DSRIP Performance Measures (Domains 2-4) - Grouped by Measure

**Targets listed for Domains 2,3 where avail*

Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
Adherence to Antipsychotic Medications for People with Schizophrenia (NYS DOH)											
HEDIS 2015	1879	# of people who remained on an antipsychotic medication for at least 80% of their treatment period (52)	# of people,ages 19 to 64 years, with schizophrenia who were dispensed at least 2 antipsychotic medications during the measurement year (66)	76.5%	78.8	**78.8**	No	No	No	1	P4P/P4P
3.a.i	*Integration of Primary Care and Behavioral Health Services*										
3.a.iv	*Development of Withdrawal Management (e.g., ambulatory detox, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community Based Addition Treatment Programs*										
Adult Access to Preventive or Ambulatory Care – 20 to 44 years (NYS DOH)											
HEDIS 2015	NA	# of adults who had an ambulatory or preventive care visit during the measurement year (6558)	# of adults ages 20 to 44 as of June 30 of the measurement year (7863)	91.1%	83.4	**84.2**	No	Yes	No	.33	P4R/P4P
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
Adult Access to Preventive or Ambulatory Care – 45 to 64 years (NYS DOH)											
HEDIS 2015	NA	# of adults who had an ambulatory or preventive care visit during the measurement year (3123)	# of adults ages 45 to 64 as of June 30 of the measurement year (3527)	94.4%	88.5	**89.1**	No	Yes	No	.33	P4R/P4P
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
Adult Access to Preventive or Ambulatory Care – 65 and older (NYS DOH)											
HEDIS 2015	NA	# of adults who had an ambulatory or preventive care visit during the measurement year (36)	# of adults ages 65 and older as of June 30 of the measurement year (41)	94.4%	87.8	**88.5**	No	Yes	No	.33	P4R/P4P
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										

DSRIP Performance Measures (Domains 2-4) - Grouped by Measure

**Targets listed for Domains 2,3 where avail*

Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
Advanced Directives – Talked about Appointing for Health Decisions (NYS DOH)											
UAS-NY	NA	# of people with a response of yes or no to one or more of the following three: legal guardian, health care proxy or family member responsible (361)	# of people with an assessment (468)	100%	77.1	**79.4**	No	No	No	1	P4R/P4P
3.g.i	*Integration of Palliative Care into the PCMH Model*										
Age-adjusted percentage of adult binge drinking during the past month (NYS DOH)											
BRFSS		# of respondents age 18 or older who reported binge drinking on one or more occasions in the past 30 days. Binge drinking is defined as men having 5 or more drinks or women having 4 or more drinks on one occasion.	# of people age 18 or older				No	No	No	PFR measure only	P4R/P4R
4.a.iii	*Strenghen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)*										
Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month (NYS DOH)											
BRFSS		# of respondents age 18 or older who reported experiencing poor mental health for 14 or more days in the last month	# of people age 18 or older				No	No	No	PFR measure only	P4R/P4R
4.a.iii	*Strenghen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)*										
Age-adjusted percentage ofadults who have a regular health care provider - Aged 18+ years (NYS DOH)											
BRFSS		# of respondents age 18 or older who reported that they had a regular health care provider	# of people age 18 or older				No	No	No	PFR measure only	P4R/P4R
4.b.i	*Promote tobacco use cessation, especially among low SES populations and those with poor mental health (Focus Area 2; Goal #2.2)*										
4.a.iii	*Strenghen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)*										
Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years (NYS DOH)											
SPARCS		# of preventable hospitalizations for people age 18 or older	# of people age 18 or older				No	No	No	PFR measure only	P4R/P4R

