, but differences were noted in patterns of care management for these populations. For example, in Table 15b, HARP and Non-HARP members had comparable rates of comorbid cardiometabolic conditions identified during the mental health inpatient stay and had similar rates of monitoring and follow-up for these conditions. For only one indicator, lipid screen(s), was there a statistically different and higher rate for the HARP members than the Non-HARP members.

All HARP members are eligible for Health Home services, yet Health Home outreach and enrollment rates were similar in the HARP and Non-HARP populations at 39.9% and 40.2%, respectively (Table 15a).

Differences were noted in patterns of care management, as MCOs were almost twice as likely to provide care management services to HARP members as compared to Non-HARP members. Only 51.4% of HARP members and 57.7% of Non-HARP members attended a behavioral health aftercare appointment within 30 days of discharge. Both HARP (57.1%) and Non-HARP (63.8%) members showed higher rates of attending an aftercare appointment with a medical provider than with a behavioral health provider within 45 days of discharge (Table 15a).

Comparison of Members—Demographics Analyses
Demographic and insurance status characteristics impacted prevalence and management of comorbid cardiometabolic conditions. For example, admitted individuals who were enrolled in the HARP plans had higher rates of any identified behavioral risk (i.e., nicotine, drug, and/or alcohol use; Table 9). Gender demographic characteristics (Table 10) showed that males had higher rates of nicotine, drug, and alcohol use, whereas females had higher rates of obesity and abnormal lab/exam findings. In Table 11, blacks had the highest rates of nicotine, drug, and alcohol use among race/ethnicity groups. In Table 12, admitted individuals aged 45 years and older had higher rates of comorbid cardiometabolic conditions compared to individuals under the age of 45 years. The increase in rate of comorbidities in the 45-64 age group is expected due to an aging population's health trajectory and status.

To investigate the overall medical care between the New York City healthcare system, Health and Hospital Corporation (HHC) facilities, versus Non- HHC facilities, a comparison analysis was conducted using selected items (Table 13). Composite scores were calculated for each indicator and showed similar rates between HHC versus non-HHC facilities. Of note, the rates were significantly higher for HHC facilities for *Obesity* and *Tobacco Use* while the rate was higher for Non- HHC facilities for the behavioral risk follow-up action *Quitline Referral*.

Relationships of Clinical Interest and Impact of Health Home and Case Management Services
Among members who received Health Home and/or MCO care management services, 63-65% of individuals attended a physical health appointment post-discharge, while 54-64% of individuals attended a behavioral health appointment post-discharge (Table 16). Further analysis was performed to investigate clinical indicators associated with adherence to physical and behavioral health follow-up visits. Of note, in Table 16, less than half of the members in the sample (46.2%) with at least one identified behavioral risk attended a behavioral health follow-up visit.

Of those eligible members for Health Home (N=305, in Table 3b), only 122 (40%) enrolled prior to admission. MCOs reported that they conducted care coordination with the members in less than half (48%) of members during the inpatient stay.

Study findings demonstrate an opportunity for improvement in the detection and follow-up of cardiometabolic condition(s) in patients. Strategies used to deliver adequate medical care rely on developing formal processes for screening and diagnosis, monitoring outcomes, effectively communicating with patients, and coordinating with providers involved in the patients care and follow-up.

In order to address the comprehensive and complex needs of an inpatient mental health member, providers should address the "total wellness" of a patient to ensure adequate follow-up care and to place the patient on a trajectory to become healthy, both mentally and physically. It is important that health care practitioners are not siloed while providing care for acute illnesses/conditions. The largest impact may be evidenced by the implementation of a holistic care model that incorporates the collaboration of all health teams across the care continuum.

VI. Recommendations

1. The MCOs should work with NYS DOH, OMH, and OASAS to inform providers of the results of this study, notably the incidence of comorbid cardiometabolic conditions among individuals admitted to inpatient psychiatric units and the need for follow-up care in the ambulatory setting for both the mental and physical health conditions. Follow-up visit rates for patients with a hospitalization for a mental health condition continue to show room for improvement.
2. The MCOs should collaborate with providers to broaden the focus on care transition interventions to include post-discharge follow-up with medical providers when comorbid cardiometabolic conditions are present.
3. The MCOs should ensure that providers are aware that care management services (from Health Homes or MCOs) can improve rates of post-discharge follow-up with medical providers among individuals with comorbid cardiometabolic conditions. MCOs should work with providers to increase rates of care management services provided to these individuals.
4. The MCOs should routinely monitor their encounter data to identify gaps in care to help intervene when members are not receiving adequate care, services, and follow-up.
5. The MCOs should work with institutions (hospitals and inpatient facilities) to improve and implement the discharge process across the care continuum. MCOs and institutions should focus on communication of aftercare for high-risk physical health conditions, ensure inpatient providers schedule aftercare appointments with a date and time noted in the discharge plan, ensure care summaries are sent to the aftercare providers, and confirm member attendance at follow-up appointments post-discharge, as well as conduct continuous outreach to the members. They should engage members with cardiometabolic conditions as a priority and ensure plans for care transitions are in place.
6. The MCOs should evaluate the study findings (using quality metrics) to identify cardiometabolic and mental health conditions and devise strategies to overcome barriers (i.e., transportation, flexibility of office hours, financial challenges, etc.) to care.
7. The MCOs should promote use of clinical practice guidelines (i.e. American Diabetes Association guidelines, etc.) to help guide providers with work-up and treatment protocols, as well as identify community resources for members with identified risks.
8. The workflow process should support a collaborative care model (CoCM), which is a data driven process and requires active care teams to adopt ongoing surveillance methods to ensure early detection of cardiometabolic conditions.
9. The MCOs should ensure that their case management systems include follow-up alerts and reminders (for appointments and/or referrals), which function to track members' adherence to physical and mental health appointments and prompt case managers to routinely review whether appointments are kept. These reminders can be forwarded to the patients' provider(s) and health care team.
10. The MCOs should promote wellness strategies by incorporating lifestyle modifications into their education and treatment programs for patients, including nutrition, exercise, and behavioral strategies.
11. Inpatient mental health institutions should promote the identification, documentation and treatment of physical health comorbidities during inpatient stays.

VII. Limitations

As with any medical or care management and case management record review, only documented services could be evaluated. Services which may have been received in visits outside the study period may be undocumented for the visit that was reviewed, since the medical record was reviewed only for documentation within the study period. Similarly, it is possible that some components of the visit were not documented or provided in submitted records, especially when no issue was recognized, as providers are less likely to make note of expected physical findings that are met or within normal limits. Comparison analyses made between the administrative EDC 2014 data and our medical record review data in 2016 may be affected by the two year time difference.

Appendix A: Frequency Tables

Domains and Indicators	N	%
Domain A: Member General Information		
Select where the member was admitted from: (n=406)		
Emergency Department	358	88.2%
Medical Unit Inpatient Transfer	12	3.0%
Outpatient Clinic/Office	1	0.2%
Direct admission to mental health unit	15	3.7%
Other	20	4.9%
Unable to determine	0	0.0%
Was the member discharged to the community? (n=406)		
Yes	406	100.0%
No	0	0.0%
Was the member enrolled/engaged in a Health Home prior to inpatient admission? (n=406)		
Yes	142	35.0%
No	264	65.0%
Was the member eligible for Health Home enrollment prior to inpatient admission? (n=406)		
Yes	305	75.1%
No	101	24.9%
Was the member outreached for Health Home enrollment prior to inpatient admission? (n=406)		
Yes	138	34.0%
No	257	63.3%
Not documented	11	2.7%
Did the MCO outreach to the Care Management Agency? (n=214)		
Yes	48	22.4%
No	105	49.1%
Not documented	61	28.5%
Did the MCO outreach to the Health Home? (n=214)		
Yes	50	23.4%
No	104	48.6%
Not documented	60	28.0%
Was there any MCO outreach while in inpatient care? (n=406)		
Yes	157	38.7%
No	226	55.7%
Not documented	23	5.7%
Was there any MCO care coordination while in inpatient care? (n=406)		
Yes	195	48.0%
No	198	48.8%
Not documented	13	3.2%

Domains and Indicators	N	%
Domain B: General Physical Health Evaluation—Prior to Inpatient Stay		
Was a physical health evaluation conducted prior to admission? (n=406)		
Yes	369	90.9%
Medical Clearance Statement Only	9	2.2%
No	28	6.9%
Select ALL Medical History components assessed prior to admission: (n=369)		
Past medical history	352	95.4%
Medications	350	94.9%
Allergies	353	95.7%
Review of systems	289	78.3%
Behavioral Health risk assessment	356	96.5%
None	1	0.3%
Select ALL components completed during the physical exam: (n=369)		
General observation	313	84.8%
HEENT	247	66.9%
Cardiac exam	259	70.2%
Pulmonary Exam	256	69.4%
Extremities	217	58.8%
Pulse	345	93.5%
Respiration	345	93.5%
Blood pressure	345	93.5%
Body Mass Index	166	45.0%
Height	213	57.7%
Weight	217	58.8%
None	9	2.4%
Select ALL documented lab testing ordered/completed prior to admission: (n=369)		
EKG	243	65.9%
Cardiac enzymes	15	4.1%
HbA1c	48	13.0%
Fasting glucose	140	37.9%
Fasting lipid profile	57	15.4%
GTT	1	0.3%
Comprehensive metabolic screening	302	81.8%
Other cardiometabolic tests	274	74.3%
None	31	8.4%
Domain C: Selected Diagnoses, Findings, and Risks Identified During Pre-Inpatient Evaluation		
Is the member pregnant? (n=406)		
Yes	6	1.5%
No	400	98.5%

Domains and Indicators	N	%
Domain C: Selected Diagnoses, Findings, and Risks Identified During Pre-Inpatient Evaluation (continued)		
Acute symptoms/diagnoses identified prior to admission (select ALL that apply): (n=369)		
Myocardial infarction	0	0.0%
Angina	2	0.5%
Stroke	0	0.0%
Hypertension	19	5.1%
None	312	84.6%
Other	36	9.8%
Cardiovascular Disease (n=369)		
Yes	22	6.0%
No	347	94.0%
Follow-up for Cardiovascular Disease (n=22)		
Medication initiation	2	9.1%
Medication discontinuation	0	0.0%
Medication titration	1	4.5%
Ordered inpatient testing	8	36.4%
Ordered inpatient consultation	2	9.1%
Nutrition/Exercise counseling	5	22.7%
None	11	50.0%
Angina (n=369)		
Yes	4	1.1%
No	365	98.9%
Follow-up for Angina (n=4)		
Medication initiation	1	25.0%
Medication discontinuation	0	0.0%
Medication titration	0	0.0%
Ordered inpatient testing	2	50.0%
Ordered inpatient consultation	1	25.0%
Nutrition/Exercise counseling	1	25.0%
None	1	25.0%
Stroke/CVA (n=369)		
Yes	2	0.5%
No	367	99.5%
Follow-up for Stroke/CVA (n=2)		
Medication initiation	0	0.0%
Medication discontinuation	0	0.0%
Medication titration	0	0.0%
Ordered inpatient testing	0	0.0%
Ordered inpatient consultation	0	0.0%
Nutrition/Exercise counseling	0	0.0%

Domains and Indicators	N	%
Domain C: Selected Diagnoses, Findings, and Risks Identified During Pre-Inpatient Evaluation (continued)		
Follow-up for Stroke/CVA (n=2)		
None	2	100.0%
Hypertension (n=369)		
Yes	113	30.6%
No	256	69.4%
Follow-up for Hypertension (n=113)		
Medication initiation	33	29.2%
Medication discontinuation	4	3.5%
Medication titration	6	5.3%
Ordered inpatient testing	35	31.0%
Ordered inpatient consultation	5	4.4%
Nutrition/Exercise counseling	39	34.5%
None	44	38.9%
Other Cardiovascular Disease (n=369)		
Yes	37	10.0%
No	332	90.0%
Follow-up for Other Cardiovascular Disease (n=37)		
Medication initiation	3	8.1%
Medication discontinuation	1	2.7%
Medication titration	0	0.0%
Ordered inpatient testing	6	16.2%
Ordered inpatient consultation	3	8.1%
Nutrition/Exercise counseling	12	32.4%
None	19	51.4%
Diabetes (n=369)		
Yes	69	18.7%
No	300	81.3%
Follow-up for Diabetes (n=69)		
Medication initiation	25	36.2%
Medication discontinuation	1	1.4%
Medication titration	7	10.1%
Ordered inpatient testing	33	47.8%
Ordered inpatient consultation	9	13.0%
Nutrition/Exercise counseling	33	47.8%
None	16	23.2%
Pre-Diabetes (n=369)		
Yes	5	1.4%
No	361	98.6%

Domains and Indicators	N	%
Domain C: Selected Diagnoses, Findings, and Risks Identified During Pre-Inpatient Evaluation (continued)		
Follow-up for Pre-Diabetes (n=5)		
Medication initiation	2	40.0%
Medication discontinuation	0	0.0%
Medication titration	0	0.0%
Ordered inpatient testing	2	40.0%
Ordered inpatient consultation	0	0.0%
Nutrition/Exercise counseling	1	20.0%
None	1	20.0%
Obesity (n=369)		
Yes	41	11.1%
No	328	88.9%
Follow-up for Obesity (n=41)		
Medication initiation	0	0.0%
Medication discontinuation	0	0.0%
Medication titration	0	0.0%
Ordered inpatient testing	2	4.9%
Ordered inpatient consultation	4	9.8%
Nutrition/Exercise counseling	18	43.9%
None	21	51.2%
Other Metabolic Disease (n=369)		
Yes	26	7.0%
No	343	93.0%
Follow-up for Other Metabolic Disease (n=26)		
Medication initiation	4	15.4%
Medication discontinuation	0	0.0%
Medication titration	0	0.0%
Ordered inpatient testing	7	26.9%
Ordered inpatient consultation	1	3.8%
Nutrition/Exercise counseling	3	11.5%
None	15	57.7%
Select ALL Behavioral Health risks documented prior to admission: (n=369)		
Tobacco Use/Smoking	178	48.2%
Marijuana Use/Smoking	114	30.9%
Synthetic Cannabinoids	35	9.5%
Cocaine	80	21.7%
Methamphetamine	10	2.7%
Prescription Opiate Abuse/Dependence	17	4.6%
IV Drug Use	4	1.1%
Alcohol Abuse/Dependence	114	30.9%

Domains and Indicators	N	%
Domain C: Selected Diagnoses, Findings, and Risks Identified During Pre-Inpatient Evaluation (continued)		
Select ALL Behavioral Health risks documented prior to admission: (continued) (n=369)		
None	98	26.6%
General Substance Abuse Statement	77	20.9%
Follow-up for Documented Tobacco Use (Select ALL that apply) (n=178)		
Counseling	77	43.3%
Pharmaceuticals	50	28.1%
QuitLine	2	1.1%
Community Referral	5	2.8%
Other	12	6.7%
None	83	46.6%
Follow-up for Documented Drug Use (Select ALL that apply) (n=197)		
Counseling	51	25.9%
Behavioral Health Provider referral	13	6.6%
Treatment Center Referral	8	4.1%
Pharmaceuticals	6	3.0%
Community Referral	1	0.5%
Other	8	4.1%
None	124	62.9%
Follow-up for Documented Alcohol Abuse/Dependence (Select ALL that apply) (n=114)		
Counseling	22	19.3%
Behavioral Health Provider referral	4	3.5%
Treatment Center Referral	5	4.4%
Community Referral	1	0.9%
Other	12	10.5%
None	83	72.8%
Documented abnormal exam findings (select ALL that apply) (n=369)		
Elevated blood pressure	36	9.8%
Elevated BMI	74	20.1%
Abnormal lung sounds	0	0.0%
Abnormal cardiac exam	0	0.0%
None	263	71.3%
Not Applicable	3	0.8%
Follow-up for Documented elevated blood pressure (select ALL that apply) (n=36)		
Counseling	4	11.1%
Inpatient consultation recommended	4	11.1%
Inpatient testing recommended	15	41.7%
Pharmaceutical therapy initiation	14	38.9%
Pharmaceutical titration	2	5.6%
None	11	30.6%

Domains and Indicators	N	%
Domain C: Selected Diagnoses, Findings, and Risks Identified During Pre-Inpatient Evaluation (continued)		
Follow-up for Documented elevated BMI (select ALL that apply) (n=74)		
Counseling	16	21.6%
Inpatient consultation recommended	3	4.1%
Inpatient testing recommended	0	0.0%
Pharmaceutical therapy initiation	0	0.0%
Pharmaceutical titration	0	0.0%
None	57	77.0%
Follow-up for Documented abnormal lung sounds (select ALL that apply) (n=0)		
Counseling	0	0.0%
Inpatient consultation recommended	0	0.0%
Inpatient testing recommended	0	0.0%
Pharmaceutical therapy initiation	0	0.0%
Pharmaceutical titration	0	0.0%
None	0	0.0%
Follow-up for Documented abnormal cardiac exam (select ALL that apply) (n=0)		
Counseling	0	0.0%
Inpatient consultation recommended	0	0.0%
Inpatient testing recommended	0	0.0%
Pharmaceutical therapy initiation	0	0.0%
Pharmaceutical titration	0	0.0%
None	0	0.0%
Documented abnormal lab test results (select ALL that apply) (n=369)		
Diabetes screen/testing	6	16.5%
FBS >100 mg dL (n=61)	31	50.8%
FBS >= 126 mg dL (n=61)	29	47.5%
HbA1c >=6.0 (n=61)	4	6.6%
HbA1c>=6.5 (n=61)	2	3.3%
HbA1c <7 (n=61)	0	0.0%
HbA1c <8 (n=61)	1	1.6%
HbA1c >=7 (n=61)	2	3.3%
HbA1c >=8 (n=61)	6	9.8%
2-h PG >=200mg/dL (11.1mmol/L) during an OGTT (n=61)	0	0.0%
2-h PG 140-199 (n=61)	0	0.0%
Lipid screening (LDL > or = 100)	19	5.1%
Abnormal EKG	54	14.6%
None	232	62.9%
Not Applicable	9	2.4%

