Holding Health Homes Accountable for High-Quality Care: Payment and Quality Measures

Part of a series designed to help advocates prioritize consumer needs in the development of Health Homes

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Despite spending the most per person on health care in the world, the U.S. health care system provides lower quality care compared to many other developed countries.[1] This is due in large part to the fact that most health care in the United States is paid for based on the volume of care, rather than on the quality of care or improvements to patient health.

Medicaid Health Homes are an exciting opportunity for states to begin linking payment and quality. A Health Home is a provider or group of providers that coordinates primary, acute, behavioral health, and long-term care for Medicaid beneficiaries with multiple chronic conditions. Health Home patients have multiple chronic conditions, mental health conditions, or substance use disorders, and therefore they often fare worst in our country's fragmented system because they need care from a range of providers.

The Affordable Care Act gives states the option to design Health Homes by amending their state Medicaid plans. A well-designed Health Home should pay providers more for high-quality care that improves patient health, giving providers the flexibility to design care around the needs of each individual patient. State advocates can support the development of good Health Homes by paying close attention to proposals for how Health Home providers will be paid and how quality will be measured, and by pushing for payments and quality measures that will support patient-centered care.

This brief describes the different options that states have for paying Health Home providers and measuring quality, including examples from the following states: Iowa, Missouri, New York, North Carolina, Ohio, Oregon, and Rhode Island. It also explains how advocates can identify and promote the best policies for consumers. It is the third in a series of three briefs that introduce Health Homes and highlight important issues for consumer advocates.

Payment

Our current system usually pays providers for how much care they give without regard to quality. This can lead to unnecessary tests and incorrect diagnoses, or to overtreatment, all of which may do patients more harm than good.

Well-designed Health Homes will not only provide the services that the Health Home population needs, but they will also give providers financial incentives to find what works for each patient in order to make real improvements to his or her health. When designing a payment methodology for Health Homes, states must decide how to pay for services, calculate payments, and incentivize high-quality care and provider transitions.

Deciding How to Pay Health Homes

Good Health Home care is designed to help patients identify their health goals and overcome any barriers they face in achieving those goals through the six required Health Home services.[2] Each patient will have a unique and complex set of needs, so providers will need the flexibility to offer medical and non-medical services that will work best for each individual patient. Under the Health Home option, states have the ability to design payment mechanisms that will provide this flexibility and incentivize high-quality care.

- **Fee-for-Service**

  In a fee-for-service payment system, each service is assigned a specific cost, and providers are paid based on how many of each service they provide. The fee-for-service payment model is not ideal for most Health Homes for a number of reasons. First, this approach encourages providers to perform whatever service is reimbursed at the highest rate, rather than the service that is best for each patient. Second, it requires providers to bill for each service separately, putting an additional administrative burden on both the provider and the state.

  Of the ten Health Homes that the Centers for Medicare and Medicaid Services (CMS) has approved so far, only one, the **Rhode Island** Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Reevaluation (CEDARR) Family Center Health Home is using a fee-for-service payment.[3] CEDARR Family Centers support families with children who have special needs by providing a predetermined set of testing and support services that do not need to vary significantly from patient to patient. Given the stability of the patient population and the limited range of services needed, a fee-for-service payment structure may be adequate in this case, but it would not be in the best interest of the majority of Health Home patients.

Capitation

In a capitated payment system, providers are paid a set amount per patient each month to provide whatever services the patient needs. Because the payment is a set amount, providers do not have the incentive to provide unnecessary services or to deliver only those services with the highest reimbursement. As a result, providers can tailor services to individual patients. Most states have opted to use a capitated per-member, per-month (PMPM) payment for Health Home services.

The payment can be made prospectively, meaning it is made prior to service delivery, or retrospectively, meaning a provider would submit a claim and receive payment after performing the services. A prospective payment gives providers the money up-front for care coordination services, which some argue is necessary for delivering them. A retrospective payment may help to ensure that providers are in fact delivering services, since they receive payment only if they demonstrate that they have either performed a service or contacted the Health Home patient within a certain time period. Most of the approved Health Homes pay providers retrospectively, providing per-member, per-month payments for each patient who received a certain minimum service from the Health Home during the payment period.[4] While a capitated payment system is likely to be a better fit for most Health Homes than fee-for-service, it does have limitations that will need to be addressed to ensure that Health Homes provide good care.

- **Ensuring Access to High-Quality Care**
  Access to quality care is a potential concern with a capitated payment model, because providers have no incentive to perform higher-cost services. If they provide services that cost less than the payment, they keep the difference, but if the services cost more than the payment, they are on the hook for the loss. As a result, providers may be reluctant to give the care that a patient needs in order to avoid incurring a loss. For this reason, it is critical that states tie payments to robust quality measurements to ensure that providers do not save money by offering poor care.

- **Ensuring Payment Adequacy**
  Because there are few existing models of care coordination for complex patients, and because different patients will require different levels of care, it may be difficult for states to calculate an accurate per-member, per-month payment. If, for example, a state sets its payment too low, providers will not have enough resources to cover the cost of needed infrastructure and personnel. Advocates should ensure that the state is including the costs of hiring and training care coordination staff and the time needed to build connections with other providers, including non-medical providers, in its calculation of the per-member, per-month payment.

Calculating Health Home Payments

One of the most difficult tasks for states that are designing Health Homes is determining the amount of Health Home payments. Most states have very little or no experience reimbursing providers for care coordination. Further complicating the calculation is the variation among and within states in terms of health care costs, delivery system models, and provider care coordination infrastructure. This variation means there is no one-size-fits-all method for calculating Health Home payments. Factors that states should take into consideration when determining how much to pay Health Home providers include the following:

- **Staffing Costs**
  Most Health Homes will need to hire additional staff to coordinate care. In calculating the costs of these additional team members, states will need to estimate the appropriate ratio of care coordination staff to Health Home patients. This ratio will vary widely depending on the needs of the Health Home population.

- **Geographic Variation**
  Care coordination may be more expensive in some parts of the state than others. For example, a rural Health Home may have greater transportation costs associated with home visits. In **New York**, Health Home payments are higher in urban counties to allow for higher staff salaries that reflect a higher cost of living.

- **Patient Needs**
  Some Health Home patients will be more expensive to treat than others. Those who are elderly or who have many chronic conditions will likely require more intensive care coordination than younger patients with only one or two conditions. One way to ensure that payments cover the cost of care for these patients is to tier, or risk adjust, payments based on age, acuity (the severity of a patient's conditions), or other demographic factors. States have done this in a number of different ways as follows:

  - **Iowa** tiers payment based on how many severe chronic conditions each patient has. The per-member, per-month payment for patients with one to three chronic conditions is $12.80, while the payment for a patient with 10 or more chronic conditions is $76.81.
  - **Minnesota** adds 15 percent to acuity-tiered payments for patients with certain barriers to care, such as a primary language other than English or a serious mental illness.[5]
  - **New York** provides higher payments to Health Homes with sicker patients.
  - **North Carolina** provides higher payments for patients who are elderly, blind, or who have disabilities.