DSRIP Performance Measures (Domains 2-4) - Grouped by Measure

**Targets listed for Domains 2,3 where avail*

Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
4.a.iii	*Strenghen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)*										
4.b.i	*Promote tobacco use cessation, especially among low SES populations and those with poor mental health (Focus Area 2; Goal #2.2)*										
Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years – Ratio of Black non-Hispanics to White non-Hispanics (NYS DOH)											
SPARCS		Rate of preventable hospitalizations for Black non- Hispanics age 18 or older	Rate of preventable hospitalizations for White non-Hispanics age 18 or older				No	No	No	PFR measure only	P4R/P4R
4.b.i	*Promote tobacco use cessation, especially among low SES populations and those with poor mental health (Focus Area 2; Goal #2.2)*										
4.a.iii	*Strenghen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)*										
Age-adjusted preventablehospitalizations rate per 10,000 - Aged 18+ years – Ratio of Hispanics to White non-Hispanics (NYS DOH)											
SPARCS		Rate of preventable hospitalizations for Hispanics age 18 or older	Rate of preventable hospitalizations for White non-Hispanics age 18 or older				No	No	No	PFR measure only	P4R/P4R
4.b.i	*Promote tobacco use cessation, especially among low SES populations and those with poor mental health (Focus Area 2; Goal #2.2)*										
4.a.iii	*Strenghen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)*										
Age-adjusted suicide death rate per 100,000 (NYS DOH)											
NYS DOHVital Statistics		# of deaths of people age 18 or older with an ICD-10 primary cause of death code: X60-X84 or Y87.0	# of people age 18 or older				No	No	No	PFR measure only	P4R/P4R
4.a.iii	*Strenghen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)*										
Antidepressant Medication Management – Effective Acute Phase Treatment (NYS DOH)											
HEDIS 2015	105	# of people who remained on antidepressant medication during the entire 12-week acutetreatment phase (303)	# of people 18 and older who were diagnosed with depression and treated with an antidepressantmedication (583)	60.0%	52.0	**52.8**	Yes - 53.6	No	No	.5	P4P/P4P
3.a.i	*Integration of Primary Care and Behavioral Health Services*										
3.a.iv	*Development of Withdrawal Management (e.g., ambulatory detox, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community Based Addition Treatment Programs*										
Antidepressant Medication Management – Effective Continuation Phase Treatment (NYS DOH)											
HEDIS 2015	105	# of people who remained on antidepressant medication for at least six months (230)	# of people 18and older who were diagnosed with depression and treated with an antidepressant medication (583)	43.5%	39.5	**39.9**	Yes - 40.3	No	No	.5	P4P/P4P

DSRIP Performance Measures (Domains 2-4) - Grouped by Measure

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3.a.i	*Integration of Primary Care and Behavioral Health Services*										
3.a.iv	*Development of Withdrawal Management (e.g., ambulatory detox, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community Based Addition Treatment Programs*										
Asthma Medication Ratio (5– 64 Years) (NYS DOH)											
HEDIS 2015	1800	# of people with aratio of controller medications to total asthma medications of0.50 or greater duringthe measurement year (216)	# of people, ages 5 to 64 years, who were identified as having persistent asthma (381)	76.0%	56.7	**58.6**	No	No	No	1	P4P/P4P
3.d.iii	*Implementation of Evidence Based Medicine Guidelines for Asthma Management*										
C&G CAHPS by PPS for uninsured - How well providers communicate with pts (PPS)											
1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	Using the C&G CAHPS Survey, Annual measure of four composite measures	Using C&G CAHPS Survey, three composite measures & one rating measure: 1) Getting timely appointments, care and information, 2) How well providers communicate with patients, 3) Helpful, courteous and respetful office staff 4) Pts' rating of the provider	NA-PFR			No	No	No	.25	P4R/P4R
2.d.i	*Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care*										
C&G CAHPS for uninsured - Getting timely appts, care and information (PPS)											
1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	Using the C&G Visit Survey, Annual measure of four composite measures	Using C&G CAHPS Survey, three composite measures & one rating measure: 1) Getting timely appointments, care and information, 2) How well providers communicate with patients, 3) Helpful, courteous and respetful office staff 4) Pts' rating of the provider	NA-PFR			No	No	No	.25	P4R/P4R
2.d.i	*Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care*										

