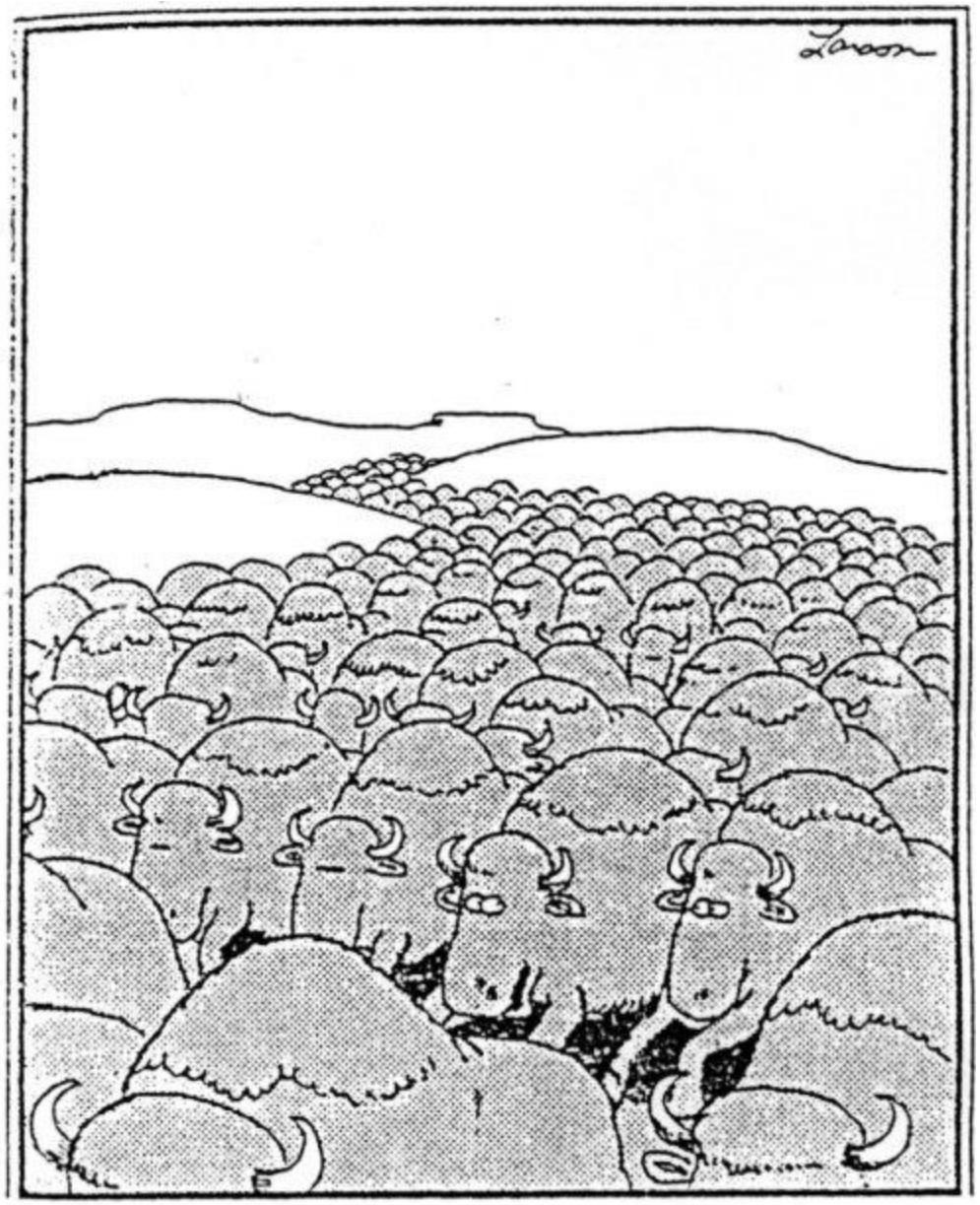
Beginning to unpack the data needs of Medicaid waiver transformation projects in King County

Performance Measurement Work Group

Public Health
Seattle & King County



"As if we all knew where we're going."

Outline

1. Healthier Washington Medicaid Transformation Projects
2. New York's Medicaid Waiver:
   Delivery System Reform Incentive Payments (DSRIP) Program
3. Comparing WA and NY Medicaid waiver projects
4. Toward understanding the data needs of ACHs for planning & performance measurement of Medicaid transformation projects

Healthier Washington Medicaid Transformation Projects

Overview of Healthier Washington Medicaid waiver transformation projects

Background

- Delivery System Reform - each region, through its Accountable Community of Health, will be able to pursue projects that will transform the Medicaid delivery system to serve the whole person and use resources more wisely

Overall goal

- Shift to paying for value over volume (i.e. away from fee-for-service):
  - Target: 80% of Medicaid payments are value-based payments by 2019

Project guidelines

- Projects will be specified by the state
- Projects must support predominantly Medicaid-eligible populations

Key players

- Focus on transforming health care delivery system by working with providers and plans

Role of metrics

- Participating providers will earn incentive payments based on performance on project metrics:
  - State will develop metrics for each waiver project
  - Metrics expected to be based on common measure set

Source: Healthier Washington, Medicaid Transformation Waiver: Framework for the Project Toolkit, 4/21/2016.

