# Health Home Goals and Outcome Measures

The Department will evaluate the Health Homes program using the measures and methodology detailed below. Core Measures are those recommended by the Centers for Medicare and Medicaid Services (CMS). The Department has supplemented these with additional measures to evaluate the program's progress towards State goals.

| Core Measure: Adult Body Mass Index (BMI) Assessment |
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| • Percentage of members 18-74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year.<br>• Numerator: Body mass index documented during the measurement year or the year prior to the measurement year.<br>• Denominator: Members 18-74 of age who had an outpatient visit. |
| Core Measure: Ambulatory Care- Sensitive Condition Admission |
| • Numerator: Total number of acute care hospitalization for ambulatory care sensitive conditions under age 75 years.<br>• Denominator: Total mid-year population under age 75. |
| Core Measure: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment |
| • Numerator: Initiation of AOD Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.<br>• Denominator: Members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18+ years) and total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators. |
| Core Measure: Controlling High Blood Pressure |
| • Numerator: The number of patients in denominator whose must recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be <140/90mm Hg.<br>• Denominator: Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year. |

**State Goal 1: Improve disease-related care for chronic conditions.**

| Health Home Measure: Comprehensive Diabetes Care: Hemoglobin A1c Testing |
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| • Description: The percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) who had Hemoglobin A1c (HbA1c) testing.<br><br>• Denominator: Continuously enrolled members ages 18-75 with diabetes as of December 31 of the measurement year.<br><br>• Numerator: An HbA1c test performed during the measurement year, as identified by claim/encounter data or automated laboratory data. Documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result of finding, with any of the following notations: A1c, HbA1c, Hemoglobin A1c, Glycohemoglobin A1c, HgbA1c. |
| Health Home Measure: Use of Appropriate Medications for People with Asthma |
| • Percentage of adult participants during the measurement period who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement period.<br><br>• Denominator: Health plan members 5 to 64 years of age by December 31 of the measurement year with persistent asthma.<br><br>• Numerator: Dispensed at least one prescription for a preferred therapy during the measurement year. |
| Health Home Measure: Medication Management for People with Asthma |
| • Percentage of adult participants during the measurement period who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates reported: (1) Percentage of members who remained on an asthma controller medication for at least 50% of their treatment period, and (2) Percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.<br><br>• Denominator: Health plan members 5 to 64 years of age by December 31 of the measurement year with persistent asthma.<br><br>• Numerator: Number of members who achieved a portion of days covered (PDC) of at least 50% for their asthma controller medications during the measurement year. |
| Health Home Measure: Comprehensive Diabetes Care: LDL-C Screening |
| • The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had an LDL-C screening.<br><br>• Numerator: An LDL-C test performed during the measurement year as identified by claim encounter data or automated laboratory data or medical record review. Documentation in the medical record must include a note indicating the date when the LDL-C test was performed and the result. May use a calculated or direct LDL for LDL-C |

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| screening and control indicators.<br><br>• Denominator: Continuously enrolled members ages 18-75 with diabetes as of December 31 of the measurement year. |
| Health Home Measure: Viral Load and Other Testing Services (HIV/AIDS) |
| • Percentage of adult participants who received viral load testing services, genotypic, phenotypic, or other HIV/AIDS drug resistance testing for the treatment of HIV/AIDS during the measurement period. |

