Alaska Department of Health and Social Services

Patient-Centered Medical Home Performance Metrics Report

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Introduction

The patient-centered medical home (PCMH) is an emerging care delivery model in the healthcare marketplace. According to the National Academy for State Health Policy (NASHP), all 50 states have initiated some level of medical home/patient-centered care model. The State of Alaska's Department of Health and Social Services (DHSS) is in the process of implementing a PCMH system for Alaskans, which will begin in 2012.

An important aspect that DHSS must consider is how and what to measure in determining the success of their PCMH system. Goals and standards of the program must first be identified. Based on the goals and standards, data driven performance metrics can be developed that will gauge the success of the PCMH system. DHSS must also determine the data and reporting capabilities within their state and their healthcare system in establishing metrics along with an analytical infrastructure.

This report's purpose is to identify potential performance metrics for Alaska's PCMH program by taking a look at existing metrics to provide DHSS with options for determining and demonstrating the success of their PCMH pilot program.

Existing Performance Metrics

There are numerous different performance metrics for Alaska DHSS to consider in evaluating their PCMH program. The Centers for Medicare and Medicaid Services (CMS) issued Electronic Health Record (EHR) Incentive Programs that provide financial incentives for the "meaningful use" of certified EHR technology to improve patient care. In order to receive an EHR incentive payment, providers have to show that they are "meaningfully using" their EHRs by meeting thresholds for a number of objectives. CMS has established the objectives for meaningful use that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet in order to receive an incentive payment.[1] EHRs are an important feature of the PCMH model in terms of coordinating and providing comprehensive care and therefore these EHR Meaningful Use Measures are an option for Alaska to consider as possible objectives and metrics for their PCMH program.

The Physician Quality Reporting System (PQRS) is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by

[1] Meaningful Use: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html

eligible professionals. The program provides an incentive payment to practices with eligible professionals who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries.[2] The 2012 PQRS Measures List consists of over 200 measures that can be reported to CMS by practices. The PQRS measures are another set of existing metrics for DHSS to consider.

The Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance (NCQA) are used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.[3] HEDIS measures address a broad range of important health issues and can be especially effective for measuring chronic care disease states. NCQA issues HEDIS core measures specifically for Accountable Care Organizations (ACOs), which are similar to the PCMH model, in terms of patient-centered, coordinated care. These care models have like goals around quality and cost of care.

Section 2703 of the Affordable Care Act (ACA) gives states the option to establish a health home for enrollees with chronic conditions. Like the ACO model, health homes are also similar to the PCMH model in that they have the same overall goals and objectives for improving the quality of care while reducing the costs of care. This option reflects the popularity and interest of the PCMH model and chronic care management. In order to have a health home program recognized, states must submit a State Plan Amendment (SPA) to CMS and have said SPA approved. As part of the SPA, each state is required to describe the goals and performance metrics of their health home model, categorized by clinical outcomes, experience of care, and quality of care.

[2] PQRS: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html
[3] HEDIS: http://www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx

Performance Metrics for Alaska

DHSS will want to identify performance metrics that determine the success of the stated goals and standards.The state must also align staffing to develop baseline data and regular reporting for the PCMH program. That being said, a source for Alaska to consider in selecting metrics is the Commonwealth Fund's Data Brief entitled, "Recommended Core Measures for Evaluating the Patient-Centered Medical Home: Cost, Utilization, and Clinical Quality."[4] This report provides a listing of recommended measures for PCMH programs keeping in mind the goals and objectives.. There is some overlap with these measures and the existing metrics referenced in the previous section as many sources use HEDIS and PQRS metrics. The matrix in *Appendix A* provides a side by side comparison of the Commonwealth Fund's recommended core measures, EHR Meaningful Use, PQRS, HEDIS, and Health Home SPA metrics. This comparison matrix provides DHSS with an overview of metrics that are most common among the different organizations, programs, and states, metrics that Alaska can easily incorporate into their PCMH program, and metrics that comprise the Commonwealth Fund's recommended PCMH measures.

All sources include a variety of quality, cost and utilization, measures. It cannot be emphasized enough that the selected measures must reflect the vision and goals for the program.

Each health home program identified in the measure list is customized dependent on the state's goals for their programs. Therefore, each State Plan amendment (SPA) consists of many different measures. The comparison matrix focuses on and captures any measures from an approved health home SPA that clearly are included in either the Commonwealth Fund's recommended PCMH measures or the HEDIS ACO measures. The SPAs provide both quality and utilization measures in this comparison. Refer to *Appendix B* for a complete summary of goals and measures from eight approved health homes SPAs. *Appendix B* demonstrates what other states are using to gauge their health home models and gives Alaska a more detailed set of and additional options to consider when selecting performance metrics.

