

# FREQUENTLY ASKED QUESTIONS

## IMPLEMENTATION PROCESS

Categories of Questions: Staffing, PMPM, Learning Collaborative, Claims Data, Patient Auto-Assignment, Miscellaneous

### *Staffing Questions:*

1. What are the expected patient ratios for the following positions: Nurse Care Manager, BHC, Care Coordinator, Health Home Director?

**Answer:** The current staffing ratios are as follows:

Health Home Director 1/2500

Nurse Care Manager 1/250

Behavioral Health Consultant 1/750

Care Coordinator 1/750

We anticipate that if an organization has fewer than the number of patients in the staff to patient ration that they will be able to use the PMPM to staff proportionately.

2. What credentials must you have to be a Health Home Director? We would like our COO to serve in this role?

**Answer:** Initial thoughts were physicians, but have since moved off that position, allowing others, provided that they are familiar with the concept of health care homes. However, we are not looking for the assignment of current staff (as that will be a cost offset), but added capacity. At all costs, we must avoid supplantation.

3. Could you post job descriptions for each of the positions you mentioned on the call?

**Answer:**

<b>Nurse Care Manager</b>	1 FTE/250 enrollees \$105,000 / year	PMPM \$35.00	<ol style="list-style-type: none"><li>a. Develop wellness &amp; prevention initiatives</li><li>b. Facilitate health education groups</li><li>c. Participate in the initial treatment plan development for all of their Health Home enrollees</li><li>d. Assist in developing treatment plan health care goals for individuals with co-occurring chronic diseases</li><li>e. Consult with Community Support Staff about identified health conditions</li></ol>
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			<ul style="list-style-type: none"> <li>f. Assist in contacting medical providers &amp; hospitals for admission/discharge</li> <li>g. Provide training on medical diseases, treatments &amp; medications</li> <li>h. Track required assessments and screenings</li> <li>i. Assist in implementing MHD health technology programs &amp; initiatives (i.e., CyberAccess, metabolic screening)</li> <li>j. Monitor HIT tools &amp; reports for treatment</li> <li>k. Medication alerts &amp; hospital admissions/discharges</li> <li>l. Monitor &amp; report performance measures &amp; outcomes</li> </ul>
<p><b>Behavioral Health Consultant</b></p>	<p>1 FTE/750 enrollees \$70,000/year</p>	<p>PMPM \$7.78</p>	<ul style="list-style-type: none"> <li>a) screening/evaluation of individuals for mental health and substance abuse disorders</li> <li>b) brief interventions for individuals with behavioral health problems</li> <li>c) behavioral supports to assist individuals in improving health status and managing chronic illnesses</li> <li>d) The behavioral health consultant both meets regularly with the primary care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal “curbside “ manner as part of the daily routine of the clinic</li> <li>e) Integration with Primary Care <ul style="list-style-type: none"> <li>o Support to Primary Care physician/teams in identifying and behaviorally intervening with patients who could benefit from behavioral intervention.</li> <li>o Part of front line interventions with first looking to manage behavioral health needs within the primary care practice.</li> <li>o Focus on managing a population of patients versus specialty care</li> </ul> </li> <li>f) Intervention <ul style="list-style-type: none"> <li>o Identification of the problem behavior, discuss impact, decide what to change</li> <li>o Specific and goal directed interventions <ul style="list-style-type: none"> <li>o Use monitoring forms</li> <li>o Use behavioral health “prescription”</li> <li>o Multiple interventions simultaneously</li> </ul> </li> </ul> </li> <li>g) Education <ul style="list-style-type: none"> <li>o Handouts</li> <li>o “Teach back” strategy</li> </ul> </li> </ul>

			<ul style="list-style-type: none"> <li>o Tailored to specific issue</li> </ul> <p>h) Feedback to PCP</p> <ul style="list-style-type: none"> <li>o Clear, concise, BRIEF</li> <li>o Focused on referral question</li> <li>o Description of action plan</li> <li>o Plan for follow-up</li> </ul>
<b>Health Home Director Administrative support</b>	1 FTE/2500 enrollees \$90,000 / year Non-PMPM paid staff training time Contracted services	PMPM \$8.87	<p>a. Provides leadership to the implementation and coordination of Healthcare Home activities</p> <p>b. Champions practice transformation based on Healthcare Home principles</p> <p>c. Develops and maintains working relationships with primary and specialty care providers including inpatient facilities</p> <p>d. Monitors Healthcare Home performance and leads improvement efforts</p> <p>a. Designs and develops prevention and wellness initiatives Referral tracking</p> <p>b. Training and technical assistance</p> <p>c. Data management and reporting</p> <p>d. Non-PMPM paid staff training time</p>
<b>Care Coordination</b>	1 FTE/750 enrollees \$65,000/year	PMPM \$7.22	<p>e. Referral tracking</p> <p>f. Training and technical assistance</p> <p>g. Data management and reporting (can be separated into second part time function)</p> <p>h. Scheduling for Health Home Team and enrollees</p> <p>i. Chart audits for compliance</p> <p>j. Reminding enrollees regarding keeping appointments, filling prescriptions, etc.</p> <p>k. Requesting and sending Medical Records for care coordination</p>
<b>TOTAL PMPM</b>		<b>\$58.87</b>	