Domain 1: Health systems capacity building

Project	Intersections with current King County work?
Primary care models: Work with primary care practices to provide whole-person care (i.e. integrated care)	• Physical/behavioral health integration
Workforce and non-conventional service sites: Focus on health care workforce development	
Data collection and analytic capacity: Support evolution of EHR and HIE to improve speed, quality, safety, and cost of care; includes linkages to community-based care models Improve data/analytics capacity to support health systems transformation, including combining clinical and claims data to advance value-based payment models and achieve Triple Aim	• Familiar Faces • KCIT data integration project • King County Hospitals for a Healthier Community

Note: Domain 1 projects must support and demonstrate a direct connection to activities undertaken in Domain 2 (Care Delivery Redesign) and/or Domain 3 (Prevention and Health Promotion)

Source: Healthier Washington, Medicaid Transformation Waiver: Framework for the Project Toolkit, 4/21/2016.

Domain 2: Care delivery redesign

Project	Intersections with current King County work?
Bi-directional integration of care: Systematic coordination of physical and behavioral healthcare	• Physical/behavioral health integration
Care coordination: Bringing together providers and data systems to coordinate health services, foundational community supports, and information to better achieve goals of treatment and care (includes optional oral health coordination project as well) Cannot duplicate care coordination currently provided under Medicaid, but can support these efforts and/or ensure local coordination Must result in improvements in clients' health outcomes	• Familiar Faces
Care transitions	• Familiar Faces

Source: Healthier Washington, Medicaid Transformation Waiver: Framework for the Project Toolkit, 4/21/2016.

Domain 3: Prevention and health promotion

Project	Intersections with current King County work?
Chronic disease prevention and/or management: Improved management of chronic conditions Identify and link existing community resources that provide targeted services for clients with chronic health conditions Identify culturally competent, cost-effective, evidence-based approaches to prevention/care of chronic disease Reduce disparities in receipt of targeted prevention services Increase rates of screening and follow-up across prevention services Expand availability of chronic disease self-management programs Implement obesity/food insecurity screening and improve referrals	• King County Hospitals for a Healthier Community • Partnerships to Improve Community Health (PICH)
Maternal and child health: Promoting improved birth outcomes and early childhood health Promoting trauma-informed approaches to care (ACEs focus)	• Best Starts for Kids

Source: Healthier Washington, Medicaid Transformation Waiver: Framework for the Project Toolkit, 4/21/2016.

New York's Medicaid Waiver: Delivery System Reform Incentive Payments (DSRIP) Program

Overview of NY DSRIP Program

Background

- CMS now considers NY DSRIP Program the standard to which other state's programs should be compared

Overall goals

- Reduce avoidable hospital use by 25%
- At least 80% of payments between Medicaid managed care plans and providers use value-based methodologies by end of 5-year waiver

Key players

- Projects are implemented by Performing Provider Systems (PPSs), which are networks of providers and CBOs led by a safety-net provider, most frequently a **hospital**

Role of metrics

- PPSs responsible for reporting to state robust set of process metrics and are accountable for meeting performance metrics, such as reductions in potentially avoidable emergency room visits, potentially avoidable readmissions, and HEDIS measures
- State sets metrics for each project

Source: Commonwealth Fund, Implementing New York's DSRIP Program: Implications for Medicaid Payment and Delivery System Reform, 4/2016.

NY DSRIP projects - lessons learned

PPS-MCO relationship

- Stakeholders noted that PPSs have only minimally engaged MCOs in their planning efforts, and as a result, may not be aware of duplication between their planned investments and services provided by MCOs

Limited focus on patients' unmet social needs (SDOH)

- Thought to be primarily due to dominance of hospitals in governance and leadership of PPSs

Working with CBOs

- New York's waiver permits only 5 percent of PPS funds to be flowed directly to non-safety-net provider
- This includes clinical providers that do not meet the state's definition of a safety-net provider and nonclinical social support services
- As a result, PPSs had to develop workarounds to flow funds to CBOs that do not provide Medicaid-reimbursable services

Absence of public health role

- Not one mention of "public health" in Commonwealth Fund's 34-page report, but development of "population health management infrastructure" a key theme
- Some lead entities created separately incorporated, wholly owned subsidiaries to house the PPS's population health capabilities, such as IT, analytics, and care management
- Continued divide between public health and health care delivery systems

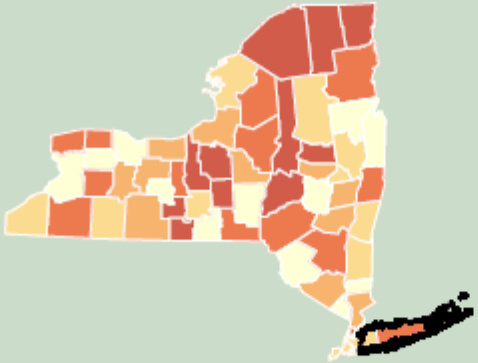
Source: Commonwealth Fund, Implementing New York's DSRIP Program: Implications for Medicaid Payment and Delivery System Reform, 4/2016.