Technically, all the quality of care metrics listed in Appendix A have some degree of overlap with the EHR Meaningful Use Measures because the EHR system would be used to record and report on all of these measures, if selected, as part of the PCMH model. However, for purposes of this comparison, the focus is on EHR Meaningful Use metrics that clearly reference the

[4]Rosenthal, Meredith B., Abrams, Melinda K., Bitton, Asaf, and the Patient-Centered Medical Home Evaluators' Collaborative. "Recommended Core Measures for Evaluating the Patient-Centered Medical Home: Cost, Utilization, and Clinical Quality". The Commonwealth Fund. May 2012.
http://www.commonwealthfund.org/~/media/Files/Publications/Data%20Brief/2012/1601_Rosenthal_recommended_core_measures_PCMH_v2.pdf

specifics of a measure from another entity already listed in the matrix. Primarily, the checked-marked EHR metrics relate to medication management, review, and reconciliation; recording specific patient information; and providing patient-specific resources. A full listing of all Meaningful Use Objectives and Measures can be found in *Appendix C*. The Core Objectives/Measures must all be met and at least 5 of the 10 Menu Objectives/Measures must be met in order for a provider to receive an EHR incentive payment.

As mentioned earlier, there are over 200 PQRS measures[5] that providers can report to CMS. Similar to the health home SPA and the EHR metrics, the PQRS comparison includes only those that match to either the Commonwealth Fund and/or HEDIS metrics. There is a great deal of overlap with PQRS because NCQA's HEDIS measures are the primary source for the PQRS metrics.

The following appendices provide a comparison matrix and the additional listings of measures from other organizations, programs, and states which provide Alaska with options to identify and select performance metrics for their PCMH model.

Recommendations:

What are the right set of metrics for Alaska?

PCG has included a suggested set of measures that we believe reflect the goals and objectives as we understand them from the DHSS using following sources:

- conversations with DHSS staff,
- the Health Care Commission's report providing direction for a PCMH program,
- data captured from Alaska's initial set of utilization and cost data for ED use and hospital data,
- the Health Care Commission's report on chronic conditions, and;
- stated goals and objectives for the pilot.

The suggested set of measures takes into consideration the limited capabilities of providers and the State to report true outcomes data by focusing primarily, with some exceptions, on metrics that can be retrieved from claims data for the short term until the State's Health Information Exchange (HIE) is in a position to provide outcomes data.

[5] The full list of 2012 PQRS Measures List can be found under ***Downloads*** on the following website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html

Stated Goals and Objectives:

- Reduce disparities in health care access, service delivery, and health status;
- Develop a patient provider partnership supporting a holistic approach, and ensuring patients and their families have the information, skills and tools necessary to maintain and manage their health, and that they are treated in a way that is respectful, engaging and empowering;
- Create an active partnership between the primary care provider, community health and social service providers, and governmental public health agencies to effectively coordinate and manage the care of patients with complex health conditions and to support primary prevention for healthy patients.
- Integrate behavioral and physical health
- Improve the quality of health care and lower health care costs, thereby creating savings to allow more Alaskans to obtain health care coverage within a sustainable health care system; and
- Provide a pragmatic method to document that each eligible Alaskan has access to health care.

PCG suggests a set of metrics supporting these goals and objectives to include:

- Prevention and Screening
- Behavioral Integration
- Cost and Efficiency
- Chronic Condition Management
- Patient Satisfaction

Next Steps:
Alaska DHSS will want to review claims data to determine if the chronic conditions cited in the Health Care Commission Report hold true for the Medicaid population. This data was not run for purposes of PCG analysis. In addition, Alaska DHSS will require resources to:

- Run Baseline Data,
- Re- measure at agreed upon time frames, and;
- Conduct data analysis.

As well as determine how to collect and conduct analysis on metrics not available thru claims data.

Below is a beginning set of suggested metrics based on the information available to PCG. Alaska can use these metrics or modify the list as desired.

Prevention and Screening Metrics	Source	Additional Comments
• **Children's EPSDT:** Percentage of members 0-20 years of age who had one or more EPSDT procedure(s) during the reporting period	Claims	Determine if we Alaska wants to split this out in more finite bands
• **Adult Preventive:** Percentage of members 21 years or older who had one or more preventive procedure(s) during the reporting period	Claims	
• **Cervical Cancer Screening:** Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer	Claims	
• **Chlamydia Screening in Women:** Percentage of women 16-24 years of age who were identified as sexually active (via pharmacy and/or claims data) and had at least one test for Chlamydia during the measurement year	Claims	
• **Colorectal Cancer Screening:** Percentage of male adults 50-64 years of age who had appropriate screening for colorectal cancer	Claims	
• **Breast Cancer Screening:** Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer	Claims	
• **Adult weight screening and follow-up; BMI Assessment** - Percentage of patients age 18 years and older with a calculated body mass index (BMI) in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside the parameters, a follow up plan is documented. Normal parameters: Age 65 and older BMI ≥23 and <30Ages 18–64 BMI ≥18.5 and <25	Medical Record or HIE	
• **Weight Assessment and Counseling** for Children and Adolescents - The percentage of patients 2-17 years of age who had an	Medical Record or HIE	