4. Are there any sites we could visit from other states to see how they are managing this workload in terms of staffing?

**Answer:** We based the staffing model on contractor input gleaned from other health home experiences. A visit to another state's facility may be possible; we suggest first discussing this idea at the Learning Collaborative.

5. Are the ratios for patients/staff member evidence based? What was the source? Is this a suggested or required number? Do you have recommendations for salary ranges for the positions?

**Answer:** Currently, there is not a lot of literature regarding health home staffing models. These are in large part under development. Our proposed ratios are based on

several things including information from other health home initiatives, salary ranges for each provider type, and the global budget. The ratios are required and projected average costs in the table above are for total employee cost including salary, fringe, and indirect costs.

6. Regarding the staffing levels and ratios, how do FTEs factor in? i.e. the nurse care coordinator position is expected to have a ratio of 1 to 250 eligible participants – is this considered to be a full-time position?

**Answer:** We would anticipate that the organizations will use the PMPM to provide a salary appropriate to the proportion of FTE required. For example, If an organization has 125 enrolled patients, the nurse care manager would be needed as a half FTE and thus draw half of the recommended salary above. 250 Health Home enrollees is the maximum caseload for a full time nurse care managers on average across all of an organizations participating sites.

### ***PMPM Questions:***

1. What is the anticipated PMPM amount?

**Answer:** The PMPM amount will be \$58.87.

2. If this is a Health Home rather than a Patient Centered Medical Home, will the patient panel size be smaller?

**Answer:** Yes, the patient panels will be smaller since the health home is focusing on the higher cost chronic disease population and not all comers.

3. What is the Behavioral Health PMPM rate for Patient Centered Medical Homes Initiative?

**Answer:** The Behavioral Health component of the PMPM amount is \$7.78.

4. How much is the Administrative Fee cost to the participating Health Homes from this rate?

**Answer:** The administrative fee cost is a total of \$3.47.

5. Will the PMPM be treated as incentive payment in order to not offset on the cost reports for Federally Qualified Health Clinics and Rural Health Clinics?

**Answer:** Health Home PMPM payments will not be offset from operating costs on FQHC and RHC cost reports. The PMPM is not considered an “incentive payment” but rather a payment for health home services provided for patients.

6. Does the PMPM available via this project in any way impact the enhanced payments currently available to Rural Health Clinics or is it strictly supplemental?

**Answer:** The PMPM for practice sites is in addition to existing fee-for-service or Managed Care plan payments for direct services as currently received by Rural Health Clinics.

7. Will the payment come on the same check as claims payments or will separate payment be made for the PMPM? If separate, will it be sent to the clinic/site or the address on claims?

**Answer:** The PMPM payment is currently planned to be with the same payment made for claims. The payment will go to the “pay to” address associated with the provider number on MO HealthNet’s provider file.

### ***Learning Collaborative Questions:***

1. How will staff be compensated for productivity time lost due to attendance at the learning collaborative?

**Answer:** There is an additional \$2.40 built into the PMPM for physician time spent out of the office for the learning collaborative. This is calculated to pay for 2 physicians to attend 6 days of training annually for 8 hours/day per every 500 enrolled patients at a reimbursed cost of \$150/hour.

2. What is the relationship between the sites selected for the learning collaborative and the actual sites that will be participating in the Health Home program?

**Answer:** The sites selected for the learning collaborative will be participating in the health home program.

3. When will we know the location for the learning collaborative (we have to choose on the form sent)? The first one starts so soon it would be nice to know which one we are to attend so we can make arrangements.

**Answer:** The Learning Collaborative locations and dates have been shared with invitees by the Missouri Foundation for Health.

### ***Claims Data Questions:***

1. We want to receive claims data to show why patients were included in the list so that we can see total cost. Will we see this data?