Domains and Indicators	N	%
Domain C: Selected Diagnoses, Findings, and Risks Identified During Pre-Inpatient Evaluation (continued)		
Follow-up for Documented abnormal Diabetes screens (select ALL that apply) (n=61)		
Counseling	4	6.6%
Inpatient consultation recommended	11	18.0%
Inpatient testing recommended	23	37.7%
Pharmaceutical therapy initiation	13	21.3%
Pharmaceutical titration	7	11.5%
None	31	50.8%
Follow-up for Documented abnormal elevated lipids (select ALL that apply) (n=19)		
Counseling	5	26.3%
Inpatient consultation recommended	1	5.3%
Inpatient testing recommended	1	5.3%
Pharmaceutical therapy initiation	1	5.3%
Pharmaceutical titration	0	0.0%
None	12	63.2%
Follow-up for Documented abnormal EKG (select ALL that apply) (n=54)		
Counseling	0	0.0%
Inpatient consultation recommended	5	9.3%
Inpatient testing recommended	15	27.8%
Pharmaceutical therapy initiation	1	1.9%
Pharmaceutical titration	1	1.9%
None	35	64.8%
Cardiometabolic Risk Medications (select ALL that apply) (n=369)		
Antipsychotic medications	333	90.2%
Anti-hypertensive medications	68	18.4%
Cardiac	15	4.1%
Diabetes	46	12.5%
Nicotine replacement therapy	41	11.1%
Other smoking cessation medication	1	0.3%
None	22	6.0%
Recommendations made during evaluation prior to admission (select ALL that apply) (n=369)		
Repeat lab evaluation	33	8.9%
Repeat EKG	17	4.6%
Check pending lab results	55	14.9%
Inpatient consultation	27	7.3%
Specialty care follow-up	14	3.8%
Primary care follow-up	19	5.1%
Medication initiation	113	30.6%
Medication titration	25	6.8%
Continue current medications	125	33.9%

Domains and Indicators	N	%
Domain C: Selected Diagnoses, Findings, and Risks Identified During Pre-Inpatient Evaluation (continued)		
Recommendations made during evaluation prior to admission (select ALL that apply) (continued) (n=369)		
None	116	31.4%
Other follow-up	37	10.0%
Domain D: General Medical Evaluation Components DURING Inpatient Stay		
Was a physical health evaluation conducted prior to admission? (n=406)		
Yes	400	98.5%
No	5	1.2%
Review of pre-inpatient evaluation only	1	0.2%
Select ALL Medical History components assessed during inpatient stay: (n=400)		
Past medical history	387	96.8%
Medications	378	94.5%
Allergies	361	90.3%
Review of systems	300	75.0%
Behavioral Health risk assessment	377	94.3%
Review of pre-inpatient medical history	236	59.0%
None	1	0.3%
Physical Exam conducted during inpatient stay? (NOT at discharge) (n=400)		
Yes	387	96.8%
No	13	3.3%
Select ALL components completed during the physical exam: (n=387)		
General observation	331	85.5%
HEENT	267	69.0%
Cardiac exam	278	71.8%
Pulmonary Exam	277	71.6%
Extremities	237	61.2%
Pulse	373	96.4%
Respiration	371	95.9%
Blood pressure	376	97.2%
Body Mass Index	248	64.1%
Height	271	70.0%
Weight	306	79.1%
None	1	0.3%
Select ALL documented lab testing ordered/completed during inpatient stay: (n=387)		
EKG	130	33.6%
Cardiac enzymes	14	3.6%
HbA1c	96	24.8%
Fasting glucose	128	33.1%
Fasting lipid profile	112	28.9%
GTT	0	0.0%
Comprehensive metabolic screening	179	46.3%

Domains and Indicators	N	%
Domain D: General Medical Evaluation Components DURING Inpatient Stay		
Select ALL documented lab testing ordered/completed during inpatient stay: (continued) (n=387)		
Other cardiometabolic tests	187	48.3%
None	93	24.0%
Domain E: Selected Diagnoses, Findings, and Risk Identified DURING Inpatient Stay		
Acute symptoms/diagnoses identified during inpatient stay (select ALL that apply): (n=387)		
Myocardial infarction	0	0.0%
Angina	1	0.3%
Stroke	1	0.3%
Hypertension	31	8.0%
None	319	82.4%
Other	42	10.9%
Cardiovascular Disease (include Angina here) (n=387)		
Yes	20	5.2%
No	367	94.8%
Follow-up for Cardiovascular Disease (include Angina here) (n=20)		
Inpatient testing	9	45.0%
Inpatient consultation	3	15.0%
Medication initiation	7	35.0%
Medication discontinuation	1	5.0%
Medication titration	2	10.0%
Nutrition/exercise counseling	10	50.0%
None	2	10.0%
Stroke/CVA (n=387)		
Yes	2	0.5%
No	385	99.5%
Follow-up for Stroke/CVA (n=2)		
Inpatient testing	1	50.0%
Inpatient consultation	0	0.0%
Medication initiation	1	50.0%
Medication discontinuation	0	0.0%
Medication titration	0	0.0%
Nutrition/exercise counseling	1	50.0%
None	1	50.0%
Hypertension (n=387)		
Yes	131	33.9%
No	256	66.1%
Follow-up for Hypertension (n=131)		
Inpatient testing	64	48.9%
Inpatient consultation	15	11.5%

Domains and Indicators	N	%
Domain E: Selected Diagnoses, Findings, and Risk Identified DURING Inpatient Stay (continued)		
Follow-up for Hypertension (n=131)		
Medication initiation	45	34.4%
Medication discontinuation	7	5.3%
Medication titration	22	16.8%
Nutrition/exercise counseling	66	50.4%
None	21	16.0%
Diabetes (n=387)		
Yes	78	20.2%
No	309	79.8%
Follow-up for Diabetes (n=78)		
Inpatient testing	60	76.9%
Inpatient consultation	21	26.9%
Medication initiation	22	28.2%
Medication discontinuation	4	5.1%
Medication titration	25	32.1%
Nutrition/exercise counseling	30	76.9%
None	5	6.4%
Pre-Diabetes (n=387)		
Yes	9	2.3%
No	378	97.7%
Follow-up for Pre-Diabetes (n=9)		
Inpatient testing	6	66.7%
Inpatient consultation	4	44.4%
Medication initiation	2	22.2%
Medication discontinuation	0	0.0%
Medication titration	0	0.0%
Nutrition/exercise counseling	7	77.8%
None	1	11.1%
Obesity (n=387)		
Yes	71	18.3%
No	316	81.7%
Follow-up for Obesity (n=71)		
Inpatient testing	7	9.9%
Inpatient consultation	18	25.4%
Medication initiation	1	1.4%
Medication discontinuation	0	0.0%
Medication titration	0	0.0%
Nutrition/exercise counseling	50	70.4%
None	17	23.9%

Domains and Indicators	N	%
Domain E: Selected Diagnoses, Findings, and Risk Identified DURING Inpatient Stay (continued)		
Other Cardiometabolic Disease (n=387)		
Yes	66	17.1%
No	321	82.9%
Follow-up for Other Cardiometabolic Disease (n=66)		
Inpatient testing	28	42.4%
Inpatient consultation	9	13.6%
Medication initiation	17	25.8%
Medication discontinuation	0	0.0%
Medication titration	5	7.6%
Nutrition/exercise counseling	34	51.5%
None	17	25.8%
Select ALL Behavioral Health risks documented during inpatient stay: (n=387)		
Tobacco Use/Smoking	204	52.7%
Marijuana Use/Smoking	139	35.9%
Select ALL Behavioral Health risks documented during inpatient stay: (n=387)		
Synthetic Cannabinoids	32	8.3%
Cocaine	93	24.0%
Methamphetamine	12	3.1%
Prescription Opiate Abuse/Dependence	20	5.2%
IV Drug Use	2	0.5%
Alcohol Abuse/Dependence	140	36.2%
General Substance Abuse Statement	69	17.8%
None	102	26.4%
Follow-up for Documented Tobacco Use (Select ALL that apply) (n=204)		
Counseling	153	75.0%
Pharmaceuticals	107	52.5%
Other	16	7.8%
None	32	29.9%
Follow-up for Documented Drug Use (Select ALL that apply) (n=213)		
Counseling	136	63.8%
Behavioral Health Provider referral	50	23.5%
Pharmaceuticals	12	5.6%
Other	10	4.7%
None	50	23.5%
Follow-up for Documented Alcohol Abuse/Dependence (Select ALL that apply) (n=140)		
Counseling	94	67.1%
Behavioral Health Provider referral	19	13.6%
Other	18	12.9%
None	35	25.0%

Domains and Indicators	N	%
Domain E: Selected Diagnoses, Findings, and Risk Identified DURING Inpatient Stay (continued)		
Documented abnormal exam findings (select ALL that apply) (n=387)		
Elevated blood pressure	55	14.2%
Elevated BMI	110	23.4%
Abnormal lung sounds	3	0.8%
Abnormal cardiac exam	4	1.0%
None	242	62.5%
Not applicable	6	1.6%
Follow-up for Documented elevated blood pressure (select ALL that apply) (n=55)		
Counseling	13	23.6%
Inpatient consultation	13	23.6%
Inpatient testing	25	45.5%
Inpatient pharmaceutical therapy initiation	22	40.0%
Inpatient pharmaceutical titration	12	21.8%
None	10	18.2%
Follow-up for Documented elevated BMI (select ALL that apply) (n=110)		
Counseling	47	42.7%
Inpatient consultation	22	20.0%
Inpatient testing	25	22.7%
Inpatient pharmaceutical therapy initiation	0	0.0%
Inpatient pharmaceutical titration	12	10.9%
None	51	46.4%
Follow-up for Documented abnormal lung sounds (select ALL that apply) (n=3)		
Counseling	0	0.0%
Inpatient consultation	2	66.7%
Inpatient testing	3	100.0%
Inpatient pharmaceutical therapy initiation	3	100.0%
Inpatient pharmaceutical titration	0	0.0%
None	0	0.0%
Follow-up for Documented abnormal cardiac exam (select ALL that apply) (n=4)		
Counseling	0	0.0%
Inpatient consultation	3	75.0%
Inpatient testing	2	50.0%
Inpatient pharmaceutical therapy initiation	3	75.0%
Inpatient pharmaceutical titration	0	0.0%
None	0	0.0%
Documented abnormal lab test results (select ALL that apply) (n=400)		
Diabetes screen/testing	72	18.6%
FBS >100 mg dL (n=72)	23	31.9%
FBS >= 126 mg dL (n=72)	36	50.0%

Domains and Indicators	N	%
Domain E: Selected Diagnoses, Findings, and Risk Identified DURING Inpatient Stay (continued)		
Documented abnormal lab test results (select ALL that apply) (n=400)		
HbA1c >=6.0 (n=72)	15	20.8%
HbA1c>=6.5 (n=72)	10	13.9%
HbA1c <7 (n=72)	3	4.2%
HbA1c <8 (n=72)	3	4.2%
HbA1c >=7 (n=72)	4	5.6%
HbA1c >=8 (n=72)	9	12.5%
2-h PG >=200mg/dL (11.1mmol/L) during an OGTT (n=72)	0	0.0%
2-h PG 140-199 (n=72)	0	0.0%
Lipid screening (LDL > or = 100)	42	10.9%
Abnormal EKG	37	9.6%
None	282	69.5%
Follow-up for Documented abnormal Diabetes screens (select ALL that apply) (n=72)		
Counseling	26	36.1%
Inpatient consultation	19	26.4%
Inpatient testing	34	47.2%
Inpatient pharmaceutical therapy initiation	15	20.8%
Inpatient pharmaceutical titration	25	34.7%
None	18	25.0%
Follow-up for Documented abnormal lipid screening (select ALL that apply) (n=42)		
Counseling	10	23.8%
Inpatient consultation	5	11.9%
Inpatient testing	0	0.0%
Inpatient pharmaceutical therapy initiation	5	11.9%
Inpatient pharmaceutical titration	2	4.8%
None	28	66.7
Follow-up for Documented abnormal EKG (select ALL that apply) (n=37)		
Counseling	0	0.0%
Inpatient consultation	4	10.8%
Inpatient testing	12	32.4%
Inpatient pharmaceutical therapy initiation	2	5.4%
Inpatient pharmaceutical titration	2	5.4%
None	24	64.9%
Cardiometabolic Risk Medications (select ALL that apply) (n=387)		
Antipsychotic medications	373	96.4%
Anti-hypertensive medications	97	25.1%
Cardiac	22	5.7%
Diabetes	59	15.2%
Nicotine replacement therapy	85	22.0%

Domains and Indicators	N	%
Domain E: Selected Diagnoses, Findings, and Risk Identified DURING Inpatient Stay (continued)		
Were there pre-inpatient evaluation recommendations/follow-up consult made for inpatient? (n=387)		
Other smoking cessation medication	1	0.3%
None	4	1.0%
Were there pre-inpatient evaluation recommendations/follow-up consult made for inpatient? (n=387)		
Yes	208	53.7%
No	179	46.3%
Repeat Lab Evaluation (n=208)		
Yes	42	20.2%
No	42	20.2%
UTD	4	1.9%
N/A	120	57.7%
Repeat EKG (n=208)		
Yes	20	9.6%
No	42	20.2%
UTD	1	0.5%
N/A	120	57.7%
Check Pending Lab results (n=208)		
Yes	78	37.5%
No	20	9.6%
UTD	1	0.5%
N/A	109	52.4%
Specialty care follow-up for discharge (n=208)		
Yes	20	9.6%
No	42	20.2%
UTD	1	0.4%
N/A	145	69.7%
Primary care follow-up for discharge (n=208)		
Yes	28	13.5%
No	38	18.3%
UTD	0	0.0%
N/A	142	68.3%
Medication initiation (n=208)		
Yes	102	49.0%
No	17	8.2%
UTD	0	0.0%
N/A	89	42.8%
Medication titration (n=208)		
Yes	38	18.3%
No	37	17.8%
UTD	0	0.0%

Domains and Indicators	N	%
Domain E: Selected Diagnoses, Findings, and Risk Identified DURING Inpatient Stay (continued)		
Medication titration (continued) (n=208)		
N/A	133	63.9%
Continue current medications (n=208)		
Yes	119	57.2%
No	9	4.3%
UTD	0	0.0%
N/A	80	38.5%
Other (n=208)		
Yes	25	12.0%
No	29	13.9%
UTD	1	0.5%
N/A	152	73.1%
Domain F: General Medical Evaluation Components AT DISCHARGE		
Was a physical health evaluation conducted at discharge? (n=406)		
Yes	385	94.8%
No	21	5.2%
Select ALL Medical History components assessed at discharge/in the discharge summary (n=385)		
Past medical history	321	83.4%
Medications	339	88.1%
Allergies	248	64.4%
Review of systems	159	41.3%
Behavioral Health risk assessment	309	80.3%
None	9	2.3%
Physical exam conducted at discharge? (n=385)		
Yes	308	80.0%
No	69	17.9%
Prior Only	8	2.1%
Select ALL components completed during the physical exam: (n=308)		
General observation	221	71.8%
HEENT	64	20.8%
Cardiac exam	70	22.7%
Pulmonary Exam	68	22.1%
Extremities	71	23.1%
Pulse	257	83.4%
Respiration	251	81.5%
Blood pressure	253	82.1%
Select ALL documented lab testing ordered/recommended at discharge: (n=308)		
EKG	5	1.6%
Cardiac enzymes	0	0.0%
HbA1c	2	0.6%

Domains and Indicators	N	%
Domain G Selected Diagnoses, Findings, and Risk Identified AT DISCHARGE (continued)		
Select ALL documented lab testing ordered/recommended at discharge: (n=308)		
Fasting glucose	7	2.3%
Fasting lipid profile	3	1.0%
GTT	0	0.0%
Comprehensive metabolic screening	6	1.9%
Other cardiometabolic tests	20	6.5%
None	275	89.3%
Cardiovascular Disease (n=308)		
Yes	22	7.1%
No	286	92.9%
Follow-up for Cardiovascular Disease (n=22)		
Medication initiation	1	4.5%
Medication discontinuation	1	4.5%
Medication titration	2	9.1%
Medication reconciliation	14	63.3%
CVD Prescription provided	9	40.9%
Scheduled PCP follow-up post-discharge	5	22.7%
Scheduled Specialist follow-up post-discharge	2	9.1%
PCP Referral	2	9.1%
Specialist Referral	0	0.0%
Scheduled outpatient testing	0	0.0%
Nutrition/Exercise counseling	9	40.9%
None	2	9.1%
Stroke/CVA (n=308)		
Yes	2	0.6%
No	306	99.4%
Follow-up for Stroke/CVA (n=2)		
Medication initiation	0	0.0%
Medication discontinuation	0	0.0%
Medication titration	0	0.0%
Medication reconciliation	1	50.0%
Stroke Prescription provided	0	0.0%
Scheduled PCP follow-up post-discharge	1	50.0%
Scheduled Specialist follow-up post-discharge	0	0.0%
PCP Referral	0	0.0%
Specialist Referral	0	0.0%
Scheduled outpatient testing	0	0.0%
Nutrition/Exercise counseling	1	50.0%
None	1	50.0%