DSRIP Performance Measures (Domains 2-4) - Grouped by Measure

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Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
C&G CAHPS for uninsured - Helpful, courteous & respectful office staff (PPS)											
1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	Using the C&G Visit Survey, Annual measure of four composite measures	Using C&G CAHPS Survey, three composite measures & one rating measure: 1) Getting timely appointments, care and information, 2) How well providers communicate with patients, 3) Helpful, courteous and respetful office staff 4) Pts' rating of the provider	NA-PFR			No	No	No	.25	P4R/P4R
2.d.i	*Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care*										
C&G CAHPS for uninsured - Pt's rating of the provider (PPS)											
1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	Using the C&G Visit Survey, Annual measure of four composite measures	Using C&G CAHPS Survey, three composite measures & one rating measure: 1) Getting timely appointments, care and information, 2) How well providers communicate with patients, 3) Helpful, courteous and respetful office staff 4) Pts' rating of the provider	NA-PFR			No	No	No	.25	P4R/P4R
2.d.i	*Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care*										
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (NYS DOH)											
HEDIS 2015	1933	# of people who had an LDL-C test during the measurement year	# of people, ages 18 to 64 years, with schizophrenia and cardiovascular disease	92.2% (health plan data)	100.0	**100.0**	Yes - 100.	No	No	1	P4P/P4P
3.a.i	*Integration of Primary Care and Behavioral Health Services*										
3.a.iv	*Development of Withdrawal Management (e.g., ambulatory detox, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community Based Addition Treatment Programs*										
Care Coordination (Q13, 17 and 20) (NYS DOH)											
1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	# responses'Usually' or 'Always' tha provider seemed to know important history, follow-up to give results from tests, and talked about all prescription medicines.	All responses	100%			No	Yes	No	1	P4R/P4P
2.b.viii	*Hospital-Home Care Collaboration Solutions*										

Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
Children's Access to Primary Care –12 to 19 years (NYS DOH)											
HEDIS 2015	NA	# of children who had a visit with a primary care provider during the measurement period or year prior (2388)	# of children ages 12 to 19 years as of June 30 of the measurement year (2893)	98.8%	82.5	**84.2**	No	Yes	No	??? Document says 0	P4R/P4P
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
Children's Access to Primary Care –12 to 24 months (NYS DOH)											
HEDIS 2015	NA	# of children who had a visit with a primary care provider during the measurement period (756)	# of children ages 12 to 24 months as of June 30 of the measurement year (778)	100.0%	97.2	**97.5**	No	Yes	No	.25	P4R/P4P
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
Children's Access to Primary Care –25 months to 6 years (NYS DOH)											
HEDIS 2015	NA	# of children who had a visit with a primary care provider during the measurement period (2578)	# of children ages 25 months to 6 years as of June 30 of the measurement year (2845)	98.4%	90.6	**91.4**	No	Yes	No	.25	P4R/P4P
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										

DSRIP Performance Measures (Domains 2-4) - Grouped by Measure

**Targets listed for Domains 2,3 where avail*

Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
Children's Access to Primary Care –7 to 11 years (NYS DOH)											
HEDIS 2015	NA	# of children who had a visit with a primary care provider during the measurement period or year prior (1813)	# of children ages 7 to 11 years as of June 30 of the measurement year (2107)	100.0%	86.0	**87.4**	No	Yes	No	.25	P4R/P4P
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
Depressive feelings - percentage of members who experienced some depression feeling (NYS DOH)											
UAS-NY	NA	# of people who respond that they experienced some feelings related to depression (112)	# of people with an assessment (468)	0.0%	23.9	**21.5**	No	No	Yes	1	P4R/P4P
3.g.i	*Integration of Palliative Care into the PCMH Model*										
Diabetes Monitoring for People with Diabetes and Schizophrenia (NYS DOH)											
HEDIS 2015	1934	# of people who had both an LDL-C test and an HbA1c test during the measurement year (14)	# of people, ages 18 to 64 years, with schizophrenia and diabetes (16)	89.8%	87.5	**87.7**	Yes - 88.	No	No	1	P4P/P4P
3.a.i	*Integration of Primary Care and Behavioral Health Services*										
3.a.iv	*Development of Withdrawal Management (e.g., ambulatory detox, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community Based Addition Treatment Programs*										
Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication (NYS DOH)											
HEDIS 2015	1932	# of people who had a diabetes screening test during the measurement year (77)	# of people,ages 18 to 64 years, with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication (103)	89.0%	74.8	**76.2**	No	No	No	1	P4P/P4P
3.a.iv	*Development of Withdrawal Management (e.g., ambulatory detox, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community Based Addition Treatment Programs*										
3.a.i	*Integration of Primary Care and Behavioral Health Services*										

