Attachment J-- NY DSRIP Strategies Menu and Metrics

Preface

a. Delivery System Reform Incentive Payment Fund

On April 14, 2014, the Centers for Medicare and Medicaid Services (CMS) approved New York's request for an amendment to the New York's Partnership Plan section 1115(a) Medicaid demonstration extension (hereinafter "demonstration") authorizing the creation of a Delivery System Reform Incentive Payment (DSRIP) Fund. The demonstration was extended in 2016, and renamed the New York Medicaid Redesign Team Demonstration. This demonstration is approved through March 31, 2021.

Section IX of the Special Terms and Conditions (STC) describes the general rules and requirements of the Delivery System Reform Incentive Payment (DSRIP) Fund.

b. DSRIP Strategies Menu and Metrics and Program Funding and Mechanics Protocol

The DSRIP requirements specified in the STCs are supplemented by two attachments to the STCs. The Program Funding and Mechanics Protocol (Attachment I) describes the State and CMS review process for DSRIP project plans, incentive payment methodologies, reporting requirements, and penalties for missed milestones. The DSRIP Strategies Menu and Metrics (this attachment, Attachment J) details the specific delivery system improvement projects and metrics that are eligible for DSRIP funding. The projects are listed in Part I and the metrics are listed in Part II. Additional information is provided in two additional documents as described below.

This version of the DSRIP Strategies Menu and Metrics is approved January 19, 2017. In accordance with STC 10.b, the state may submit modifications to this protocol for CMS review and approval in response to comments received during the post-award comment period and as necessary to implement needed changes to the program as approved by CMS.

c. Supporting operational guides

This attachment will be supplemented by two additional operational guides developed by the state and submitted to CMS, which will assist performing provider systems in developing and implementing their projects and will be used in the state's review of the approvability and the valuation of DSRIP projects.

First, the state will develop a *Project Toolkit* that will describe the core components of each DSRIP project listed on the DSRIP project menu below (Part I). This supplement will also describe how DSRIP projects are distinct from each other and the state's rationale for selecting each project (i.e. the evidence base for the project and its relation to community needs for the Medicaid and uninsured population). The core components and other elements of the project description will be used as part of the DSRIP plan checklist (described in section V of Attachment I). To assist providers in valuing

projects, this supplement will also include the index score of transformation/ health care improvement potential determined by the state (according to the process described in section IV.c. of Attachment I).

Second, the state will develop a *Metric Specification Guide* that provides additional information on the metrics described in the metrics list below (Part II). Specifically, the state will specify the data source for each measure (specifically whether the measure is collected by the state or providers), the measure steward for each metric (if applicable), the National Quality Forum reference number (if applicable), and the high performance level for each pay-for-performance metric. The high performance level for each metric will be used to establish outcome targets for all pay-for-performance measures, as described in Attachment I.

Part I – Projects Menu

Each Performing Provider System will employ multiple projects both to transform health care delivery as well as to address the broad needs of the population that the performing provider system serves. These projects described in Attachment J are grouped into different strategies, such as behavioral health, within each Domain (System Transformation Projects (Domain 2), Clinical Improvement Projects (Domain 3), and Population-wide Projects (Domain 4). For each strategy, there is a set of metrics that the performing provider system will be responsible for if they do any one of the projects within that strategy.

Each project selected by a Performing Provider System will be developed into a specific set of focused milestones and metrics that will be part of the Performing Provider System's DSRIP project plan. Project selection will be driven by the mandatory community needs assessment, and the rationale and starting point for each project must be described in the DSRIP project plan, as described in Attachment I.

DSRIP project plans must include a minimum of five projects (at least two system transformation projects, two clinical improvement projects, and one population-wide project). As described further in Attachment I, a maximum of 11 projects will be considered for project valuation scoring purposes. Additional projects can be included in the application, but they will not affect the project valuation.

Domain 2: System Transformation Projects

All DSRIP plans must include at least two of the following projects based on their community needs assessment. At least one of those projects must be from sub-list A and one of these projects must be from sub-list B or C, as described below. Performing Provider Systems can submit up to 4 projects from Domain 2 for valuation scoring purposes. For eligible Performing Provider Systems pursuing 11 projects in their plan, they will be allowed to select up to 5 projects (the fifth project being project 2.d.i) from Domain 2 for scoring purposes (as described in attachment I).