outpatient visit with a PCP who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the 90 day reporting period.		
• Tobacco Use Assessment	Medical Record or HIE	
• Tobacco Cessation Intervention	Claims	
Cost and Efficiency Metrics:		
In Patient Hospitalization – • Number of admissions by practice for the patient panel	Claims	
Inpatient Hospital Readmissions – • Number of readmissions by practice within 7 days and 30 days	Claims	
ER Utilization (Utilization): • Average number of emergency room (ER) visits per member per reporting period	Claims	
Chronic Condition Metrics:		
Diabetic Care HbA1c: • Percentage of members 21-64 years of age with diabetes (type 1 and/or type 2) who had a Hemoglobin A1c test in the measurement year	Claims	
Diabetic Eye Care Exam: • Percentage of members 21-64 years of age with diabetes (type 1 and/or type 2) who had a retinal eye exam performed	Claims	
Diabetic LDL Screening: • Percentage of members any age with diabetes (type 1 and/or type 2) who had an LDL-C screening performed	Claims	

Behavioral Health: • Percentage of patients 18 years of age and older receiving depression screening through the use of a standardized screening instrument within the measurement period	Medical Record or HIE	
Behavioral Health: • Percentage of children screened through EPSDT for mental health issues	Medical Record or HIE	
Behavioral Health: • Percentage of members aged 18 years and older screened for substance abuse using a standardized tool with a follow-up plan documented, as necessary	Medical Record or HIE	
Behavioral Health: • Percentage of drug/alcohol abusers counseled and referred to drug/alcohol treatment	Medical Record or HIE	
• **Behavioral Health** • Follow up After Hospitalization for Alcohol and Chemical Dependency Detoxification	Claims	
• **Cardiovascular Disease:** • Cholesterol Management for Patients With Cardiovascular Conditions	Claims	
• **Medication management for controlling High Blood Pressure**	Claims	
• **Care Coordination** - • Percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 2 days of discharge and performed medication reconciliation with input from PCP.	Medical Record	
• **Patient Satisfaction** • **CAHPS 4.0 survey administered by the State or providers participating in the pilot.**	Survey Data	

Appendix A – Metrics Comparison

Measure	Commonwealth Fund's Core Recommended Measures for PCMHs	HEDIS 2013 ACO Core Measures	Health Home SPA Measures	EHR Meaningful Use Measures	PQRS
Quality					
Adult weight screening and follow-up; BMI Assessment	✓	✓	✓	✓	✓
Weight Assessment for Children/ Adolescents	✓	✓	✓	✓	✓
Childhood Immunization Status	✓	✓		✓	✓
Immunizations for Adolescents	✓	✓		✓	
Breast Cancer Screening	✓	✓	✓		✓
Cervical Cancer Screening	✓	✓	✓		✓
Colorectal Cancer Screening	✓	✓	✓	✓	✓
Chlamydia Screening in Women	✓	✓	✓		✓
Care for Older Adults: Medication Review	✓	✓		✓	
Appropriate Testing for Children With Pharyngitis	✓	✓			✓
Appropriate Treatment for Children With Upper Respiratory Infection		✓			✓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓	✓			✓
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		✓			✓
Use of Appropriate Medications for People With Asthma		✓	✓	✓	✓
Medication Management for People with Asthma	✓	✓	✓	✓	✓

Measure	Commonwealth Fund's Core Recommended Measures for PCMHs	HEDIS 2013 ACO Core Measures	Health Home SPA Measures	EHR Meaningful Use Measures	PQRS
Cholesterol Management for Patients With Cardiovascular Conditions	✓	✓	✓	✓	✓
Controlling High Blood Pressure	✓	✓	✓	✓	✓
Comprehensive Diabetes Care *Note: This measure includes 7 core measures as indicators.*	✓	✓	✓		
Comprehensive diabetes care: Hemoglobin A1c (HbA1c) testing	✓	✓	✓		✓
Comprehensive diabetes care: HbA1c poor control (>9.0%)	✓	✓	✓		✓
Comprehensive diabetes care: HbA1c control (<8.0%)	✓	✓	✓		✓
Comprehensive diabetes care: blood pressure control (<140/80 mm Hg)	✓	✓	✓		
Comprehensive diabetes care: blood pressure control (<140/90 mm Hg)	✓	✓	✓		✓
Comprehensive diabetes care: Eye exam (retinal) performed	✓	✓	✓		✓
Comprehensive diabetes care: LDL–C screening	✓	✓	✓		✓
Comprehensive diabetes care: LDL–C <100 mg/dL	✓	✓	✓		✓
Comprehensive diabetes care: Medical attention for nephropathy	✓	✓			✓
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis		✓			✓
Osteoporosis Management in Women Who Had a Fracture		✓			✓