- **Provider Group Size**
  Becoming a Health Home will be especially difficult for small providers. A primary care practice with only one or two physicians might have trouble paying for the staff and technology needed to become a Health Home. Payment for care coordination will not make up for the fixed costs of that transition. Because these small providers may be the only ones who can provide Health Home services in rural areas, states should consider paying small practices more to encourage them to become Health Homes. **New York** has considered providing higher payments for a very small rural Health Home if current fees would not cover the fixed costs of providing Health Home services.

However a state decides to address these issues, it is very important that the payments be adequate to ensure that Health Homes are able to provide the services that patients need and to ensure the long-term sustainability of Health Homes. States will need to routinely evaluate payment adequacy, particularly in the first few years. State Medicaid agencies are not used to paying for the six Health Home services, so setting initial payment amounts requires a great deal of estimation. Advocates should encourage states to include frequent assessments of payment adequacy in the first few years of a Health Home to ensure that providers can maintain Health Home status. States should also have a process in place for making adjustments to payments as quickly as possible if the rates are inadequate.[6]

Supporting Providers Transitioning to Health Homes

For most providers, becoming a Health Home will require significant upfront costs for hiring new staff, changing work flows, and buying an electronic health records system. All of this will need to happen before the provider begins receiving payments for Health Home services. As a result, it may be too expensive, especially for smaller providers, to become a Health Home without state support. States have taken a number of approaches to supporting providers as they transition to Health Homes:

- **Facilitating Learning Collaboratives**
  Missouri, **New York**, and **Oregon** are organizing learning collaboratives, which allow providers to learn from each other as they take the necessary steps to become Health Homes. **Missouri** built $2.40 into each per-member, per-month payment to account for the time providers spend outside of the office participating in the learning collaborative.[7]
- **Leveraging Additional Sources of Funding**
  Some states are using other funding sources to support provider transitions. **Missouri** raised $1.5 million for training and Health Home implementation from foundations, state agencies, and providers.

- **Tiering Based on Accreditation, Certification, or Function**
  Offering larger payments for Health Homes that reach a higher level of certification, accreditation,[8] or function can encourage providers to invest in the transition process. For example, **Oregon** has developed its own system to tier payments for providers based on their Health Home functions, with Health Homes that provide more advanced services receiving higher per-member, per-month payment levels.[9]

Issues for Advocates to Consider

- Will the state's payment methodology encourage providers to identify what works for each individual patient?
- How will the state ensure that payments adequately cover the costs of Health Home services?
- How will the state support provider transitions?

Quality Measurement

A critical part of developing new care models is identifying what works to improve health outcomes and patient experiences and what does not work. Good quality measures will help states identify the most effective types of care and direct resources to providers that perform well. Quality measurement is also an important consumer protection. Any effort to reduce health care costs must be paired with robust quality measurement to ensure that providers do not cut necessary care to achieve short-term savings but instead work to improve patient outcomes and experiences.

Types of Quality Measures

In order to ensure that Health Home patients receive high-quality care and that the state can reward providers that deliver high-quality services, it is important to have a robust set of measures that reflects the goals of the Health Home. For tips on how to evaluate quality measurements, see page 7.

The table on page 7 lists basic types of quality measures, provides an example of what each type might look like in a Health Home that is focused on patients with diabetes, and discusses when the measure will be most important for Health Homes.

Type of Measure	Description	Example	Timeframe
Structural	Assesses whether a provider has certain capacities associated with high-quality care	Does the Health Home have a diabetes patient registry?	Most important in the early years of the transition to Health Homes because structural measures provide a way for states to track and incentivize provider transformation. States are including most of these measures in their provider standards.
Process	Determines whether specific services were provided to patients, consistent with clinical guidelines	What percentage of diabetic Health Home patients had their A1c levels tested and recorded within the past six months?	Process measures are always an important way to track progress and identify best practices. In the early years of a Health Home, they can also be the basis for payment incentives. Health Homes should be rewarded for following best practices, since it will take time for improved care to result in improved outcomes.
Outcome	Evaluates the results of the care provided	What percentage of patients' most recent hemoglobin A1c test shows that their diabetes is under control?	While Health Homes should begin measuring outcomes as early as possible, payments should not be tied to outcomes at first. Even the best patient-centered, coordinated care will not be able to immediately undo the effects of years of poor care, and it is important that Health Homes not be penalized for taking on patients with acute chronic illnesses.
Patient Experience	Assesses provider performance based on patients' accounts of the care they received and their experience	Do patients report that their provider explains things in ways that are easy to understand?	Patient experience is an essential measure of care quality, and it should be tracked and tied to payment at all times.

Evaluating Quality Measures

State advocates can use the following questions to assess the validity of quality measures that a state plans to use:

- **Is It Actionable?**
  All quality measures should be actionable, meaning that the provider can use the results to make changes that improve care. A measurement should be selected because there is evidence that it is needed. For example, an area where quality is consistently low or highly variable across providers would be an important quality measure to track. Measuring an area in which providers consistently perform well is unnecessary and will not help improve care.

- **Is It Reliable and Valid?**
  The measurements that are selected should be reliable and valid, which will ensure that they can be used to compare different providers and that they truly measure what they are intended to measure. This is particularly important for states that plan to offer performance payments for providers. It is important to select measurements that have been tested and for which there is evidence of their appropriateness.

- **Is There a Way for Providers to Collect These Data?**
  Finally, there must be a way for providers to collect the data for the measurement. These data can come from a variety of sources, including claims data, patient files, and surveys. But it should be data that providers can readily obtain. As more providers implement electronic medical records and other forms of health information technology, it should be easier to collect a wide range of data for a variety of measurements.

Required Measures

In its letter to state Medicaid directors guiding the development of Health Homes, CMS lists the following areas that states are required to monitor:[10]

- Avoidable hospital readmissions
- Cost savings from improved care coordination and chronic disease management
- The use of health information technology to improve service delivery and care coordination
- Emergency room visits
- Skilled nursing facility admissions

CMS has also released the following set of eight core quality measures that both states and Health Homes will need to track and report:[11]

1. **Adult Body Mass Index (BMI) Assessment (Process Measure)**
   What percentage of adults who have had an outpatient visit had their BMI documented in the past two years?
2. **Ambulatory Care-Sensitive Condition Admission (Outcome Measure)**
   How often are patients hospitalized for conditions that could have been addressed through outpatient care?
3. **Care Transition - Transition Record Transmitted to Healthcare Professional (Process Measure)**
   How often did the member of the Health Home who is charged with follow-up care receive a transition record within 24 hours of a patient being discharged?