**Answer:** MHD has recently shared with health home organizations their respective lists of patient DCNs that have been assigned based on prior year claim data.

2. Can we access MO HealthNet data directly and would it be timely?

**Answer:** MHD posts the most current 36 months of paid claims history for each patient via CyberAccess. If your facility is not already using CyberAccess, please email us for information on how to register as a secure user of this web-based tool. Regular use of CyberAccess for Care Coordination is a required Health Home Activity and will be a monitored performance indicator. Health Homes are expected to use CyberAccess at a minimum average rate of once per member per month.

3. Will we receive total patient cost claims data (hospital, specialty care, pharmacy, primary care, etc.) from MO HealthNet and from Medicaid Managed Care companies so we can manage costs? How often will the claims data be shared?

**Answer:** Summary data reports will be generated for Health Homes on a regular basis to assist with utilization and financial management.

### ***Patient Auto-Assignment Questions:***

1. Are the managed care Medicaid participants covered the same as those with straight Medicaid?

**Answer:** MO HealthNet Managed Care participants are included in the population of MO HealthNet participants eligible to participate in this program.

2. Can patients be auto-assigned by system, what if we are at capacity?

**Answer:** The initial auto-assignment of patients will be based on claims submitted to MO HealthNet by each practice site. As a result, the patients assigned to each Health Home site should be patients that are currently treated at that site. Patients can then be added or removed from the practice site or Health Home program at the provider's and/or patient's discretion.

3. Are there geographic limits to auto-assign?

**Answer:** No, The initial auto-assignment of patients will be based on claims previously submitted to MO HealthNet by each practice site. As a result, the patients assigned to each Health Home site should be patients that are currently treated at that site. Eligible patients have the ability to choose their health home and can be added or removed from the practice site or Health Home program at the provider's and/or patient's discretion. Health Homes and MHD are required to notify persons auto-enrolled or considering enrollment that they can choose any designated Health Home that is available. Accordingly, we will be requesting that all designated Health Homes provide a list of counties of patient residence that their Health Home services will cover. This information will be used to make a table that Health Homes can use to provide the CMS required patient choice.

4. How many total patients do you anticipate to be enrolled?

**Answer:** Our current estimate is approximately 25,000 MO HealthNet eligible participants initially enrolled in the Health Home program.

5. Do patients have to agree to participate/what is the sign-up process?

**Answer:** Initially auto-enrolled participants will remain enrolled unless they decline Health Home Services or request to switch to another Health Home. The letter that MHD will mail to auto-enrolled patients will explain that they can choose to decline Health Home Services or choose a different Health Home than the one in which they are auto-enrolled. The first time that a member of your Health Home Team meets with a newly auto-enrolled health home patient they will have to provide the same written notice of the right to decline services and choice of Health Home and document that notification in some manner. They do not have to sign any agreement to participate. Providers have the option to add or remove participants from their practice/site at their discretion. Patients have the ability to opt out of the program or to request to change their Health Home site.

6. Will the Health Home project for MO HealthNet include individuals with dual eligibility?

**Answer:** Yes, dual Medicaid – Medicare participants are included in the population of MO HealthNet participants eligible to participate in this program.

### ***Miscellaneous Questions:***

1. How will we ensure cooperation by the hospitals to provide admit/discharge information so that the care manager can contact patients within 72 hours?

**Answer:** Each practice site participating in the Primary Care Health Home Program must enter into a Memorandum of Understanding (MOU) with the hospitals with which they have patients in common to ensure proper coordination of services.

2. What is the definition of “plan of care”? What plan of care will be monitored?

**Answer:** A plan of care is a written plan for services developed by the Care Management team and the patient to assess and determine the patient’s status and needs. The plan of care also outlines the services that will be provided to the patient to meet their identified needs and goals. The plan of care for patients enrolled in the health home will be monitored.

3. Are we to be using the ICD-9 codes for BMI’s? We are using the generic overweight codes and not the BMI specific codes per previous guidance.

**Answer:** No, For Reporting BMI and tobacco use the practice will have to provide an EMR extract file of the actual values to the MPCA data warehouse. MPCA will be handling data aggregation and reporting from the PC-HH practices to MHD. On a separate note regarding claims submission, all claims submitted to MO HealthNet for

payment must use the appropriate ICD-9 codes with the highest level of specificity to describe the patient's condition and/or status.

4. What are the essential elements that need to be addressed in the care plans?

**Answer:** In the primary care health home program, key components include care coordination, care management, behavioral health integration, and quality. Additional assistance with care plans may be offered in the Learning Collaboratives.