Domains and Indicators	N	%
Domain G Selected Diagnoses, Findings, and Risk Identified AT DISCHARGE		
Hypertension (n=308)		
Yes	99	32.1%
No	209	67.9%
Follow-up for Hypertension (n=99)		
Medication initiation	3	3.0%
Medication discontinuation	3	3.0%
Medication titration	7	7.1%
Medication reconciliation	66	66.7%
Hypertension Prescription provided	31	31.3%
Scheduled PCP follow-up post-discharge	25	25.3%
Scheduled Specialist follow-up post-discharge	9	9.1%
PCP Referral	11	11.1%
Specialist Referral	1	1.0%
Scheduled outpatient testing	0	0.0%
Nutrition/Exercise counseling	39	39.4%
None	8	8.1%
Diabetes (n=308)		
Yes	56	18.2%
No	252	81.8%
Follow-Up for Diabetes (n=56)		
Medication initiation	2	3.6%
Medication discontinuation	3	5.4%
Medication titration	5	8.9%
Medication reconciliation	40	71.4%
Diabetes Prescription provided	13	23.2%
Scheduled PCP follow-up post-discharge	14	25.0%
Scheduled Specialist follow-up post-discharge	7	12.5%
PCP Referral	6	10.7%
Specialist Referral	1	1.8%
Scheduled outpatient testing	1	1.8%
Nutrition/Exercise counseling	29	51.8%
None	2	3.6%
Pre-Diabetes (n=308)		
Yes	8	2.6%
No	300	97.4%
Follow-up for Pre-Diabetes (n=8)		
Medication initiation	0	0.0%
Medication discontinuation	0	0.0%
Medication titration	0	0.0%
Medication reconciliation	3	37.5%

Domains and Indicators	N	%
Domain G Selected Diagnoses, Findings, and Risk Identified AT DISCHARGE		
Follow-up for Pre-Diabetes (n=8)		
Pre-Diabetes Prescription provided	1	12.5%
Scheduled PCP follow-up post-discharge	1	12.5%
Scheduled Specialist follow-up post-discharge	0	0.0%
PCP Referral	0	0.0%
Specialist Referral	0	0.0%
Scheduled outpatient testing	0	0.0%
Nutrition/Exercise counseling	6	75.0%
None	0	0.0%
Obesity (n=308)		
Yes	40	13.0%
No	268	87.0%
Follow-up for Obesity (n=40)		
Medication initiation	0	0.0%
Medication discontinuation	0	0.0%
Medication titration	0	0.0%
Medication reconciliation	2	5.0%
Obesity Prescription provided	0	0.0%
Scheduled PCP follow-up post-discharge	8	20.0%
Scheduled Specialist follow-up post-discharge	1	2.5%
PCP Referral	3	7.5%
Specialist Referral	2	5.0%
Scheduled outpatient testing	1	2.5%
Follow-up for Obesity (continued)		
Nutrition/Exercise counseling	19	47.5%
None	13	32.5%
Other Cardiometabolic Condition (n=308)		
Yes	32	10.4%
No	276	89.6%
Follow-up for Other Cardiometabolic Condition (n=32)		
Medication initiation	2	6.3%
Medication discontinuation	0	0.0%
Medication titration	1	3.1%
Medication reconciliation	18	56.3%
Other Prescription provided	11	34.4%
Scheduled PCP follow-up post-discharge	10	31.3%
Scheduled Specialist follow-up post-discharge	2	6.3%
PCP Referral	2	6.3%
Specialist Referral	0	0.0%
Scheduled outpatient testing	0	0.0%

Domains and Indicators	N	%
Domain G Selected Diagnoses, Findings, and Risk Identified AT DISCHARGE		
Follow-up for Other Cardiometabolic Condition (continued) (n=32)		
Nutrition/Exercise counseling	17	53.1%
None	7	21.9%
Select ALL Behavioral Health risks documented at discharge: (n=308)		
Tobacco Use/Smoking	134	43.5%
Marijuana Use/Smoking	94	30.5%
Synthetic Cannabinoids	18	5.8%
Cocaine	64	20.8%
Methamphetamine	9	2.9%
Prescription Opiate Abuse/Dependence	16	5.2%
IV Drug Use	1	0.3%
Alcohol Abuse/Dependence	88	28.6%
General Substance Abuse Statement	49	15.9%
None	101	32.8%
Follow-up for Documented Tobacco Use (Select ALL that apply) (n=134)		
Counseling	73	54.5%
Pharmaceuticals	43	32.1%
QuitLine	12	9.0%
Community Referral	37	27.6%
Other	12	9.0%
None	30	22.4%
Follow-up for Documented Drug Use (Select ALL that apply) (n=157)		
Counseling	64	40.8%
Behavioral Health Provider referral	100	63.7%
Treatment Center Referral	46	29.3%
Pharmaceuticals	10	6.4%
Community support	12	7.6%
Other	4	2.5%
None	19	12.1%
Follow-up for Documented Alcohol Abuse/Dependence (Select ALL that apply) (n=88)		
Counseling	32	36.4%
Behavioral Health Provider referral	55	62.5%
Treatment Center Referral	39	44.3%
Community support	3	3.4%
Other	5	5.7%
None	3	3.4%
Documented abnormal exam findings (select ALL that apply) (n=308)		
Elevated blood pressure	10	3.2%
Elevated BMI	37	12.0%

Domains and Indicators	N	%
Domain G Selected Diagnoses, Findings, and Risk Identified AT DISCHARGE		
Documented abnormal exam findings (select ALL that apply) (n=308)		
Abnormal lung sounds	0	0.0%
Abnormal cardiac exam	1	0.3%
None	261	84.7%
Follow-up for Documented elevated blood pressure (select ALL that apply) (n=10)		
Counseling	0	0.0%
Medication initiation	3	30.0%
Medication titration	5	50.0%
Outpatient PCP referral	3	30.0%
Outpatient specialist referral	1	10.0%
Outpatient testing scheduled	0	0.0%
None	3	30.0%
Follow-up for Documented elevated BMI (select ALL that apply) (n=37)		
Counseling	15	40.5%
Medication initiation	0	0.0%
Medication titration	0	0.0%
Outpatient PCP referral	8	21.6%
Outpatient specialist referral	1	2.7%
Outpatient testing scheduled	0	0.0%
None	19	51.4%
Follow-up for Documented abnormal lung sounds (select ALL that apply) (n=0)		
Counseling	0	0.0%
Medication initiation	0	0.0%
Medication titration	0	0.0%
Outpatient PCP referral	0	0.0%
Outpatient specialist referral	0	0.0%
Follow-up for Documented abnormal lung sounds (select ALL that apply) (n-0)		
Outpatient testing scheduled	0	0.0%
None	0	0.0%
Follow-up for Documented abnormal cardiac exam (select ALL that apply) (n=1)		
Counseling	0	0.0%
Medication initiation	0	0.0%
Medication titration	0	0.0%
Outpatient PCP referral	1	100.0%
Outpatient specialist referral	0	0.0%
Outpatient testing scheduled	0	0.0%
None	0	0.0%
Documented abnormal lab test results (select ALL that apply) (n=308)		
Diabetes screen/testing	12	3.9%

Domains and Indicators	N	%
Domain G Selected Diagnoses, Findings, and Risk Identified AT DISCHARGE		
Documented abnormal lab test results (select ALL that apply) (n=308)		
FBS >100 mg dL (n=12)	5	41.7%
FBS >= 126 mg dL (n=12)	6	50.0%
HbA1c >=6.0 (n=12)	1	8.3%
HbA1c>=6.5 (n=12)	0	0.0%
HbA1c <7 (n=12)	0	0.0%
HbA1c <8 (n=12)	0	0.0%
HbA1c >=7 (n=12)	0	0.0%
HbA1c >=8 (n=12)	1	8.3%
2-h PG >=200mg/dL (11.1mmol/L) during an OGTT (n=12)	0	0.0%
2-h PG 140-199 (n=12)	0	0.0%
Lipid screening (LDL > or = 100)	7	2.3%
Abnormal EKG	6	1.9%
None	284	92.2%
Follow-up for Documented abnormal Diabetes screens (select ALL that apply) (n=12)		
Counseling	3	25.0%
Outpatient testing ordered/recommended	1	8.3%
Outpatient testing scheduled	0	0.0%
Outpatient PCP referral	2	16.7%
Outpatient PCP scheduled	1	8.3%
Outpatient specialist referral	2	16.7%
Outpatient specialist scheduled	2	16.7%
Discharge pharmaceutical therapy initiation	0	0.0%
Discharge pharmaceutical titration	5	41.7%
None	2	16.7%
Follow-up for Documented abnormal lipids screen (select ALL that apply) (n=7)		
Counseling	0	0.0%
Outpatient testing ordered/recommended	0	0.0%
Follow-up for Documented abnormal lipids screens (select ALL that apply) (n=7)		
Outpatient testing scheduled	0	0.0%
Outpatient PCP referral	2	28.6%
Outpatient PCP scheduled	1	14.3%
Outpatient specialist referral	1	14.3%
Outpatient specialist scheduled	1	14.3%
Discharge pharmaceutical therapy initiation	1	14.3%
Discharge pharmaceutical titration	1	14.3%
None	3	42.9%
Follow-up for Documented abnormal EKG (select ALL that apply) (n=6)		
Counseling	0	0.0%

Domains and Indicators	N	%
Domain G Selected Diagnoses, Findings, and Risk Identified AT DISCHARGE		
Follow-up for Documented abnormal EKG (select ALL that apply) (n=6)		
Outpatient testing ordered/recommended	0	0.0%
Outpatient testing scheduled	0	0.0%
Outpatient PCP referral	1	16.7%
Outpatient PCP scheduled	0	0.0%
Outpatient specialist referral	0	0.0%
Outpatient specialist scheduled	0	0.0%
Discharge pharmaceutical therapy initiation	0	0.0%
Discharge pharmaceutical titration	0	0.0%
None	5	83.3%
Cardiometabolic Risk Medications (select ALL that apply) (n=308)		
Antipsychotic medications	299	97.1%
Anti-hypertensive medications	80	26.0%
Cardiac	13	4.2%
Diabetes	45	14.6%
Nicotine replacement therapy	41	13.3%
Other smoking cessation medication	0	0.0%
None	6	1.9%
Domain H: Components of Discharge Plan/Planning		
Select ALL elements included in the discharge plan (n=406)		
PCP Referral (n=406)		
Yes	170	41.9%
PCP identified by name (n=170)	90	52.9%
Member advised to contact PCP following discharge to make appointment (n=170)	46	27.1%
PCP appointment made prior to discharge (n=170)	120	70.6%
PCP appointment date (n=170)	114	67.1%
PCP address and phone number (n=170)	108	63.5%
No	236	58.1%
Medical (PH) Specialist Referral (n=406)		
Yes	84	20.7%
Specialist identified by name (n=84)	46	54.8%
Member advised to contact Specialist following discharge to make appointment (n=84)	13	15.5%
Specialist appointment made prior to discharge (n=84)	70	83.3%
Specialist appointment date (n=84)	68	81.0%
Specialist address and phone number (n=84)	60	71.4%
No	322	79.3%
Clinic Follow-up UTD	57	14.0%
Referral/Appointment Made for Behavioral Health	339	83.5%
Referral to Nutritionist	0	0.0%
Referral for Tobacco/QuitLine	33	8.1%

Domains and Indicators	N	%
Domain H: Components of Discharge Plan/Planning (continued)		
Referral to Treatment Center	79	19.5%
Lab re-testing scheduled	3	0.7%
Referral to Health Plan	7	1.7%
Referral to Health Home	51	12.6%
Select ALL elements included in the discharge plan (n=406)		
None	14	3.4%
Are there documented potential barriers to follow-up at discharge? (n=406)		
Yes	66	16.3%
No	340	83.7%
If yes, was assistance provided or suggested? (n=66)		
Yes	55	83.3%
No	11	16.7%
Did the discharge planning documentation include medication reconciliation? (n=406)		
Yes	366	90.1%
No	40	9.9%
If yes, select all that apply: (n=366)		
Medications taken pre-inpatient admission	104	28.4%
Medications prescribed at discharge	360	98.4%
Name (n=360)	358	99.4%
Dosage (n=360)	357	99.2%
Schedule (n=360)	356	98.9%
Reason for taking medication(s) (n=360)	209	58.1%
Medications to be discontinued	87	23.8%
Domain I: Care Coordination at Discharge		
Established primary care provider (PCP) in discharge plan? (n=406)		
Yes, has an established PCP	98	24.1%
No established PCP but PCP was identified at discharge	31	7.6%
No established PCP and no PCP identified at discharge	277	68.2%
Communication with PCP at discharge? (n=406)		
Documented communication with established PCP	49	12.1%
Documented communication with PCP identified at discharge	32	7.9%
No communication documented with any PCP	325	80.0%
Communication with medical clinical referrals at discharge? (n=406)		
Documented communication with established clinician referral (Not established PCP)	23	5.7%
Documented communication with newly identified clinician referral (other than PCP identified at discharge)	47	11.6%
No communication documented with clinician referrals	336	82.8%
Communication with Health Plan for post-discharge needs? (n=406)		
Yes	60	14.8%
No	336	82.8%
Other	10	2.5%

Domains and Indicators	N	%
Domain I: Care Coordination at Discharge (continued)		
If yes, is the communication regarding cardiometabolic conditions? (n=70)		
Yes	4	5.7%
No	66	94.3%
Communication with Health Home for post-discharge needs (anywhere in medical record)? (n=406)		
Yes	54	13.3%
No	352	86.7%
If yes, inpatient/discharge provider attempted to contact Health Home care manager? (n=54)		
Yes	36	66.7%
No	18	33.3%
If yes, documented communication between inpatient/discharge team and member's Health Home care manager? (n=54)		
Yes	41	75.9%
No	13	24.1%
If yes, documented communication regarding cardiometabolic conditions? (n=41)		
Yes	6	14.6%
No	35	85.4%
Member engagement with Health Home (HH) care manager (CM)? Select ALL that apply (n=406)		
HH CM visited member on inpatient unit/prior to discharge	11	2.7%
Appointment made with HH CM prior to discharge	15	3.7%
Member advised to contact HH CM following discharge	21	5.2%
UTD	36	8.9%
No engagement with Health Home documented	325	80.0%
Were non- HH CMs involved during hospitalization? (n=406)		
Yes	107	26.4%
No	148	36.5%
UTD	151	37.2%
Were non- HH CMs involved at discharge with discharge planning? (n=406)		
Yes	117	28.8%
No	139	34.2%
UTD	150	36.9%

Appendix B: Abstraction Instructions

NY HARP Study: Record Review Tool Instructions–*draft 2.17.17 Document request will include face sheet, problem list, mental health (MH) inpatient admission physical exam, emergency department evaluation, inpatient transfer note, clinician progress notes, consultations, discharge records for members:* **aged 21-64 years, who had a mental health inpatient admission event with discharge between January 7, 2016 and July 7, 2016.**		
FIELD	***INSTRUCTIONS***	***Comment***
Nurse reviewer identification	Select your name from drop down box	
A. Member General Information	• IPRO ID and member name will be pre-populated • CIN will be pre-populated • Admission date will be pre-populated • Discharge date will be pre-populated • Follow-up visit date will be linked to analysis, post abstraction	Nurse reviewer will use the pre-populated MH inpatient Admission and Discharge dates to distinguish: • "**pre-MH inpatient" documentation** (i.e., any documentation prior to the inpatient mental health unit stay, e.g., could be emergency department (ED), medical unit/physical health (PH) inpatient stay, outpatient clinic or provider office, or direct admit from home) • "**inpatient documentation**" (the dates of documentation between the pre-populated MH inpatient admission and discharge dates) • **"discharge plan or summary documentation**" (documentation on the day of, or related to, the pre-populated discharge date)
1. MCO/Health Plan 2. Type of Health Plan 3. A. Enrollment date B. Disenrollment date	• 1. Name of MCO health insurance plan pre-populated. • 2. HARP/Mainstream/HIV-SNP pre-populated. • 3A. Date of enrollment in health plan will be linked post analysis • 3B. Date of disenrollment in health plan linked post analysis	
4. Facility	Facility name will be pre-populated _____(text enter option)	If the name of the facility on the medical record differs from the name pre-populated, confirm the medical record is for the correct member during the review period **(aged 21-64 years, who had a mental health (MH) inpatient stay with discharge between January 7, 2016 and July 7, 2016**), and **notify the IPRO clinical lead**. If the IPRO clinical lead instructs to review the chart provided, enter the name of facility in the box provided, and continue abstraction. **NOTE: the review period is the entire mental health stay from admission to discharge between January 7 and July 7, 2016 (records will exclude mental health treatment notes); therefore, the beginning of the review period will vary by member's admission date.**
5. Member date of birth	Member date of birth will be pre-populated _____(text enter option)	Confirm correct member and enter the DOB that differs from pre-populated.
6. Sex	Male/female will be pre-populated _____(text enter option)	Confirm correct member and enter the Sex that differs from pre-populated.