A. Create Integrated Delivery Systems (required)

2.a.i	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.ii	Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the New York State Health Innovation Plan (SHIP))
2.a.iii	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services.
2.a.iv	Create a medical village using existing hospital infrastructure
2.a.v	Create a medical village/alternative housing using existing nursing home

B. Implementation of Care Coordination and Transitional Care Programs

- 2.b.i Ambulatory Intensive Care Units (ICUs)
- 2.b.ii Development of co-located of primary care services in the emergency department (ED)
- 2.b.iii ED care triage for at-risk populations
- 2.b.iv Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
- 2.b.v Care transitions intervention for skilled nursing facility (SNF) residents
- 2.b.vi Transitional supportive housing services
- 2.b.vii Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
- 2.b.viii Hospital-Home Care Collaboration Solutions
- 2.b.ix Implementation of observational programs in hospitals

C. Connecting Settings

- 2.c.i. Development of community-based health navigation services
- 2.c.ii Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services

D. Utilizing Patient Activation to Expand Access to Community Based Care for Special Populations

- 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

Domain 3: Clinical Improvement Projects

All DSRIP plans must include at least two projects from this domain, based on their community needs assessment. At least one of those projects must be a behavioral health project from sub-list A, as described below. Performing Provider Systems can submit up to 4 projects from Domain 3 for valuation scoring purposes (as described in Attachment I).

A. Behavioral Health (required)

- 3.a.i Integration of primary care and behavioral health services
- 3.a.ii Behavioral health community crisis stabilization services
- 3.a.iii. Implementation of evidence-based medication adherence program (MAP) in community based sites for behavioral health medication compliance
- 3.a.iv Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs

3.a.v Behavioral Interventions Paradigm (BIP) in Nursing Homes

B. Cardiovascular Health

Note: Performing provider systems selecting cardiovascular health projects will be expected to utilize strategies contained in the Million Hearts campaign as appropriate (http://millionhearts.hhs.gov/index.html).

3.b.i Evidence-based strategies for disease management in high risk/affected populations (adult only)

3.b.ii Implementation of evidence-based strategies in the community to address chronic disease -- primary and secondary prevention projects (adult only)

C. Diabetes Care

3.c.i Evidence-based strategies for disease management in high risk/affected populations (adults only)

3.c.ii Implementation of evidence-based strategies in the community to address chronic disease – primary and secondary prevention projects (adults only)

D. Asthma

3.d.i Development of evidence-based medication adherence programs (MAP) in community settings –asthma medication

3.d.ii Expansion of asthma home-based self-management program

3.d.iii Implementation of evidence-based medicine guidelines for asthma management

E. HIV/AIDS

3.e.i. Comprehensive Strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations – development of a Center of Excellence for management of HIV/AIDS

F. Perinatal Care

3.f.i. Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)

G. Palliative Care

3.g.i	Integration of palliative care into the PCMH Model
3.g.ii	Integration of palliative care into nursing homes

H. Renal Care

3.h.i.	Specialized Medical Home from Chronic Renal Failure

Domain 4: Population-wide Projects

The following represent priorities in the State's Prevention Agenda with health care delivery sector projects to influence population-wide health (available at : http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm). The alignment of these projects with the New York State Prevention Agenda (including focus areas, etc.) is described further in the Project Description Supplement.

All DSRIP plans must include at least one project from this domain, based on their community needs assessment. Performing Provider Systems can submit up to 2 projects from Domain 4 for valuation scoring purposes (as described in Attachment I).