5. I understand the PCMH organizations have been decided, but when will the sites be defined?

**Answer:** MHD has forwarded reports to each organization, including projected staffing ratios and salaries, projected initial patient volumes, and a projected fiscal impact. Please take some time to review this information. Organizations will need to determine how they would like to proceed in the health home process based upon this information, including how many sites will participate for your organization. In many cases, this will be a business decision to be made by the individual organization.

6. What date range do you want for Tobacco Use and BMI? Is it on straight Medicaid and Medicaid Managed Care? What age ranges?

**Answer:** The most recent Information regarding tobacco use and BMI within the previous 12 months must be provided on both fee-for-service and MO HealthNet Managed Care participants. We are looking for both adult and pediatric obesity data.

7. Do we have to have the site operational in order to get full reimbursement beginning in February? If we are trained in April, will we be able to participate for 2 years after that date?

**Answer:** Once MHD has obtained approval by CMS to start the program, there will be federal funding for a full 8 quarters. Your site must be operational and reimbursement will depend on evidence of patient contact during the prior quarter.

8. When do we anticipate formal sign-up/contract finalized between us and the department?

**Answer:** We anticipate beginning the program in the first quarter of 2012. Agreements would need to be completed prior to that time.

9. Is this call being recorded so it can be played back at a later date?

**Answer:** The call was not recorded but a document outlining the highlights of the call is available at <http://dss.mo.gov/mhd/cs/health-homes/> under "October 13, 2011 Health Home Conference Call Highlights".

10. Will there be specific quality measures other than UDS or other standard reports such as health disparities data that will be required to report?

**Answer:** Both the CMHC and primary care health homes will be reporting measures that have been decided upon by the health home work groups. These measures may need

to be modified once CMS finalizes its set of health home measures. Please see Attachment 1.

11. Will agreements be between the Health Centers and MO HealthNet, or through definition in regulation?

**Answer:** MO HealthNet is currently exploring whether an MOU type of agreement will be needed.

**Quality Measures: Goal Based Quality Measures**

Please describe a measurable goal of the health home model that will be operationalized utilizing measures within the domains listed below. The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.

**A. Goal 1: Improve Health Outcomes for Persons with Chronic Conditions****1. Clinical Outcomes**

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
<b>(1) Ambulatory Care-Sensitive Condition Admission:</b> 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	Claims	Numerator = Total # of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years / Denominator = Total mid-year population under age 75	Hospital discharge events will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Primary care health homes against each other and disseminated by email.	50 <sup>th</sup> percentile regional rate for Medicaid managed care.
<b>(2) Emergency Department Visits:</b> preventative / ambulatory care-sensitive ER visits (algorithm, not formally a measure)	Claims	Missouri will utilize the NYU Emergency Department Classification algorithm [V2.0] for this measures, which is too lengthy to place in the SPA. The algorithm is a nationally recognized method of calculating preventable ED visits.	Hospital ER visits will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Primary care health homes against each other and disseminated by email.	50 <sup>th</sup> percentile regional rate for Medicaid managed care
<b>(3) Hospital Readmission:</b> Hospital readmissions within 30 days	Claims	Percentage of patients readmitted for all-cause conditions within 30 days of hospital discharge using the CMS Hospital Compare methodology.	Hospital discharge events will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Primary care health homes against each other and disseminated by email.	50 <sup>th</sup> percentile regional rate for Medicaid managed care

## 2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

## 3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) 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.	Claims & EMR	Numerator: Number of patients contacted (by phone or face-to-face) within 72 hours of discharge / Denominator: Number of all patients discharged	The numerator will be aggregated from the monthly primary care health home report. The denominator will be aggregated from claims. Results will be reported in a spreadsheet and benchmark style by individual Primary care health home.	80%

## B. Goal 2: Improve Behavioral Healthcare

### 1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) Reduce the proportion of adults (18 and older) reporting use of any illicit drug during the past 30 days.	EMR	Numerator = Over the prior 12 months the Number of adults who report using illicit drugs in the previous 30 days / Denominator = Total number of adults in the past 12 months x 100	Results will be reported in a spreadsheet and benchmark style by individual Primary care health home	<7.1% (HP2020 goal)
(2) Reduce the proportion of adults (18 and older) who drank excessively in the previous 30 days	EMR	Numerator = Over the prior 12 months the Number of adults who report drinking excessively in the previous 30 days / Denominator = Number of all adult in the past 12 mo. x 100	Results will be reported in a spreadsheet and benchmark style by individual primary care health home.	>25.3% (HP2020 goal)