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Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
ED use by uninsured (NYS DOH)											
NA	NA	Annual measure of # Emergency Medicaid ED visits/1000 Emergency Medicaid Recipients	Baseline measure of #Emergency Medicaid ED visits/1000 Emergency Medicaid Recipients	Ratio < 1			No	No	No	1	P4R/P4P
2.d.i	*Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care*										
Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days) (NYS DOH)											
HEDIS 2015	0004	# of people who initiated treatment AND who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit (137)	# of people age 13 and older with a new episode of alcohol or other drug (AOD) dependence (729)	31.4%	18.8	**19.5**	No	No	No	.5	P4P/P4P
3.a.iv	*Development of Withdrawal Management (e.g., ambulatory detox, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community Based Addition Treatment Programs*										
3.a.i	*Integration of Primary Care and Behavioral Health Services*										
Follow-up after hospitalization for Mental Illness – within 30 days (NYS DOH)											
HEDIS 2015	576	# of discharges where the patient was seen on an ambulatory basis or who was in intermediate treatment with a mental health provider within 7 days of discharge (125)	# of discharges between the start of the measurement period to 30 days before the end of the measurement period for patients ages 6 years and older, who were hospitalized for treatment of selected mental health disorders (173)	88.2%	72.3	**73.9**	Yes - 75.5	No	No	.5	P4P/P4P
3.a.iv	*Development of Withdrawal Management (e.g., ambulatory detox, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community Based Addition Treatment Programs*										
3.a.i	*Integration of Primary Care and Behavioral Health Services*										
Follow-up after hospitalization for Mental Illness – within 7 days (NYS DOH)											
HEDIS 2015	576	# of discharges where the patient was seen on an ambulatory basis or who was in intermediate treatment with a mental health provider within 7 days of discharge (84)	# of discharges between the start of the measurement period to 30 days before the end of the measurement period for patients ages 6 years and older, who were hospitalized for treatment of selected mental health disorders (173)	74.2%	48.6	**51.1**	Yes - 53.7	No	No	.5	P4P/P4P
3.a.iv	*Development of Withdrawal Management (e.g., ambulatory detox, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community Based Addition Treatment Programs*										
3.a.i	*Integration of Primary Care and Behavioral Health Services*										

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Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
Follow-up care for Children Prescribed ADHD Medications – Continuation Phase (NYS DOH)											
HEDIS 2015	108	# of children who, in addition to the visit in the Initiation Phase, had at least 2 follow-up visits in the 9- month period after the initiation phase ended (41)	# children ages 6 to 12 years,who were newly prescribed ADHD medication and remained on the medication for 7 months (69)	78.7% (health plan data)	59.4	**61.3**	No	No	No	.5	P4R/P4P
3.a.iv	*Development of Withdrawal Management (e.g., ambulatory detox, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community Based Addition Treatment Programs*										
3.a.i	*Integration of Primary Care and Behavioral Health Services*										
Follow-up care for Children Prescribed ADHD Medications – Initiation Phase (NYS DOH)											
HEDIS 2015	108	# of children who had one follow-up visit with a practitioner within the 30 days after starting the medication (80)	# of children, ages 6 to 12 years, who were newly prescribed ADHD medication (163)	72.3%	49.1	**51.4**	No	No	No	.5	P4R/P4P
3.a.i	*Integration of Primary Care and Behavioral Health Services*										
3.a.iv	*Development of Withdrawal Management (e.g., ambulatory detox, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community Based Addition Treatment Programs*										
Getting Timely Appointments, Care and information (Q6, 8, and 10) (NYS DOH)											
1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	# responses'Usually' or 'Always' got appt for urgent care or routine care as soon as needed , and got answers the same day if called during the day	# who answered they called for appointments or called for information	100%			No	Yes	No	.5	P4R/P4P
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
H-CAHPS – Care Transition Metrics (Q23, 24, and 25) (NYS DOH)											
V9.0	NA	Average of hospital specific results for the Care Transition composite	Hospitals with H-CAHPS participating in the PPS network	100%			No	No	No	1	P4R/P4P
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										

Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
Helpful, Courteous, and Respectful Office Staff (Q21 and 22) (NYS DOH)											
1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	# responses 'Usually' or 'Always' that clerks and receptionists were helpful and courteous and respectful	All responses	100%			No	Yes	No	.5	P4R/P4P
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days) (NYS DOH)											
HEDIS 2015	0004	# of people who initiated treatmentthrough an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode (389)	# of people age 13 and older with a new episode of alcohol or other drug (AOD) dependence (729)	86.0%	53.4	**53.7**	No	No	No	.5	P4P/P4P
3.a.i	*Integration of Primary Care and Behavioral Health Services*										
3.a.iv	*Development of Withdrawal Management (e.g., ambulatory detox, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community Based Addition Treatment Programs*										
Medicaid Spending on ER and Inpatient Services (NYS DOH)											
	NA	Total spending on ER and IP services	Per member per monthof members attributedto the PPS as of June of the measurement year	NA – P4R			No	No	Yes	1	P4R/P4R
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										

DSRIP Performance Measures (Domains 2-4) - Grouped by Measure

**Targets listed for Domains 2,3 where avail*

Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
Medicaid spending on Primary Care and community based behavioral health care (NYS DOH)											
	NA	Total spending on PrimaryCare and Community Behavioral Health care as defined by MMCOR categories	Per member per month of members attributed to the PPS as of June of the measurement year	NA – P4R			No	No	No	1	P4R/P4R
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
Medication Management for People with Asthma (5 – 64 Years) – 50% of Treatment Days Covered (NYS DOH)											
HEDIS 2015	1799	# people who filled prescriptions for asthma controller medications during at least 50% of their treatment period (166)	# of people,ages 5 to 64 years, who were identified as having persistent asthma, and who received at least one controller medication (299)	68.6%	55.5	**56.8**	No	No	No	.5	P4P/P4P
3.d.iii	*Implementation of Evidence Based Medicine Guidelines for Asthma Management*										
Medication Management for People with Asthma (5 – 64 Years) – 75% of Treatment Days Covered (NYS DOH)											
HEDIS 2015	1799	# people who filled prescriptions for asthma controller medications during at least 75% of their treatment period (91)	# of people,ages 5 to 64 years,who were identified as having persistent asthma, and who received at least one controller medication (299)	44.9%	30.4	**31.9**	No	No	No	.5	P4P/P4P
3.d.iii	*Implementation of Evidence Based Medicine Guidelines for Asthma Management*										
PAM Level (PPS)											
NA	NA	Interval measure of % of members of total with Level 3 or 4 on PAM	Baseline measure of %of members of totalwith Level 3 or 4 on PAM	Ratio > 1			No	No	No	1	P4R/P4P
2.d.i	*Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care*										

DSRIP Performance Measures (Domains 2-4) - Grouped by Measure

**Targets listed for Domains 2,3 where avail*

Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
PDI 90– Composite of all measures (NYS DOH)											
AHRQ 4.4	NA	# of admissions which were in thenumerator of one of the pediatric prevention quality indicators (4)	# of people 6 to 17 years as of June 30 of measurement year (7817)	40.94 per 100K MA Enrollees	51.2	**46.1**	No	Yes	Yes	1	P4R/P4P
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
Pediatric Quality Indicator# 14 Pediatric Asthma (NYS DOH)											
AHRQ 4.4	728	# of admissions with a principal diagnosis of asthma (7)	# of people ages 2 to 17 as of June 30 of the measurement year (10973)	46.56 per 100K MA Enrollees	63.8	**57.4**	No	No	Yes	1	P4P/P4P
3.d.iii	*Implementation of Evidence Based Medicine Guidelines for Asthma Management*										
Percent of eligible providers meeting Meaningful Use Criteria who have participating agreements with qualified entities (RHIOs) and are able to participate in bidirectional exchange (NYS DOH)											
NA	NA	# of eligible providers meeting meaningful use criteria, who have at least one participating agreement with a qualified entity (RHIO), and are able to participate in bidirectional exchange	# of eligible providers meeting meaningful use criteria in the PPS network	NA – P4R			No	Yes	No	1	P4R/P4R
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
Percent of PCP providers meeting PCMH (NCQA) or Advance Primary Care (SHIP) standards (NYS DOH)											
NA	NA	# of PCP providers meeting PCMH or Advance Primary Care Standards	# of PCP providers in the PPS network	NA – P4R			No	Yes	No	1	P4R/P4R
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										

