

CT Duals Demonstration
Quality Measures

Model Core Measures	Data Collection Point	Year 1	Year 2	Year 3
All Cause Hospital Readmission (NQF)	Claims			
Ambulatory Care-Sensitive Condition Hospital Admission (PQI)	Claims			
ED Visits for Ambulatory Care-Sensitive Conditions (Rosenthal)	Claims			
Follow-Up after Hospitalization for Mental Illness (NQF)	Claims			
Depression Screening and follow-up	Partially claims based			
Care Transition record transmitted to health care professional (NQF)	Partially claims based			
Screening for fall risk (NQF)	Partially claims based			
Initiation and engagement of alcohol and other drug dependence treatment: (a) initiation, (b) engagement	Partially claims based			
State Specific Measure : Care Plan				
State Specific Measure: Training				
State Specific Measure: Process Measure				
Discharge Follow-Up: Percentage of beneficiaries with 30 days between hospital discharge to first follow-up visit				
Real Time Hospital Admission Notification: Percentage of hospital admission notifications occurring within specified timeframe				
Percentage of Providers with an agreement to receive data from beneficiaries' Medicare Part D Plans				
State Specific Demonstration Measure				
State Specific Demonstration Measure				
State Specific Demonstration Measure				

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Proposed Process Measures

Proposed Care Plan Measure	Discussion	Decision
Health Action Plan/Plan of Care: Percentage of beneficiaries with Health Action Plans within 90 days of being assigned to a Care Coordination Agency		

Proposed Training Measure		
State delivery of training for Lead Care Management Agencies on Demonstration Core Topics including: Motivational Interviewing, Person-Centered Care Planning, Dignity of Risk, and Disability		

Other Process Measures		
Patients discharged from a hospital-based inpatient setting with a continuing care plan created overall and stratified by age groups		
Patients discharged from a hospital-based inpatient setting with a continuing care plan provided to the next level of care clinician or entity overall and stratified by age		
Percent of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge		
Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred		

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Proposed Demonstration Measures

Demonstration Measures	Discussion	Decision
Hospital-wide all cause unplanned readmission		
Access to Primary Care: Percent of all plan members who saw their primary care doctor during the year		
Follow-up with any provider within 14 days following emergency department visit		
Ambulatory care follow-up visit within 14 days of having an inpatient hospital stay		
Percent of members with specified time frame between discharge to first follow-up visit		

LTSS Measures		
Reporting the number of enrollees who were discharged to a community setting from a nursing facility and who did not return to the nursing facility during the current measurement year as a proportion of the number of enrollees who resided in a nursing facility during the previous year		
Unmet need in ADLs/IADLs and, and IHSS functional level		
Percent of waiver individuals who experience an increase or decrease in the authorization of personal care hours	No additional information. CCC felt this might be too vague of a measure	