Sample PQI chart

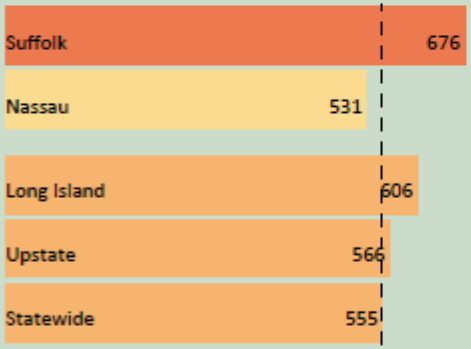
Long Island

Medicaid Avoidable Hospitalizations
Adult Acute Conditions Composite

Admission Rate per 100,000 Recipients



Countywide Rates



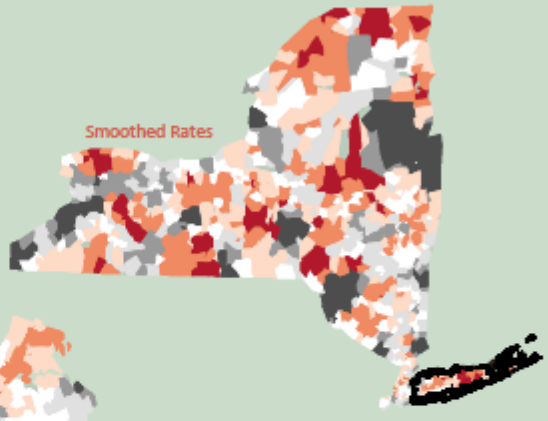
Number of avoidable visits

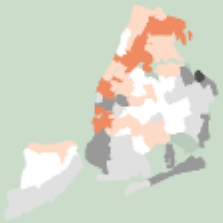
Suffolk	2,196
Nassau	1,586

Delivery System Reform Incentive Payment
Domain 2: System Transformation Metrics
A. Create Integrated Delivery System
Potentially Avoidable Services

Prevention Quality Indicators (PQI91)
Medicaid Recipients
2011-2012

Smoothed Rates

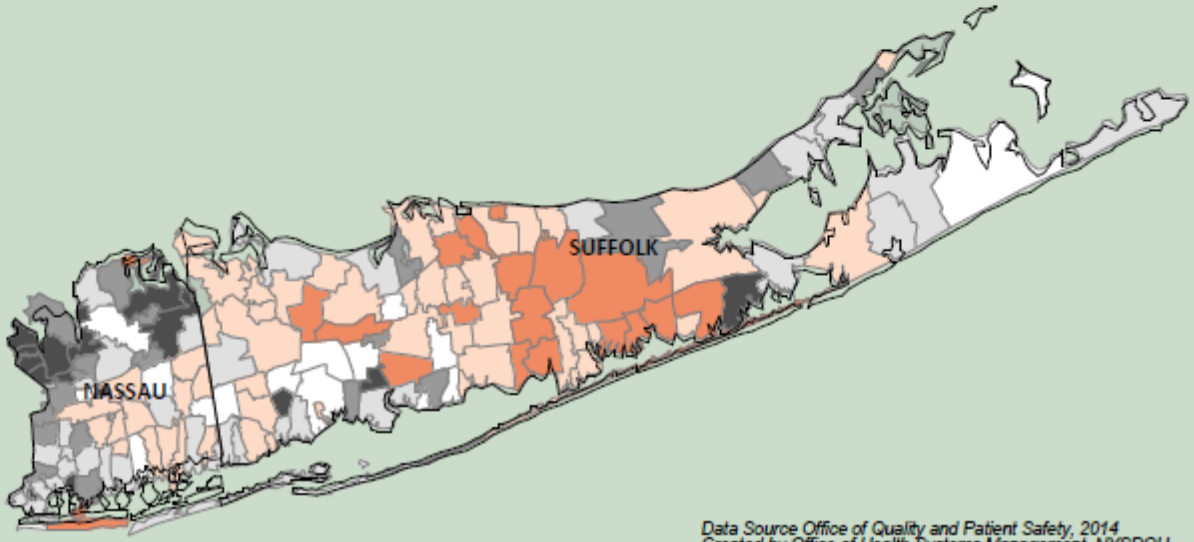




Ratio of Observed to Expected Admissions

Lower — Average — Higher

No admissions



Data Source Office of Quality and Patient Safety, 2014
Created by Office of Health Systems Management, NYSDOH

Sample DSRIP Dashboard

Department of Health
Information for a Healthy New York

Return to Landing Page

Dashboard B4
Medicaid Members by Primary Diagnosis Class (CY 2014)

Geographic Filters

Member DSRIP Region
All

Member County/Borough
All

Member Current Zip Code
All

Provider Filters

Service County
All

Managed Care Plan Name
All

Note:
The region, county and zip code filters represent the Medicaid member's home area - typically their area of residency. The service county is where the service was rendered.