Measure	Commonwealth Fund's Core Recommended Measures for PCMHs	HEDIS 2013 ACO Core Measures	Health Home SPA Measures	EHR Meaningful Use Measures	PQRS
Osteoporosis testing in older women	✓*				✓
Use of Imaging Studies for Low Back Pain	✓	✓			
Antidepressant Medication Management	✓	✓	✓	✓	✓
Follow-Up Care for Children Prescribed ADHD Medication	✓	✓	✓		
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓		
Annual Monitoring for Patients on Persistent Medications	✓	✓		✓	
Medication Reconciliation Post-Discharge	✓*	✓	✓	✓	✓
Potentially Harmful Drug-Disease Interactions in the Elderly		✓		✓	
Use of High-Risk Medications in the Elderly	✓*	✓		✓	
Fall risk management	✓*				✓
Flu shots for adults ages 50–64 and flu shots for older adults	✓*				✓
Management of urinary incontinence in older adults	✓*				✓
Pneumonia vaccination status for older adults	✓	✓			✓
Preventive Care and Screening Measure Pair a) Tobacco Use Assessment b) Tobacco Cessation Intervention	✓	✓		✓	✓
Medical assistance with smoking and tobacco use cessation	✓*			✓	✓
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		✓	✓		✓
Adolescent well-care visits	✓		✓		
Well-child visit in the first 15 months of life	✓		✓		

Measure	Commonwealth Fund's Core Recommended Measures for PCMHs	HEDIS 2013 ACO Core Measures	Health Home SPA Measures	EHR Meaningful Use Measures	PQRS
Well-child visit in the third, fourth, fifth, and sixth years of life	✓		✓		
Utilization					
All-Cause Readmissions		✓	✓		
Emergency department visits, ambulatory care–sensitive and all	✓		✓		
Acute inpatient admissions, ambulatory care-sensitive and all	✓		✓		
Readmissions within 30 days	✓		✓		
Relative Resource Use for People With Diabetes		✓		✓	
Relative Resource Use for People With Asthma		✓		✓	
Relative Resource Use for People With Cardiovascular Conditions		✓		✓	
Relative Resource Use for People With Hypertension		✓		✓	
Relative Resource Use for People With COPD		✓		✓	
Cost					
Total per member per month costs	✓				
Total per member per month costs for high-risk patients	✓				

* = supplemental recommended measure

Appendix B – Health Home State Plan Amendments (SPA)

New York - Health Home SPA for Individuals with Chronic Behavioral and Mental Health Conditions	
Goal	**Measure**
Reduce utilization associated with avoidable (preventable) inpatient stays	Inpatient Utilization – General hospital/Acute Care
Reduce utilization associated with avoidable (preventable) emergency room visits	Ambulatory Care (ED Visits)
Improve Outcomes for persons with Mental Illness and/or Substance Use Disorders	Mental Health Utilization
	Follow Up After Hospitalization for Mental Illness
	Follow up After Hospitalization for Alcohol and Chemical Dependency Detoxification
	Antidepressant Medication Management
	Follow Up Care for Children Prescribed ADHD Medication
	Adherence to Antipsychotics for Individuals with Schizophrenia
	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
Improve Disease-Related Care for Chronic Conditions	Use of Appropriate Medications for People with Asthma
	Medication Management for People With Asthma
	Comprehensive Diabetes Care (HbA1c test and LDL-c test)
	Persistence of Beta-Blocker Treatment after Heart Attack
	Cholesterol Testing for Patients with Cardiovascular Conditions
	Comprehensive Care for People Living with HIV/AIDS
Improve Preventive Care	Chlamydia Screening in Women
	Colorectal Cancer Screening

Iowa - SPA	
Goal	**Measure**
Change patient behavior to increase the use of preventative services, and increase awareness of appropriate chronic condition management.	(NQF 038) Increase use of preventive services
	(NQF 055) Improve diabetes management: Dilated eye exam (annual by optometrist or ophthalmologist)
N/A	(NQF 062) Improve diabetes management: Micro albumin (annual)
	(NQF 056) Improve diabetes management: Foot exam (annual)
N/A	(NQF 0064) Improve diabetes management: Proportion with HgA1c less than 7
	(NQF 013) Improve diabetes management: Proportion with LDL less than 100
Transform provider practices by the adoption of the patient centered medical home model to improve the population health of members.	(CHIPRA 10)Well Child visits in the first 15 months of life The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. No well-child visits One well-child visit Two well-child visits Three well-child visits Four well-child visits Five well-child visits
	(CHIPRA 21) Follow-up care for children prescribed ADD medication The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.
N/A	(CHIPRA 13) Annual Dental Visit

Iowa - SPA	
Goal	**Measure**
	(NQF 031) Breast cancer screening
N/A	(NQF 032) The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer
	NQF 041 Percentage of patients aged 6months and older who received an influenza immunization

Oregon - Health Home SPA	
Goal	**Measure**
Reduce the rate of potentially avoidable hospital readmissions.	Pneumonia (PN): hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization.
Decrease potentially avoidable hospitalizations and increase the ratio of ambulatory care to emergency room visits.	Providers discuss illness prevention.
	Ambulatory care: summary of utilization of ambulatory care in the following categories: outpatient visits, emergency department visits. Ambulatory surgery/procedures and observation room stays.
Improve transitions of care between primary care providers and inpatient facilities.	Provider's aware of care that patients received from other health providers.
	Care transitions: Emergency department (ED) to ambulatory care.
Improve care transitions for people with mental health conditions.	Mental health: percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge.