A. Promote Mental Health and Prevent Substance Abuse (MHSA)

4.a.ii.	Promote mental, emotional and behavioral (MEB) well-being in communities
4.a.iii.	Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
4.a.iv.	Strengthen Mental Health and Substance Abuse Infrastructure across Systems

B. Prevent Chronic Diseases

4.b.i.	Promote tobacco use cessation, especially among low SES populations and those with poor mental health
4.b.ii.	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3., such as cancer)

C. Prevent HIV and STDs

4.c.i	Decrease HIV morbidity

4.c.ii	Increase early access to, and retention in, HIV care
4.c.iii	Decrease STD morbidity
4.c.iv	Decrease HIV and STD disparities

D. Promote Healthy Women, Infants and Children

4.d.i	Reduce premature births

II. Metrics

The domains of metrics here are intended to provide specificity to the overall intent to promote system transformation, using measures of system transformation as well as including avoidable events as a marker for positive transformation. Items associated with pay for reporting or pay for performance are described in requirements for all domains as well.

An overview of the metric domains from the funding and mechanics protocol is below:

i. Overall project progress metrics (Domain 1)
ii. System transformation metrics (Domain 2)
iii. Clinical improvement metrics (Domain 3)
iv. Population-wide project implementation metrics (Domain 4)

All DSRIP plans must include all core metrics in Domain 1, all metrics in Domain 2, and all core metrics in Domain 4. DSRIP plans must also include the behavioral health metrics in Domain 3.a. and strategy-specific metrics based on the Domain 3 and 4 projects selected, as further described in the Project Toolkit. The state or CMS will add project-specific Domain 1 metrics to DSRIP project plans as necessary to address concerns with "at risk" projects, based on input from the independent assessor. Behavioral health metrics are included because those diagnoses are highly correlated with avoidable events.

A subset of these metrics related to avoidable hospitalizations, behavioral health and cardiovascular disease will also be part of the high performance fund, described in attachment I and as noted below: These latter markers align with the nationwide Million Hearts Initiative on cardiac outcomes, in order to tackle the leading cause of mortality in New York State.

Metric	Domain reference
Potentially Preventable Emergency Room Visits (All Population)	2.a
Potentially Preventable Readmissions (All Population)	2.a
Potentially Preventable Emergency Room Visits (BH Population)	3.a
Potentially Preventable Readmissions (BH Population)	3.a

Follow-up after Hospitalization for Mental Illness (NQF 0576)	3.a
Antidepressant Medication Management	3.a
Diabetes Monitoring for People with Diabetes and Schizophrenia (NQF 1934)	3.a
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (NQF 1933)	3.a
Controlling High Blood Pressure (NQF 0018)	3.b
Medical Assistance with Smoking and Tobacco Use Cessation (NQF 0027) (component on discussing smoking and tobacco use cessation strategies)	3.b

Where possible, the state will make drillable data available for PPSs to be able to better understand the impact of disparities on the PPSs and improvements seen in specific populations through these projects. Because of small population size and lack of standards for comparison, the state will not be able to provide meaningful state wide metrics for each population segment.

Domain 1. Overall Project Progress Metrics

Domain 1 metrics assess overall implementation of all DSRIP projects (regardless of whether the project was developed from a project selected from Domain 2, 3, or 4 listed above). All

Core Domain 1 Metrics (for all providers):

1. Semi-annual reports (pay for reporting), which will include:
    a. Project narrative on status and challenges
    b. Information on project spending/budget and any other financial information requested by the state, including financial sustainability of system and projects.
    c. Documentation on the number of beneficiaries served through the projects
    d. Update on project governance
    e. Update on workforce strategy implementation
    f. Percent of providers that are reporting relevant DSRIP project data
    g. Description of steps taken by the system to prepare for non-FFS reimbursement systems (including an update on any on-going negotiations with Medicaid managed care plans)
    h. Engagement in learning collaboratives

2. Approval of DSRIP Plan (DY 1 only)

3. Workforce milestones (P4P/ P4R, as specified in the Metrics Specification Guide)
    - Percent Complete of System's preapproved Workforce Plan Number of health care workers retrained/redeployed vs. # eligible based on system service changes
    - Net change in number of new MDs hired – PCP; specialty

- Net change in number of new mid-levels providers hired (RPA, NP, NM)

- Net change in number of other mid-level providers hired

4. System Integration milestones (P4P/ P4R, as specified in the Metrics Specification Guide)

- Percent complete of preapproved system integration plan in the PPS project plan
- For HH population, % in O/E; % in Active Care Management; % with Care Plan <u>Additional project-specific Domain 1 metrics:</u>

5. Additional project-specific metrics, established by the state or CMS for a particular project, especially "at risk" projects. (Pay for performance, i.e. achievement of corrective action as specified by the state or CMS for "at risk" projects) The state's independent assessor will develop a rubric for assessing semi-annual reports, workforce milestones, and system integration milestones to identify at risk projects.