Source: Salient NYS Medicaid DSRIP Dashboard System Version 1.0

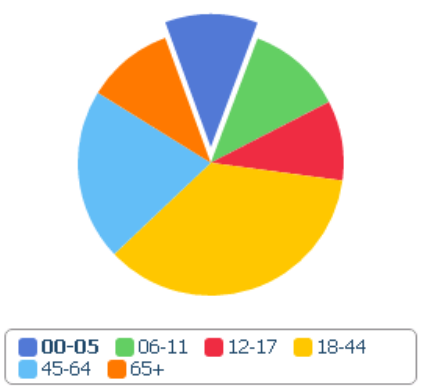
Widget 1: Unique Medicaid Members by Primary Diagnosis Class with Downlevel to Providers

Primary Diagnosis Class	Claim Count	Unique Members w Services
SIGNS, SYMPTOMS, AND ILL-DEFINED CONDITIONS	56,012,013	2,805,780
MENTAL DISORDERS ALL DSMIII C	40,888,050	1,177,223
SUPPLE CLASS/DESC OF PATIENT STATUS AND OTHER HLTH	30,994,079	2,753,137
DISEASES OF THE MUSCULOSKELETAL SYSTEM	25,077,448	1,494,055
REASON FOR SPECIAL ADMISSIONS AND EXAMS	19,364,179	2,211,713
ENDOCRINE, NUTRITIONAL, METABOLIC	15,846,262	1,271,241
NOT AVAILABLE	15,419,062	2,142,941
CIRCULATORY SYSTEM DISEASES	15,202,178	1,091,605
DISEASES OF THE NERVOUS SYSTEM	14,838,268	2,041,483
DISEASES OF THE RESPIRATORY SYSTEM	12,180,907	1,859,246
GENITOURINARY SYSTEM DISEASES	11,430,866	1,097,092
NATURE OF INJURY, ADVERSE EFFECTS AND POISONING	7,041,460	1,040,572
INFECTIVE AND PARASITIC DISEASE	6,893,818	1,217,742
DIGESTIVE SYSTEM DISEASES	6,282,155	1,042,620
NEOPLASMS	5,433,964	590,492
DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE	4,284,219	935,307
DELIVERY AND COMPLICATIONS OF PREGNANCY	3,800,481	260,305
DISEASES OF BLOOD & BLOOD FORM	3,027,627	334,781
CONGENITAL ANOMALIES	1,528,041	172,409
CERTAIN CAUSES OF PERINATAL MORBIDITY & MORTALITY	900,206	96,630
LIVEBORN INFANTS ACCORDING TO TYPE OF BIRTH	457,109	143,680
EXTERNAL CAUSE OF INJURY	73,795	15,840
Total (22)	296,976,187	5,607,650

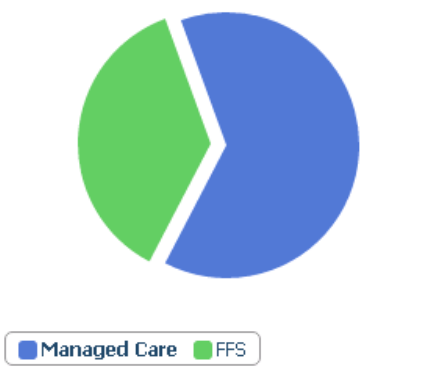
Page 1 of 1

SIGNS, SYMPTOMS

Widget 2: Unique Medicaid Members by Current Age Group



Widget 3: Unique Medicaid Members by Current FFS/MC Coverage



Sample APDE Tableau
data visualization

Comparing WA and NY Medicaid waiver projects

High-level differences between WA and NY Medicaid waiver projects

Washington

Key players

- ACHs, working with providers and plans

Overall goal

- 80% value-based payments by 2019

Funding flow

- No current restrictions on funding flows to non-providers/plans

Data commitment to DSRIP leads

- Unclear whether ACHs will have access to anything other than summary-level dashboards/reports

Social determinants of health

- Intentionally addressed by multiple waiver projects

Performance metrics

- Will be based on WA state common measure set

New York

Key players

- Hospitals, working mostly with other providers

Overall goal

- 25% reduction in avoidable hospital use AND 80% value-based payments by end of 5-year waiver

Funding flow

- No more than 5% funding can flow to CBOs

Data commitment to DSRIP leads

- Substantial investment in building data portals, data extracts, and data dashboards for lead entities

Social determinants of health

- Limited focus potentially due to dominant role of hospitals AND limited funds to pay for social services and CBO-based efforts

Performance metrics

- Domain 2-4 metrics moderate overlap with WA state common measure set

Toward understanding the data needs of ACHs for planning & performance measurement of Medicaid transformation projects

WHAT data will be needed for Medicaid waiver project planning & performance measurement?