Oregon - Health Home SPA	
Goal	**Measure**
Improve documentations, tracking, and reporting of health risks and use of preventive services.	Body mass index (BMI) assessment: percentage of members 18 to 74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year.
Service	**Measure**
Comprehensive Care Management	Mental health care.
	Body mass index (BMI) assessment

North Carolina - Health Home SPA	
Goal	**Measure**
Reduce Avoidable ED Utilization	Any Diagnosis Emergency Department (ED) visit rate, non-dual ABD, non-ABD
	Access Getting Needed Care Getting Care Quickly
Reduce Avoidable Hospitalizations	1) Inpatient Admissions per 1000 Member Months, Enrolled Non-Dual ABD 2) Asthma: Asthma Hospitalization 3) Heart Failure: Heart Failure Admissions
Increase Integration of Primary Care and Behavioral Healthcare	CAHPS 4.0 Chronic Conditions supplemental questions
	Practices with co-located behavioral health providers

North Carolina - Health Home SPA	
Service	**Measure**
Comprehensive Care Management	Care Management Patients meeting CCNC priority criteria who received a Comprehensive Health Assessment or an Intervention.
Care Coordination	CAHPS Quality of Care Coordination of Care supplemental questions CAHPS Behavioral Health supplemental questions
Health Promotion	1) Mammography among women 40-69 2) Pap smear among women 21-64 3) Colorectal cancer screening among men and women 50-75 4) Well-child visits in the first 15 months of life 5) Well-child visits in the Third, Fourth, Fifth, and Sixth Years of Life 6) Adolescent well-care visits
	CAHPS HEDIS measure set supplemental questions
	1) Blood pressure control (good) - hypertension 2) Blood pressure control (good) - diabetes
Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)	1) Any Diagnosis Potentially Preventable Readmissions as a Percent of Total Admissions, Enrolled Non-Dual ABD population 2) Heart Failure Heart Failure 30-day readmissions
	CAHPS 4.0 Survey CAHPS Quality of Care Coordination of Care supplemental questions
	Medication Reconciliation after non-mental health hospital discharge of targeted patients

Missouri - Community Mental Health Center Health Homes SPA	
Goal	**Measure**
Improve Health Outcomes for persons with Mental Illness	1. Ambulatory Care-Sensitive Condition Admission: Ambulatory care-sensitive conditions: age standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years. 2. Emergency Department Visits: Preventable/ambulatory care-sensitive emergency room visits [algorithm, not formally a measure] 3. Hospital Readmission: Hospital readmissions within 30 days
	1. All Members: Medication Adherence to Antipsychotics, Antidepressants, and Mood Stabilizers 2. Care Coordination: Percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 2 days of discharge and performed medication reconciliation with input from PCP.
Reduce Substance Abuse	1. Reduce the proportion of adults (18 and older) reporting use of any illicit drug during the past 12 months. 2. Reduce the proportion of adults (18 and older) who drank excessively in the previous 12 months.
Increase patient empowerment and self-management	Patient use of personal EHR (Direct Inform, or its successor)
	Satisfaction with services
Improve coordination of care	Care Coordination - Percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 2 days of discharge and performed medication reconciliation with input from PCP.

Missouri - Community Mental Health Center Health Homes SPA	
Goal	**Measure**
	Use of CyberAccess per member per month (or its successor) for non-MCO enrollees
Improve preventive care	Body Mass Index (BMI) Control - Percentage of patients with documented BMI between 18.5–24.9
	Metabolic Screening - % of members screened in previous 12 months. Metabolic screening (BMI, BP, HDL cholesterol, triglycerides, and HbA1c or FBG).
Improve Diabetes Care	Adult Diabetes - % of patients 18–75 years of age with diabetes (type 1 or type 2) who had HbA1c <8.0%.
	Preventive - % of members screened in previous 12 months - Metabolic screening (BMI, BP, HDL cholesterol, triglycerides, and HbA1c or FBG)
Improve asthma care	1. Pediatric Asthma - % of patients 5-17 years of age who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period. 2. Adult Asthma - % of patients 18-50 years of age who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period.
	Members with Asthma: Adherence to prescription medications for asthma and/or COPD.
Improve Cardiovascular (CV) Care	1. Hypertension - % of patients aged 18-85 years and older with a diagnosis of hypertension who have been seen will for at least two office visits, with blood pressure adequately controlled (BP < 140/90) during the measurement period 2. CAD - % of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100).

Missouri - Community Mental Health Center Health Homes SPA	
Goal	**Measure**
Improve Cardiovascular (CV) Care - continued	1. Members with CVD: Adherence to Meds – CVD and Anti-Hypertensive Meds 2. Members with CVD: Use of statin medications by persons with a history of CAD (coronary artery disease).