### 2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

### 3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
% of patients 18 years of age and older receiving depression screening through the use of a standardized screening instruments within the measurement period	EMR	Numerator = Number of adults screened for Depression in the previous 12 months / Denominator = Total number of adults in the past 12 months x 100	Results will be reported in a spreadsheet and benchmark style by individual primary care health home.	90%
Percentage of children screened through EPSDT for mental health issues.	EMR or MHN on-line tool	Numerator = Number of children 0 – 18 y.o. with EPSTD MH items completed in prior 12 months Denominator= total number of unique children enrolled in Health Home in prior 12 months	Results will be reported in a spreadsheet and benchmark style by individual primary care health home.	>85%
% of members aged 18 years and older screened for substance abuse using a standardized tool with a follow-up plan documented, as necessary	EMR	Numerator = Number of adults screened for drinking excessively in the previous 12 months / Denominator = Number of all adult in the past 12 mo. x 100	Results will be reported in a spreadsheet and benchmark style by individual primary care health home.	90%

### C. Goal 3: Increase patient empowerment and self-management

#### 1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Patient Use of personal EHR (Direct Inform, or its successor) or practice EMR patient portal	Cyber Access or its success-sor or practice EMR patient portal	Numerator = Number of times Direct Inform was used (patients online EHR record was opened) in a 90 day period / Denominator = Number of patients actively enrolled in the primary care health home at any point during the 90 days x 90	This is a standard management report available within the CyberAccess tool or via EMR reporting. Results will be reported by individual Primary care health home on the spreadsheet and benchmark style and disseminated all Primary care health homes.	Greater than 0.25

## 2. Experience of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Satisfaction with services	CAPHS CG 1.0 Adult and Child Primary Care Surveys Adult Questions #6, 17, 19, and 20. Child Questions #6, 17, 19, and 22.	Numerator = number questions with response of 3-usually or 4-always Denominator = total number of questions with any answer	Results of the CAPHS survey will be aggregated by Primary care health home and across the entire statewide initiative. Final report will benchmark individual Primary care health home performance compared to other Primary care health homes and the statewide average and identify individual items for performance improvement.	>80%

## 3. Quality of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

## D. Goal 4: Improve coordination of care

### 1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Care Coordination - % of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performance medication reconciliation with input from PCP.	Claims and EMR	Numerator = Number of patients contacted (phone or face-to-face) within 72 hours of discharge / Denominator = Number of all patients discharged x 100	The numerator will be aggregated from the monthly Primary care health home report. The denominator will be aggregated from claims. Results will be reported in a spreadsheet and benchmark style by individual Primary care health home.	80%

### 2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

### 3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Use of CyberAccess per member per month (or its successor) enrollees	Cyber-Access or successor	PMPM Numerator = the number of times cyber access was open a healthcare home number for the 90 day reporting period. Denominator = Number of patients actively enrolled in the primary care health home at any point during the 90 days x 90	This is a standard management report available within the Cyber Access tool. Results will be reported by individual Primary care health home on the spreadsheet and benchmark style and disseminated all primary care health homes.	One cyber access utilization PMPM

### E. Goal 5: Improve preventive care

#### 1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Body Mass Index (BMI) Control - % of patients with documented BMI between 18.5 – 24.9	EMR	Numerator = Number of patients with BMI of 18.5 - 24.9 / Denominator = Number of all patients with a documented BMI x 100	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	37%

<p>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.</p>	<p>EMR</p>	<p>Numerator= Patients in the denominator with a calculated BMI in the past 3 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./ Denominator= All active patients aged 18 years or older.</p>	<p>The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance</p>	<p>37 %</p>
<p>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.</p>	<p>EMR</p>	<p>Numerator= Patients in the denominator with BMI % documentation, counseling for nutrition and counseling for physical activity during the 90 day reporting period/ Denominator= All active patients 2-17 years of age.</p>	<p>The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of</p>	<p>15% (HP 2020- NWS-6.3) The percentage was derived from the HP 2020 goal of: Increase the proportion of physician visits made by all child or adult patients that include counseling about nutrition or diet.</p>

			action required “to-do” lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	
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**2. Experience of Care**

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

**3. Quality of Care**

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
% 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.	EMR	Numerator = number 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.  Denominator total= number of children 2 years of age	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals’ healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required “to-do” lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	>80% completion (HP 2020)