DSRIP Performance Measures (Domains 2-4) - Grouped by Measure

**Targets listed for Domains 2,3 where avail*

Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
Percent of total Medicaid provider reimbursement received through sub- capitation or other forms of non-FFS reimbursement (NYS DOH)											
NA	NA	Dollars paid by MCO under value based arrangements	Total Dollars paid by MCOs	NA – P4R			No	No	No	1	P4R/P4R
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
Percentage of adults with health insurance - Aged 18- 64 years (NYS DOH)											
US Census		# of respondents age 18-64 who reported that they had health insurance coverage	# of people age 18- 64				No	No	No	PFR measure only	P4R/P4R
4.a.iii	*Strenghen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)*										
4.b.i	*Promote tobacco use cessation, especially among low SES populations and those with poor mental health (Focus Area 2; Goal #2.2)*										
Percentage of cigarette smoking among adults (NYS DOH)											
BRFSS		# of people age 18 or older who report currently smoking cigarettes	# of people age 18 or older				No	No	No	PFR measure only	P4R/P4R
4.b.i	*Promote tobacco use cessation, especially among low SES populations and those with poor mental health (Focus Area 2; Goal #2.2)*										
Percentage of premature death (before age 65 years) (NYS DOH)											
NYS DOHVital Statistics		# of people who died before age 65 in the measurement period	# of deaths in the measurement period				No	No	No	PFR measure only	P4R/P4R
4.a.iii	*Strenghen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)*										
4.b.i	*Promote tobacco use cessation, especially among low SES populations and those with poor mental health (Focus Area 2; Goal #2.2)*										
Percentage of prematuredeath (before age 65 years) – Ratio of Black non-Hispanics to White non-Hispanics (NYS DOH)											
NYS DOHVital Statistics		Percentage of Black non- Hispanics who died before age 65	Percentage of White non- Hispanics who died before age 65				No	No	No	PFR measure only	P4R/P4R

DSRIP Performance Measures (Domains 2-4) - Grouped by Measure

**Targets listed for Domains 2,3 where avail*

Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
4.a.iii	*Strenghen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)*										
4.b.i	*Promote tobacco use cessation, especially among low SES populations and those with poor mental health (Focus Area 2; Goal #2.2)*										
Percentage of prematuredeath (before age 65 years) – Ratio of Hispanics to White non-Hispanics (NYS DOH)											
NYS DOHVital Statistics		Percentage of Hispanics who died before age 65	Percentage of White non- Hispanics who died before age 65				No	No	No	PFR measure only	P4R/P4R
4.b.i	*Promote tobacco use cessation, especially among low SES populations and those with poor mental health (Focus Area 2; Goal #2.2)*										
4.a.iii	*Strenghen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)*										
Potentially Avoidable Emergency Room Visits (NYS DOH)											
3M	NA	# of preventable emergency visits as defined by revenue and CPT codes (15865)	# of people(excludes those born during the measurement year) as of June 30 of measurement year (32805)	15.15 per 100 Medicaid Enrollees	48.4	**46.0**	Yes - 43.5	Yes	Yes	1	P4R/P4P
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
Potentially Avoidable Readmissions (NYS DOH)											
3M	NA	# of readmission chains (at risk admissions followed by one or more clinically related readmissions within 30 days of discharge) (127)	# of people as of June 30 of the measurement year (34032)	167.94 per 100K MA Enrollees	373.2	**335.9**	Yes - 298.5	Yes	Yes	1	P4R/P4P
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										