7. Race/ethnicity	Race/ethnicity- pre-populated _____(text enter option)	Enter race as documented in chart if different from pre-populated.
8. Primary language	Primary language • English • Spanish • Other_____ • UTD	Select primary language if documented in chart. If record indicates patient primarily speaks language other than English or Spanish select Other, and enter the documented language. If not documented or not specifically addressed select UTD.
9. Translation	Translation • Yes • No • NA • UTD	**If answer to 9a is English, 9b will be auto-populated with NA.** If answer to 9a is Spanish or other, select YES if translation services were documented during MH inpatient stay, either face to face or telephonic. Select NO if there is indication/documentation of a language barrier, but site was unable to provide translator, or if there is documentation of a language barrier but no note of translator. Select NA if there is explicit documentation that a translator was not needed due to member speaking English well or proficient in English. Select UTD if not clear from documentation or illegible. Family interpretation is not acceptable for member offered translation.
10. Discharge diagnosis(es)-administrative	10. Primary discharge diagnosis	This item will not be available for review; administrative data will be linked for analysis.
11. Historical medical diagnoses-administrative	11. Historical medical diagnoses-administrative (not provided for review/linked to analysis	This item will not be available for review; administrative data will be linked for analysis.
12. Site from which member was admitted to inpatient mental health/ unit	12. Select the site from which member was admitted to mental health inpatient: • Emergency department • Medical unit inpatient transfer • Outpatient clinic/office • Direct admission to MH inpatient • Other • UTD	Appears from literature that most MH inpatient stays originate from emergency department or inpatient transfer. Assume that all documents in record that address medical or physical health evaluation will be reviewed. Select the type of facility from which the member was admitted to the psychiatric/mental health unit, which may be a site at which medical clearance conducted only. This should be documented in pre-MH inpatient notes, and could indicate admitted from emergency department (CPEP, Psych ER or Psych Observation Suite), transferred from inpatient unit, admitted from outpatient clinic/office. Select the most recent site of member's care prior to MH inpatient. For example, if member admitted from ER to medical inpatient unit and then to psych inpatient unit; select medical inpatient.

		Select **direct admission to MH inpatient** if member admitted from home setting to MH inpatient unit. Select **other if site not listed as an option**, e.g. another psychiatric facility; if "Other" selected please text enter/specify in comment box. Select **UTD if site of origin of MH inpatient is not documented**.
13. Member discharged to community	Member discharged to the community? Select one: • Yes • No	Select YES if there is medical record documentation that member was discharged to home, group home or other community based housing. Discharges to congregate housing, supported apartment programs are considered community-based. Select NO, if it is documented that the member was transferred to another inpatient facility, including a rehabilitation facility or nursing home. **If No, STOP the REVIEW and notify IPRO clinical lead. This notification "pop-ups" in Access tool if no is selected.**
14. Health Home Engagement	Was member enrolled/engaged in health home prior to inpatient admission? • Yes • No • Not documented (not queried)	Select YES if the coversheet on the medical record has the box checked "yes" for enrolled/engaged in health home on pre-MH inpatient, or if there is any documentation in the record that the member was enrolled in a health home pre-MH inpatient. Select NO, if the coversheet is marked "NO" or if there is documentation in the medical record that the member was not enrolled. Otherwise, select Not Documented if the coversheet box is not checked and there is no documentation in the record.
15a. Health Home Enrollment	Was member eligible for health home enrollment prior to or during admission? • Yes • No • Not documented (not queried)	Select YES if the coversheet on the medical record has the box checked "YES" for eligible for health home prior to or during admission or if there is any documentation in the record that the member was eligible for health home prior to or during admission. Select NO if the coversheet box is checked "NO". Otherwise, select Not Documented if the coversheet box is not checked, and there is no documentation in the record.
15b. Member outreach for Health Home	Was member in outreach for health home enrollment • Yes • No	Select YES if the coversheet on the medical record has the box checked "YES" for in outreach for health home or if there is any documentation in the record that the member was in outreach for health home enrollment.

	• Not documented (not queried)	Select NO if the coversheet box is checked "no". Otherwise, select "Not Documented" if the coversheet box is not checked, and there is no documentation in the record. **If No or Not Documented selected, the questions in 15c will gray out.**
15c.	If in outreach or enrolled: • Text enter the name of the care management agency:_____ • Text enter the name of the health home:_____ Did the MCO outreach the CMA • Yes • No • Not Documented Did the MCO outreach to the HH • Yes • No • Not documented (not queried)	Text enter the names documented on the coversheet or documented on the medical record. Select YES if the coversheet on the medical record has the box checked "YES" for outreach to the CMA and/or HH: Select NO if the coversheet box is checked "NO". Otherwise, select Not Documented if the coversheet box is not checked, and there is no documentation in the record.
16. Was there any MCO outreach/care coordination while inpatient	Was there MCO outreach: • Yes • No • Not documented (not queried) Was there MCO care coordination: • Yes • No • Not documented (not queried)	Select YES if the coversheet on the medical record has the box checked "YES" for MCO outreach or MCO care coordination while inpatient, or if there is any documentation in the record that the member was engaged with the MCO (vs. the Health Home care management staff) during the inpatient stay. Select NO if the coversheet box is checked "NO". Otherwise, select Not Documented if the coversheet box is not checked, and there is no documentation in the record.
B. General Medical/Physical Health (PH) evaluation components pre-MH inpatient	• Admission date will be pre-populated	Nurse reviewer will use the pre-populated admission date to determine: "**pre-MH inpatient" documentation** (i.e., any documentation prior to the inpatient mental health unit stay, e.g., could be emergency department (ED), medical unit/physical health (PH) inpatient stay, outpatient clinic or provider office, or direct admit from home).
1a. Physical health (PH) evaluation pre-MH inpatient	Evaluation of PH status pre-MH inpatient: • Yes • Medical clearance statement only • No	Assume all documentation valid if included in medical record for review period, (RP = inpatient documentation between pre-populated dates of admission and discharge).

		Select YES if an evaluation of physical health (PH) status by history, physical exam and/or laboratory testing as per medical record documentation pre-MH inpatient. Individual components will be abstracted in following items. Evaluation could take place in **Emergency department (include CPEP, Psych ER or Psych Observation Suite stays), medical inpatient, outpatient office/clinic.** Evaluation description could include "medical clearance", medical screening, medical assessment, documentation in inpatient transfer note. Documentation could include type of evaluation (e.g. "medical clearance", medical screening, medical assessment). Select "Medical clearance statement only", if it is documented that medical clearance was conducted prior to the admission, but the medical clearance notes are not included in the medical record. This could include simply a statement that "patient was medically cleared" without further documentation. Otherwise, select NO, if no PH evaluation conducted pre-MH inpatient. **NOTE: if "medical clearance statement only" or "no" are selected, items 1b-1e, will gray out. These will need to be selected again in the next Section C for the gray-out and will not be available for review**.
1b. Medical history assessed pre-MH inpatient	Medical history components assessed pre-MH inpatient Select all: • Past medical history • Medications • Allergies • Review of systems • Behavioral health risk assessment • None	Select all component of history taking documented in record pre-MH inpatient: **NOTE: Do not include information from inpatient stay or at discharge documentation, which will be evaluated separately below.** • Past medical history (e.g. past hospitalizations, illnesses, conditions, OB history) • Medications • Allergies • Review of systems • Behavioral health risk assessment - e.g. tobacco, substance use • None - select if no medical history is documented in the record pre-MH inpatient stay. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1c. Components completed during the physical exam (pre-MH inpatient)	Components of physical exam - select all that apply: • General observation • HEENT • Cardiac exam	Select all that apply: • General observation • HEENT • Cardiac exam • Pulmonary exam

	• Pulmonary exam • Extremities • Pulse • Respiration • Blood pressure • Body Mass Index (BMI) – enter BMI Value • Height (in feet and inches) • Weight (in pounds) • None	• Extremities • Pulse • Respiration • Blood pressure • Body Mass Index (BMI) – If selected, enter the BMI Value as documented in the chart. Note, if there is more than one BMI Value documented in the pre-inpatient note, select the most recent BMI value documented in the medical record. **(if BMI not selected, the BMI value entry box will remain grayed out**). • Height (in feet and inches from same date/source as weight) – If selected, enter the height as documented in the chart. Note, if there is more than one height documented in the pre-inpatient note, select the most recent height documented in the medical record. (**if height not selected, the height entry box will remain grayed out**). • Weight– If selected, enter the weight as documented in the chart. Note, if there is more than one weight documented in the pre-inpatient note, select the most recent weight documented in the medical record. **(if weight not selected, the weight entry box will remain grayed out).** • None - select if no physical exam components are documented pre-MH inpatient, For example, if there is only a "general observation" statement of "physical exam completed" or "exam unremarkable", or if there is a statement of "see medical clearance note". In these instances, both "general observation" and "none" should be selected. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1d. BMI calculation at pre-MH inpatient	BMI will be calculated from height and weight and auto-populated	BMI will be calculated from height and weight and auto-populated during analysis.
1e. Laboratory testing pre-MH inpatient	Documented lab testing ordered/completed pre-MH inpatient – select all that apply: • EKG • Cardiac enzymes • Hemoglobin A1c • Fasting glucose • Fasting lipid profile • GTT (Glucose Tolerance Test) • Comprehensive metabolic screening • Other cardiometabolic: text enter _____ • None	Select al that apply from lab testing documented in records pre-MH inpatient: • EKG • Cardiac Enzymes (measures blood levels of the **enzyme** creatine phosphokinase (CPK), also called creatine kinase (CK), and a more specific form of this **enzyme** called CK-MB). • Hemoglobin A1c • Fasting glucose • Fasting lipid profile • GTT (Glucose Tolerance Test) • Comprehensive metabolic screening (measures your sugar (glucose) level, electrolyte and fluid balance, kidney function, and liver function). Can be documented as SMA16. • Other cardiometabolic testing. If selected, text enter the name of other cardiometabolic labs documented pre-MH inpatient unit stay. • None - select if none of the lab options are documented as ordered or

		completed pre-MH inpatient unit stay. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
C. Selected diagnoses, findings and risks identified by pre-MH inpatient evaluation		**NOTE: This section will gray-out and not be available for review if "medical clearance statement only" or "no" are selected in question 1a.**
1a. Pregnancy Diagnosis/history	Is member pregnant pre-MH inpatient or diagnosed during MH inpatient stay? • Yes • No	Select YES if member is documented as pregnant pre-MH inpatient or is diagnosed during MH inpatient stay. Otherwise, select NO.
Was a physical health evaluation conducted prior to admission?	• Yes • Medical clearance statement only • No	Select YES if a physical evaluation was conducted prior to admission. **All of the questions in the remainder of Section C will gray-out and not be available for review if "medical clearance statement only" or "no" are selected.**
1b. Any Acute Symptoms / Diagnoses pre-MH inpatient	Check all that apply: **<u>Acute symptoms/diagnosis pre-MH inpatient:</u>** • Myocardial Infarction • Angina • Stroke • HTN • Other - Text Enter Other: _____ • None	Select any following acute symptoms or diagnoses documented in the medical record during ED, medical inpatient evaluation or outpatient evaluation pre-MH inpatient: • Myocardial Infarction • Angina • Stroke • HTN • Other – select if an acute physical health cardiometabolic symptom or condition not listed above is present and enter the name in the space provide for Other. **Note: for any non-cardiometabolic physical health symptoms or conditions documented in the pre-inpatient documentation, please notes these items in the comment section in the last section of the database.** • None - select if no acute symptoms or diagnoses are documented in the pre-MH evaluation documentation. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1c. Cardiovascular disease diagnosis pre-MH inpatient and follow-up	Select all that apply: **<u>PMHX/diagnosis: CVD pre-MH inpatient:</u>** ▪ <u>Yes/No</u> CVD pre-MH Diagnosis Follow –up: ▪ Medication initiation ▪ Medication discontinuation ▪ Medication titration • Ordered Inpatient testing • Ordered Inpatient consultation	• **<u>Select NO if a CVD diagnosis or past medical history (PMHX) is not documented in the pre-MH inpatient evaluation record; NOTE: If NO is selected, follow up will "gray-out" and will not be available for review.</u>** • Select YES if a CVD past medical history (PMHX) or diagnosis (CVD includes coronary artery disease CAD, Ischemic heart disease, Arteriosclerotic CVD, history of myocardial infarction) is documented in the medical record pre-MH inpatient (includes any site prior to inpatient, i.e., medical unit, ED, etc.). Select all that apply for CVD follow-up:

	• Nutrition/Exercise counseling • None	• Select medication initiation if new medication prescribed during evaluation pre-MH inpatient for the physical conditions (exclude one-time orders, for example, epinephrine). • Select medication discontinuation if it is documented that a medication member had been taking was discontinued pre-MH inpatient. • Select medication titration if medication that the patient was taking pre-MH inpatient for the physical conditions was adjusted per dosage, route, and/or frequency during pre-MH inpatient evaluation. • Select inpatient testing if additional diagnostic tests to further **evaluate the condition were ordered** to be conducted during inpatient stay, such as EKG, imaging, ECHO, lab testing. • Select inpatient consultation if pre-MH inpatient evaluation included a **recommendation for consultation during mental health inpatient stay** to address/evaluate a physical health condition/diagnosis e.g., "cardiology to follow on floor for CVD". • Nutrition/Exercise counseling, Select if special diet is ordered (i.e., low sodium diet), if counseling is provided on nutrition pre-MH inpatient, or if nutrition counseling is ordered for follow-up during inpatient stay. • Select None, if none of the above options are documented as follow-up to CVD diagnosis. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1d. Angina diagnosis documented pre-MH inpatient and follow-up	Select all that apply: **PMHX/diagnosis: Angina pre-MH inpatient** ▪ Yes/No Angina Pre-MH inpatient Follow –up: ▪ Medication initiation ▪ Medication discontinuation ▪ Medication titration • Ordered Inpatient testing • Ordered Inpatient consultation • Nutrition/Exercise counseling • None	• **Select NO if an Angina diagnosis or past medical history (PMHX) is not documented during medical evaluation pre-MH inpatient; NOTE: If no is selected, follow up will "gray-out" and will not be available for review.** • Select YES if an Angina past medical history (PMHX) or diagnosis is documented in the medical record during the member's pre-MH inpatient evaluation (includes any site prior to inpatient, i.e., medical unit, ED, etc.). Select all that apply for Angina follow-up: • Select medication initiation if new medication prescribed during pre-MH inpatient evaluation for the physical condition (exclude one-time orders, for example, epinephrine). • Select medication discontinuation if it is documented that a medication member had been taking was discontinued during the pre-MH inpatient evaluation. • Select medication titration if medication that the patient was taking during the pre-MH inpatient was adjusted per dosage, route, and/or frequency. • Select inpatient testing if additional diagnostic tests to further evaluate the condition **were ordered during pre-MH inpatient evaluation to be**

		conducted during inpatient stay, such as EKG, imaging, ECHO, lab testing. • Select inpatient consultation if pre-MH inpatient evaluation included a recommendation for consultation during mental health inpatient stay to address/evaluate a physical health condition/diagnosis while member was inpatient, e.g., "cardiology to follow on floor for angina history". • Nutrition/Exercise counseling, Select if special diet is ordered (i.e., low sodium, diabetic diet), if counseling is provided on nutrition during pre-MH inpatient evaluation, or if nutrition counseling is ordered for follow-up during inpatient stay. • Select None, if none of the above options are documented as follow-up to Angina diagnosis. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1e. Stroke/CVA diagnosis documented pre-MH inpatient and follow-up	Select all that apply: **PMHX/diagnosis: Stroke/CVA** pre-MH inpatient**:** ▪ Yes/No Stroke/CVA Pre-MH inpatient Follow –up: ▪ Medication initiation ▪ Medication discontinuation ▪ Medication titration • Ordered Inpatient testing • Ordered Inpatient consultation • Nutrition/Exercise counseling • None	• **Select NO if a Stroke/CVA diagnosis or past medical history (PMHX) is not documented during medical evaluation pre-MH inpatient; NOTE: If no is selected, follow up will "gray-out" and will not be available for review.** • Select YES if Stroke/CVA past medical history (PMHX) or diagnosis is documented in the medical record during the member's pre-MH inpatient evaluation (includes any site prior to inpatient, i.e., medical unit, ED, etc.). Select all that apply for Stroke/CVA follow-up: • Select medication initiation if new medication prescribed during the pre-MH inpatient evaluation for one of the physical conditions (exclude one-time orders, for example, epinephrine). • Select medication discontinuation if it is documented that a medication member had been taking during the pre-MH inpatient evaluation was discontinued. • Select medication titration if medication that the patient was taking during the pre-MH inpatient evaluation for the physical condition was adjusted per dosage, route, and/or frequency. • Select inpatient testing if additional diagnostic tests to **further evaluate the condition were ordered during the pre-MH inpatient evaluation to be conducted during inpatient stay, such as** EKG, imaging, ECHO, lab testing. • Select inpatient consultation if pre-MH inpatient evaluation included a recommendation for consultation during mental health inpatient stay to address/evaluate a physical health condition/diagnosis while member was inpatient, e.g., "cardiology to follow on floor for stroke/CVA history". • Nutrition/Exercise counseling, Select if special diet is ordered (i.e., low

		sodium, diabetic diet), if counseling is provided on nutrition during pre-MH inpatient evaluation, or if nutrition counseling is ordered for follow-up during inpatient stay. • Select None, if none of the above options are documented as follow-up to Stroke/CVA diagnosis. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1f. Hypertension (HTN) diagnosis documented pre-MH inpatient and follow-up	Select all that apply: **PMHX/diagnosis: Hypertension** documented pre-MH inpatient**:** ▪ Yes/No Hypertension Pre-MH inpatient Follow –up: ▪ Medication initiation ▪ Medication discontinuation ▪ Medication titration • Ordered Inpatient testing • Ordered Inpatient consultation • Nutrition/Exercise counseling • None	• **Select NO if a hypertension (HTN) diagnosis or past medical history (PMHX) is not documented during medical evaluation** pre-MH inpatient**; NOTE: If NO is selected, follow up will "gray-out" and will not be available for review.** • Select YES, if HTN past medical history (PMHX) or diagnosis is documented in the medical record during the member's pre-MH inpatient evaluation record (includes any site prior to inpatient, i.e., medical unit, ED, etc.). Select all that apply for HTN follow-up: • Select medication initiation if new medication prescribed during the pre-MH inpatient evaluation process for the physical condition (exclude one-time orders, for example, epinephrine). • Select medication discontinuation if it is documented that a medication member had been taking was discontinued during the pre-MH inpatient evaluation. • Select medication titration if medication that the patient was taking pre-MH inpatient for one of the physical conditions was adjusted per dosage, route, and/or frequency. • Select inpatient testing if additional diagnostic tests to further evaluate the condition **were ordered during pre-MH inpatient evaluation to be conducted during inpatient stay,** such as EKG, imaging, ECHO, lab testing. • Select inpatient consultation if during pre-MH inpatient evaluation, a consultant was **requested to address/evaluate a physical health condition/diagnosis while member was inpatient,** e.g., "cardiology to follow on floor for HTN history". • Nutrition/Exercise counseling, Select if special diet is ordered (i.e., low sodium, diabetic diet), if counseling is provided on nutrition during pre-MH inpatient evaluation, or if nutrition counseling is ordered for follow-up during inpatient stay. • Select None, if none of the above options are documented as follow-up to HTN diagnosis. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**