4. **Follow-Up after Hospitalization for Mental Illness (Process Measure)**
   How often do patients who were hospitalized for treatment of mental health conditions have a follow-up visit within seven days of being discharged?
5. **Plan - All Cause Readmission (Outcome Measure)**
   How often are patients readmitted within 30 days of being discharged for an acute inpatient admission?
6. **Screening for Clinical Depression and Follow-Up Plan (Process Measure)**
   How many patients who are screened for depression receive a documented follow-up plan?
7. **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Process Measure)**
   How often is treatment initiated for patients with a new episode of alcohol or drug dependence? How often is treatment both initiated and followed with at least two treatment visits within 30 days of treatment initiation?
8. **Controlling High Blood Pressure (Outcome Measure)**
   How often is blood pressure adequately controlled (less than 140/90) among adult patients with hypertension?

State-Specific Measures

The state plan amendment process gives each state the opportunity to develop its own goals and to describe what additional data it will collect to measure the quality of Health Homes. This is a key area for state advocate involvement. Advocates should push the state to do two things:

1. Require strong measures of care coordination and patient experience.
2. Link payment to quality measures.

While state advocates may not have the expertise to comment on clinical outcome measures, they do have a critical role to play in encouraging states to measure care coordination and patient experience and to pay providers based on those quality measures.

Measuring Care Coordination

Care coordination is central to the Health Home model and key to providing high-quality care, particularly for complex patients. The National Quality Forum (NQF)[12] recently endorsed a set of 12 measures of care coordination. These measures gauge providers' performance of key functions, such as reconciling patients' medications, establishing advanced care plans, and making medical records available to other providers and patients in a timely manner.[13] Advocates should push for these measures to be included in the standards that states will use for evaluating Health Home performance.

Measuring Patient Experience

Quality of care depends not just on what services are provided, but on *how* they are provided. The success of Health Home care depends heavily on a Health Home's ability to give the patient the tools she needs to self-manage her chronic conditions. For this to happen, the care team must be accessible, communicate with the patient in a way that is easy for her to understand, and value her input and participation in her own care. Patient experience measures evaluate how well the Health Home supports its patients.

Patient Experience vs. Patient Satisfaction

When helping a state select good measures of patient experience, consumer advocates should be careful to ensure that the tools that are used measure patient experience, not just patient satisfaction. Both patient experience and patient satisfaction surveys ask questions like, "Was the waiting room comfortable and clean?" and "Were the front desk staff friendly?" However, patient experience surveys also ask more detailed questions about how care was actually delivered and what the patient experienced during his or her interaction with a provider. For example, a patient experience survey might ask whether a health care provider explained a treatment in a way that the patient understood or whether the provider listened carefully to the patient. These measures of patient experience are essential to determining provider performance.

State advocates should encourage states to require all Health Homes to use robust measures of patient experience and to tie financial incentives to patient-centered care. In its template state plan amendment for Health Homes, CMS asks states to develop goals for Health Homes and to outline the measures of clinical outcomes, quality of care, and experience of care that will be used to evaluate state progress toward reaching its goals. While most Health Homes that CMS has approved so far do measure key elements of patient experience, two states do not. Consumer advocates have a critical role to play in making sure that all future Health Homes measure patient experience.

- ### Types of Patient Experience Measures

  The best patient experience measures for a Health Home will depend on the Health Home population. State advocates should consider the characteristics of the Health Home population and evaluate which survey tools best reflect the needs of those patients. Measures that states are using include the following:

  - **The Consumer Assessment of Health Care Providers and Systems (CAHPS) Surveys**
    The most common patient experience measuring tools are the CAHPS surveys, which were developed by the Agency for Healthcare Research and Quality (AHRQ). This set of surveys, which are modified for different types of providers (hospitals, clinicians and groups, nursing homes, etc.), goes beyond asking the patient whether she was satisfied with her care by asking about her experience and what she did and did not receive from her provider.

AHRQ has also developed several supplemental item sets that align particularly well with the goals of Health Homes. The basic CAHPS survey can be expanded to include questions that evaluate performance as a Patient-Centered Medical Home,[14] cultural competence,[15] and health literacy.[16]

- **Patient-Centered Medical Home Item Set**
  The Patient-Centered Medical Home (PCMH) item set includes important questions about access and patient engagement, such as:
  - In the last 12 months, did anyone in this provider's office ask you if there are things that make it hard for you to take care of your health?
  - When you talked about starting or stopping a prescription medicine, did this provider ask you what you thought was best for you?
  - Did this provider's office give you information about what to do if you needed care during evenings, weekends, or holidays?
- **Cultural Competence Item Set**
  The cultural competence item set includes questions that are designed to gauge a provider's responsiveness to the racial, ethnic, cultural, and linguistic diversity of the patient population and to cultural factors such as language, communication styles, beliefs, attitudes, and behaviors that can affect health and health care. For example, if a provider talks too fast or interrupts the patient, he or she will have difficulty understanding the provider and will be less likely to volunteer information. In cases where the patient needs to communicate with a provider through an interpreter, poor quality interpretation can lead to misunderstandings and limit the patient's ability to be engaged in his or her own care. A culturally competent health care provider uses interpersonal and organizational strategies to bridge these barriers to communication and understanding.
- **Health Literacy Item Set**
  The health literacy item set measures how well a provider ensures that patients understand and feel confident communicating about their care. All too often, patients are unable to understand their conditions, treatment, or medications because providers use medical jargon when they explain things. This limits patients' ability to self-manage their health and often discourages them from being engaged with their providers. For example, if a provider is trying to engage a patient in deciding between two possible medications, but he uses technical terms to describe the possible side effects, the patient will not have the information she needs to make a choice. As a result, she may make a choice that doesn't accurately reflect her priorities, leading her to stop taking the medication when the side effects interfere with her life.

Health literacy refers to the capacity to obtain, communicate, process, and understand basic health information. Providers should always work to improve the health literacy of their patients. Health literacy is particularly important for the Health Home population because of the importance of adhering to medication and other self-management practices to control chronic illness. Using plain language, encouraging the patient to ask questions, and using drawings or models to explain things are examples of health literacy best practices.[17]

States with Health Homes that focus primarily on patients with physical chronic conditions should consider using the CAHPS survey as the basis for their patient experience measures. Advocates should push states to include questions from the Patient-Centered Medical Home, cultural competency, and health literacy item sets if the state decides to use the CAHPS survey. Of the Health Homes approved so far, three (**Missouri's** chronic physical conditions Health Home, **North Carolina**, and **Oregon**) use CAHPS surveys to measure patient experience.

- **Patient Experience Measures for Behavioral Health Homes**

  Advocates in states with Health Homes that focus on patients with mental illnesses and substance use disorders should consider encouraging their states to use a patient experience measure that is developed specifically for this population. States that currently have behavioral Health Homes are taking the following approaches:

  - **Missouri** and **Ohio**'s behavioral Health Homes use the Mental Health Statistic Improvement Program patient experience survey from the Substance Abuse and Mental Health Services Administration (SAMHSA).[18] This survey assesses perceptions of care, social functioning, and social connectedness among patients who receive behavioral health services.
  - **Rhode Island** uses its own survey, the Rhode Island Outcomes Evaluation Instrument, to measure patient experience for members of its behavioral Health Homes.