Which data sources?	If ACHs work with providers, plans, and other partners to implement Medicaid waiver projects, what data will be needed for planning & performance measurement?
Which populations?	Will Medicaid waiver projects be targeted to ALL Medicaid enrollees within each ACH, or will projects target selected sub-populations by provider, plan, demographics (e.g. place) or clinical characteristics?
Crossing providers/plans	If projects target sub-populations that span multiple providers and/or plans, how will this cross provider/plan data be prepared for planning and performance measurement?
Use of non-provider/ plan data	How will data sources not traditionally used by providers/plans (population-based surveys, vital statistics) be incorporated into project performance measurement?
Performance measurement roles	Will performance measurement be centralized (i.e. state) or localized (i.e. ACHs/partners)?
Role of non-health data in planning	For projects that focus on working with partners outside of the traditional health care delivery system, how will these projects use cross agency, cross sector data for planning?

HOW will data will be used for Medicaid waiver project planning & performance measurement?

Data infrastructure	What data infrastructure will ACHs or waiver project partners need to receive, process, manage and analyze data?
HIPAA	Do ACHs need to be HIPAA covered entities or be partnered with a HIPAA covered entity to have their data needs met?
Data sharing agreements	What infrastructure or tools would be helpful to ACHs and their waiver project partners in establishing data sharing agreements?
Minimum data capacity	What minimum data capacities should ACHs have either through staffing, contracting, or collaboration with ACH partners?
Budgeting for data	What percent of administrative budget or other lines should be directed towards meeting data needs?
Data technical assistance	What level of data technical assistance provided by whom will be needed by ACHs and their partners? What about regional or centralized support beyond AIM for the waiver?

Pay for performance metrics to be drawn from common measure set

Measures based on claims/hospitalization data typically drawn from identifiable data
- Able to assess custom groups defined by participation in intervention (e.g. waiver project)

CLAIMS/HOSPITALIZATION DATA-BASED MEASURES

access to primary care providers
well-child visits
weight assessment & nutrition/physical activity counseling
primary caries prevention offered by primary care
medical assistance with smoking
health screenings (cancers, chlamydia)
follow/up after hospitalization for mental illness
follow/up after discharge from ED for MH/CD concern
mental health service penetration
substance use disorder treatment penetration
30-day psychiatric inpatient readmissions
depression: medication management
asthma: medication management
COPD: use of spirometry in diagnosis
hospitalization for COPD or asthma
diabetes: blood sugar testing
diabetes: blood sugar poor control
diabetes: eye exam
diabetes: kidney disease screening
diabetes: blood pressure control
cardiovascular disease: blood pressure control
cardiovascular disease: statin therapy
medication safety: adherence to prescribed medications
medication safety: hypertension medication monitoring
generic medication prescribing
appropriate testing for pharyngitis
avoidance of antibiotics for acute bronchitis
avoidance of X-ray, MRI, CT scan for low back pain
potentially avoidable ED use
ED visit rate
30-day all-cause hospital readmissions
Cesarean deliveries
hospital 30-day mortality for heart attacks
catheter-associated urinary tract infections
stroke care: timely thrombolytic therapy
patient falls with injury
patient safety for 11 indicators (composite)
annual per-capita state-purchased health care spending
Medicaid per enrollee spending
Public Employee per enrollee spending

Measures based on surveys or vital statistics typically *not* drawn from identifiable data
- Not typically able to assess custom groups defined by participation in intervention (e.g. waiver project)
- Able to assess groups defined by demographic characteristics including place

POPULATION-BASED SURVEY MEASURES

tobacco use
unintended pregnancies
immunization status
mental health status

VITAL STATISTICS-BASED MEASURES

immunization status

PATIENT EXPERIENCE SURVEY MEASURES

patient experience with primary care provider communication
patient experience (discharge information, medicine explained)

This is a simplified list of the common measure set for presentation purposes only. Full information on the common measure set can be found at http://www.hca.wa.gov/hw/pages/performance_measures.aspx

Who will measure Delivery System Reform project performance?

If measured by the state

Lessons learned

- In New York, much of the data needed for planning waiver projects comes from state claims data, which is on a year-plus delay.
- In addition, much of the data analysis is done by state and carries a large administrative burden that causes further delays in information disseminated to DSRIP implementers (providers).
- This causes significant obstacles in timely reporting of clinical outcomes for payment.

In Washington State…

- How will state assume the substantial administrative burden of performance measurement for ACHs?
- How will this administrative burden and the lag of claims data impact pay for performance reporting and payments?
- Will multi-provider/plan claims data be made available to ACHs and their partners for project planning?

If measured by ACHs & their partners

Lesson learned

- In Texas, DSRIP implementers (providers) do not have access to statewide claims data and must rely on internal data systems to report many population measures.
- This limited data reduces state's ability to measure waiver impact because reported data is not standardized across providers.

In Washington State…

- If statewide claims and other data sources are provided to ACHs/partners, how will state ensure that available data are timely and produced at required intervals (e.g. for quarterly reporting)?
- If providers/plans are instead expected to use their own internal data for performance measurement, how will state ensure that this is standardized across ACHs?
- What level of analytics and support will need to be given to ACHs and their partners?

