GUIDANCE FOR CONDUCTING COMMUNITY NEEDS ASSESSMENT REQUIRED FOR DSRIP PLANNING GRANTS AND FINAL PROJECT PLAN APPLICATIONS

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GUIDANCE FOR CONDUCTING COMMUNITY NEEDS ASSESSMENT
REQUIRED FOR DSRIP PLANNING GRANTS AND FINAL PROJECT PLAN APPLICATIONS

Preamble: In order to advance the aims of the Delivery System Reform Incentive Program (DSRIP) and the goals of Domains 2, 3 and 4, Performing Provider Systems are required to conduct a community needs assessment. This process includes a description of the population to be served, an assessment of its health status and clinical care needs, and an assessment of the health care and community wide systems available to address those needs. The essential components of an assessment are described below in Section IV, in the order corresponding to Domains 2, 3, and 4 of DSRIP. Regardless of that order, each component of the needs assessment is essential to a well-developed application for DSRIP funding. Each part of the assessment is dependent on and should inform the other parts of the assessment. The ultimate goal is the selection of DSRIP projects that are based on a solid understanding of the health needs of the population and the resources available to address them that will help achieve the Triple Aim: improved health, lower costs and improved quality.

I. Introduction

The Delivery System Reform Incentive Program (DSRIP) has four key goals:

- Transformation of the health care safety net at both the system and state level.
- Reducing avoidable hospital use and improve other health and public health measures at both the system and state level.
- Ensure delivery system transformation continues beyond the waiver period through leveraging managed care payment reform.
- Near term financial support for vital safety net providers at immediate risk of closure.

The key focus of DSRIP is reducing avoidable hospital use by 25% over 5 years for the Medicaid and uninsured population in New York State. DSRIP is an incentive payment program, i.e., Performing Provider Systems (PPS), the functional unit undertaking a DSRIP Project Plan, must meet certain process and outcome goals/metrics in four Domains in order to receive payments:

Domain 1: Overall Project Progress
Domain 2: System Transformation
Domain 3: Clinical Improvement
Domain 4: Population-wide Strategy Implementation – The Prevention Agenda.

Domains 2 – 4 have specific projects and aligned metrics that have been approved by CMS. The PPS should have familiarity with these projects and metrics (See Project Toolkit and Attachments I and J on DSRIP website: http://www.health.state.ny.us/DSRIP) as it plans for its community needs assessment. A key outcome of the assessment will be the identification of where the findings of the community needs assessment align with projects and metrics that are then appropriately chosen by the PPS for the submitted Project Plan. By this we mean that the projects should be chosen to clearly address the greatest need in the community and where the DSRIP metrics for the community show the widest gap from the highest performing communities. This alignment with community need will be an important component of the project plan review process.

II. Purpose of this Guidance Document

This guidance document is to assist PPS DSRIP applicants to plan, undertake and complete a Community Needs Assessment efficiently and effectively. To choose the most appropriate projects for the PPS to undertake, the PPS needs a solid understanding of the health status of the population and components of the health care system currently in place in the geographic region in which they are functioning. Additionally, since DSRIP will be evaluated based upon metrics that have been approved by the Centers for Medicare and Medicaid Services

(CMS), the community needs assessment must include review of the metric sets for DSRIP for Domains 2, 3 and 4 with comparison of the community level metrics with the metric results for the state as a total and for the highest performing systems. The areas that have the largest metric gaps should drive project choice.

The Community Needs Assessment should be a comprehensive assessment of the demographics and health needs of the population to be served and the health care resources and community based service resources currently available in the service area. By health care resources, we mean the broad array of health resources including but not limited to primary care providers, federally qualified community health centers, ambulatory surgical centers, urgent care centers, health homes, local health departments, specialty medical providers, dental providers, rehabilitation services, hospitals, behavioral health resources, home care services, managed care organizations and others. (Please see a more detailed list of all the health care resources to be considered in section IIa, below.) Similarly, the assessment must consider the broad array of community services which support the Medicaid and uninsured within communities even if not funded with Medicaid dollars. Inclusion of a broad and diverse set of health and community resources will ensure an adequate Community Needs Assessment and support the inclusion of such resources in the PPS networks, improving opportunities for success in health system transformation. This comprehensive assessment will also identify needed services, resources and connectivity that have the ability to be corrected through DSRIP projects.

III. Data:

As previously noted, health data will be required by the PPSs to understand further the complexity of the health care delivery system and how it is currently functioning. The Department of Health is posting data on the DSRIP website to assist developing PPSs in the project planning:
http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_performance_data.htm
The Department of Health will post consolidated data books on the DSRIP website that will provide, by region, a compilation of data sources and outcomes available in the state that are relevant to DSRIP. This will include regional results for metrics that will be utilized to assess the outcomes of PPS' projects and trigger incentive payments. This is in addition to the data currently available on the same site. PPS should review and use this data as they prepare the community needs assessment. Again, it will be important to review Attachment J on the website to understand the metrics, the Toolkit to understand the project structure, and the Data Specifications (to be posted) to understand the detail behind each metric. Part of the community assessment will be collecting a preliminary set of baseline metrics based upon the DSRIP metric sets that the PPS will use for comparison to high performing regions to identify projects that will be most effective in closing performance gaps.