1g. Other Cardiovascular disease diagnosis documented pre-MH inpatient and follow-up	Select all that apply: **<u>Other CVD PMHX/diagnosis</u>** documented pre-MH inpatient**:** ▪ <u>Yes/No</u> ▪ <u>If yes, enter other _____</u> Other CVD Pre-MH inpatient Follow –up: ▪ Medication initiation ▪ Medication discontinuation ▪ Medication titration • Ordered Inpatient testing • Ordered Inpatient consultation • Nutrition/Exercise counseling • None	• **<u>Select NO if no Other CVD diagnosis or past medical history (PMHX) is documented in the pre-MH inpatient evaluation record; NOTE: If no is selected, follow up will "gray-out" and will not be available for review.</u>** • Select Yes, if a CVD other than as described above is documented in past medical history (PMHX) or diagnosis is documented in the medical record during the member's pre-MH inpatient evaluation record (includes any site prior to inpatient, i.e., medical unit, ED, etc.). If yes is selected, enter the name of the other CVD diagnosis. Select all that apply for Other CVD follow-up: • Select medication initiation if new medication prescribed during the pre-MH inpatient evaluation process for the physical condition (exclude one-time orders, for example, epinephrine). • Select medication discontinuation if it is documented that a medication member had been taking was discontinued during pre-MH inpatient evaluation. • Select medication titration if medication that the patient was taking on pre-MH inpatient for one of the physical conditions was adjusted per dosage, route, and/or frequency during the during pre-MH inpatient evaluation. • Select inpatient testing if additional diagnostic tests to further evaluate the condition were **<u>ordered during the during pre-MH inpatient evaluation to be conducted during inpatient stay, such as</u>** EKG, imaging, ECHO, lab testing. • Select inpatient consultation if during pre-MH inpatient evaluation, **<u>a consultant was requested to address/evaluate a physical health condition/diagnosis while member was inpatient,</u>** e.g., "cardiology to follow on floor for CVD history". • Nutrition/Exercise counseling, Select if special diet is ordered (i.e., low sodium, diabetic diet), if counseling is provided on nutrition during the during pre-MH inpatient evaluation, or if nutrition counseling is ordered for follow-up during inpatient stay. • Select None, if none of the above options are documented as follow-up to CVD diagnosis. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1h. Diabetes diagnosis documented pre-MH inpatient and follow-up	Select all that apply: **<u>PMHX/diagnosis: Diabetes</u>** documented pre-MH inpatient**:** ▪ <u>Yes/No</u>	• **<u>Select NO if diabetes diagnosis or past medical history (PMHX) is not documented in the pre-MH inpatient evaluation record; NOTE: If no is selected, follow up will "gray-out" and will not be available for review.</u>** • Select Yes, if diabetes past medical history (PMHX) or diagnosis is documented in the medical record during the member's pre-MH inpatient

	Diabetes Pre-MH inpatient Follow –up: ▪ Medication initiation ▪ Medication discontinuation ▪ Medication titration • Ordered Inpatient testing • Ordered Inpatient consultation • Nutrition/Exercise counseling • None	evaluation record (includes any site prior to inpatient, i.e., medical unit, ED, etc.). Select all that apply for diabetes follow-up: • Select medication initiation if new medication prescribed during the pre-MH inpatient evaluation process for the physical condition (exclude one-time orders, for example, epinephrine). • Select medication discontinuation if it is documented that a medication member had been taking was discontinued during the pre-MH inpatient evaluation. • Select medication titration if medication that the patient was taking pre-MH inpatient for one of the physical conditions was adjusted during the pre-MH inpatient evaluation per dosage, route, and/or frequency. • Select inpatient testing if additional diagnostic tests to further evaluate the condition were ordered during the pre-MH inpatient evaluation **to be conducted during inpatient stay,** such as EKG, imaging, ECHO, lab testing for fasting blood glucose, etc. • Select inpatient consultation if during pre-MH inpatient evaluation, a consultant was **requested to address/evaluate a physical health condition/diagnosis while member was inpatient**, e.g., "endocrinology to follow on floor for diabetes". • Nutrition/Exercise counseling, Select if special diet is ordered (i.e., low sodium, diabetic diet), if counseling is provided on nutrition during the pre-MH inpatient evaluation, or if nutrition counseling is ordered for follow-up during inpatient stay. • Select None, if none of the above options are documented as follow-up to diabetes diagnosis. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1i. Pre-Diabetes diagnosis documented pre-MH inpatient and follow-up	Select all that apply: **PMHX/diagnosis: Pre-diabetes** documented pre-MH inpatient**:** ▪ Yes/No Pre-diabetes Pre-MH inpatient Follow –up: ▪ Medication initiation ▪ Medication discontinuation ▪ Medication titration • Ordered Inpatient testing • Ordered Inpatient consultation	• **Select NO if Pre-diabetes diagnosis or past medical history (PMHX) is not documented in the pre-MH inpatient evaluation record; NOTE: If no is selected, follow up will "gray-out" and will not be available for review.** • Select Yes, if Pre-diabetes past medical history (PMHX) or diagnosis is documented in the medical record during the member's pre-MH inpatient evaluation record (includes any site prior to inpatient, i.e., medical unit, ED, etc.). Select all that apply for pre-diabetes follow-up: • Select medication initiation if new medication prescribed during the pre-

	• Nutrition/Exercise counseling • None	MH inpatient evaluation process for the physical condition (exclude one-time orders, for example, epinephrine). • Select medication discontinuation if it is documented that a medication member had been taking was discontinued during the pre-MH inpatient evaluation. • Select medication titration if medication that the patient was taking on pre-MH inpatient for the physical condition was adjusted per dosage, route, and/or frequency during the pre-MH inpatient evaluation. • Select inpatient testing if additional diagnostic tests to further evaluate the condition **were ordered during the pre-MH inpatient evaluation to be conducted during inpatient stay,** such as EKG, imaging, ECHO, lab testing for fasting blood glucose, etc. • Select inpatient consultation if during pre-MH inpatient evaluation, a consultant **was requested to address/evaluate a physical health condition/diagnosis while member was inpatient**, e.g., "endocrinology to follow on floor for pre-diabetes". • Nutrition/Exercise counseling, Select if special diet is ordered (i.e., low sodium, diabetic diet), if counseling is provided on nutrition during the pre-MH inpatient evaluation, or if nutrition counseling is ordered for follow-up during inpatient stay. • Select None, if none of the above options are documented as follow-up to pre-diabetes diagnosis. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1j. Obesity diagnosis documented pre-MH inpatient and follow-up	Select all that apply: **PMHX/diagnosis: Obesity** documented pre-MH**:** ▪ Yes/No Obesity Pre-MH inpatient Follow –up: ▪ Medication initiation ▪ Medication discontinuation ▪ Medication titration • Ordered Inpatient testing • Ordered Inpatient consultation • Nutrition/Exercise counseling • None	• **Select No if obesity diagnosis or past medical history (PMHX) is not documented in the pre-MH inpatient evaluation record; NOTE: If no is selected, follow up will "gray-out" and will not be available for review.** • Select Yes, if obesity past medical history (PMHX) or diagnosis is documented in the medical record during the member's pre-MH inpatient evaluation record (includes any site prior to inpatient, i.e., medical unit, ED, etc.). Select all that apply for obesity follow-up: • Select medication initiation if new medication prescribed during the pre-MH inpatient evaluation process for the physical condition (exclude one-time orders, for example, epinephrine). • Select medication discontinuation if it is documented that a medication member had been taking was discontinued during the pre-MH inpatient evaluation. • Select medication titration if medication that the patient was taking pre-

		MH inpatient for the physical condition was adjusted per dosage, route, and/or frequency during the pre-MH inpatient evaluation. • Select inpatient testing if additional diagnostic tests to further evaluate the condition were **ordered during the pre-MH inpatient evaluation to be conducted during inpatient stay, such** as EKG, imaging, ECHO, lab testing for fasting blood glucose, etc. • Select inpatient consultation if during pre-MH inpatient evaluation, a **consultant was requested to address/evaluate a physical health condition/diagnosis while member was inpatien**t, e.g., "endocrinology to follow on floor for pre-diabetes". • Nutrition/Exercise counseling, Select if special diet is ordered (i.e., low sodium, diabetic diet, low calorie), if counseling is provided on nutrition during pre-MH inpatient evaluation, or if nutrition counseling is ordered for follow-up during inpatient stay. • Select None, if none of the above options are documented as follow-up to obesity diagnosis. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1k. Other metabolic diagnosis/condition documented pre-MH inpatient	Select all that apply: **PMHX/diagnosis: Other metabolic** documented prior pre-MH inpatient**:** ▪ Yes/No ▪ If yes, enter other _____ Other metabolic Pre-MH inpatient Follow –up: ▪ Medication initiation ▪ Medication discontinuation ▪ Medication titration • Ordered Inpatient testing • Ordered Inpatient consultation • Nutrition/Exercise counseling • None	**Examples of other cardiometabolic conditions include Cardiac dysrhythmia, prolonged QTC interval, dyslipidemia/hyperlipidemia, etc. If you are not sure, ask us to review the chart.** • **Select NO if no other metabolic diagnosis or past medical history (PMHX) is documented in the pre-MH inpatient evaluation record; NOTE: If no is selected, follow up will "gray-out" and will not be available for review.** • Select Yes, if a metabolic past medical history (PMHX) or diagnosis is documented in the medical record during the member's pre-MH inpatient evaluation record (includes any site prior to inpatient, i.e., medical unit, ED, etc.). **Cardiometabolic risk refers to your chances of having diabetes, heart disease or stroke. If yes, enter** the name of the metabolic diagnosis. Select all that apply for other metabolic follow-up: • Select medication initiation if new medication prescribed during the pre-MH inpatient evaluation process for the physical condition (exclude one-time orders, for example, epinephrine). • Select medication discontinuation if it is documented that a medication member had been taking was discontinued during the pre-MH inpatient evaluation. • Select medication titration if medication that the patient was taking on pre-MH inpatient for one of the physical conditions was adjusted per dosage, route, and/or frequency during the pre-MH inpatient evaluation.

		• Select inpatient testing if additional diagnostic tests to further evaluate the condition were ordered **during the pre-MH inpatient evaluation to be conducted during inpatient stay,** such as EKG, imaging, ECHO, lab testing for fasting blood glucose, etc. • Select inpatient consultation if during the pre-MH inpatient evaluation, a consultant was requested to address/evaluate the physical health condition/diagnosis while member was inpatient, e.g., "endocrinology to follow on floor for metabolic diagnosis". • Nutrition/Exercise counseling, Select if special diet is ordered (i.e., low sodium, diabetic diet, low calorie), if counseling is provided on nutrition during the pre-MH inpatient evaluation, or if nutrition counseling is ordered for follow-up during inpatient stay. • Select None, if none of the above options are documented as follow-up to metabolic diagnosis. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
2a. Documented behavioral risk documented pre-MH inpatient	Behavioral risks documented pre-MH inpatient – select all that apply: • Tobacco Use/Smoking • Marijuana Use/Smoking • Synthetic cannabinoid • Cocaine • Methamphetamine • Prescription Opiates Abuse/Dependence • IV drug use • Alcohol abuse/dependence • General Substance Abuse Statement (Specify:_____) • None	Select all behavioral risks that are documented in the pre-MH inpatient evaluation medical record. Tobacco includes chewing as well as smoking; Synthetic cannabinoid (includes K2, Spice etc.) Select "General Substance Abuse Statement" if the provider documents a blanket statement about substance abuse (i.e., "patient has a history of substance abuse") and/or references a substance no listed in the other check boxes (i.e., "Molly", etc.). Select NONE if none documented in the pre-MH inpatient evaluation medical record. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.** **NOTE: if none selected, follow-up will not be available for review.**
2b. Follow-up of identified behavioral risk documented pre-MH inpatient	For each identified risk, select all that apply **Tobacco: Check box for FU** • Counseling • Pharmaceuticals • Quitline • Community referral • None • Other: _____	**NOTE: Only those risks selected above will be available for follow-up review**. For each identified risk, select all follow up actions that apply conducted/recommended during pre-MH inpatient evaluation: • Tobacco: counseling, pharmaceuticals (Tobacco pharmaceuticals-nicotine replacement, Chantix, Wellbutrin), Quitline, community referral, none, other • Drug use (Drug use includes cocaine, methamphetamine, cannabinoid, opiates, IV drugs): behavioral health provider referral, treatment center referral, pharmaceuticals (include methadone, buprenorphine), community

	Drug use: Check box FU • Counseling • Behavioral health provider • Referral • Treatment center referral • Pharmaceuticals • Community referral/support • None • Other: _____ **Alcohol abuse/dependence: Check box FU** • Counseling • Behavioral health provider • referral • treatment center referral • community referral/support • None • Other: _____	support, none, other. • Alcohol abuse/dependence: behavioral health provider, treatment center, community support, none, other. • Select None if none of the options are documented in the pre-MH inpatient evaluation medical record. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.** • Select Other, if there is documented follow-up that differs from the options provided and enter the name of the documented follow up.