Source: Chau, N. & Springer, H, *Lessons for Washington 1115 Waiver Participants*. Cope Health Solutions, 2015, https://copehealthsolutions.org/cblog/lessons-for-washington-1115-waiver-participants/

Additional populations

- Delivery System Reform projects must support predominantly Medicaid-eligible populations, but other populations also important for overall health reform in WA state

Additional data & metrics

- Pay for performance metrics will be drawn from common measure set, which does not include measures for social determinants of health (e.g. housing, education, employment), but these factors are likely essential focus areas for effective & sustainable health reform
- Common measure set does not include measures drawn from electronic health record data; with development of the Clinical Data Repository, will these data eventually be available for Delivery System Reform project planning & performance measurement?
- What about market-wide claims data from the All Payer Claims Database?

APPENDIX

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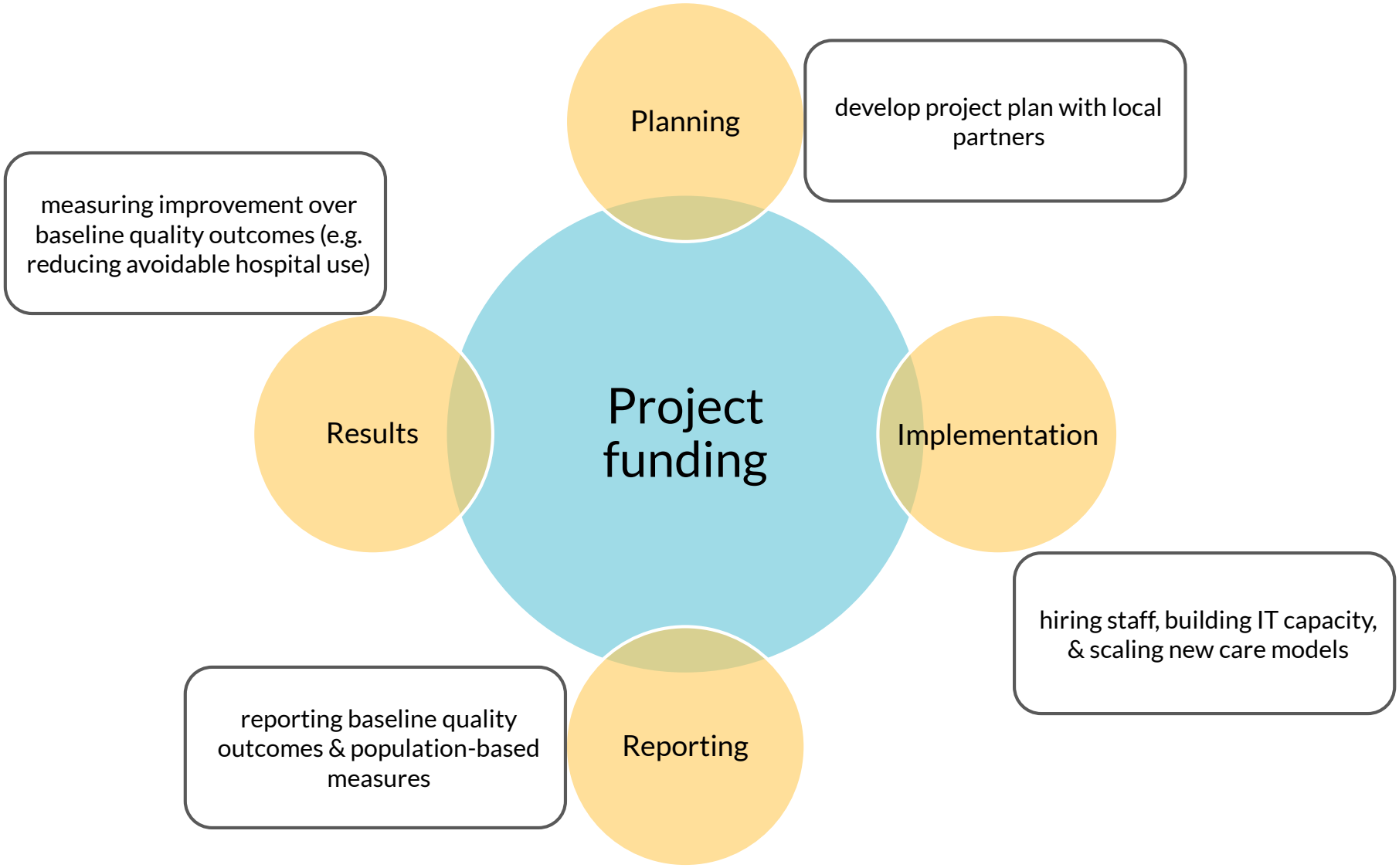
How can waiver project funding potentially be used in WA state?



Source: Healthier Washington, Medicaid Transformation Waiver: Framework for the Project Toolkit, 4/21/2016.