Missouri - Primary Care Practice Health Homes (PCP-HH) Clinic - SPA	
Goal	**Measure**
Improve Health Outcomes for Persons with Chronic Conditions	1. Ambulatory Care - Sensitive Condition Admission: Ambulatory care-sensitive condition - age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces need for admission to hospital, per 100,000 population under age 75 yrs 2. Emergency Department Visits: preventive/ambulatory care-sensitive ER visits (algorithm, not formally a measure) 3. Hospital Readmission: Hospital readmissions within 30 days
	Care Coordination: % of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performed medication reconciliation with input from PCP.
Improve Behavioral Healthcare	1. Reduce the proportion of adults (18 and older) reporting use of any illicit drug during the past 30 days. 2. Reduce the proportion of adults (18 and older) who drank excessively

Missouri - Primary Care Practice Health Homes (PCP-HH) Clinic - SPA	
Goal	**Measure**
Improve Behavioral Healthcare – continued	1. % of patients 18 years of age and older receiving depression screening through the use of a standardized screening instrument within the measurement period 2. Percentage of children screened through EPSDT for mental health issues 3. % of members aged 18 years and older screened for substance abuse using a standardized tool with a follow-up plan documented, as necessary
Increase patient empowerment and self-management	Patient Use of personal EHR (Direct Inform, or its successor) or practice EMR patient portal
	Satisfaction with services
Improve coordination of care	Care Coordination: % of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performed medication reconciliation with input from PCP.
	Use of CyberAccess per member per month (or its successor) enrollees
Improve preventive care	1. Body Mass Index (BMI) Control - % of patients with documented BMI between 18.5-24.9 Adult Weight Screening and Follow-Up Percentage of patients aged 18 years or older with a calculated BMI in the past three months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented. 2. Weight Assessment and Counseling for Children and Adolescents - The percentage of patients 2-17 years of age who had an outpatient visit with a PCP who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the 90 day reporting period.

Missouri - Primary Care Practice Health Homes (PCP-HH) Clinic - SPA	
Goal	**Measure**
	% of children 2 years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday.
Improve Diabetes Care	1. Adult Diabetes - % of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0% 2. % of patients 18-75 years of age with diabetes (type 1 or type 2) who had BP < 140/90 mmHg. 3. % of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C < 100mg/dL. 4. Child Diabetes - % of patients under 18 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%
	Members with Diabetes: Adherence to prescription medications for Diabetes.
Improve asthma care	1. Pediatric Asthma - % of patients 5-17 years old who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period. 2. Adult Asthma - % of patients 18-50 years old who were identified as having persistent asthma & were appropriately prescribed medication (controller medication) during the measurement period.
	Members with Asthma: Adherence to prescription medications for asthma and/or COPD

Missouri - Primary Care Practice Health Homes (PCP-HH) Clinic - SPA	
Goal	**Measure**
Improve Cardiovascular (CV) Care	1. Hypertension - % of patients aged 18-85 years and older with a diagnosis of hypertension who have been seen will for at least 2 office visits, w/blood pressure adequately controlled (BP<140/90) during the measurement period. 2. CAD - % of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100).
	Members with CVD: Adherence to Meds - CVD and Anti-Hypertensive Meds

Rhode Island - CEDARR Family Center Health Homes SPA	
Goal	**Measure**
Improve care coordination	1. Concept: Communication and collaboration between the Health Home Team and the Primary Care Physician during the development and review of the plan of care leads to a comprehensive plan of care Measure: Percentage of Physician Consultation claims to the number of Care plans developed and renewed. 2. Concept: Use of an electronic medical record ensures that recommended screenings, immunizations and assessments are performed. Measure: Number of hits on the RI KIDSNET Child Health Information system per 1,000 enrollees (KIDSNET stores child specific information on blood lead levels, immunization, newborn developmental assessment, newborn blood spot screening, hearing assessment, home visiting, WIC and Early Intervention). 3. Concept: Communication and collaboration between the Health Home Team and the Managed Care Plan ensures that services are not being duplicated. Measure: Percentage of CEDARR MCO enrollees with outreach to MCO documented in the CEDARR record.

Rhode Island - CEDARR Family Center Health Homes SPA	
Goal	**Measure**
Improve care coordination – continued	1. Concept: Clients perceive that they are receiving appropriate and effective servicesMeasure: Satisfaction with services, accessibility of services, availability of services\ 2. Concept: Timely delivery of Health Home servicesMeasure: Percentage of Initial Assessment (IFIND) appointment dates offered within 30 days of request. 3. Concept: Timely delivery of Health Home servicesMeasure: Percentage of Care Plans completed within 30 days of completion of the Initial Assessment (IFIND) 4. Concept: Timely delivery of Health Home servicesMeasure: Percentage of Care Plans reviews completed prior to expiration of current care plan.
	1. Concept: Knowledge of condition by client and family leads to improved management of condition and access to care. Measure: % of clients who indicate having adequate or higher level of knowledge of condition 2. Concept: Well coordinated care reduces caregiver stress. Measure: % of clients who indicate having a high level of stress caused by condition(s)