- **Measuring the Experience of All Patients**

  Patient experience surveys are usually written in English and mailed to patients or their caregivers. If used exclusively, this method of measuring patient experience would prevent a range of patients from participating, including those with limited English proficiency, low literacy, certain disabilities, or who are homeless. Advocates should push states to require providers to make sure that all patients have the opportunity to provide feedback on their care experience.

Improving Quality Measurement over Time

Methods for measuring quality will change over time. As providers develop new Health Home functions and gain experience coordinating care, they should be asked to meet progressively higher quality thresholds. New quality measures for key functions, such as the integration of behavioral health and patient engagement, are being developed and tested, and states and advocates should look for ways to incorporate these new measures into the evaluation of Health Homes.

Advocates can also focus on filling the serious gaps in quality measures for patients with multiple chronic conditions. Development and testing of quality measures for these patients has lagged behind the design of quality measures for patients who are healthy or who have only one chronic illness. While a fairly robust set of measures exists for healthy populations, these are inadequate for assessing the quality of care for complex patients. As delivery system reform focuses increasingly on bending the cost curve for the most expensive patients, robust quality measures for this population will be critical to ensuring that these changes result in better care. State advocates should encourage organizations that develop quality measures to make ones that apply to care coordination and that are appropriate for patients with multiple chronic conditions.

Issues for Advocates to Consider

- How will the state measure care coordination and patient experience?
- What are the gaps in the measures that are currently available for Health Homes?

Tying Payments to Quality

Realigning the health care delivery system to pay for the quality of care rather than the volume of care means tying financial incentives to the quality of care delivered. While reimbursing providers for coordinating care is an important step toward delivery system reform, all Health Homes should work toward paying providers for quality as well.

Types of Financial Incentives

Financial incentives for quality of Health Home services could take one of the following forms:

- **Tiered Payments**
  While each Health Home will need to demonstrate its ability to perform core functions before being approved as a Health Home, more advanced functions can help Health Homes provide even better care. For example, having a primary care provider on site in a community mental health center Health Home is not necessary for successful delivery of Health Home services, but it can improve care.

One way to incentivize providers to develop advanced functions is to tier payments based on these functions. For example, **Oregon** developed a robust set of state-based standards that breaks Health Home functions into three tiers. Health Homes with advanced functions receive per-member, per-month payments that are more than twice as high as those paid to Health Homes with only basic functions, thus creating a significant incentive for practice transformation and improvement.[19]

- **Performance Payments**

  States can also give providers bonus payments for meeting quality targets, either in the form of increased monthly payments or as annual lump sum payments. For example, beginning in 2013, **Iowa** will offer Health Home providers an annual lump sum payment for meeting quality targets in prevention, disease management, and behavioral health integration. Performance bonuses for Health Homes that successfully meet these targets could be as much as 20 percent of the total amount of payments the Health Home receives during the year.[20] Performance payments can mitigate some of the risk that Health Homes take on when caring for high-need patients in a capitated system by enabling Health Homes that meet quality targets to recoup the money they spent caring for complex patients.

- **Quality Withholds**

  Another way to tie payment to quality is through the use of quality withholds. In a quality withhold, the state retains a certain portion of a provider's payment each month (for example, 10 percent). The amount of the withheld payments that the provider receives at the end of the year is based on performance. If a state chooses to use quality withholds, it is important that the amount withheld is significant enough to give providers an incentive to change, but not so high that it forces them to take on untenable financial risks to offer services.

- **Shared Savings**

  A shared savings model gives a portion of any savings on patient care to providers, as long as quality standards are met. To implement a shared savings model for Health Homes, the state would need to first establish a benchmark for the average per capita amount it costs to treat Health Home patients. Because events beyond the control of the Health Home (for example, a flu outbreak or natural disaster) might lead to higher or lower than average costs in a given year, the state also needs to set a minimum savings threshold (for example, 5 percent). The Health Home would have to meet this minimum savings threshold in order to qualify for a portion of shared savings.

  To ensure that savings are the result of improving the quality of care rather than denying necessary care, the state must also establish quality targets. If the provider meets quality targets while spending less than the benchmark amount

and saving more than the minimum savings threshold, then an agreed-upon portion of the savings (for example, 60 percent) is given to the Health Home.[21] While no states currently use this model, **Missouri** plans to implement shared savings for its Health Homes through a future state plan amendment that would allow Health Homes to receive up to 50 percent of shared savings.

The appropriate type of accountability payment for a Health Home will change over time. The focus of the first year of Health Home implementation should be on provider transformation, ensuring payment adequacy, and gathering cost and quality benchmarks. The costs and impacts of Health Home services are currently unknown, so it is important that states take the time needed for proper implementation.

While implementing performance payments in the first year may not be a good idea for most states, advocates should encourage states to develop a performance payment methodology and a timeline for integrating the payments during Health Home development. States can include these details either in the initial state plan amendment that sets up Health Homes or in a later state plan amendment that would change the payment methodology to include incentive payments.

For a list of the quality measures being used by the first nine Health Homes that have been approved by CMS, see the Appendix on page 18.

Issues for Advocates to Consider

- How will the state incentivize high-quality care?
- When will the state begin tying payments to quality?

Conclusion

Setting up Health Homes is an important opportunity for states to begin aligning how providers are paid with the quality of care they provide. A well-designed Health Home will have the flexibility to meet the specific needs of each individual patient, and providers will benefit financially from improving the health and care experiences of these vulnerable patients. Advocates have a critical role to play in ensuring that the ways in which Health Homes are paid, quality of care is measured, and payment is tied to quality reflect the goals of patient-centered care.

Resources

National Quality Forum: http://www.qualityforum.org/Home.aspx

National Quality Measure Clearinghouse: http://www.qualitymeasures.ahrq.gov/

Endnotes

[1] Organization for Economic Co-Operation and Development (OECD), *OECD Health Data 2012: How Does the United States Compare?* (Paris, France: OECD, 2012), available online at http://www.oecd.org/unitedstates/BriefingNoteUSA2012.pdf.

[2] The six Health Home services are comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referrals to community and social support services. For more information, see Sarah Baggé, *Health Homes in Medicaid: Challenges and Opportunities for Advocates* (Washington: Families USA, November 2012), available online at http://familiesusa2.org/assets/pdfs/health-system-reform/Health-Homes-in-Medicaid.pdf, and Sarah Baggé, *Designing Consumer-Friendly Health Homes* (Washington: Families USA, January 2013), available online at http://familiesusa2.org/assets/pdfs/health-system-reform/Consumer-Friendly-Health-Homes.pdf.

[3] For more on the Health Homes that CMS has approved so far, see the chart at the end of Sarah Baggé, *Health Homes in Medicaid: Challenges and Opportunities for Advocates*, op. cit.