Domain 2. System Transformation Metrics

All Domain 2 metrics are pay-for-reporting in DY 1 and 2. As described below, some metrics become pay-for-performance in DY 3-5. All of these metrics will be assessed on a statewide level as part of the statewide Domain 2 performance test described in STC 14.g.i in section IX, with the exception of the Medicaid spending metric and the provider reimbursement metric and (which are included as part of other statewide accountability tests described in STC 14.g.iii and 14.g.iv in section IX respectively).

Domain 2 – System Transformation Metrics						
				DSRIP Year 2		DSRIP Years 3 - 5
State- wide Measure	Measure Name	Measure Steward		Pay for Reporting/Pay for Performance		Pay for Reporting/Pay for Performance
A. Create Integrated Delivery System						
Potentially Avoidable Services						
X	Potentially Preventable Emergency Room Visits	3M		Reporting		Performance
X	Potentially Preventable Readmissions	3M		Reporting		Performance
X	PQI 90 – Composite of all measures	AHRQ		Reporting		DY 3 Reporting/ DY 4 and 5 Performance
X	PDI 90 – Composite of all measures	AHRQ		Reporting		DY 3 Reporting/ DY 4 and 5 Performance
Provider Reimbursement						
	Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement			Reporting		Reporting
System Integration						
X	Percent of Eligible Providers meeting Meaningful Use criteria, who have participating agreements with qualified entities (RHIOS) and are able to participate in bidirectional exchange			Reporting		Reporting
Primary Care						
X	Percent of PCP meeting PCMH (NCQA)/ Advance Primary Care (SHIP)			Reporting		Reporting

Domain 2 – System Transformation Metrics						
X	CG CAHPS Measures including usual source of care Patient Loyalty (Is doctor/clinic named the place you usually go for care? How long have you gone to this doctor/clinic for care?)	AHRQ		Reporting		Performance
Access to Care						
X	HEDIS Access/Availability of Care (Adult Access to Preventive or Ambulatory Care, Children's Access to Primary Care)	NCQA		Reporting		Performance
X	CG CAHPS Measures: - Getting Timely Appointments, Care and Information	AHRQ		Reporting		Performance
Medicaid Spending for Projects Defined Population on a PMPM Basis						
	Medicaid spending on ER and Inpatient Services			Reporting		Reporting
	Medicaid spending on PC and community based behavioral			Reporting		Reporting
B. Implementation of care coordination and transitional care programs						
Performing Provider Systems will be required to meet all of the above metrics with the addition of the following:						
Care Transitions						
	H-CAHPS – Care Transition Metrics	AHRQ		Reporting		Performance
X	CG CAHPS Care Coordination composite	AHRQ		Reporting		Performance
C. Connecting Settings						
Performing Provider Systems will be required to meet all of the above metrics for A and B.						
D. Utilizing Patient Activation to Expand Access to Community Based Care for Special Populations						
	Interval change of the mean in Patient Activation Measure® (PAM®) –scores among eligible members by weighted project cohorts compared to baseline year.	Insignia Health		Reporting		Performance

	Non-use of Primary and Preventive Care Services	NYS		Reporting		Performance
	Emergency department use by uninsured persons as measured by percent of emergency room visits among individuals that are uninsured in the measurement year compared to same in baseline year.	NYS		Reporting		Performance
	CG CAHPS done by PPS documenting the uninsured population experience with the health care system	AHRQ		Reporting		Performance

Domain 3. Clinical Improvement Metrics

All Domain 3 metrics are pay-for-reporting in DY 1. As described below, some metrics continue as pay-for-reporting in DY 2-3 but become pay-for-performance in DY 4-5. In general, provider systems will include all metrics associated with the project selected, unless otherwise specified below. Metrics will be reported annually. In the event that a measure is removed from a project (such as if the measure is retired by the steward), the State and CMS reserve the right to introduce a replacement measure for the project. PPSs conducting the project will be notified of the removal or replacement.