DSRIP Performance Measures (Domains 2-4) - Grouped by Measure

**Targets listed for Domains 2,3 where avail*

Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
Potentially Preventable Emergency Department Visits (for persons with BH diagnosis) (NYS DOH)											
3M	NA	# of preventable emergency visits as defined by revenue and CPT codes (1872)	# of people with a BH diagnosis (excludes those born during the measurement year) as of June 30 of measurement year (1687)	47.55 per 100 Medicaid enrollees with Behavioral Health Qualifying Svc	111.0	**99.9**	Yes - 88.8	No	Yes	1	P4P/P4P
3.a.i	*Integration of Primary Care and Behavioral Health Services*										
3.a.iv	*Development of Withdrawal Management (e.g., ambulatory detox, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community Based Addition Treatment Programs*										
PQI 90 – Composite of all measures (NYS DOH)											
AHRQ 4.4	NA	# of admissions which were in the numerator of one of the adult prevention quality indicators (177)	# of people 18 years and older as of June 30 of measurement year (20497)	330.79 per 100K MA Enrollees	863.5	**777.2**	No	Yes	Yes	1	P4R/P4P
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
Prevention Quality Indicator #15 Younger Adult Asthma (NYS DOH)											
AHRQ 4.4	283	# of admissions with a principal diagnosis of asthma (2)	# of people ages 18 to 39 as of June 30 of the measurement year (12667)	12.63 per 100K MA Enrollees	15.8	**14.2**	No	No	Yes	1	P4P/P4P
3.d.iii	*Implementation of Evidence Based Medicine Guidelines for Asthma Management*										
Primary Care – Length of Relationship – Q3 (NYS DOH)											
1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	% of Responses at least '1 year' or longer	All Responses	100%			No	Yes	No	.5	P4R/P4P

DSRIP Performance Measures (Domains 2-4) - Grouped by Measure

**Targets listed for Domains 2,3 where avail*

Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
Primary Care - Usual Source of Care - Q2 (NYS DOH)											
1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	% of Reponses 'Yes'	All Responses	100%			No	Yes	No	.5	P4R/P4P
2.a.ii	*Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))*										
2.c.i	*To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently*										
2.b.vii	*Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)*										
2.b.viii	*Hospital-Home Care Collaboration Solutions*										
Project Specific - Community Project – PPS will conduct assessments for all members that are not enrolled in Managed Long Term Care (MLTC) plans or other waiver programs which are already conducting Uniform Assessment System (UAS-NY) assessments (PPS)											
NA							No	No	No		/
3.g.i	*Integration of Palliative Care into the PCMH Model*										
Risk-Adjusted percentage of members who had severe or more intense daily pain± (NYS DOH)											
UAS-NY	NA	# of people with an assessment response indicating pain in the last three days and a pain intensity response of severe or worse (58)	# of people with valid responses for the questions (468)	0.0%(unadjusted)	12.4	**11.2**	No	No	Yes	1	P4R/P4P
3.g.i	*Integration of Palliative Care into the PCMH Model*										
Risk-Adjusted percentage of members who remained stable or demonstrated improvement in pain (NYS DOH)											
UAS-NY	NA	# of people whose current assessment indicates the same or better response to pain than prior assessment	# of people with a valid response for the question in both assessment periods	100%			No	No	No	1	P4R/P4P
3.g.i	*Integration of Palliative Care into the PCMH Model*										

DSRIP Performance Measures (Domains 2-4) - Grouped by Measure

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Specification Version	NQF #	Numerator Description/Value	Denominator Description/Value	State Perf Goal	LCHP Baseline Result:	Annual Impvt Target*:	High Perf elig/ Goal?	SW meas ?	Lower Better ?	Achvmnt Value if goal met	Pymnt: DY 2/3, 4/5
Risk-adjusted percentage of members whose pain was not controlled (NYS DOH)											
UAS-NY	NA	# of people with an assessment response indicating pain and a pain control response indicating not controlled (84)	# of people with valid responses for the questions (457)	0.0%(unadjusted)	18.4	**16.5**	No	No	Yes	1	P4R/P4P
3.g.i	*Integration of Palliative Care into the PCMH Model*										
Screening for Clinical Depression and follow-up (PPSandNYS DOH)											
NYS DOH	NA	# of people screened for clinical depression using a standardized depression screening tool, and if positive, with follow-up within 30 days.	# of people with a qualifying outpatient visit who are age 18 and older	100%			No	No	No	1	P4R/P4P
3.a.iv	*Development of Withdrawal Management (e.g., ambulatory detox, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community Based Addition Treatment Programs*										
3.a.i	*Integration of Primary Care and Behavioral Health Services*										
Use of primary andpreventive care services-- Percent of attributed Medicaid members with no claims history for primary care and preventive services in measurement year compared to same in baseline year (For NU and LU Medicaid Members) (NYS DOH)											
NA	NA	The % of NU and LU Medicaid members who do not have at least one claim with a preventive services CPT or equivalent code.	Baseline percentage of NU and LU Medicaid members who do not have at least one claim with a preventive services CPT or equivalent code.	Ratio <1			No	No	No	1 if ratio lower than 1	P4R/P4P
2.d.i	*Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care*										