44 DSRIP projects fall into three domains

Domain 1 - Building care management and population health management infrastructure

- Improve care coordination and transitional care
- Connect care occurring in multiple settings
- More systematically engage with patients

Domain 2 - Clinical programs

- Home-based asthma interventions
- Primary care and behavioral health integration
- Cardiovascular care, diabetes care, palliative care, and renal care

Domain 3 - Population health projects

- Focus on chronic disease, HIV, maternal and infant health, and mental health and substance abuse prevention

Project selection

- PPSs required to select between 5 and 11 projects to implement over 5-year waiver period
- Each PPS accountable for between 100 and 330 process and outcome metrics, creating a heavy administrative burden

Source: Commonwealth Fund, Implementing New York's DSRIP Program: Implications for Medicaid Payment and Delivery System Reform, 4/2016.

NY DSRIP - commitment to performance monitoring

- NY used waiver funds to build a Medicaid Analytics Performance Portal (MAPP) with "the goal of building a 360-degree view of a patient that is not constrained by organizational barriers":
  - MAPP houses performance dashboards, acts as a data warehouse, and serves as an electronic care planning tool for the health home population

- NY also committed to sharing Medicaid claims data with PPSs and requires DSRIP-eligible providers be connected to a qualified regional health information organization to promote clinical data-sharing and access to data for treatment purposes
  - Some PPSs are working with health plans to directly access plans' claims feeds, which typically have a shorter lag time than those provided by the state

- Stakeholders skeptical whether MAPP tool or information exchange through state's HIE will help them achieve DSRIP performance objectives because of issues of timing and utility:
  - Most stakeholders are taking a wait-and-see attitude, while investing significantly in their own IT and population health capabilities

Source: Commonwealth Fund, Implementing New York's DSRIP Program: Implications for Medicaid Payment and Delivery System Reform, 4/2016.

NY DSRIP performance data

In addition to providing access to MAPP and sharing Medicaid claims data, NY has provided PPSs with additional data assets for DSRIP project selection and applications, including:

DSRIP Performance Chartbooks

- Maps and charts of avoidable hospitalization and health care quality indicators
- Developed by NY Department of Health (yay public health) using Medicaid claims data
- Avoidable hospitalization chartbooks:
  - Includes 26 metrics, all of which are Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs), plus two additional indicators - Potentially Preventable ER Visits (PPVs) and Potentially Preventable Hospital Readmission (PPRs), both of which are developed using software from 3M
  - APDE routinely develops PQIs based on CHARS data (though could also be done with Medicaid claims data), PDIs follow the same principle
- Clinical metrics chartbooks:
  - Includes 16 HEDIS measures, all of which are generated using Medicaid claims data (i.e. Community Checkup)

DSRIP Dashboards

- 15 interactive dashboards developed by DOH and Salient HHS, a performance management solutions corporation
- All dashboards are based on Medicaid claims data

Source: NY Department of Health, DSRIP Performance Data, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/performance_data

Selected NY DSRIP Dashboards

Dashboard	Data required for dashboard
Where do members go for services?	Medicaid claims data*
Who provides services to members?	Medicaid claims data
What type of service do members receive?	Medicaid claims data
What type of conditions are being treated?	Medicaid claims data
Who is providing ER, inpatient and primary care?	Medicaid claims data
Who are the providers in my DSRIP region and county?	Medicaid claims data
How many Medicaid members are enrolled in each county?	Medicaid claims data
How often do people go the ER in your catchment area?	Medicaid claims data
How have ER utilization rates changed over the past 3 years?	Medicaid claims data
How often do people have primary care visits in your area?	Medicaid claims data
How have Primary Care Visit rates changed over the past 3 years?	Medicaid claims data
How often are people admitted for Inpatient Care in your area?	Medicaid claims data
How have Inpatient Admission rates changed over the past 3 years?	Medicaid claims data

* Would require geocoding of all client residences AND location for each rendered service

NY DSRIP project performance monitoring

- DSRIP project performance is measured through four domains of metrics:
  - Domain 1: Overall project progress metrics (process measures only)
  - Domain 2: System transformation metrics
  - Domain 3: Clinical improvement metrics
  - Domain 4: Population-wide project implementation metrics

- Metrics in domains 2-4 are either process or outcome measures:
  - All metrics in domains 2-3 are pay-for-reporting in Year 1, and some transition to pay-for-performance between Years 2-5
  - All domain 4 metrics are pay-for-reporting only

Source: NY Department of Health, Centers for Medicare and Medicaid Services (CMS) Official Documents - Attachment J: Strategies and Metrics Menu, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/cms_official_docs.htm

Select system transformation metrics (domain 2)

Metric	Source	Other considerations
Potentially avoidable ER visits*†	Medicaid claims	3M grouping & risk adjustment software
Potentially avoidable readmissions*	Medicaid claims	3M grouping & risk adjustment software
PQI Suite - composite of all measures*	Medicaid claims	
PDI Suite - composite of all measures*	Medicaid claims	
% of provider reimbursement that is value-based payment	Medicaid claims?	
Assorted patient/provider experience measures (usual source of care, timeliness of care, care transition, care coordination)*†	CAHPS survey	
Assorted HEDIS measures (access/availability of care, use of services)*†	Medicaid claims	
Medicaid spending on specific services†	Medicaid claims	
Use of primary, preventive care and ER services among uninsured or newly insured patients*	?	