Domain 3 – Clinical Improvement Metrics							
					DSRIP Years 2 – 3		DSRIP Years 4 - 5
Measure Name	Measure Steward	NQF#	Source	Measure Type	Pay for Reporting/Pay for Performance		Pay for Reporting/Pay for Performance
A. Behavioral Health (Required) – All behavioral health projects will use the same metrics except for SNF programs implementing the BIP in Nursing Homes project. These providers will include the additional behavioral health measures below in A-2.							
Potentially Preventable Emergency Room Visits (for persons with BH diagnosis)	3M		Claims	Outcome	Performance		Performance
Antidepressant Medication Management	NCQA	0105	Claims	Process	Performance		Performance
Diabetes Monitoring for People with Diabetes and Schizophrenia	NCQA	1934	Claims	Process	Performance		Performance
Diabetes Screening for People with Schizophrenia or Bipolar Disease Using Antipsychotic Medication	NCQA	1932	Claims	Process	Performance		Performance
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia.	NCQA	1933	Claims	Process	Performance		Performance
Follow-up care for Children Prescribed ADHD Medications	NCQA	0103	Claims	Process	Reporting		Performance
Follow-up after hospitalization for Mental Illness	NCQA	0576	Claims	Process	Performance		Performance

Domain 3 – Clinical Improvement Metrics							
Screening for Clinical Depression and follow-up	CMA	0418	Medical Record	Process	Reporting		Performance
Adherence to Antipsychotic Medications for People with Schizophrenia	NCQA	1879	Claims	Process	Performance		Performance
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA	0004	Claims	Process	Performance		Performance
A – 2. Additional behavioral health measures for provider systems implementing the Behavioral Interventions Paradigm (BIP) in Nursing							
Antipsychotic Use in Persons with Dementia for Long Stay Residents	3M		MDS 3.0	Outcome	Performance		Performance
Percent of Long Stay Residents who have Depressive Symptoms	CMS		MDS 3.0	Process	Performance		Performance

Domain 3 – Clinical Improvement Metrics							
B. Cardiovascular Disease							
					DSRIP Years 2 – 3		DSRIP Years 4 - 5
Measure Name	Measure Steward	NQF#	Source	Measure Type	Pay for Reporting/Pay for Performance		Pay for Reporting/Pay for Performance
PQI # 7 (HTN)	AHRQ		Claims	Outcome	Reporting		Performance
PQI # 8 (Heart Failure)	AHRQ		Claims	Outcome	Reporting		Performance
Statin Therapy for Patients with Cardiovascular Disease	NCQA		Medical Record	Process	Reporting		Performance
Controlling High Blood Pressure	NCQA	0018	Medical Record	Outcome	Reporting		Performance
Aspirin Discussion and Use	CAHPS		Survey	Process	Reporting		Performance
Medical Assistance with Smoking and Tobacco Use Cessation	NCQA	0027	Survey	Process	Reporting		Performance
Flu Shots for Adults Ages 50 – 64	NCQA	0039	Survey	Process	Reporting		Performance
Health Literacy Items (includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if	CAHPS		Survey	Process	Reporting		Performance
C. Diabetes Mellitus							
PQI # 1 (DM Short term complications)	AHRQ	0274	Claims	Outcome	Reporting		Performance
Comprehensive Diabetes screening (HbA1c, dilated eye exam, nephropathy)	NCQA		Medical Record	Process	Reporting		Performance
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	Medical Record	Outcome	Reporting		Performance