[4] While retrospective payment of providers can be problematic for some services that require upfront costs, the six Health Home services are non-medical. Rather than covering a particular test or procedure, Health Home payments cover staff time and the maintenance of disease registries and electronic health records. With adequate support for the costs of provider transition, retrospective payments for Health Home services should work for most providers.

[5] Minnesota was one of the states that pioneered a medical home model of caring for those with multiple chronic conditions. Minnesota's health care homes pre-date the Affordable Care Act, but they share many similarities with Health Homes.

[6] For example, Rhode Island's behavioral Health Homes, which will be paid on a capitated basis, are required to collect and submit encounter data for the first six months. The state will then use that data to analyze program costs, develop recipient profiles, explore potential adjustments to the case rate payments, and explore alternative payment methodologies. After the first year, this evaluation will take place annually.

[7] For more on Missouri's Health Homes learning collaborative and the PMPM payment, see "Learning Collaborative Questions" in Missouri Department of Social Services, *Health Home Implementation Process, Frequently Asked Questions* (Jefferson City, MO: Missouri Department of Social Services, December 2011), available online at http://dss.mo.gov/mhd/faq/pages/health-homes-implementation-learning-collaborative.htm.

[8] For a more detailed description of state options for the certification or accreditation of Health Homes, see Sarah Baggé, *Designing Consumer-Friendly Health Homes*, op. cit..

[9] For more on Oregon's Patient-Centered Primary Care Home tiers, see Office for Oregon Health Policy and Research, *Oregon Patient-Centered Primary Care Home Model* (Salem, OR: Oregon Health Authority, October 2011), available online at http://www.oregon.gov/oha/OHPR/HEALTHREFORM/PCPCH/docs/implementation-guide-2011-10.pdf.

[10] Centers for Medicare and Medicaid Services, *State Medicaid Director Letter Re: Health Homes for Enrollees with Chronic Conditions* (Baltimore: Department of Health and Human Services, November 16, 2010), available online at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf.

[11] Centers for Medicare and Medicaid Services, *State Medicaid Director Letter Re: Health Homes Core Quality Measures* (Baltimore: Department of Health and Human Services, January 15, 2013), available online at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-13-001.pdf.

[12] National Quality Forum (NQF) members include physicians, nurses, hospitals, public and private payers, accrediting bodies, consumer organizations, supporting industries, and health care research and quality improvement organizations. This group of health care stakeholders works to develop consensus around quality measures and best practices. NQF's multi-stakeholder approach to developing quality measures can help create buy-in for the measures they endorse. For more on the work of NQF, see the organization's website at http://www.qualityforum.org/Home.aspx.

[13] For more on the care coordination measures endorsed by NQF, see National Quality Forum, *Care Coordination Endorsement Maintenance* (Washington: National Quality Forum, October 2012), available online at http://www.qualityforum.org/Projects/c-d/Care_Coordination_Endorsement_Maintenance/Care_Coordination_Endorsement_Maintenance.aspx.

[14] For the full Patient-Centered Medical Home (PCMH) Item Set, see Agency for Healthcare Research and Quality, *About the CAHPS Patient-Centered Medical Home (PCMH) Item Set* (Rockville, MD: Department of Health and Human Services, September 2011), available online at https://cahps.ahrq.gov/clinician_group/cgsurvey/aboutpatientcenteredmedicalhomeitemset.pdf.

[15] For more on the CAHPS Cultural Competence Item Set, see Agency for Healthcare Research and Quality, *About the CAHPS Cultural Competence Item Set* (Rockville, MD: Department of Health and Human Services, May 2012), available online at https://cahps.ahrq.gov/clinician_group/cgsurvey/aboutculturalcompetenceitemset.pdf.

[16] For more on the CAHPS Health Literacy Item Set, see Agency for Healthcare Research and Quality, *About the CAHPS Item Set for Addressing Health Literacy* (Rockville, MD: Department of Health and Human Services, May 2012), available online at https://cahps.ahrq.gov/clinician_group/cgsurvey/aboutitemsetaddressinghealthliteracy.pdf.

[17] For more on health literacy, see The Joint Commission, *"What Did the Doctor Say?" Improving Health Literacy to Protect Patient Safety* (Oakbrook Terrace, IL: The Joint Commission, 2007), available online at http://www.jointcommission.org/assets/1/18/improving_health_literacy.pdf.

[18] States are required to collect and report Mental Health Statistics Improvement Program survey data in order to qualify for SAMHSA mental health block grant funding.

[19] For a list of Oregon's Patient Centered Primary Care Home functions at each level, see Office for Oregon Health Policy and Research, *Standards and Measures for Patient Centered Primary Care Homes* (Salem OR: Oregon Health Authority, November 2010), available online at http://www.oregon.gov/oha/action-plan/pcpch-report.pdf.

[20] Information on Iowa's Health Home performance payments is available at Iowa Department of Human Services, *Financial Alignment Demonstration Proposal for Medicare-Medicaid Members* (Des Moines, IA: Iowa Department of Human Services, April 2012), available online at http://www.ama-assn.org/resources/doc/arc/ia-state-proposal.pdf.

[21] For more on the methodology for developing a shared savings system, see Michealle Gady, *Accountable Care Organizations: Determining Shared Savings or Losses* (Washington: Families USA, January 2012), available online at http://familiesusa2.org/assets/pdfs/health-reform/ACOs-Shared-Savings-or-Losses.pdf.

Appendix: State Health Home Quality Measures

States must decide which quality measures each Health Home will be required to track to ensure that patients receive high-quality care. The following is a list of the quality measure that are included in the first nine Health Homes that have been approved by CMS. Most structural quality measures are incorporated into states' provider standards, which is why few structural measures are included in this list.[1]

Iowa

- **Process Measures:**
  - **Annual Dental Visit**
    Percentage of children who received preventive dental services in the past year
  - **Cancer Screening**
    Percentage of women who had age-appropriate cancer screenings (measured separately for pap tests and mammograms)
  - **Child Immunization**
    Percentage of 2-year-old children who have received all recommended vaccines
  - **Diabetes Care, Annual Foot Exam**
    Percentage of adult diabetic patients who received a foot exam
  - **Diabetes Care, Dilated Eye Exam**
    Percentage of adult diabetic patients who received a dilated eye exam from an optometrist or ophthalmologist
  - **Diabetes Care, Micro Albumin**
    Percentage of adult diabetic patients who received a micro albumin test
  - **Follow-Up Care for Children with Newly Prescribed ADHD Medication**
    Percentage of children prescribed ADHD medication with at least three follow-up visits in 10 months, one of which was within 30 days after medication was dispensed
  - **Influenza Immunization**
    Percentage of patients older than 6 months who received an influenza immunization from October through February
  - **Well-Child Visits**
    Percentage of children who receive a specified number of well-child visits in the first 15 months
- **Outcome Measures:**
  - **Diabetes Management, Hemoglobin A1c Levels**
    Percentage of diabetic patients with hemoglobin A1c levels below a specified standard
  - **Diabetes Management, Lipid Levels**
    Percentage of diabetic patients with low-density lipoprotein (LDL) levels below 100
- **Patient Experience Measures:**
  - **None**