* Metric transitions to a pay-for-performance metric
† Same or similar metric included in the 2016 WA State Common Measure Set

Source: NY Department of Health, Centers for Medicare and Medicaid Services (CMS) Official Documents - Attachment J: Strategies and Metrics Menu, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/cms_official_docs.htm

Select clinical improvement metrics (domain 3)

Metric	Source	Other considerations
Assorted process and outcome measures for behavioral health service utilization*†	BHO claims	
Chronic disease-related PQIs (cardiovascular disease, diabetes, asthma)*†	Medicaid claims	
Blood pressure, cholesterol, diabetes management*†	Medical record	
Health literacy items (i.e. management of chronic disease)*	CAHPS survey	
Medical assistance with smoking cessation (NCQA) *†	?	
Flu shots for adults age 50-64*†	BRFSS	
Asthma medication ratio (NCQA)*	Medicaid claims	
Medication management for people with asthma (NCQA)*†	Medicaid claims	
Low birth weight PQI*	Medicaid claims	
Prenatal care timeliness & frequency, post-partum visits*	Medical record	Could we use claims?
Well-care visits in first 15 months*	Medicaid claims	
Childhood immunization status*†	Medical record	Could we use WSIIS?

* Metric transitions to a pay-for-performance metric
† Same or similar metric included in the 2016 WA State Common Measure Set

Source: NY Department of Health, Centers for Medicare and Medicaid Services (CMS) Official Documents - Attachment J: Strategies and Metrics Menu, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/cms_official_docs.htm

Select population-wide project implementation metrics (domain 4)

Metric*	Source
Premature death rate (death before ag 65)**	Death records
Age-adjusted preventable hospitalization rate per 10,000 (age 18+)**	All-payer claims
Non-elderly adults with health insurance	ACS
Adults with regular health care provider†	BRFSS
Adults with poor mental health for 14+ days/month	BRFSS
Adult binge drinking during past month	BRFSS
Age-adjusted suicide rate per 10,000	Death records
Adult obesity	BRFSS
Child and adolescent obesity	HYS
Cigarette smoking among adults†	BRFSS
Colorectal cancer screening (age 50-75)†	BRFSS
Asthma ER visit rate per 10,000	All-payer claims
Age-adjusted heart attack hospitalization rate per 10,000	CHARS
Hospitalization rates for short-term complications of diabetes	CHARS
Pre-term birth rates**	Birth records
Infants exclusively breastfed in hospital**	Birth records?
Maternal mortality rate	Death records
Children with health insurance	ACS
Adolescent pregnancy rate**	PRAMS?
Unintended pregnancy rate among live birth**†	PRAMS

* These metrics are calculated for the entire population living in defined geographical areas; thus, not exclusive to Medicaid members only.
** Also includes racial/ethnic breakdowns.
† Same or similar metric included in the 2016 WA State Common Measure Set

Source: NY Department of Health, Centers for Medicare and Medicaid Services (CMS) Official Documents - Attachment J: Strategies and Metrics Menu, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/cms_official_docs.htm

Glossary of Terms

ACEs – Adverse childhood experiences

ACH – Accountable Community of Health

ACS – American Community Survey

AHRQ – Agency for Healthcare Research & Quality

AIM - Analytics, Interoperability & Measurement

APDE – Assessment, Policy Development & Evaluation, PHSKC

BHO – Behavioral Health Organization

BHRD – Behavioral Health & Recovery Division, DCHS

BRFSS – Behavioral Risk Factor Surveillance System

BSK – Best Starts for Kids

CAHPS – Consumer Assessment of Healthcare Providers & Systems

CBO – Community-based Organization

CDR - Clinical Data Repository, Link4Health

CHNA – Community Health Needs Assessment

COO – Communities of Opportunity

COPD - Chronic obstructive pulmonary disease

CPPW – Communities Putting Prevention to Work

CTG – Community Transformation Grant

DCHS – King County Department of Community and Human Services

DOH – New York State Department of Health

DSRIP – Delivery System Reform Incentive Payments

EHR – Electronic health record

ER – Emergency room

HCA - WA State Health Care Authority

HEDIS – Healthcare Effectiveness Data & Information Set

HHSTP – King County Health & Human Services Transformation Plan

HIE – Health Information Exchange

HYS – Healthy Youth Survey

MAPP – Medicaid Analytics Performance Portal

MCH – Maternal & child health

MCO – Managed care organization

NCQA – National Committee for Quality Assurance

PBHI – Physical/Behavioral Health Integration

PDI – Pediatric Quality Indicator

PHSKC – Public Health – Seattle & King County

PICH – Partnerships to Improve Community Health

PMW – Performance Measurement Work Group, King County ACH

PPR – Potentially Preventable Readmission

PPS – Performing Provider System

PPV – Potentially Preventable ER Visit

PQI – Prevention Quality Indicator

PRAMS – Pregnancy Risk Assessment Monitoring System

SDOH – Social determinants of health

VBP - Value-based payments