Domain 3 – Clinical Improvement Metrics							
Medical Assistance with Smoking and Tobacco Use Cessation	NCQA	0027	Survey	Process	Reporting		Performance
Flu Shots for Adults Ages 50 – 64	NCQA	0039	Survey	Process	Reporting		Performance
Health Literacy Items (includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the	CAHPS		Survey	Process	Reporting		Performance
D. Asthma							
PQI # 15 Adult Asthma	AHRQ	0283	Claims	Outcome	Reporting		Performance
PDI # 14 Pediatric Asthma	AHRQ	0638	Claims	Outcome	Reporting		Performance
Asthma Medication Ratio	NCQA	1800	Claims	Process	Performance		Performance
Medication Management for People with Asthma	NCQA	1799	Claims	Process	Performance		Performance
E. HIV/AIDS							
HIV/AIDS Comprehensive Care : Engaged in Care	NYS		Claims	Process	Performance		Performance
HIV/AIDS Comprehensive Care : Viral Load Monitoring	NYS		Claims	Process	Performance		Performance
HIV/AIDS Comprehensive Care : Syphilis Screening	NYS		Claims	Process	Performance		Performance
Cervical Cancer Screening	NCQA	0032	Claims	Process	Reporting		Performance
Chlamydia Screening	NCQA	0033	Claims	Process	Performance		Performance
Medical Assistance with Smoking and Tobacco Use Cessation	NCQA/	0027	Survey	Process	Reporting		Performance
Viral Load Suppression	HRSA	2082	Medical	Outcome	Reporting		Performance
F. Perinatal Care							
PQI # 9 Low Birth Weight	AHRQ	0278	Claims	Outcome	Reporting		Performance

Domain 3 – Clinical Improvement Metrics							
Prenatal and Postpartum Care—Timeliness and Postpartum Visits	NCQA	1517	Medical Record	Process	Reporting		Performance
Frequency of Ongoing Prenatal Care	NCQA	1391	Medical Record	Process	Reporting		Performance
Well Care Visits in the first 15 months	NCQA	1392	Claims	Process	Reporting		Performance
Childhood Immunization Status	NCQA	0038	Medical Record	Process	Reporting		Performance
Lead Screening in Children	NCQA		Medical Record	Process	Reporting		Performance
PC-01 Early Elective Deliveries	Joint Commission	0469	Medical Record	Process	Reporting		Reporting
G. Palliative Care – All projects will use the same metric set.							
Percentage of patients indicating need who were offered or provided an intervention for pain symptoms experienced during the past week	NYS		IPOS	Process	Reporting		Performance
Percentage of patients indicating need who were offered or provided an intervention for physical symptoms (other than pain) experienced during the past week	NYS		IPOS	Process	Reporting		Performance
Percentage of patients indicating need who were offered or provided an intervention for not feeling at peace during the past week	NYS		IPOS	Process	Reporting		Performance

Percentage of patients indicating need who were offered or provided an intervention for depressive feelings experienced during the past week	NYS		IPOS	Process	Reporting		Performance
Percentage of patients who were offered or provided an intervention when there was no advance directive in place	NYS		IPOS	Process	Reporting		Performance
H. Renal Care							
Comprehensive Diabetes screening (HbA1c, dilated eye exam, nephropathy)	NCQA		Medical Record	Process	Reporting		Performance
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	Medical Record	Outcome	Reporting		Performance
Annual Monitoring for Patients on Persistent Medications – ACE/ARB	NCQA		Claims	Process	Reporting		Performance
Controlling High Blood Pressure	NCQA	0018	Medical Record	Outcome	Reporting		Performance
Flu vaccine 18-64	NCQA	0039			Reporting		Performance
Medical Assistance with Smoking and Tobacco Use Cessation	NCQA	0027			Reporting		Performance

Domain 4. Population-Wide Metrics

This domain includes pay-for-reporting for relevant measures from the New York State Prevention Agenda related to the Domain 4 projects selected. All Domain 4 metrics will be measured by a geographical area denominator of all New York State residents that New York State has already developed for the Prevention Agenda. Some metrics are not collected on an annual basis but will be reported on their usual collection cycle. For example, the BRFSS is done biannually.

The metrics that are part of the New York State Prevention Agenda are available here: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm and will be further described in the metric specification guide.