Missouri (Behavioral Health)

- **Process Measures:**
  - **Asthma Care**
    Percentage of patients with asthma who are prescribed appropriate medication (measured separately for kids and adults)
  - **Asthma Medication Adherence**
    Percentage of patients with asthma and chronic obstructive pulmonary disease (COPD) with a medication possession rate of more than 80 percent
  - **Care Coordination**
    Percentage of patients discharged from the hospital with whom the care manager made contact in person or by phone within two days and performed medication reconciliation with input from a primary care physician
  - **Medication Adherence for Antipsychotics, Antidepressants, and Mood Stabilizers**
    Percentage of patients on these medications with a medication possession rate of more than 80 percent
  - **Medication Adherence for Cardiovascular Disease (CVD)**
    Percentage of patients with CVD with a medication possession rate of more than 80 percent
  - **Metabolic Screening**
    Percentage of patients that received a metabolic screening within the last 12 months
  - **Use of Online Electronic Health Records (EHRs) by Health Home**
    Rate at which Health Home accesses online EHR per member
  - **Use of Personal EHR by Patients**
    Percentage of patients who view their EHR online
  - **Use of Statins to Treat CVD**
    Percentage of patients with CVD who are prescribed a statin
- **Outcome Measures:**
  - **Ambulatory Care-Sensitive Conditions Admissions**
    Rate of acute care hospitalizations for ambulatory care-sensitive condition
  - **Blood Pressure Management**
    Percentage of patients with hypertension who have at least two office visits where blood pressure is adequately controlled (less than 140/90)
  - **Body Mass Index (BMI) Management**
    Percentage of patients with documented BMI between 18.5 and 24.9
  - **Diabetes Management, Hemoglobin A1c**
    Percentage of adult diabetic patients with hemoglobin A1c levels that are less than 8 percent at most recent screening
  - **Emergency Department Visits**
    Rate of preventive/ambulatory care sensitive emergency department visits
  - **Excessive Drinking**
    Percentage of adult patients who report drinking heavily in the past 12 months

- **Hospital Readmissions**
  Percentage of patients with all-cause readmissions within 30 days of a hospital discharge
- **Illicit Drug Use**
  Percentage of adult patients who report illicit drug use in the past year
- **Lipid Level Management**
  Percentage of adult patients with coronary artery disease (CAD) who had lipid levels adequately controlled (LDL of less than 100)

- **Patient Experience Measures:**
  - **Experience of Care**
    Percentage of patients who give the Health Home an average score of 2.5 or higher (5 point scale) on general satisfaction measures in the SAMHSA Mental Health Statistic Improvement Program satisfaction survey

Missouri (Physical Health)

- **Process Measures:**
  - **Asthma Care**
    Percentage of patients with asthma who are prescribed appropriate medication (measured separately for kids and adults)
  - **Asthma Medication Adherence**
    Percentage of patients with asthma and chronic obstructive pulmonary disease (COPD) with a medication possession rate of more than 80 percent
  - **BMI Follow-Up**
    Percentage of patients with documented BMI that is too high or too low within last three months who received follow-up
  - **Care Coordination**
    Percentage of patients discharged from the hospital with whom the care manager made contact in person or by phone within three days and performed medication reconciliation with input from a primary care physician
  - **Child Immunization**
    Percentage of 2-year-old children who have received all recommended vaccines
  - **Depression Screening**
    Percentage of adults screened for depression in the last year
  - **Medication Adherence for Cardiovascular Disease (CVD)**
    Percentage of patients with CVD with a medication possession rate of more than 80 percent
  - **Medication Adherence for Diabetes**
    Percentage of diabetic patients with a medication possession rate of at least 80 percent

- **Mental Health Screening for Children**
  Percentage of children screened for mental health issues using Early Periodic Screening, Diagnosis, and Treatment (EPSDT) tools in the past year
- **Use of Personal Electronic Health Record (EHR) by Patients**
  Percentage of patients who view their EHR online

- **Outcome Measures:**
  - **Ambulatory Care-Sensitive Conditions Admissions**
    Rate of acute care hospitalizations for ambulatory care-sensitive condition
  - **Blood Pressure Management**
    Percentage of patients with hypertension who have at least 2 office visits where blood pressure is adequately controlled (less than 140/90)
  - **BMI Management**
    Percentage of patients with documented BMI between 18.5 and 24.9
  - **Diabetes Management, Hemoglobin A1c**
    Percentage of diabetic patients with hemoglobin A1c levels of less than 8 percent at most recent screening (measured separately for adults and children)
  - **Emergency Department Visits**
    Rate of preventive/ambulatory care sensitive emergency department visits
  - **Excessive Drinking**
    Percentage of adult patients who report drinking heavily in the past 12 months
  - **Hospital Readmissions**
    Percentage of patients with all-cause readmissions within 30 days of a hospital discharge
  - **Illicit Drug Use**
    Percentage of adult patients who report illicit drug use in the past year
  - **Lipid Level Management**
    Percentage of adult patients with coronary artery disease (CAD) who had lipid level adequately controlled (LDL of less than 100)
- **Patient Experience Measures:**
  - **Experience of Care**
    Percentage of positive responses to questions in CAHPS Adult and Child primary care survey (select questions)

New York

- **Process Measures:**
  - **Adherence to Antipsychotics**
    Percentage of individuals with bipolar 1 disorder who had a proportion of days covered greater than 80 percent for a mood stabilizer
  - **Adherence to Mood Stabilizers**
    Percentage of individuals with schizophrenia who had a proportion of days covered greater than 80 percent for an antipsychotic

- **Antidepressant Medication Management**
  Percentage of patients with a new diagnosis of depression treated with an antidepressant who remained on the antidepressant for the acute and recovery phases of treatment
- **Asthma Care**
  Percentage of patients with asthma appropriately prescribed medication
- **Asthma Medication Management**
  Percentage of patients with asthma who were given appropriate medications to cover at least 50 percent of their treatment period and percentage of patients with asthma who were given appropriate medications to cover at least 75 percent of their treatment period
- **Chlamydia Screening**
  Percentage of women who identified as sexually active who had at least one chlamydia screening
- **Cholesterol Testing for Patients with Cardiovascular Conditions**
  Percentage of patients with cardiovascular conditions that had at least one LDL screening
- **Colorectal Cancer Screening**
  Percentage of those older than 50 who had appropriate colorectal cancer screening
- **Diabetes Care**
  Percentage of patients with diabetes who had at least one hemoglobin A1c test and at least one LDL-C test
- **Follow-Up on Alcohol Hospitalization and Chemical Dependency Detoxification**
  Percentage of patients with alcohol or chemical dependency discharges who received follow-up in 7 and 30 days and 90 days
- **Follow-Up after Hospitalization for Mental Illness**
  Percentage of patients with mental health discharges who received follow-up in 7 and 30 days
- **Follow-Up Care for Children with Newly Prescribed ADHD Medication**
  Percentage of children prescribed ADHD medication with at least 3 follow-up visits in 10 months, one of which was within 30 days after medication was dispensed
- **HIV/AIDS Care**
  Percentage of patients living with HIV who received 2 outpatient primary care visits, viral load monitoring, and syphilis screening
- **Mental Health Service Utilization**
  Number and percentage of patients receiving inpatient, outpatient/partial hospitalization, or outpatient/emergency department mental health services
- **Post-Heart Attack Treatment**
  Percentage of patients who were hospitalized and discharged alive for a heart attack who received persistent beta blocker for six months after discharge