3a. Documented abnormal exam findings documented pre-MH inpatient	Select all documented pre-MH inpatient exam findings:
	
	Elevated blood pressure
	• Check box for Yes/ leave blank for No
	• If yes: select level
	• ≥150/90
	• ≥140/90
	• ≥180/120
	
	Elevated BMI documented
	• Check box = Yes. If yes, select category:
	  ○ Overweight(≥ 25-29.9)
	  ○ Obese (≥30)
	
	• **Abnormal lung sounds:** Check box = Yes.
	• **Abnormal cardiac exam:** Check box = Yes.
	• **None of above: check box**
	• **NA: check box**
		Select all exam findings from the below list that are documented in the medical record during pre-MH inpatient evaluation: ***Check box if yes, leave unchecked if "no".***
		
		Elevated blood pressure ≥150/90, ≥140/90, or ≥ 180/120) Select highest sustained blood pressure reading category in the medical record for pre-MH inpatient evaluation. Sustained blood pressure means that reading stayed in selected range when repeated, **not the average of all BP's recorded in the medical record.**
		
		BMI documented (primary) or calculated (secondary) overweight or obese (25-29, ≥30) If there is a BMI documented, select appropriate category 25-29, ≥30. If there is no documented BMI, select the calculated BMI category 25-29, ≥30
		
		Abnormal lung sounds (rales, rhonchi, wheeze)
		
		Abnormal cardiac exam (murmur, gallop, irregular rhythm)
		
		Select None, if no abnormal exam findings documented on pre-MH inpatient evaluation. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**

		Select NA, if a physical exam was not documented in pre-MH inpatient evaluation. **<u>NOTE: if None or NA selected, follow up will not be available for review</u>**.
3b. Follow-up of abnormal exam findings pre-MH inpatient	For each finding, check which had follow-up • Elevated B/P • Elevated BMI • Lungs • Cardiac Select all admit follow-up that apply: • Counseling • Inpatient consultation recommended • Inpatient testing recommended • pharmaceutical therapy initiation • pharmaceutical titration • None	**NOTE: Only selected documented findings will be available for review.** For each documented finding above, select all corresponding actions: • Counseling could include diet (BP and BMI), exercise (BMI), weight management (BMI) • Select inpatient testing if additional diagnostic tests to further evaluate the condition were recommended for the inpatient stay, such as EKG, imaging, ECHO, lab testing • Select inpatient consultation recommended if consultant evaluation for the condition were made by pre-MH inpatient staff to be conducted while member was inpatient. • Select pharmaceutical therapy/medication initiation if new medication prescribed during pre-MH inpatient for one of the findings • Select pharmaceutical/medication titration if medication that the patient was taking prior to pre-MH inpatient for one of the physical conditions was adjusted per dosage, route, frequency during the pre-MH inpatient evaluation. • Select None **<u>If no follow-up is documented.</u> Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.** **<u>NOTE: if a general statement was made for follow-up, and it is not clear which abnormality is being followed, i.e., "to follow-up with cardiology" when one or more abnormality is documented, assign that follow-up (i.e., testing or whichever follow-up is documented) to all the abnormalities. For example, if B/P and BMI are documented as elevated and there is a general statement "request cardiology consult" assign the cardiology consult as follow up to the elevated B/P and BMI.</u>**
4a. Documented abnormal lab test results documented on pre-MH inpatient evaluation	Select all abnormal lab tests: **<u>Diabetes screening/testing</u>** Check box for Yes; otherwise No • FBS >100 • FBS >=126 mg/dL • HbA1c >= 6.0	***Check box if yes, leave unchecked if "no".*** Select all abnormal lab tests from the below list that are documented in the medical record during the pre-MH inpatient evaluation: • Diabetes screening (FBS >100; HbA1c >= 6.0, HbA1c>=6.5, HbA1c>8) • Lipid screening (LDL > or = 100) • Abnormal EKG • Select None if there are no abnormal lab results in pre-MH inpatient

	• HbA1c>=6.5 • HB A1c < 7 • HB A1c > 7 • HbA1c < 8 • HbA1c> 8 **2 Hour GTT:** • 2-h PG>=200 mg/dL (11.1mmol/L) during an OGTT • 2-h PG 140-199 **Lipid screening (LDL > or = 100)** Yes check box/otherwise No **Abnormal EKG** • Yes check box/otherwise No **None of above: check box** **NA: check box**	record. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.** • Select NA if no labs were ordered during pre-MH inpatient. **NOTE: if none or NA selected, follow up will not be available for review**
4b. Follow-up of abnormal lab findings during pre-MH inpatient evaluation	For each finding check which had follow-up during pre-MH inpatient evaluation: • Diabetes • Elevated Lipids • EKG Select all that apply • Counseling • Inpatient consultation recommended • Inpatient testing recommended • pharmaceutical therapy initiation • pharmaceutical titration • None	**NOTE: Only selected documented findings will be available for review** • For each documented finding above, select all corresponding actions: Counseling could include diet (BP and BMI), exercise (BMI), weight management (BMI) • Select inpatient testing recommended during pre-MH inpatient evaluation if additional diagnostic tests to further evaluate the condition were recommended for the inpatient stay, such as EKG, imaging, ECHO, lab testing. • Select inpatient consultation recommended if consultant evaluation for the condition were made by pre-MH inpatient staff to be conducted while member was inpatient. • Select pharmaceutical therapy/medication initiation if new medication prescribed during pre-MH inpatient evaluation for one of the findings. • Select pharmaceutical/medication titration if medication that the patient was taking prior to pre-MH inpatient evaluation for one of the physical conditions was adjusted per dosage, route, frequency during pre-MH inpatient evaluation. • **Select None if no follow-up is documented, select "none". Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**

		NOTE: if a general statement was made for follow-up, and it is not clear which abnormality is being followed, i.e., "to follow-up with cardiology" when one or more abnormality is documented, assign that follow-up (i.e., testing or whichever follow-up is documented) to all the abnormalities. For example, if EKG is documented as abnormal and there is a general statement "request cardiology consult" assign the cardiology consult as follow up to the EKG results.
5. Cardiometabolic risk-medications during pre-MH inpatient evaluation	Select all that apply: • Antipsychotic medications • Antihypertensive • Cardiac • Diabetes • Nicotine replacement therapy • Other smoking cessation medication • None	Select all that apply for each medication--medications taking pre-MH inpatient evaluation or prescribed during pre-MH inpatient evaluation: • Antipsychotic medications • Antihypertensive • Cardiac • Diabetes • Nicotine replacement therapy • Other smoking cessation medication • None **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
6. Recommendations during pre-MH inpatient evaluation	Select all pre-MH inpatient evaluation follow-up recommendations • Repeat lab evaluation • Repeat EKG • Check pending lab results • Inpatient consultation • Specialty care follow-up • Primary care follow-up • Medication initiation • Medication titration • None • Other Follow-up:_____	Select all documented follow-up recommendations from pre-MH inpatient medical evaluation or inpatient medical consultation conducted prior to MH inpatient stay (i.e., performed on medical unit if member transferred to MH inpatient from PH inpatient unit). If the ED evaluation/inpatient medical evaluation (in evaluation setting pre-MH inpatient) documents that follow up actions are recommended be completed during the mental health inpatient stay, Select all follow-up recommendations documented. Select None if no recommendations for care to be completed during MH inpatient stay are documented in pre-MH inpatient evaluation medical record. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
D. General Medical/Physical Health (PH) evaluation components during MH inpatient stay	Dates of inpatient stay calculated between Admission and Discharge Dates	Nurse reviewer will use the dates of "**inpatient documentation**" (the dates of documentation between admission and discharge dates) to abstract the following items in this section.
1a. Physical health (PH) evaluation during inpatient stay	Evaluation of PH status during inpatient stay: • Yes • No	Assume all documentation valid if included in medical record for review period. **Select Yes if an evaluation of physical health (PH) status by history,**

	• Review of pre-MH inpatient evaluation only	**physical exam and/or laboratory testing as per medical record documentation during MH inpatient stay/on inpatient unit were conducted and documented during the MH inpatient stay, <u>by any clinical provider type, including registered dietician, nurse practitioner, and behavioral health clinicians</u>.** Select "review of pre-MH inpatient evaluation only: if no components of a physical health evaluation **<u>were conducted during the MH inpatient stay</u>**, but there is **<u>documentation of review</u>** of the pre-MH evaluation, such as review of "medical clearance", medical screening, medical assessment, documentation in inpatient transfer note or physical health evaluation on inpatient unit provided by inpatient staff or consultant. Documentation could include type of evaluation reviewed (e.g. "medical clearance" medical screening, medical assessment). Otherwise, select No, if **<u>no PH evaluation conducted</u>** and no review of pre-MH inpatient evaluation documented during inpatient stay/on inpatient unit. **<u>NOTE: if "no" or "review of pre-inpatient evaluation only" selected, items 1b-1e will gray-out and will not be available for review</u>**. T**<u>he same should be selected for same question in next Section E</u>**
1b. Medical history assessed during inpatient stay	Medical history documented during inpatient stay - select all that apply: • Past medical history • Medications • Allergies • Review of systems • Behavioral health risk assessment • Review of pre-MH inpatient medical history • None	Select all component of history taking documented in records during inpatient stay: **<u>NOTE: Do not include information from discharge summary/plan even if conducted on inpatient unit, which will be evaluated separately.</u>** • Past medical history-e.g. past hospitalizations, illnesses conditions, OB history • Medications taken prior to admission • Allergies • Review of systems • Behavioral health risk assessment-e.g. tobacco, substance use • Select "**review of pre-MH inpatient medical history**" if medical history evaluation **<u>was not conducted during the inpatient stay, but there is documentation that the pre-admission history was reviewed, e.g., might be documented as "refer to PHx from admission".</u>** • Select none, if no medical history is documented in the record, excluding discharge documentation, or pre-MH admission history that is not documented as reviewed during inpatient stay. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1c. Physical exam during inpatient stay/site	Physical Exam during MH inpatient stay (**not @ d/c**): Yes/No	Select all component of exam conducted on MH inpatient unit documented in records from inpatient unit/site (i.e., prior to discharge documentation; will be evaluated separately, from inpatient MH). Include any physical exam

	If yes, Components of physical exam - select all that apply: • General observation • HEENT • Cardiac exam • Pulmonary exam • Extremities • Pulse • Respiration • Blood pressure • Body Mass Index (BMI) • Yes/no If yes enter_____ • Height Yes/no If yes enter_____ Weight Yes/no If yes enter_____ • None	documentation by a consulting provider during the MH inpatient stay. **Do not include physical exam conducted pre-MH**, even if documented as "reviewed" during inpatient stay. Select Yes, if BMI is documented during inpatient stay, and enter BMI value as documented from inpatient chart. Note, if there is more than one BMI value is documented in the inpatient note, select the most recent height documented in the medical record. (**if BMI not selected, the BMI value entry box will remain grayed out**). Select yes, if height is documented during inpatient stay, and enter height as documented in chart in inches from same date/source as weight. Note, if there is more than one height documented in the inpatient note, select the most recent height documented in the medical record. (**if height not selected, the height entry box will remain grayed out**). Select yes, if weight is documented during inpatient stay, and enter weight as documented in chart in pounds from same date/source as height. Note, if there is more than one weight documented in the inpatient note, select the most recent weight documented in the medical record. (**if weight not selected, the weight entry box will remain grayed out**). Select none, if no physical exam components are documented prior to discharge summary or conducted during MH inpatient stay. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1d. BMI calculation	BMI will be calculated from height and weight and auto-populated	BMI will be calculated from height and weight and auto-populated for analysis.
1e. Laboratory testing during MH inpatient	Select all documented lab testing during MH inpatient stay • EKG • Cardiac Enzymes • Hemoglobin A1c • Fasting glucose • Fasting lipid profile • GTT • Comprehensive metabolic screening • Other cardiometabolic labs: enter_____ • None	Select all lab testing documented in records during MH inpatient stay (refer to dates for this section. • EKG • Cardiac Enzymes (measures blood levels of the **enzyme** creatine phosphokinase (CPK), also called creatine kinase (CK), and a more specific form of this **enzyme** called CK-MB). • Hemoglobin A1c • Fasting glucose • Fasting lipid profile • GTT (Glucose Tolerance Test) • Comprehensive metabolic screening (measures your sugar (glucose) level, electrolyte and fluid balance, kidney function, and liver function). Can be documented as SMA16. • Other cardiometabolic testing. If selected, text enter the name of other

		cardiometabolic labs documented MH inpatient unit stay. • None - select if none of the lab options are documented as ordered or completed pre-MH inpatient unit stay. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
E. Selected diagnoses, findings and risks identified during MH inpatient stay		
Physical health evaluation during inpatient stay?	• Yes • No • Review of pre-inpatient evaluation only	**Note: This section will gray-out and not be available for review if as for item D1a above "no" or "review of pre-inpatient evaluation only" Is selected.**
1a. Any Acute Symptoms / Diagnoses during inpatient stay	Check all that apply: **<u>Acute symptoms/diagnosis during inpatient:</u>** • Myocardial Infarction • Angina • Stroke • HTN • Other • Text Enter Other: _____ • None	As above, during MH inpatient stay-member acutely symptomatic or displaying acute signs or diagnoses. Select None, if the MH inpatient documentation does not include any documentation of acute diagnoses/symptoms active during the MH inpatient stay. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1b. CVD diagnoses during inpatient stay	**<u>PMHX/diagnosis: CVD during MH Inpatient</u>** • <u>Yes/No</u> CVD Inpatient Follow –up: • MH Inpatient testing • MH Inpatient consultation • Medication initiation • Medication discontinuation • Medication titration • Nutrition/Exercise counseling • None	As above, select CVD diagnosis documented during inpatient stay and documented **<u>follow up action conducted during inpatient stay</u>**. This can include a reference to diagnoses documented during the pre-MH inpatient evaluation, e.g., "see ED note re: PMHX, CVD". **<u>NOTE: If the diagnosis is a reference to an ED note or pre-MH evaluation, do not include follow-up from ED, or pre-MH inpatient, i.e., if there was no follow-up documented during inpatient stay for diagnosis, select "none."</u>** **Note: If None is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1c. Stroke/CVA diagnosis inpatient stay and follow-up	Select all that apply: **<u>PMHX/diagnosis: Stroke/CVA during MH Inpatient</u>** • <u>Yes/No</u> Stroke/CVA Inpatient Follow –up:	As above, select CVA diagnosis documented during inpatient stay and documented follow up action conducted during inpatient stay. Stroke can be documented as cerebrovascular accident, CVA, brain attack. **Note: If None is selected, all of the remaining responses in this question**

	• MH Inpatient testing • MH Inpatient consultation • Medication initiation • Medication discontinuation • Medication titration • Nutrition/Exercise counseling • None	**will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1d. Hypertension (HTN) diagnosis during inpatient stay and follow-up	Select all that apply: **PMHX/diagnosis: Hypertension during MH Inpatient** • Yes/No Hypertension Inpatient Follow –up: • MH Inpatient testing • MH Inpatient consultation • Medication initiation • Medication discontinuation • Medication titration • Nutrition/Exercise counseling • None	As above, select HTN diagnosis documented during inpatient stay and documented follow up action conducted during inpatient stay. **Note: If None is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1e. Diabetes diagnosis during inpatient stay and follow-up	Select all that apply: **PMHX/diagnosis: Diabetes during MH Inpatient** • Yes/No Diabetes Inpatient Follow –up: • MH Inpatient testing • MH Inpatient consultation • Medication initiation • Medication discontinuation • Medication titration • Nutrition/Exercise counseling • None	As above, select diabetes diagnosis documented during inpatient stay and documented follow up action conducted during inpatient stay. **Diabetes is meant to be captured as diagnoses here, not values.** **Note: If None is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1f. Pre-Diabetes diagnosis during inpatient stay and follow-up	Select all that apply: **PMHX/diagnosis: Pre-Diabetes during MH Inpatient** • Yes/No	As above, select pre-diabetes diagnosis documented during inpatient stay and documented follow up action conducted during inpatient stay. **Pre-diabetes is meant to be captured as diagnoses here, not values.**

	Pre-Diabetes Inpatient Follow –up: • MH Inpatient testing • MH Inpatient consultation • Medication initiation • Medication discontinuation • Medication titration • Nutrition/Exercise counseling • None	**Note: If None is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1g. Obesity diagnosis during inpatient stay and follow-up	Select all that apply: **PMHX/diagnosis: Obesity during MH Inpatient** • Yes/No Obesity Inpatient Follow –up: • MH Inpatient testing • MH Inpatient consultation • Medication initiation • Medication discontinuation • Medication titration • Nutrition/Exercise counseling • None	As above, select obesity diagnosis documented during inpatient stay and documented follow up action conducted during inpatient stay. **Obesity is meant to be captured as diagnoses here, not values or general observations within a physical exam.** **Note: If None is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1h. Other metabolic diagnosis/condition during inpatient stay	Select all that apply: **PMHX/diagnosis: Other metabolic during MH Inpatient** • Yes/No • If yes, enter other:_____ Other metabolic Inpatient Follow –up: • MH Inpatient testing • MH Inpatient consultation • Medication initiation • Medication discontinuation • Medication titration • Nutrition/Exercise counseling • None	**Examples of other cardiometabolic conditions include Cardiac dysrhythmia, prolonged QTC interval, dyslipidemia/hyperlipidemia, etc. If you are not sure, ask us to review the chart.** Select Yes if there is a documented metabolic disease that is not addressed in above diagnoses; Enter the documented diagnosis. As above, during inpatient stay. **Note: If None is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
2a. Documented behavioral risk during	Select all behavioral risks: • Tobacco Use/Smoking	Select all behavioral risks that are documented in the inpatient medical record: • Tobacco includes chewing as well as smoking

MH inpatient stay	• Marijuana Use/Smoking • Synthetic cannabinoid • Cocaine • Methamphetamine • Prescription Opiates Abuse/Dependence • IV drug use • Alcohol abuse/dependence • General Substance Abuse Statement (Specify:_____) • None	• Synthetic cannabinoid (includes K2, Spice etc.) Select "General Substance Abuse Statement" if the provider documents a blanket statement about substance abuse (i.e., "patient has a history of substance abuse") and/or references a substance no listed in the other check boxes (i.e., "Molly", etc.). Select None, if no behavioral risks are documented in the inpatient stay record. **Note: If None is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.** **NOTE: if none selected, follow up will gray-out and will not be available for review.**
2b. Follow-up of identified behavioral risk during MH inpatient stay	For each identified risk, select all that apply **Tobacco: Check box for FU** • Counseling • Pharmaceuticals • None • Other: _____ **Drug use: Check box FU** • Counseling • behavioral health provider referral • pharmaceuticals • None • Other: _____ **Alcohol abuse/dependence: Check box FU** • Counseling • behavioral health provider referral • None • Other: _____	**NOTE: Only those risks selected above will be available for follow-up review**. For each identified risk, select all that apply/are documented in MH inpatient medical record (includes a reference to "reviewing pre-MH evaluation documentation". Select "other' if there is a reference to "follow up at discharge planning" with for example, community support or treatment center referral recommendation for discharge.): • Tobacco: counseling, pharmaceuticals (Tobacco pharmaceuticals-nicotine replacement, Chantix, Wellbutrin). Select "other' if there is a reference to "follow up at discharge planning" with for example, community support or Quitline referral recommendation for discharge.) • Drug use: Drug use includes cocaine, methamphetamine, cannabinoid, opiates, IV drugs. Select behavioral health provider referral or pharmaceuticals (include methadone, buprenorphine). Select "other' if there is a reference to "follow up at discharge planning" with for example, community support recommendation or treatment center referral at discharge. • Alcohol abuse/dependence: Select behavioral health provider, or Select other if a treatment center or community support referral is recommended for discharge planning. • Select None, if none of the options are documented in the MH inpatient record, none are referenced as reviewed from the pre-MH inpatient evaluation medical record, and no recommendations for referrals to include in discharge planning are documented. **Note: If None is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**

