

SOLICITATION #: 2017000265

Appendix U

Performance Measures

Key Performance Indicators (KPIs)

Cost

- 1) Total Cost of Care Risk adjusted measure of average per member per month costs for both physical and behavioral health
- 2) ED Visits for Ambulatory Sensitive Conditions Number of ED visits per thousand members within a rolling twelve (12) month period, using the SIM ambulatory sensitive conditions criteria

Prevention/Care/Health and Wellness

- 1) Behavioral Health Engagement Members engaged in behavioral health services delivered either in primary care settings or under the Capitated Behavioral Health Benefit within a twelve (12) month rolling period.
- 2) Well Visits Members of all ages and populations with at least 90 days of continuous program enrollment that have had a well visit within a rolling twelve (12) month period
- 3) Prenatal Care Members with a prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of program enrollment and the gaps in enrollment during the pregnancy. The data source for the measure is claims.
- 4) Dental Visit Percentage of Members with a dental visit within a rolling twelve (12) month period

Public Health

1) Obesity – Rates of overweight and obesity as measured through the BRFSS OR by CDPHE as part of Colorado's 10 Winnable Battles

Health Neighborhood

Health Neighborhood – Hybrid measure of utilization of Colorado Medical Society's Primary Care-Specialty Care Compact (Appendix S CMS Care Compact) and number of electronic consultations made within a twelve (12) month period.

Performance Measures

In addition to the Key Performance indicators, the Department will track several other measures to monitor the performance of the program and RAE efforts in each region. These measures will be publicly reported and tracked throughout the life of the contract. The following measures are still under development.

MEASURE	ALIGNMENT WITH OTHER INITIATIVES
WIEASCRE	OTHER INITIATIVES
Use of appropriate medications for asthma	Adult and Child Core Sets
HbA1c Screening	Adult core set, SIM
Well-visits 3 domainsall Children, Children in Child Welfare, LTSS	Current ACC
Clinical depression screening	SIM, Adult core set
Maternal Health Depression Screening	MIH Grant
SUD Screening	SIM, Adult core set
Total cost of care	
ED Visits for Ambulatory Care-sensitive Conditions	Adult core set, child core set, MMP
CAHPS - Physical Health (Rating of all Health Care, Rating of Personal Doctor, Rating of specialist seen most often, Getting needed care)	Adult core set, child core set, Triple Aim
ECHO - Behavioral Health (Rating of all Counseling or Treatment, Getting Treatment Quickly, How Well Clinicians Communicate, Perceived Improvement)	Triple Aim, BH Indicator 6
National Core Indicators Survey	Triple Aim
Percent of 1st time mothers connect to NFP	
Percent of Medicaid clients with a dental visit	CHIPRA Core measure set
Number of Behavioral Health visits in primary care settings	
Percent of Clients Who Were Recently Released from Corrections with an office visit within 30 days of release	Performance Improvement Projects
Risky behavior screening for adolescents (11-20)	MIH Grant

Prenatal Care and Postpartum Care (HEDIS)	
Screening for Fall Risks	
Child and adolescent major depressive disorder	
(MDD): Suicide risk assessment	NQF 1365, BH Indicator 1
Adult major depressive disorder (MDD): suicide risk	,
assessment	NQF 0104, BH Indicator 2
BH Hospital Readmissions: 7,30,90,180 days	1768/SIM, BH Indicator 3
Percent of members prescribed redundant or duplicated	
atypical antipsychotic medication	BH Indicator 4
Adhaman as to antinovalection for individuals with	CMC Come NOE 1970 DII
Adherence to antipsychotics for individuals with schizophrenia	CMS Core, NQF 1879, BH Indicator 5
Penetration Rates	BH Indicator 6
1 chettation Rates	BII indicator 0
Diabetes screening for individuals with schizophrenia or	
bipolar disorder who are using antipsychotic medication	1932 NQF, BH Indicator 8
BH Inpatient Utilization	BH Indicator 9
211 Inputer Cumpunon	211 1110110001
ED Utilization for mental health conditions	BH Indicator 10
Follow up after ED visit for Mental health or Alcohol or	
Drug Dependence	2605 NQF, BH Indicator 11
	BHO Incentive measure,
Mental Health Engagement	indicator 12
Initiation and Engagement of Alcohol and other drug	BHO Incentive measure,
dependence program	indicator 13, CMS 0004
	,
Follow up appointments within 7 and 30 days after	
hospital discharge for a mental health condition - adult	BHO Incentive measure,
and child/adolescent	indicator 14, CMS Core 0576
Democration Remission at 12 months weight attack	DIIO Stratah Massara Indiata
Depression Remission at 12 months using standard PHQ-9	BHO Stretch Measure, Indicator 15, NQF 0710
Substance Use Screening Composite: Screening and Intervention	BHO Stretch Measure, Indicator 16, SIM 2597
Intervention	10, SHVI 2371
Adolescent Health Risk Screening and	BHO Stretch Measure, Indicator
Referral/coordination of care	17, MIH Grant

	BHO Stretch Measure, Indicator
Develop a person/Family Centered Advisory Council	18
Children involved with child welfare with a behavioral	
health claim (0-21 years)	ССВНС
Low Birth Weight	MIH
Developmental Screens	WIIII
Percent of Clients with an E&M Claim with their	
assigned PCP	
ED Utilization	
Readmissions	
30 Day Post-discharge Follow-up	
High Cost Imaging	
Breast Cancer Screening Rate	
Cervical Cancer Screening Rate	
Fall-related Hospitalizations	
Asthma Related ED Visits	
Asthma Related Admissions	
Teen Pregnancy Rate	
Number of PCMPs participating in Alternative Payment	
Methodologies	
Percentage of administrative PMPM funding passed-	
through to PCMPs	
Care Coordination Measure	
Member engagement measure	
Children with a positive BH screening in primary care	aanua
with a follow up visit to a BH provider	ССВНС
Percent of clients who have completed the Health Needs	
Survey or other health risk assessment (HRA)	
Demonst of anactions in the ACC with compaction to	
Percent of practices in the ACC with connection to CORHIO/QHN and actively working on sharing data	
for care coordination	SIM
Percent of clients with access to their Patient Health	~414
Record	
Quality of Life	

Weight Assessment and physical activity and nutrition counseling	
Client/Caregiver Experience of Care	
BMI Documented	
Percent of pregnant women/new mothers connected to SNAP and WIC	
Immunizations	
Living Independently in the Community	
Access to Care measure	
LTSS Transition measure	
Individuals with special health care needs with a well-visit	
VISIT	
Member Decision Tool or Patient Activation measure	
Influenza Vaccinations	
Percentage of children and youth who qualify for the	
Wraparound Program that are receiving Wraparound services	
Percentage of youth released from the Department of	
Youth Corrections that require a mental health	
appointment that receive a mental health appointment	
within 15 days of release	
Percentage of high risk children/youth (defined through	
the drug utilization review as either: a) on three or more	
psychotropic medications, or b) under age 5 on	
psychotropic medication) that receive therapy at least	
monthly	