- **Outcome Measures:**
  - **Emergency Department Visits**
    Rate of emergency department visits
  - **Inpatient Care Utilization**
    Rate of utilization of acute inpatient care
- **Patient Experience Measures:**
  - **None**

North Carolina

- **Structural Measures:**
  - **Co-Location of Behavioral Health**
    Percentage of practices with co-located behavioral health providers
- **Process Measures:**
  - **Cancer Screenings**
    Percentage of patients who received recommended cancer screenings (pap tests, mammograms, and colonoscopies)
  - **Comprehensive Care**
    Percentage of high priority patients who received comprehensive assessment or intervention
  - **Medication Reconciliation**
    Percentage of patients discharged from a hospital who received medication reconciliation within 30 days
  - **Well-Child Visits**
    Rate of well-child visits and adolescent well-care visits to OB/GYN or primary care provider
- **Outcome Measures:**
  - **Asthma Hospital Admissions**
    Rate of admissions for asthma for non-dual aged, blind, and disabled (ABD) patients
  - **Blood Pressure Control**
    Percentage of hypertensive and diabetic patients with blood pressure under control (less than 130/80), measured separately
  - **Emergency Department Visits**
    Rate of emergency room visits by non-dual ABD patients and by non-ABD patients
  - **Heart Failure Hospital Admissions**
    Rate of non-dual admissions for heart failure
  - **Heart Failure Readmissions**
    Rate of 30-day readmissions for patients with heart failure
  - **Hospital Admissions**
    Rate of inpatient admissions for non-dual ABD patients
  - **Preventable Readmissions**
    Rate of potentially preventable readmissions

- **Patient Experience Measures:**
  - **Experience of Care**
    CAHPS 4.0 survey + Community Care of North Carolina supplements; also coordination of care and behavioral health supplements and HEDIS measure set supplements

Ohio

- **Process Measures:**
  - **Access to Preventive and Ambulatory Health Services**
    Percentage of adults who had an ambulatory care or preventive care visit
  - **Adolescent Well-Care Visits**
    Percentage of adolescents with well-care visits
  - **Annual Assessments of BMI, Glycemic Control, and Lipids for patients with Bipolar Disorder Prescribed Mood Stabilizer Medications**
    Percentage of patients with bipolar diagnosis who were prescribed antipsychotic medication with assessment of BMI, glycemic control, and lipids in the past year
  - **Annual Assessments of BMI, Glycemic Control, and Lipids for patients with Schizophrenia Prescribed Antipsychotic Medications**
    Percentage of patients with a schizophrenia diagnosis who were prescribed antipsychotic medication with assessment of BMI, glycemic control, and lipids in the past year
  - **Annual Dental Visit**
    Percentage of patients who had one or more dental visits (children and adults measured separately)
  - **Appropriate Treatment of Upper Respiratory Infection for Children**
    Percentage of children with upper respiratory infection diagnosis who were not dispensed an antibiotic prescription
  - **Asthma Care**
    Percentage of patients with asthma who are appropriately prescribed medication
  - **BMI Screening**
    Percentage of adult patients with outpatient visits who received BMI screening
  - **Depression Screening**
    Percentage of adult patients receiving a depression screening
  - **Hospitalization Follow-Up**
    Percentage of discharges followed by visit with mental health practitioner within seven days
  - **Initiation or Engagement of Alcohol or Other Drug (AOD) Dependence Treatment**
    Percentage of patients with a new episode of AOD dependence who initiate treatment and percentage who had two or more additional services with a diagnosis of AOD within 30 days

- **Medication Coverage**
  Percentage of patients reaching proportion of days covered for medications for cardiovascular disease, mental illness, diabetes, asthma, and other chronic disease
- **Prenatal and Postpartum Care**
  Percentage of patients with live births who completed pre- and postnatal care visits in recommended times
- **Smoking and Tobacco Use Cessation**
  Percentage of tobacco-using patients who receive tobacco cessation intervention
- **Timely Transmission of Medication List**
  Percentage of patients discharged from inpatient facilities whose reconciled medication list was transmitted to the Health Home within 24 hours
- **Timely Transmission of Transition Record**
  Percentage of patients discharged from inpatient facility whose transition record was transmitted to the Health Home within 24 hours
- **Weight Assessment for Children**
  Percentage of children with outpatient primary care or OB-GYN visit who received BMI assessment and counseling for nutrition and physical activity

- **Outcome Measures:**
  - **Ambulatory Care-Sensitive Conditions Admissions**
    Rate of acute care hospitalizations for ambulatory care-sensitive conditions
  - **Blood Pressure Management**
    Percentage of patients with a hypertension diagnosis with blood pressure less than 140/90
  - **Cholesterol Management For Patients with Cardiovascular Conditions**
    Percentage of patients with certain cardiovascular conditions with LDL level less than 100
  - **Diabetes Management, Hemoglobin A1c**
    Percentage of diabetic patients with hemoglobin A1c levels below 7 percent
  - **Diabetes Management, Lipid Levels**
    Percentage of diabetic patients who had lipid level adequately controlled (LDL-C of less than 100)
  - **Hospital Readmissions**
    Percentage of patients with all-cause readmissions within 30 days of a hospital discharge
  - **In-Patient and Emergency Department Utilization Rate**
    Rate of inpatient discharges, emergency department visits, alcohol or other drug inpatient discharges, and mental health discharges
  - **Underweight Births**
    Percentage of live births by Health Home patients under 2,500 grams
- **Patient Experience Measures:**
  - **Experience of Care**
    Number of patients scoring 3.5 or higher (5 point scale) on each of SAMHSA's National Outcome Measures subscales

Oregon

- **Process Measures:**
  - **BMI Screening**
    Percentage of adult patients with an outpatient visit in the last year who had their BMI screened and documented
  - **Care Transitions**
    Percentage of patients discharged from an emergency department to ambulatory care, home health care, or a caregiver, who received transition record when discharged
  - **Mental Health Follow-Up**
    Percentage of patients age six and over hospitalized for mental health disorders who had follow-up visit with a mental health practitioner within 30 days
- **Outcome Measures:**
  - **Ambulatory Care Utilization**
    Utilization of ambulatory care through outpatient visits, emergency department visits, ambulatory surgery/procedures, and observation room stays
  - **Avoidable Hospital Readmissions**
    Rate of hospital readmissions within 30 days following a pneumonia hospitalization
- **Patient Experience Measures:**
  - **Experience of Care**
    Percentage of adult health plan members who reported receiving certain types of care in CAHPS survey (health plans and systems, clinics, and groups or PCMH version)