**State Goal 2: Improve outcomes for persons with mental illness and/or opioid substance use disorders.**

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| Health Home Measure: Initiation and Engagement of Alcohol and Other Drug Dependency Treatment |
| • Description: Percentage of adolescent and adult members with new episode of alcohol or other drug dependence (AOD) with 1) Initiation of AOD treatment and 2) Engagement of AOD treatment.<br><br>• Denominator: 13-17 years, 18+ years, and total rate. 60 days (2 months) enrollment prior to initial episode start date (IESD) through 44 days after IESD (inclusive). Members with detoxification-only chemical benefits excluded.<br><br>• Numerator: For Initiation: Varies according to type of visit (inpatient, outpatient, intensive outpatient, partial hospitalization, emergency department, or detoxification program).<br><br>• For Engagement: the member must have initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalization with an AOD diagnosis within 14 days of the IESD. |
| Health Home Measure: Medical Assistance with Smoking and Tobacco Use Cessation |
| • Advising Smokers and Tobacco Users to Quit - rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year.<br><br>• Discussing Cessation Medications - rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.<br><br>• Discussing Cessation Strategies - rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users who discussed or were provided cessation methods or strategies during the measurement year. |
| Health Home Measure: Antidepressant Medication Management |
| • Percentage of members 18 years and older diagnosed with new episode of major depression and treated with antidepressants, and remained on antidepressants. |

- Two rates reported: effective acute phase treatment (percentage of newly diagnosed and treated members who remained on antidepressants for at least 84 days) and effective continuation phase treatment (percentage of newly diagnosed and treated members who remained on antidepressants for at least 180 days).

Health Home Measure: Follow-Up After Hospitalization for Mental Illness

- Description: Percentage of discharges for members 6 years of age or older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visits, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates: percentage of discharges for which the member received follow-up within 30 days of discharge and percentage of discharges for which the member received follow-up within 7 days of discharge.

- Denominator: Based on discharges of members 6 years and older as of the date of discharge, continuously enrolled from the date of discharge through 30 days after discharge with no gaps in enrollment. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

- Numerator: An outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioners within 30 days after discharge and within 7 days after discharge. Include outpatient visits, intensive outpatient encounters, or partial hospitalizations that occur on the date of discharge.

**State Goal 3: Improve preventive care.**

Health Home Measure: Breast Cancer Screening

- Description: The percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.

- Denominator: Continuously enrolled women ages 40-69 years as of December 31 of the measurement.

- Numerator: One or more mammograms during the measurement year or the year prior to the measurement year.

Health Home Measure: Cervical Cancer Screening

- Description: The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.

- Denominator: Continuously enrolled women ages 21-64 years as of December 31 of the measurement year.

- Numerator: One or more Pap test during the measurement year or the two years prior to the measurement year.

Health Home Measure: Chlamydia Screening in Women Ages 21-24

- Description: Percentage of women 16-24 years of age who were identified as sexually active (identified by either pharmacy data or claim/encounter data) and who had at least one test for chlamydia during the measurement year.

- Denominator: Continuously enrolled women ages 16-24 years as of December 31 of the measurement year; two age stratifications (16-20; 21-24) and total

- Numerator: At least one chlamydia test during the measurement year as documented through administrative data.

Health Home Measure: Postpartum Care Rate

- Description: Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.

- Denominator: Live births from women with continuous enrollment from 43 days prior to delivery through 56 days after delivery; includes women in birthing centers and women who had two separate deliveries on different dates of service during the measurement year; women with multiple births counted once.

- Numerator: A postpartum visit for the pelvic exam or postpartum care on or between 21 and 56 days after delivery, as documented through either administrative data or medical record review.

Health Home Measure: Annual Monitoring for Patients on Persistent Medications

- Description: Percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year; report for each of the four rates separately and as a total rate annual monitoring for ACE inhibitors, ARB, digoxin, diuretics, and anticonvulsants.

- Denominator: Members 18 years and older as of December 31 continuously enrolled with an allowable enrollment gaps of one month during the measurement year (for Medicaid)

- Numerator: ACE/ARB/digoxin/diuretics - members who received at least 180 treatment days of the medication during the measurement year, with at least one serum potassium and either a serum creatinine or blood urea nitrogen therapeutic monitoring test in the measurement year. Must meet one of the following criteria during the measurement year to become compliant: 1) a code for a lab panel test, 2) a code for a serum potassium and a code for serum creatinine, or 3) a code for serum potassium and a code for blood urea nitrogen. Tests do not need to occur on the same service date. Anticonvulsants - Members who received at least 180 treatment days of the medication during the measurement year, with at least one drug serum concentration level monitoring test for the prescribed drug in the measurement year. If received only one type of anticonvulsant, the test must be for the specific drug taken; if member persistently received multiple types of anticonvulsants, each medication and test combination is counted as an unique event.