**F. Goal 6: Improve Diabetes Care**

**1. Clinical Outcomes**

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Adult Diabetes - % of patients 18 – 75 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%	EMR	Numerator = For a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in primary care health home registry and a documented Hba1c in the previous 12 months for whom the most recent documented Hba1c level is .8% / Denominator = For a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in primary care health home registry and having a documented Hba1c in the previous 12 months	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	>60% (NCQA 2009 DRP)
% of patients 18–75 years of age with diabetes (type 1 or type 2) who had BP <140/90 mmHg.	EMR	Numerator = number of patients 18–75 years of age with diabetes (type 1 or type 2) whose most recent BP in the previous 12 months was <140/90 mmHg. Denominator = total number of patients in the previous 12 months 18–75 years of age with diabetes (type 1 or type 2)	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and	>65% (NCQA 2009 DRP)

			aggregate reports of the overall Primary care health home performance	
% of patients 18–75 years of age with diabetes (type 1 or type 2) who had LDL-C <100mg/dL.	EMR	Numerator = number of patients 18–75 years of age with diabetes (type 1 or type 2) whose most recent LDL-C in the previous 12 months was <100mg/dL. Denominator = total number of patients in the previous 12 months 18–75 years of age with diabetes (type 1 or type 2)	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	>36% (NCQA 2009 DRP)
Child Diabetes - % of patients under 18 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%	EMR	Numerator = For a given 90-day period, number of patients under the age of 18 years old identified as having diabetes in primary care health home registry and a documented Hba1c in the previous 12 months for whom the most recent documented Hba1c level is .8% / Denominator = For a given 90-day period, number of patients under the age of 18 years old identified as having diabetes in primary care health home registry and having a documented Hba1c in the previous 12 months	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate	>60%

			reports of the overall Primary care health home performance.	
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**2. Experience of Care**

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

**3. Quality of Care**

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Members with Diabetes: Adherence to prescription medications for Diabetes.	Claims	Numerator = number of members on medication for Diabetes in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on medication for Diabetes in the past 90 days	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	>90%

**G. Goal 7: Improve asthma care**

**1. Clinical Outcomes**

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(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.	Claims	Numerator = for a given 90 day period number of patients between the age of 5 to 17 years old identified as having asthma in primary care health home registry and a prescription for a controller medication / Denominator = for a given 90 day period number of patients between the age of 5 to 17 years old identified as having asthma in primary care health home registry	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	>70%
(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.	Claims	Numerator = for a given 90 day period number of patients between the age of 18 to 50 years old identified as having asthma in primary care health home registry and a prescription for a controller medication / Denominator = for a given 90 day period number of patients between the age of 18 to 50 years old identified as having asthma in primary care health home registry	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that	>70%

			recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required “to-do” lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	
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**1. Experience of Care**

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

**2. Quality of Care**

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Members with Asthma: Adherence to prescription medications for asthma and/or COPD.	Claims	Numerator = number of members on medication for asthma/COPD in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on medication for asthma/COPD in the past 90 days	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals’ healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required “to-do” lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	>90%

**H. Goal 8: Improve Cardiovascular (CV) Care**

**1. Clinical Outcomes**

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) Hypertension - % of patients aged 18-85 years and older with a diagnosis of hypertension who have been seen with for at least 2 office visits, w/ blood pressure adequately controlled (BP < 140/90) during the measurement period	EMR	Numerator = for a given 90 day period number of patients between the age of 18 to 85 years old identified as having hypertension in primary care health home registry and who had two documented episodes of care in the previous 12 months where the most recent documented blood pressure in the previous 12 months is < 140/90 / Denominator = for a given 90 day period number of patients between the age of 18 to 75 years old identified as having hypertension in primary care health home registry who had two documented episodes of care in the previous 12 months	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines.	>50% (HP 2020)
(2) CAD - % of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100).	Claims and Disease Registry	Numerator = for a given 90 day period number of patients between the age of 18 years or older identified as having cardiovascular disease in primary care health home registry months where the most recent documented LDL level in the previous 12 months is < 100 / Denominator = for a given 90 day period number of patients between the age of 18 years and older identified as having cardiovascular disease in primary care health home registry	Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	>70%

**2. Experience of Care**

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

**3. Quality of Care**

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Members with CVD: Adherence to Meds – CVD and Anti-Hypertensive Meds	Claims and Disease Registry	Numerator = number of members on that class of medication in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on that class of medication in the past 90 days	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals’ healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required “to-do” lists of specific individuals needing specific evidence- based treatments and aggregate reports of the overall Primary care health home performance.	>90%