Rhode Island (CEDARR)

- **Process Measures:**
  - **Access**
    Percentage of clients offered initial appointment within 30 days of interest
  - **BMI Screening**
    Percentage of participants age six and over with documented BMI screening
  - **Collaboration between Health Home and Primary Care Provider**
    Number of billing claims for medical team conference with interdisciplinary team of health care professionals
  - **Community Referrals**
    Average number of referrals made per client
  - **Depression Follow-Up**
    Percentage of clients with a positive depression screen who received evaluation or treatment within 2 months
  - **Depression Screening**
    Percentage of participants age 12 years or older with depression screen conducted
  - **Discharge Follow-Up**
    Percentage of hospitalized patients who receive medical follow-up within seven days of discharge

- **Emergency Department Visit Follow-Up**
  Percentage of clients with emergency department visits who had medical follow-up within seven days of discharge
- **Improved Care Transitions**
  Percentage of patients with hospital stays of more than a week who had a Health Home staff service claim during stay
- **Improved Care Transitions**
  Percentage of patients with hospital stays of more than a week who had a Health Home staff service claim within 7 days of discharge
- **Outreach**
  Percentage of managed care organization enrollees with documented outreach from the Health Home
- **Timely Delivery of Health Home Care Coordination Services**
  Percentage of treatment plans reviewed within 30 days of receipt
- **Timely Delivery of Services**
  Percentage of care plans completed within 30 days of initial assessment
- **Timely Delivery of Services**
  Percentage of care plan reviews conducted before expiration of previous plan
- **Use of Electronic Medical Record**
  Rate at which Health Home views children's electronic medical records per member

- **Outcome Measures:**
  - **Avoidable Admissions**
    Percentage of admissions that could have been avoided with proper preventive care
  - **Avoidable Readmissions**
    Percentage of patients with an inpatient admission who have a readmission or emergency department visit within 30 days of discharge for the same diagnosis (measured separately for psychiatric and non-psychiatric admissions)
  - **BMI Control**
    Percentage of clients with BMI below the 85th percentile
  - **Emergency Department Use**
    Percentage of emergency department visits that could have been appropriately treated in non-emergency setting
  - **Family Support**
    Percentage of clients who say that knowledge of their child's condition has improved
  - **Family Support**
    Percentage of clients scoring well in response to question about how much stress their child's condition causes
  - **Family Support**
    Percentage of clients scoring well in response to question about how much their child can take part in age appropriate community and social activities

- **Patient Experience Measures:**
  - **Experience of Care**
    Percentage of families who fill out annual survey who say that the care plan met their child's needs, they know who to contact if needed, and appointments were scheduled in timely manner, etc.

Rhode Island (Behavioral Health)

- **Process Measures:**
  - **Alcohol and Drug Abuse Counseling and Treatment**
    Percentage of drug/alcohol abusers counseled and referred to treatment
  - **Alcohol and Drug Dependence Treatment**
    Percentage of adolescents and adults with a new episode of alcohol or other drug dependence who received initiation of treatment or engagement of treatment
  - **Asthma Care**
    Percentage of asthma patients appropriately prescribed medication
  - **Asthma Medication Adherence**
    Percentage of patients on medication for asthma and/or chronic obstructive pulmonary disease with a medication possession rate of more than 80 percent
  - **BMI Screening**
    Percentage of adult patients with outpatient visits who received BMI screening
  - **Cancer Screening**
    Percentage of patients who received age- and gender-appropriate pap tests, mammograms, or colonoscopies
  - **Care Transitions**
    Percentage of patients discharged from the hospital with a follow-up visit within 14 days
  - **Care Transitions**
    Percentage of discharged patients contacted by someone at the Health Home by phone or in person within two days of discharge
  - **Care Transitions**
    Percentage of discharges following hospitalization for mental health disorders with follow-up within seven days by a mental health practitioner
  - **Care Transitions**
    Percentage of discharged patients contacted by a Health Home member or liaison by phone or in person within two days of discharge
  - **Care Transitions**
    Percentage of patients discharged from any site for whom their transition record was transmitted to provider designated for follow-up within 24 hours
  - **Care Transitions**
    Percentage of hospital-discharged patients with a follow-up visit to a Health Home or medical provider within 14 days of discharge

- **Depression Screening**
  Percentage of adult patients screened for clinical depression using a standardized tool who also had follow-up documented
- **Documentation of Physical and Behavioral Health Needs**
  Percentage of patients whose charts include documentation of physical and behavioral health needs
- **Medication Adherence for Cardiovascular Disease and High Blood Pressure**
  Percentage of patients prescribed anti-hypertensives and medications for cardiovascular disease who had a medication possession rate of more than 80 percent
- **Physical Exams**
  Percentage of patients who received a physical exam in the past 12 months
- **Smoking Cessation Counseling**
  Percentage of smokers counseled and referred for smoking cessation
- **Statin Use**
  Percentage of patients using a statin medication who have a history of coronary artery disease
- **Well Visits and Physical Exams**
  Percentage of patients having one or more well-visits/physical examination visits in a 12-month period

- **Outcome Measures:**
  - **Acute Readmissions**
    Number of adult inpatient stays followed by an acute readmission within 30 days and predicted probability of acute readmission
  - **Ambulatory Care-Sensitive Conditions Admissions**
    Rate of acute care hospitalizations for ambulatory care-sensitive condition
  - **Blood Pressure Control**
    Percentage of patients with hypertension who have had at least two office visits with blood pressure adequately controlled (less than 140/90)
  - **Designated Provider**
    Percentage of patients who identify a regular source of physical health care other than the emergency department
  - **Diabetes Control**
    Percentage of patients with diabetes who had hemoglobin A1c levels below 8 percent
  - **Drug Use and Alcohol Abuse**
    Percentage of patients who report using illicit substances or alcohol
  - **Emergency Department Visits**
    Percentage of emergency department visits for non-emergency care or primary care preventable reasons
  - **Emergency Department Visits**
    Percentage of emergency department visits that were for a mental health condition

- **Lipid Level Control**
  Percentage of patients diagnosed with coronary artery disease with lipid levels adequately controlled (less than 100)
- **Smoking**
  Percentage of patients who smoke

- **Patient Experience Measures:**
  - **Experience of Care**
    Satisfaction with care and accessibility of care as measured by the Rhode Island Outcome Evaluation Instrument survey

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[1] Most structural measures for Health Homes are included either in the state's standards for Health Home providers or in the requirements to receive accreditation. Both of these topics are discussed in detail in the second brief in this series, *Designing Consumer-Friendly Health Homes,* available online at http://familiesusa2.org/assets/pdfs/health-system-reform/Consumer-Friendly-Health-Homes.pdf.

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