Rhode Island - CEDARR Family Center Health Homes SPA	
Goal	**Measure**
Improve Health Outcomes of Children and Youth with Special Health Care Needs (CYSHCN)	1. Concept: Increased knowledge of conditions and skills and strategies acquired to address consequences of condition will result in better health outcomes. Measure: % of clients who indicate having adequate or higher level of knowledge of condition. 2. Concept: Provision of clinical information and community based treatment options Measure: Number of referrals to Community Based Resources per member per year
	1. Concept: Clients perceive that they are receiving appropriate and effective servicesMeasure: Satisfaction with services, accessibility of services, availability of services 2. Concept: Timely delivery of Health Home Care Coordination servicesMeasure: Percentage of Community Based service treatment plans reviewed within 30 days of submission to the Health Home.
	1. Concept: Improved Medical Outcomes will result in lower stress levels related to the diagnosed condition Measure: % of clients who indicate having a high level of stress caused by condition(s) 2. Concept: Increased participation in age appropriate activities Measure: Parent/Guardian self rating of child's ability to take part in age appropriate community and social activities

Rhode Island - CEDARR Family Center Health Homes SPA	
Goal	**Measure**
Decrease the occurrence of secondary conditions	1. Concept: Regular screenings for Obesity will result in a decrease of related conditions Measure: Yearly BMI Index is calculated for all clients 6 years of age and older with documented intervention if <85th percentile 2. Concept: Participants will be screened regularly for depression Measure: Yearly Screening for Depression for all clients 12 years of age or above
	1. Concept: Clients perceive that they are receiving appropriate and effective services Measure: Satisfaction with services, accessibility of services, availability of services
	1. Concept: Rates of Obesity as measured by BMI < 85th percentile will decrease over timeMeasure: Reduction of Clients with a BMI >85th percentile.2. Concept: Treatment for DepressionMeasures: Clients who screened positive for depression who received further treatment or evaluation.

Rhode Island - CEDARR Family Center Health Homes SPA	
Goal	**Measure**
Decrease the use of Emergency Department and Inpatient Treatment for Ambulatory Sensitive Conditions	1. Concept: Clients do not use the emergency department for care or treatment of an illness that could have been treated in a different setting Measure: Percentage of patients with one or more ED visits for any conditions appearing in a state defined list of diagnoses that can be appropriately treated in a non-ED setting 2. Concept: Acute admissions for Ambulatory Sensitive Conditions that could be avoided with proper preventive care. Measures: Percentage of patients with one or more acute care admissions for any conditions appearing in a state defined list of diagnoses that can be avoided through proper preventive care
	1. Concept: Clients perceive that they are receiving appropriate and effective services Measures: Satisfaction with Care, accessibility of care
	1. Concept: Prevention of further Acute Care utilization Measures: Medical Follow up within 7 days of ACS admission 2. Concept: Prevention of additional ED utilization Measures: Medical Follow up within 7 days of ACS ED visit

Rhode Island - CEDARR Family Center Health Homes SPA	
Goal	**Measure**
Improve the quality of Transitions from Inpatient/Residential Care to Community	1. Concept: Health Home staff is actively involved in discharge planningMeasure: Percentage of discharges for admissions >7 days in length with active participation of Health Home staff.2. Concept: Health Home staff contacts client after dischargeMeasure: Percentage of discharges for admissions >7 days in length who are contacted by Health Home staff within 7 days of discharge.3. Concept: Re-Admissions for same diagnosis reducedMeasure: Percentage of clients re-admitted or utilizing ED within 30 days of discharge with same diagnosis as admission
	1. Concept: Clients perceive that they are receiving appropriate and effective services Measures: Satisfaction with Care, accessibility of care
	1. Concept: Clients are able to avoid re-admissions for physical health conditions Measure: Percentage of clients with non-psychiatric admissions within 30 days of hospital discharge 2. Concept: : Clients are able to avoid re-admissions for psychiatric conditions Measure: Percentage of clients with a psychiatric admission within 30 days of psychiatric hospital discharge

Rhode Island - Community Mental Health Organization Health Homes SPA	
Goal	**Measure**
Improve Care Coordination	1. Percentage of patients whose chart includes documentation of physical and behavioral health needs 2. Percentage of hospital-discharged patients with a follow-up visit within 14 days of hospital discharge
	1. Percentage of patients with a regular source of health care 2. Percentage of patients who had a physical exam in the past 12 months
	Percentage of hospital-discharged patients contacted by the CMHO hospital liaison or a member of the health home team by phone or in person within 2 days of discharge
Reduce preventable hospital emergency department (ED) visits	1. Percent of patients with one or more ED visits for any conditions named in NYU ED methodology, available at: http://wagner.nyu.edu/ld.lpsr/Index.html?p=61 2. Percent of patients with one or more ED visits for a mental health condition
	Satisfaction with care, accessibility of care
	Percentage of hospital-discharged patients contacted by the CMHO hospital liaison or a member of the Health Home team by phone or in person within 2 days of discharge
Increase use of preventive services	1. Percentage of patients who report that they smoke 2. Percentage of patients who report using illicit substances or abusing alcohol 3. Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year 4. Age and gender appropriate use of pap test, mammogram, and colonoscopy, using HEDIS specifications.