		• Select Other, if there is documented follow-up that differs from the options provided and enter the name of the documented follow up; include recommendations to be included in discharge plan, but not implemented during inpatient stay.
3a. Documented abnormal exam findings during MH inpatient stay	Select all inpatient exam findings: **Elevated blood pressure** • Check for Yes/ Otherwise No ○ If yes: select level • ≥150/90 • ≥140/90 • ≥180/120 **Elevated BMI documented** Check for Yes/Otherwise No. If yes, select category: • Overweight(≥ 25-29.9) • Obese (≥30) **Abnormal lung sounds: check box yes** **Abnormal cardiac exam: check box yes** **None of above: check box yes** **NA: check box yes**	***Check box if yes, leave unchecked if "no".*** • Select all exam findings from the below list that are documented in the medical record during MH inpatient stay: • Elevated blood pressure ≥150/90, ≥140/90, or ≥ 180/120) Select highest sustained blood pressure reading category in the medical record for the MH inpatient stay (refer to pre-populated dates of inpatient documentation). Sustained blood pressure means that reading stayed in selected range when repeated. • BMI documented (primary) or calculated (secondary) overweight or obese (25-29, ≥30) If there is a BMI documented, select appropriate category 25-29, ≥30. If there is no documented BMI, select the calculated BMI category 25-29, ≥30. • Abnormal lung sounds (rales, rhonchi, wheeze) • Abnormal cardiac exam (murmur, gallop, irregular rhythm) • Select none, if no abnormal exam findings are documented in MH inpatient documentation, and there is no reference to reviewing pre-MH inpatient evaluation results. **Note: If None is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.** • Select NA, if a physical exam was not documented prior to or during MH inpatient stay. **NOTE: if none or NA selected, follow up will not be available for review**.
3b. Follow-up of abnormal exam findings during MH inpatient stay	For each finding, check which had follow-up • Elevated B/P • Elevated BMI • Lungs • Cardiac Select all follow-up that apply: • Counseling • Inpatient consultation • Inpatient testing • Inpatient pharmaceutical therapy initiation • Inpatient pharmaceutical titration • None	**NOTE: Only selected documented findings will be available for review.** For each documented finding above, select all corresponding actions: • Counseling could include diet (BP and BMI), exercise (BMI), weight management (BMI). • Select inpatient testing if additional diagnostic tests to further evaluate the condition was **conducted during the inpatient stay**, such as EKG, imaging, ECHO, lab testing. • Select inpatient consultation if consultant evaluation for the condition **was conducted while member was inpatient.** • Select pharmaceutical therapy/medication initiation if new medication prescribed during inpatient stay for one of the findings.

		• Select pharmaceutical/medication titration if medication that the patient was taking pre-MH inpatient for one of the physical conditions was adjusted per dosage, route, frequency **during inpatient stay**. • **If no follow-up is documented, select "none".** Note: If None is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected. **NOTE: if a general statement was made for follow-up, and it is not clear which abnormality is being followed, e.g., "to follow-up with cardiology" when one or more abnormalities is documented, assign that follow-up (i.e., inpatient consult) to all the abnormalities. For example, if elevated B/P and cardiac are documented and there is a general statement "request cardiology consult" assign the cardiology consult as follow up to the elevated B/P and cardiac exam findings.**
4a. Documented abnormal lab test results conducted or reviewed during MH inpatient stay	Select all abnormal lab tests documented during inpatient stay: **Diabetes screening/testing** Yes/No. If yes, select highest inpatient range: • FBS >100 • FBS>=126 • HbA1c >= 6.0 • HbA1c>=6.5 • HbA1c <7 • HB A1c > 7 • HbA1c< 8 • HbA1c> 8 2 Hour OGTT: • 2-h PG>=200 mg/dL (11.1mmol/L) during an OGTT • FPG 100-125 ■ **Lipid screening (LDL > or = 100)** • Yes/No **Abnormal EKG** • Yes/No **None of above: check box**	Select highest inpatient abnormal lab tests results from the below list that are documented as conducted (check inpatient stay dates) or reported, and/or reviewed (if conducted outside the inpatient stay timeframe) in the medical record during inpatient stay: Select abnormal diabetes screening/testing: • FBS >100 • FBS >126; • HbA1c >= 6.0 • HbA1c>=6.5 • HbA1c <7 • HB A1c > 7 • HbA1c< 8 • HbA1c> 8 • 2-h PG>=200 mg/dL (11.1mmol/L) during an OGTT • FPG 100-125 Select abnormal lipid screening if LDL > or =100 **Abnormal EKG** • Select None if no abnormal lab or test results are documented as ordered, reported or reviewed (could be from pre-MH inpatient evaluation) during the MH inpatient stay. **Note: If None is selected, all of the remaining responses in this question will gray out. Make sure that none of the**

		other responses are selected when "none" is selected.
4b. Follow-up of abnormal lab findings during inpatient stay	For each finding check which had follow-up during inpatient: • Diabetes • Elevated Lipids • EKG Select all that apply • Counseling • Inpatient consultation • Inpatient testing • Inpatient pharmaceutical therapy initiation • Inpatient pharmaceutical titration • None	**NOTE: if none selected, follow up will not be available for review**. • Select counseling if provided during inpatient stay. • Select inpatient consultation if consultant evaluated condition while member was inpatient. • Select inpatient testing if additional diagnostic tests to further evaluate the condition were conducted inpatient, such as EKG, imaging, ECHO, lab testing, including repeat testing. • Select pharmaceutical/medication initiation if new medication prescribed either while inpatient for one of the physical conditions. • Select pharmaceutical/medication titration if medication that the patient was taking pre-MH inpatient for one of the physical conditions was adjusted per dosage, route, frequency **during the MH inpatient stay.** • **If no follow-up is documented, select "none". Note: If None is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.** **NOTE: if a general statement was made for follow-up, and it is not clear which abnormality is being followed, e.g., "to follow-up with cardiology" when one or more abnormalities is documented, assign that follow-up (i.e., inpatient consult) to all the abnormalities. For example, if abnormal EKG and lipid panel are documented and there is a general statement "request cardiology consult" assign the cardiology consult as follow up to the EKG and lipid findings.**
5. Cardiometabolic risk-medications ordered/given during MH inpatient stay	Select all that apply: • Antipsychotic medications • Antihypertensive • Cardiac • Diabetes • Nicotine replacement therapy • Other smoking cessation medication • None	Select all that apply for each medication--medications **prescribed during Inpatient stay:** • Antipsychotic medications • Antihypertensive • Cardiac • Diabetes • Nicotine replacement therapy • Other smoking cessation medication • None **Note: If None is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
6. Follow up of initial pre-MH inpatient medical evaluation/recommendations for inpatient care	MH inpatient recommendations/consult follow-up made for inpatient: • Yes/No	Were there pre-MH inpatient evaluation recommendations/consult follow-up made for inpatient: Yes/No

	Select all pre-MH inpatient recommendations/consult follow-up during inpatient: • Repeat lab evaluation Yes ■ No ■ UTD ■ NA ■ • Repeat EKG Yes ■ No ■ UTD ■ NA ■ • Check pending lab results Yes ■ No ■ UTD ■ NA ■ • Specialty care follow-up for discharge Yes ■ No ■ UTD ■ NA ■ • Primary care follow-up for discharge Yes ■ No ■ UTD ■ NA ■ • Medication initiation Yes ■ No ■ UTD ■ NA ■ • Medication titration Yes ■ No ■ UTD ■ NA ■	**Note: All of the items in this section require a response – don't leave any items blank.** **Select No**: if there were no documented follow-up recommendations to be conducted during the inpatient stay from the pre-MH inpatient medical evaluation. **NOTE: if NO is selected, none of the follow up items will be available for review. Please check for consistency of abstraction with the pre-MH evaluation section above**. If yes, select all documented follow-up recommendations to be conducted during the inpatient stay from the pre-MH inpatient medical evaluation or inpatient medical consultation conducted prior to MH inpatient stay (i.e., evaluations on physical health inpatient unit prior to MH inpatient transfer, e.g., If the ED/admit evaluation/inpatient consultation (in evaluation setting prior to MH inpatient stay, i.e., pre-MH inpatient) documents that follow up actions are recommended be completed during the inpatient stay, Select all ED/consult evaluation follow-up recommendations that were completed during the inpatient stay. Select Yes, if the recommendation was made and conducted during inpatient stay. Select No, if the recommendation was made **but was not conducted during inpatient stay.** Select UTD if it is unclear whether recommendation was made or followed up. Select UTD if follow-up action is unclear. For example, physician follow-up is documented, but unknown whether PCP or specialist. **Select NA if the item was not recommended on admit note for follow-up during inpatient stay.** Select repeat lab evaluation/EKG if recommended in pre-MH inpatient medical evaluation or medical consultation while MH inpatient. Select Check pending lab results for documentation of lab results that were pending on pre-MH inpatient. Select medication initiation if new medication prescribed/ recommended Select medication titration if recommended that medication the patient was taking on pre-MH inpatient should be adjusted per dosage, route, frequency, during inpatient stay.

F. General Medical/Physical Health (PH) evaluation components at discharge site/in discharge summary stay	Discharge date will be pre-populated	Nurse reviewer will use the pre-populated Discharge date as a guide to review items for **"discharge plan or summary documentation**" (documentation on the day of or related to the pre-populated discharge date).
1a. Physical health (PH) evaluation at discharge/ in discharge summary	Evaluation of PH status at discharge: • Yes • No	Assume all documentation valid if included in medical record for review period. Select Yes if an evaluation of physical health (PH) status by history, physical exam and/or laboratory testing as per discharge medical record documentation, could occur on inpatient unit prior to discharge, can include reference to any component of a physical health evaluation conducted during pre-MH inpatient evaluation or during the MH inpatient stay, e.g., "refer to ED H&P". Could include discharge transfer note or physical health evaluation on inpatient unit provided by inpatient staff or consultant for discharge summary. **NOTE: if "No" selected, items 1b-1e, will gray-out and will not be available for review. Will need to select as well as the next Section G, for gray outs there.**
1b. Medical history assessed at discharge site/in discharge summary	Components of medical history documented at discharge - select all that apply • Past medical history • Medications • Allergies • Review of systems • Behavioral health risk assessment • None	Select all components of history taking documented in records from discharge site, might include reference to reviewing components conducted prior to discharge: • Past medical history-e.g. past hospitalizations, illnesses ,conditions, OB history • Medication • Allergies • Review of systems • Behavioral health risk assessment-e.g. tobacco, substance use. • Select none, if no medical history is documented, or referenced if completed prior to discharge, in the discharge documentation/summary. **Note: If None is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1c. Physical exam at discharge site	Physical Exam at discharge: Yes/No/prior only If yes, Components of physical exam: Select all • General observation • HEENT • Cardiac exam	Select all components of exam documented in records from discharge evaluation site (i.e., during or immediately prior to discharge documentation which will be evaluated separately, from inpatient BH). **Note: If NO is selected, all of the remaining responses in this question will gray out.** Select prior only, If there is only a reference to a physical exam (or components) conducted during pre-MH inpatient evaluation, or during the inpatient stay.

	• Pulmonary exam • Extremities • Pulse • Respiration • Blood pressure • None	Select none, if no physical exam components are documented in the discharge summary, for example, if there is only a "general observation" statement of "physical exam completed" or "exam unremarkable", or if there is a statement of "see inpatient exam note". In these instances both "general observation" and "none" should be selected. **Note: If None is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1d. Laboratory testing at discharge/ in discharge summary	Select all documented lab testing ordered/recommended for outpatient or abnormalities noted in discharge summary: • EKG • Cardiac Enzymes • Hemoglobin A1c • Fasting glucose • Fasting lipid profile • GTT • Comprehensive metabolic screening • Other cardiometabolic: enter_____ • None	Select all lab testing documented in discharge summary record, include both documented abnormal labs that were conducted during the inpatient stay and are included/referenced in the discharge summary, as well as labs documented as recommended to be repeated for follow-up by the outpatient provider. • EKG • Cardiac Enzymes (measures blood levels of the **enzyme** creatine phosphokinase (CPK), also called creatine kinase (CK), and a more specific form of this **enzyme** called CK-MB). • Hemoglobin A1c • Fasting glucose • Fasting lipid profile • GTT (Glucose Tolerance Test) • Comprehensive metabolic screening (measures your sugar (glucose) level, electrolyte and fluid balance, kidney function, and liver function). Can be documented as SMA16. • Other cardiometabolic testing. If selected, text enter the name of other cardiometabolic labs documented pre-MH inpatient unit stay. • None - select if none of the lab options are documented as ordered in discharge instructions/summary. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
G. Selected diagnoses, findings and risks identified during discharge planning/at discharge/site/in discharge summary		**Note: This section will gray-out and not be available for review if item F1a above is "no".**
1a. Cardiovascular disease diagnosis at discharge site and follow-up	Select all that apply: **PMHX/diagnosis: CVD diagnosis at Discharge** • Yes/No **CVD Discharge Plan Follow –up:** • Medication initiation • Medication discontinuation • Medication titration	• Select Yes, if a CVD past medical history (PMHX) or diagnosis (CVD includes coronary artery disease CAD, Ischemic heart disease, Arteriosclerotic CVD, **history of myocardial infarction) as well as angina and other CVD diagnosis** in this section is documented in the medical record on discharge; Yes discharge, for diagnosis documented in discharge documentation. • **Note: If NO is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**

	• Medication reconciliation • CVD RX provided • Scheduled PCP follow-up post discharge • Scheduled specialist follow-up post discharge • Referral PCP • Referral specialist • Scheduled outpatient testing • Nutrition/Exercise counseling • None	Select all that apply for CVD discharge follow-up" • Select medication initiation if new medication prescribed at discharge for the physical conditions. • Select medication discontinuation if it is documented that a medication member had been taking will be discontinued post discharge. • Select medication titration if medication that the patient was taking on pre-MH inpatient evaluation for one of the physical conditions was adjusted per dosage, route, and/or frequency for discharge. • Select outpatient testing if additional diagnostic tests to further evaluate the condition were conducted for discharge or for follow up as outpatient, such as EKG, imaging, ECHO, lab testing. • Select outpatient consultation if consultant is ordered/recommended post discharge. • Select medication reconciliation if at discharge, the medications prior to pre-MH inpatient and discharge are reviewed for continuation/discontinuation at home/post-discharge. • Select referral to PCP or specialist if it is documented that member was referred without an appointment being scheduled for the member; select scheduled if it is documented that the appointment with PCP/specialist was scheduled for the member. **NOTE: Select PCP follow-up for any PCP follow-up of any diagnosis, i.e., even if the CVD diagnosis is not referenced/documented specifically OR, if PCP referral or PCP scheduled without a specific reason.** • Nutrition/Exercise counseling, Select if special diet is ordered (i.e., low sodium) for discharge. • Select none, if none of the options are documented in discharge summary. **NOTE: If none is selected, follow up will "gray out" and will not be available for review.**
1b. Stroke/CVA diagnosis at discharge site and follow-up	Select all that apply: **PMHX/diagnosis: Stroke/CVA at Discharge** • Yes/No **Stroke/CVA Discharge Plan Follow –up:** • Medication initiation • Medication discontinuation • Medication titration • Medication reconciliation • Stroke Rx provided • Scheduled PCP follow-up post	As above, at discharge. Stroke can be documented as cerebrovascular accident, CVA, brain attack **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**

	discharge • Scheduled specialist follow-up post discharge • Referral PCP • Referral specialist • Scheduled outpatient testing • Nutrition/Exercise counseling • None	
1c. Hypertension (HTN) diagnosis at discharge site and follow-up	Select all that apply: **PMHX/diagnosis: Hypertension at Discharge** • Yes/No **Hypertension Discharge Plan Follow –up:** • Medication initiation • Medication discontinuation • Medication titration • Medication reconciliation • HTN Rx provided • Scheduled PCP follow-up post discharge • Scheduled specialist follow-up post discharge • Referral PCP • Referral specialist • Scheduled outpatient testing • Nutrition/Exercise counseling • None	As above, at discharge. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1d. Diabetes diagnosis at discharge site and follow-up	Select all that apply: **PMHX/diagnosis: Diabetes at Discharge** • Yes/No **Diabetes Discharge Plan Follow –up:** • Medication initiation • Medication discontinuation • Medication titration • Medication reconciliation	As above, at discharge. **Diabetes meant to be captured as diagnoses here, not values** **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**