**State Goal 4: Reduce utilization associated with avoidable hospitalization/ER usage.**

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| Health Home Measure: Hospital Readmissions |
| Health Home Measure: Inpatient Utilization |
| Health Home Measure: Ambulatory Care |

**State Goal 5: To reduce emergency room visits for chronic health home participants.**

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| Health Home Measure: Nursing Facility admission rate per 1000 Health Home participants per month |
| Health Home Measure: Skilled Nursing Facility costs per member per month |

**State Goal 6: To reduce hospital admissions for chronic health home participants.**

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| Health Home Measure: Inpatient admissions per 1000 Health Home participants per month, stratified by mental health diagnoses and all other diagnoses. |
| Health Home Measure: Potentially preventable readmissions within 30 days as a percentage of potentially preventable hospital admissions, stratified by mental health diagnoses and all other diagnoses. |
| Health Home Measure: Mental health readmissions within 30 days. |
| Health Home Measure: Hospital admissions with congestive heart failure and/or heart disease as a primary or secondary diagnosis, per 1000 Health Home participants per month. |
| Health Home Measure: Hospital admissions with asthma complications as a primary or secondary diagnosis, per 1000 Health Home participants per month. |
| Health Home Measure: Hospital admissions with substance use disorder as a primary or secondary diagnosis, per 1000 Health Home participants per month. |
| Health Home Measure: Hospital admissions with diabetes-related complications as a primary or secondary diagnosis, per 1000 Health Home participants per month. |
| Health Home Measure: Hospital admissions with HIV/AIDS-related complications as a primary or secondary diagnosis, per 1000 Health Home participants per month. |
| Health Home Measure: Hospital admissions with viral hepatitis-related complications as a primary or secondary diagnosis, per 1000 Health Home participants per month. |

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| Health Home Measure: Hospital admissions with mental health conditions as a primary or secondary diagnosis, per 1000 Health Home participants per month. |
| Health Home Measure: Hospital admissions with hypertension related complications as a secondary diagnosis, per 1000 Health Home participants per month. |
| Health Home Measure: Hospital admissions with obesity related complications as a secondary diagnosis, per 1000 Health Home participants per month. |
| Health Home Measure: Hospital admissions with chronic kidney disease complications as a primary or secondary diagnosis, per 1000 Health Home participants per month. |
| Health Home Measure: Hospitalization costs per member per month, aggregated and by CHH provider. |

**State Goal 7: To reduce skilled nursing admissions for chronic health home participants.**

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| Health Home Measure: Emergency Department (ED) visit rate per 1000 Health Home participants per month, stratified by mental health diagnoses and all other diagnoses. |
| Health Home Measure: Asthma ED visit rate per 1000 Health Home participants per month. |
| Health Home Measure: Diabetes-related ED visit rate per 1000 Health Home participants per month. |
| Health Home Measure: Substance use disorder ED visit rate per 1000 Health Home participants per month. |
| Health Home Measure: Congestive heart failure and/or heart disease ED visit rate per 1000 Health Home participants per month. |
| Health Home Measure: HIV/AIDS-related ED visit rate per 1000 Health Home participants per month. |
| Health Home Measure: Viral Hepatitis-related ED visit rate per 1000 Health Home participants per month. |
| Health Home Measure: Obesity-related complications ED visit rate per 1000 Health Home participants per month. |
| Health Home Measure: Chronic kidney disease ED visit rate per 1000 Health Home participants per month. |
| Health Home Measure: Hypertension related ED visit rate per 1000 Health Home participants per month. |

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| Health Home Measure: Emergency Room costs per member per month, aggregated and by CHH provider. |