Rhode Island - Community Mental Health Organization Health Homes SPA	
Goal	**Measure**
	Percentage of patients who are satisfied with their access to outpatient services and with the quality of those services
	1. Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented 2. Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following: (a) Initiation of AOD treatment (b) Engagement of AOD treatment 3. Percentage of patients having one or more well-visits/physical examination visits in 12 month period 4. Percentage of smokers counseled and referred for smoking cessation 5. Percentage of drug/alcohol abusers counseled and referred to drug/alcohol treatment
Improve management of chronic conditions	1. % of patients with diabetes (type 1 or type 2) who had HbA1c < 8.0% 2. % of patients identified as having persistent asthma & were appropriately prescribed medication (controller medication) during the measurement period. 3. % of patients with a diagnosis of hypertension who have been seen for at least 2 office visits, w/ blood pressure adequately controlled (BP < 140/90) during the measurement period 4. % of patients diagnosed with CAD with lipid level adequately controlled (LDL<100).

Rhode Island - Community Mental Health Organization Health Homes SPA	
Goal	**Measure**
	1. % of patients who are adherent to prescription medications for asthma and/or COPD. 2. % of patients who are adherent to Meds – CVD and Anti-Hypertensive Meds 3. % of patients using statin medications who have a history of CAD (coronary artery disease).
Improve Transitions to CMHO Services	Mental health: percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge. http://qualitymeasures.ahrq.gov/content.aspx?id=14965
	Percentage of patients satisfied with their access to outpatient services and with the quality of those services
	1. Percentage of hospital-discharged patients contacted by the CMHO hospital liaison/or a member of the Health Home team) by phone or in person within 2 days of discharge 2. Care transitions: percentage 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. http://qualitymeasures.ahrq.gov/content.aspx?id=15178

Rhode Island - Community Mental Health Organization Health Homes SPA	
Goal	**Measure**
Reduce Hospital Readmissions	1. Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years. http://www.guideline.gov/content.aspx?id=15067 2. For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
	Satisfaction with care, accessibility of care
	1. Percentage of hospital-discharged patients with a follow-up visit to a CMHO or medical provider within 14 days of hospital discharge. 2. Percentage of hospital-discharged patients contacted by the CMHO hospital liaison or a member of the Health Home team by phone or in person within 2 days of discharge

Appendix C – EHR Meaningful Use

Meaningful Use Metrics			
Eligible Professional (EP) Core Objectives and Measures			
	Objective	**Measure**	**Exclusion**
1	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
2	Implement drug-drug and drug-allergy interaction checks.	The EP has enabled this functionality for the entire EHR reporting period.	
3	Maintain an up-to-date problem list of current and active diagnoses.	More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.	
4	Generate and transmit permissible prescriptions electronically (eRx).	More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
5	Maintain active medication list.	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	
6	Maintain active medication allergy list.	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	

Meaningful Use Metrics			
Eligible Professional (EP) Core Objectives and Measures			
	Objective	**Measure**	**Exclusion**
7	Record all of the following demographics: (A) Preferred language. (B) Gender. (C) Race. (D) Ethnicity. (E) Date of birth.	More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.	
8	Record and chart changes in the following vital signs: (A) Height. (B) Weight. (C) Blood pressure. (D) Calculate and display body mass index (BMI). (E) Plot and display growth charts for children 2–20 years, including BMI.	For more than 50 percent of all unique patients age 2 and over seen by the EP, height, weight, and blood pressure are recorded as structured data.	Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.
9	Record smoking status for patients 13 years old or older.	More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	Any EP who sees no patients 13 years or older.
10	Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the States.	Successfully report to CMS ambulatory clinical quality measures selected by CMS in the manner specified by CMS.	
11	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.	Implement one clinical decision support rule.	

Meaningful Use Metrics			
Eligible Professional (EP) Core Objectives and Measures			
	Objective	**Measure**	**Exclusion**
12	Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request.	More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.	Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.
13	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.	Any EP who has no office visits during the EHR reporting period.
14	Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	
15	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	

Meaningful Use Metrics			
Eligible Professional (EP) Menu Objectives and Measures			
	Objective	**Measure**	**Exclusion**
1	Implement drug formulary checks.	The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
2	Incorporate clinical lab-test results into EHR as structured data.	More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.
3	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP with a specific condition.	
4	Send patient reminders per patient preference for preventive/follow-up care.	More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.	An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.
5	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.	At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.	Any EP that neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) during the EHR reporting period.

Meaningful Use Metrics			
Eligible Professional (EP) Menu Objectives and Measures			
	Objective	**Measure**	**Exclusion**
6	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.	
7	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.	An EP who was not the recipient of any transitions of care during the EHR reporting period.
8	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.
9	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).	An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.

Meaningful Use Metrics			
Eligible Professional (EP) Menu Objectives and Measures			
	Objective	**Measure**	**Exclusion**
10	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically).	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.

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