		Source	Geographic Granularity
Improve Health Status and Reduce Health Disparities (required for all projects)			
1.	Percentage of premature death (before age 65 years)	NYS NYSDOH Vital Statistics	State, County
2.	*Ratio of Black non-Hispanics to White non-Hispanics*		
3.	*Ratio of Hispanics to White non-Hispanics*		
4.	Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years	SPARCS	Statewide Region County
5.	*Ratio of Black non-Hispanics to White non-Hispanics*		
6.	*Ratio of Hispanics to White non-Hispanics*		
7.	Percentage of adults with health insurance - Aged 18-64 years	US Census	
8.	Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	eBRFSS	Statewide NYC/ROS County
Promote Mental Health and Prevention Substance Abuse			
8.	Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month	eBRFSS	Statewide NYC/ROS County

9.	Age-adjusted percentage of adult binge drinking during the past month	eBRFSS	Statewide NYC/ROS County
10.	Age-adjusted suicide death rate per 100,000	NYS NYSDOH Vital Statistics	State, county
	Prevent Chronic Diseases		
11.	Percentage of adults who are obese	eBRFSS	Statewide NYC/ROS County
12.	Percentage of children and adolescents who are obese	NYS excluding NYC: - Student Weight Status Category Reporting; NYC – Fitnessgram	Statewide NYC/ROS County
13.	Percentage of cigarette smoking among adults	eBRFSS	Statewide NYC/ROS County
14.	Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years	eBRFSS	Statewide
15.	Asthma emergency department visit rate per 10,000	SPARCS	Statewide Region County
16.	Asthma emergency department visit rate per 10,000 - Aged 0-4 years	SPARCS	Statewide Region County

17.	Age-adjusted heart attack hospitalization rate per 10,000	SPARCS	Statewide Region County
18.	Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years	SPARCS	Statewide Region County
19.	Rate of hospitalizations for short-term complications of diabetes per 10,000 -	SPARCS	Statewide
	Aged 18+ years		Region County
	Prevent HIV/STDs		
20.	Newly diagnosed HIV case rate per 100,000	NYS HIV Surveillance System	
21.	*Difference in rates (Black and White) of new HIV diagnoses*		
22.	*Difference in rates (Hispanic and White) of new HIV diagnoses*		
23.	Gonorrhea case rate per 100,000 women - Aged 15-44 years	NYS STD Surveillance System	
24.	Gonorrhea case rate per 100,000 men - Aged 15-44 years	NYS STD Surveillance System	
25.	Chlamydia case rate per 100,000 women - Aged 15-44 years	NYS STD Surveillance System	
26.	Primary and secondary syphilis case rate per 100,000 males	NYS STD Surveillance System	
27.	Primary and secondary syphilis case rate per 100,000 females	NYS STD Surveillance System	

	Promote Healthy Women, Infants, and Children		
28.	Percentage of preterm births	NYS NYSDOH Vital Statistics	State, County
29.	*Ratio of Black non-Hispanics to White non-Hispanics*		
30.	*Ratio of Hispanics to White non-Hispanics*		
31.	*Ratio of Medicaid births to non-Medicaid births*		
32.	Percentage of infants exclusively breastfed in the hospital	NYS NYSDOH Vital Statistics	State, County
33.	***Ratio of Black non-Hispanics to White non-Hispanics***		
34.	***Ratio of Hispanics to White non-Hispanics***		
35.	***Ratio of Medicaid births to non-Medicaid births***		
36.	Maternal mortality rate per 100,000 births	NYS NYSDOH Vital Statistics	State, County
37.	Percentage of children with any kind of health insurance - Aged under 19 years	U.S. Census	State, County
38.	Adolescent pregnancy rate per 1,000 females - Aged 15-17 years	NYS NYSDOH Vital Statistics	State, County
39.	***Ratio of Black non-Hispanics to White non-Hispanics***		
40.	***Ratio of Hispanics to White non-Hispanics***		
41.	Percentage of unintended pregnancy among live births	NYSDOH Vital Statistics	State
42.	***Ratio of Black non-Hispanics to White non-Hispanics***		
43.	***Ratio of Hispanics to White non-Hispanics***		
44.	***Ratio of Medicaid births to non-Medicaid births***		
45.	Percentage of women with health coverage - Aged 18-64 years	U.S. Census	State, County