	• Diabetes Rx provided • Scheduled PCP follow-up post discharge • Scheduled specialist follow-up post discharge • Referral PCP • Referral specialist • Scheduled outpatient testing • Nutrition/Exercise counseling • None	
1e. Pre-diabetes diagnosis at discharge site and follow-up	Select all that apply: **PMHX/diagnosis: Pre-diabetes at Discharge** • Yes/No **Pre-Diabetes Discharge Plan Follow –up:** • Medication initiation • Medication discontinuation • Medication titration • Medication reconciliation • Diabetes Rx provided • Scheduled PCP follow-up post discharge • Scheduled specialist follow-up post discharge • Referral PCP • Referral specialist • Scheduled outpatient testing • Nutrition/Exercise counseling • None	As above, at discharge. **Pre-diabetes meant to be captured as diagnoses here, not values.** **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
1f. Obesity diagnosis at discharge site and follow-up	Select all that apply: **PMHX/diagnosis: Obesity at Discharge** • Yes/No **Obesity Discharge Plan Follow –up:** • Medication initiation • Medication discontinuation • Medication titration • Medication reconciliation	As above, at discharge. Obesity meant to be captured as diagnoses here, not values or as part of a general observation in a physical exam. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**

	• Obesity Rx provided • Scheduled PCP follow-up post discharge • Scheduled specialist follow-up post discharge • Referral PCP • Referral specialist • Scheduled outpatient testing • Nutrition/Exercise counseling • None	
1g. Other metabolic diagnosis / condition at discharge	Select all that apply: **PMHX/diagnosis: Other metabolic diagnosis at Discharge** • Yes/No • If yes, enter other: _____ **Other metabolic diagnosis Discharge Plan Follow–up:** • Medication initiation • Medication discontinuation • Medication titration • Medication reconciliation • Other diagnosis Rx provided • Scheduled PCP follow-up post discharge • Scheduled specialist follow-up post discharge • Referral PCP • Referral specialist • Scheduled outpatient testing • Nutrition/Exercise counseling • None	**Examples of other cardiometabolic conditions include Cardiac dysrhythmia, prolonged QTC interval, dyslipidemia/hyperlipidemia, etc. If you are not sure, ask us to review the chart.** As above, at discharge. Select Yes if there is a documented metabolic disease that is not addressed in above diagnoses; Enter the documented diagnosis. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
2a. Documented behavioral risk at discharge	Select all behavioral risks: • Tobacco Use/Smoking • Marijuana Use/Smoking • Synthetic cannabinoid • Cocaine • Methamphetamine • Prescription Opiates	Select all behavioral risks that are documented in the discharge plan/summary or discharge medical record: • Tobacco includes chewing as well as smoking; • Synthetic cannabinoid (includes K2, Spice etc.) Select "General Substance Abuse Statement" if the provider documents a blanket statement about substance abuse (i.e., "patient has a history of substance abuse") and/or references a substance no listed in the other check

	Abuse/Dependence • IV drug use • Alcohol abuse/dependence • General Substance Abuse Statement (Specify:_____) • None	boxes (i.e., “Molly”, etc.). **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when “none” is selected.**
2b. Follow-up of identified behavioral risk at discharge site	For each identified risk, select all that apply: **Tobacco: Check box for FU** • Counseling • Pharmaceuticals • Quitline • Community referral • None • Other_____ **Drug use: Check box FU** • Counseling • Behavioral health provider referral • Treatment center referral • Pharmaceuticals • Community support • None • Other_____ **Alcohol abuse/dependence: Check box FU** • Counseling • Behavioral health provider referral • Treatment center referral • Community support • None • Other_____	**NOTE: Only those risks selected above will be available for follow-up review**. For each identified risk, select all that apply/are documented in discharge summary/plan: Tobacco: counseling, pharmaceuticals (Tobacco pharmaceuticals-nicotine replacement, Chantix, Wellbutrin), Quitline, community referral, none, other Drug use (Drug use includes cocaine, methamphetamine, cannabinoid, opiates, IV drugs): behavioral health provider referral, treatment center referral, pharmaceuticals (include methadone, buprenorphine), community support, none, other. Alcohol abuse/dependence: behavioral health provider, treatment center, community support, none, other. Select none, if none of the options are documented in the discharge plan or summary in medical record. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when “none” is selected.** Select Other, if there is documented follow-up that differs from the options provided and enter the name of the documented follow up.
3a. Documented abnormal exam findings at discharge	Select all exam findings in discharge plan: **Elevated blood pressure** • Check for Yes/Otherwise No If yes: select level: ○ ≥150/90 ○ ≥140/90 ○ ≥180/120	Exam findings: Select none if no abnormal exam findings are documented or referenced in the discharge plan or summary. If none selected, follow-up will not be available for review. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when “none” is selected.**

	Elevated BMI documented • Check for Yes/Otherwise No. If yes, select category: o Overweight(≥ 25-29.9) o Obese (≥30) **Abnormal lung sounds: check box yes** **Abnormal cardiac exam: check box yes** **None of above: check box**	
3b. Follow-up of abnormal exam findings at discharge site	For each finding, check which had follow-up • Elevated B/P • Elevated BMI • Lungs • Cardiac Select all follow-up that apply: • Counseling • Medication initiation • Medication titration • Outpatient PCP referral • Outpatient specialist referral • Outpatient testing scheduled • None	**NOTE: Only selected documented findings will be available for review.** For each documented finding above, select all corresponding actions • Counseling could include diet (BP and BMI), exercise (BMI), weight management (BMI) • Select medication initiation if new medication prescribed at discharge for one of the findings. • Select medication titration if medication that the patient was taking on pre-MH inpatient for one of the physical conditions was adjusted per dosage, route, frequency at discharge. • Select PCP follow-up post discharge if documentation indicates that a referral was made to the PCP, whether or not there is reference to a specific abnormal exam finding documented, i.e., select for any/all documented abnormalities . • Select specialist follow-up post discharge if documentation indicates as for PCP. • Select outpatient testing post discharge if documentation indicates. • Select None if no follow-up is documented. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
4a. Documented abnormal lab test results at discharge site	Select most recent abnormal lab tests documented in discharge plan: **Diabetes screening** Check for Yes/Otherwise No. If yes, select range: • FBS >100 • FBS >126 • HbA1c >= 6.0 • HbA1c>=6.5	Select **most recent** abnormal lab tests from the below list that are documented in the discharge summary/plan medical record: Select none if no abnormal tests or lab results are documented in the discharge summary or plan. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.** **NOTE: If none selected, follow up will not be available for review.**

	• HbA1c <7 • HbA1c ≥ 7 • HbA1c < 8 • HbA1c ≥ 8 2 hour GTT • 2-h PG>=200 mg/dL (11.1mmol/L) during an OGTT • 2-h PG 140-199 **Lipid screening (LDL > or = 100): check box yes** **Abnormal EKG: check box yes** **None of above: check box yes**	
4b. Follow-up of abnormal lab findings at discharge/in discharge plan	For each finding check which had follow-up at discharge: Diabetes ■ Elevated Lipids ■ EKG ■ Select all that apply: • Counseling • Outpatient testing ordered/recommended • Outpatient testing scheduled • Outpatient PCP referral • Outpatient PCP scheduled • Outpatient specialist referral • Outpatient specialist scheduled • Discharge pharmaceutical therapy initiation • Discharge pharmaceutical titration • None	**NOTE: Only selected documented findings will be available for review** • Select Counseling if provided for any abnormal lab finding at discharge/in discharge plan. • Select outpatient testing if additional diagnostic tests to further evaluate the condition are **ordered post discharge**, such as EKG, imaging, ECHO, lab testing Select also if a referral is made in the discharge plan, include testing that is not specifically referenced for follow up for an abnormal lab. Select scheduled, **if the outpatient test was scheduled.** • Select PCP referral vs. scheduled follow-up post discharge as documentation indicates; **include if tied not to a specific abnormal lab finding, as well as if more than one abnormal lab finding**. • Select specialist referral vs. scheduled follow-up post discharge as documentation indicates; **include if not tied to a specific abnormal lab finding, as well as if more than one lab finding.** • Select pharmaceutical therapy/medication initiation if new medication prescribed at discharge for one of the physical conditions. • Select pharmaceutical/medication titration if medication that the patient was taking on pre-MH inpatient for one of the physical conditions was adjusted per dosage, route, frequency at discharge. • Select "none" if no follow-up is documented. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.** **NOTE: if a general statement was made for follow-up, and it is not clear which abnormality is being followed, e.g., "to follow-up with cardiology"**

		<u>when one or more abnormalities is documented, assign that follow-up (i.e., cardiology FU) to all the abnormalities. For example, if abnormal EKG and lipid panel are documented and there is a general statement "request cardiology consult" assign the cardiology consult as follow up to the EKG and lipid findings.</u>
5. Cardiometabolic risk-medications at discharge/in discharge plan	Select all that apply: • Antipsychotic medications • Antihypertensive • Cardiac • Diabetes • Nicotine replacement therapy • Other smoking cessation medication • None	Select all that apply for each medication--medications at discharge/prescribed at discharge • Antipsychotic medications • Antihypertensive • Cardiac • Diabetes • Nicotine replacement therapy • Other smoking cessation medication • None **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
H. Components of Discharge Plan/Planning		
1. Discharge Plan components: follow up actions	Select all elements included in the **<u>discharge plan:</u>** **<u>PCP referral</u>**: yes/no. If yes: select all: • PCP identified by name • Member advised to contact PCP following discharge to make appt. • PCP appointment made prior to discharge • PCP appointment date • PCP address and phone # **<u>Medical (PH) Specialty referral:</u>** yes/no If yes: select all: • PH referral provider identified by name • Member advised to contact PH Specialist to make appt. post d/c • PH Specialist referral appointment made prior to d/c • PH specialist referral appt. date	Select all elements included in discharge plan or summary note. **<u>If there is no discharge plan, select "pending" for chart status, and notify the IPRO Clinical lead to request the discharge plan.</u>** PCP referral **Note: If NO is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.** • PCP identified by name • Member advised to contact PCP following discharge to make appt. • PCP appointment made prior to discharge • PCP appointment date • PCP address and phone **<u>Medical (PH) Specialty referral:</u> Note: If NO is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.** • PH referral provider identified by name • Member advised to contact PH Specialist to make appt. post d/c • PH Specialist referral appointment made prior to d/c • PH specialist referral appt. date • PH specialist address and phone # Select None of the above if none of the options are documented in the discharge

	• PH specialist address and phone # **<u>Clinic Follow-Up UTD: check box yes</u>** **<u>Referral nutritionist: check box yes</u>** **<u>Referral Tobacco/Quitline: check box yes</u>** **<u>Referral to treatment center: check box yes</u>** **<u>Lab re-testing scheduled: check box yes</u>** **<u>Referral to Health Plan: check box yes</u>** **<u>Referral to Health Home: check box yes</u>** None of the above: Check_ if none	plan or discharge note in the medical record. **Note: If none is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**
2. Potential barriers to follow-up	Documented potential barriers to FU at discharge? • Yes • No If yes, was assistance provided or suggested: Yes/No Text enter comment_____	CMS Does documentation indicate that potential barriers to follow-up were discussed with member at discharge? (e.g. transportation needs, lack of insurance, homeless, etc.) Select one: • Yes/No If yes, Was assistance provided or suggested: Yes/No Select yes, if a barrier such as transportation was documented at discharge, and the documentation indicates that assistance was provided or suggested, i.e., "MCO case management contacted to arrange transportation to FU". Text enter_____: make a comment related to type of assistance or barrier documented in discharge plan or summary.

3. Discharge plan medication reconciliation	Did the discharge planning documentation include a medication reconciliation: yes/ no
	
	If yes, check all that apply:
	• Medications taken pre-MH inpatient
	• Medications prescribed at discharge: if yes:
	  ○ name
	  ○ dosage
	  ○ schedule
		If no selected, drop down options will not be available for review. **Note: If NO is selected, all of the remaining responses in this question will gray out. Make sure that none of the other responses are selected when "none" is selected.**

	○ reason for taking • Medications to be discontinued	
I. Care Coordination In Discharge Plan (Discharge Summary Notes)		
1. Established primary care provider (PCP) in discharge plan	Select **one:** • Yes, has established PCP • No established PCP, but PCP ID at d/c • No established PCP, no PCP ID at d/c	Members without a PCP most at risk as per Improving the Discharge Planning Process. Select one: • Yes, **the discharge plan/summary documents** that member has an established PCP-i.e. member knows who PCP is, has seen PCP • No, member has no established PCP but PCP identified at discharge • No, member does not have an established PCP and does not have PCP identified at discharge
2. Communication with PCP at discharge/in discharge plan	Select **one:** • Documented communication with established PCP • Documented communication with the PCP identified at discharge • No communication documented with any PCP	Communication includes telephonic, transmission of discharge summary; communication can occur at any time during hospitalization. • There is documented communication with the established PCP • There is documented communication with the PCP who was identified at discharge • There is no documented communication with established PCP or the PCP identified at discharge
3. Communication with medical clinician (PH) referrals at discharge in discharge plan	Select **one:** • Documented communication with established (PH) clinician referral (not established PCP) • Documented communication with (PH) newly ID clinician referral (other than PCP identified at d/c) • No communication documented with (PH) clinician referrals	As above : • Documented communication with established physical health (PH) clinician (not established PCP) • There is documented communication with clinician other than PCP who was identified at discharge • There is no documented communication with PH clinician referrals (excludes PCP)
4. Communication with Health Plan for post discharge needs	Documented communication with member's MCO: Yes/No/other Other MCO documented_____ • If yes, is the communication regarding cardiometabolic condition(s)? Yes/No	**Refer to the pre-populated MCO (insurance plan) in A2.** Select Yes, if the MCO is the same MCO pre-populated in tool. Select Other if a different MCO is documented than the pre-populated and enter the name of the documented MCO. Select No if there is no documentation of communication with the MCO related to post discharge needs. Note: If no is selected, communication about cardiometabolic conditions will not be available for review • There is documented communication with member's health plan (HARP, HIV-SNP, mainstream) If yes, is the communication regarding cardiometabolic condition(s)? Select "Yes", if the communication is related to the member's physical health condition. Select No, if the MCO communication is not related to

		cardio-metabolic condition, e.g., if communication is related to mental/behavioral health or other non-PH issue.
5. Communication with Health Home for post discharge needs anywhere in medical record	Documented communication with member's Health Home: Yes/No Select all that apply: • Inpatient/discharge provider attempted to contact Health Home care manager? Yes/No • Documented communication between inpatient/discharge team and member's Health Home care manager: Yes/No **If yes:** Documented communication regarding cardiometabolic condition(s)? Yes/No	**Refer to the pre-populated Health Home:** Is there documentation of communication between the facility staff and the member's Health Home (note definition of health home below) anywhere in the medical record, i.e., at any point in care trajectory. **Note: a health home is not a home health care agency or provider of at home services; additional information on health homes is available at:** http://www.integration.samhsa.gov/integrated-care-models/health-homes A health home (aka Medicaid health home) — as defined in Section 2703 of the Affordable Care Act — offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders. The health home is a team-based clinical approach that includes the consumer, his or her providers, and family members, when appropriate. The health home builds linkages to community supports and resources as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses. Care management is central to the recent shift away from focus on episodic acute care to focus on health management of defined populations, especially those living with chronic health conditions. This shift in focus results from lessons learned from primary and behavioral health care integration efforts, as health homes recognize the importance of caring for the whole person. Such a shift would necessitate **integrating primary and behavioral healthcare** and, as seen in the **IMPACT model**, explicitly building care manager/behavioral health consultant and consulting psychiatrist functions into the medical home model. If yes, Select all that apply as documented in the medical record: • Inpatient/discharge provider/staff member attempted to contact Health Home care manager Yes/No • There is documented communication between inpatient/discharge team and member's Health Home care manager: Yes/No • If yes, is the communication regarding cardiometabolic condition(s)? Otherwise, select no if there is no documented communication with member's Health Home anywhere in medical record.

6. Member engagement with Health Home (HH) care manager (CM)	Check all that apply: • HH CM visited member on inpatient unit/ prior to d/c? • Appt. made with HH CM prior to discharge: • Member advised to contact HH CM following discharge • UTD • No engagement with Health Home documented	Was the Health Home (not MCO) care manager documented as involved in care planning? Select UTD if it's unclear whether a documented CM note is from the Health Home CM or MCO CM.
7. Other (MCO) care management (CM)	Were non-HHCMs involved during hospitalization • Yes • No • UTD Were non-HHCMs involved at d/c with d/c planning • Yes • No • UTD	Select Yes if the MCO embedded or "field" care managers (CMs) are documented as involved in member care planning during the hospitalization or for discharge planning. Select UTD if CM involvement is documented, but it's not clear if the CM is with the MCO, the facility or the Health Home.
Quality of care concerns	Quality concerns in medical record_____	Document and immediately notify IPRO clinical lead of any quality concerns in medical record Examples: Severe hypertension not addressed Active angina inpatient not addressed Uncontrolled diabetes not addressed
Chart Status	Select Chart Review Status: • Pending • Complete • Excluded	Select pending if there is an issues with the documentation (i.e., illegible, or incomplete–outside RP, or no discharge plan) Select complete if the abstraction has been completed. Select excluded if the IPRO clinical lead has instructed to do so.
Comments on Chart Status	Reason for exclusion or pending status: Text enter:_____	Enter the reason the chart is pending review, or enter the reason provided by the IPRO clinical lead for the exclusion. **NOTE: Please indicate whether or not there is: 1) ED/pre-admission documentation; 2) inpatient documentation and 3) Discharge plan/documentation along with the page numbers for these sections of the medical record.**