DSRIP Metrics vs Projects

		2ai	2aii	2aiv	2bviii	2di	3ai	3aii	3aiv	3gi	4aiii	4bii
1	Potentially Preventable ED Visit Rate (PPV)	■	■	■	■						■	■
2	PPV rate for patients w/ Behavioral Health Dx						■	■	■		■	
3	Potentially Preventable Readmission (PPR) Rate	■	■	■	■						■	■
4	% diabetic schizophrenics w/ diabetes monitoring						■	■	■		■	■
5	% BH discharge w/ timely follow up - 7 days						■	■	■		■	
6	% BH discharge w/ timely follow up - 30 days						■	■	■		■	
7	PDI 90 Rate	■	■	■	■							
8	% with primary care visit, 20-44	■	■	■	■							
9	% with primary care visit, 45-64	■	■	■	■							
10	% with primary care visit, 65+	■	■	■	■							
11	% with primary care visit, 12 to 24 months	■	■	■	■							
12	% with primary care visit, 25 months to 6	■	■	■	■							
13	% with primary care visit, 7 to 11	■	■	■	■							
14	% with primary care visit, 12-19	■	■	■	■							
15	% antipsychotic med users with diabetes screening						■	■	■		■	■
16	% schizophrenics with antipsychotic Med adherence						■	■	■		■	
17	% with timely initiative of substance abuse treatment						■	■	■		■	
18	% engaged in substance abuse treatment						■	■	■		■	
19	% on ADHD meds with timely follow-up - initial						■	■	■		■	
20	% on ADHD meds with timely follow-up - continuation						■	■	■		■	
21	PQI 90 rate	■	■	■	■							
22	% w care transitions (H-CAHPS)	■	■	■	■							
23	% w care coordination (C&G CAHPS)	■	■	■	■							
24	Change in Medicaid % w no primary care					■						
25	Change in uninsured % of ED visits					■						
26	% w antidepressant med mgmt - acute						■	■	■		■	
27	% w antidepressant med mgmt - continuation						■	■	■		■	
28	% w always/usually timely access (C&G CAHPS)	■	■	■	■							
29	% w usual source of primary care (C&G CAHPS)	■	■	■	■							
30	% w 1+ year provider relationship (C&G CAHPS)	■	■	■	■							
31	% w positive depression screen and timely follow-up						■	■	■		■	
32	Palliative care proxy measure									■		
33	PAM Score					■						

2ai: Create an integrated delivery system focused on evidence based medicine and population health management - ADDENDUM NOT YET RELEASED

2aii: Increase certification of primary care practitioners with PCMH Certification and/or advanced primary care models (as developed under the NYS Health Innovation Plan - SHIP)

2aiv: Create a medical village using existing hospital infrastructure

2bviii: Hospital-Home care collaborative solutions

2di: Implementation of Patient Activation activities to engage, educate and integrate uninsured and low/non-utilizing medicaid populations into community based care

3ai: Integration of primary care and behavioral health services

3aii: Behavioral health community crisis stabilization services

3aiv: Development of withdrawl management capabilities and appropriate enhanced abstinence services within community based addiction treatment programs

3gi: Integration of palliative care inito the PCMH model

4aiii: Strengthen mental health and substance abuse infrastructure across systems

4bii: Increase access to high quality chronic disease preventative care and management in both clinical and community settings (COPD) - ADDENDUM NOT YET RELEASED