In addition, the Division of Public Health has listed numerous specific resources at the end of this document that may be used as reference material for the community assessment. PPSs are also encouraged to use recently prepared Community Health Needs Assessments recently completed by LHDs and hospitals in conjunction with the New York State Prevention Agenda, understanding that these generally focus on the full community population and not just the Medicaid and uninsured persons that are the primary focus of DSRIP. Examples of recently completed good assessments are available here:
http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/implementation/examples.htm

IV. Components of a Community Needs Assessment

The Community Needs Assessment should contain all of the components listed below. As the PPS undertakes this community needs assessment, there should, again, be consistent referral back to Attachment J to ensure capture of the data necessary to assess current community performance in Domain 2, 3, and 4 metrics for project planning purposes.

A. Description of the Health Care Resources (Including Medical and Behavioral Health) and Community Resources

While this information is important for Domains 2, 3, and 4, it will have particular relevance to Domain 2, System Transformation.

i. Description of Health Care Resources

Each PPS should do a complete assessment of the health care resources that are available within its service area, whether they are part of the PPS or not. For each of these providers, there should be an assessment of capacity, service area, Medicaid status, as well as any particular areas of expertise. This health care resource assessment will allow the PPS to know what capacities exist in their geographic area and, with the health needs assessment, allow them to understand the gaps in service/excess services that need to be addressed to meet the DSRIP goal of 25% reduction in avoidable hospital use. It will also help the PPS identify additional providers to invite to join the PPS.

This assessment should include data on the availability, accessibility, affordability, acceptability and quality of health services and what issues may influence utilization of services such as hours of operation, transportation, sliding fee scales, etc. For example, what is the average distance and range that a person would need to travel to receive primary health care services? What is the availability of transportation for the average Medicaid recipient? Are there areas where there is no readily accessible medical services within a certain distance? This is essentially taking the information from the health care resources and community based resources and laying it on the population to gain a better understanding of the population's potential experience of accessing health care services.

The following list of health care resources will assist PPSs to begin to identify health care resources but should not be considered exclusive:

- Hospitals,
- Ambulatory surgical centers,
- Urgent care centers,
- Health Homes,
- Federally qualified health centers,
- Primary care providers including private, clinics, hospital based including residency programs,
- Specialty medical providers including private, clinics, hospital based including residency programs,
- Dental providers including public and private,
- Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based,
- Behavioral health resources:
    - County/city behavioral health services and oversight (including SPOA),
    - Mental health clinics, inpatient hospitals (state operated, OMH licensed referred to as article 31, DOH and OMH licensed referred to as article 28),, Family Support, Residential, Partial Hospital, CPEP, CDT, Education, Employment, Adult Home SCM ACT, PROS, Day Treatment, HCBS Waiver services, private psychiatrists, LCSW, Intensive Outpatient Programs; Club Houses; crisis intervention, and Children Specific Services - RTF, Day Treatment, HCBS Waiver, Early Recognition/Screening, TCM
    - Addiction services to include Medically Managed Detoxification, Medically Supervised Withdrawal –both Inpatient and Outpatient; Medically Monitored Withdrawal, hospital, clinic and private addiction treatment providers-Outpatient Clinic; Opioid Treatment Program, physicians providing buprenorphine treatment; Inpatient

Rehabilitation Programs; Outpatient Residential; Community Residence Programs; Intensive Residential; Residential Rehabilitation Services for Youth,

- Specialty medical programs such as eating disorders program, autism spectrum early diagnosis/early intervention,
- Skilled nursing homes, assisted living facilities,
- Home care services,
- Laboratory and radiology services including home care and community access,
- Specialty developmental disability services,
- Specialty services providers such as vision care and DME,
- Pharmacies,
- Local Health Departments,
- Managed care organizations,
- Foster Children Agencies,
- Area Health Education Centers (AHECs).

ii. Description of Community Based Resources

Community based resources take many forms. This wide spectrum will include those that provide basic life needs to fragile populations as well as those specialty services such as educational services for high risk children. There is literature that supports the role of these agencies is stabilizing and improving the health of fragile populations. For each of these providers, there should be an assessment of capacity, service area, certification status, population served, gaps as well as any particular areas of expertise. The following is a partial list that should be considered:

- Housing services for the homeless population including advocacy groups as well as housing providers,
- Food banks, community gardens, farmer's markets,
- Clothing, furniture banks,
- Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges),
- Community outreach agencies,
- Transportation services,
- Religious service organizations,
- Not for profit health and welfare agencies,
- Specialty community-based and clinical services for individuals with intellectual or developmental disabilities,
- Peer and Family Mental Health Advocacy Organizations,
- Self-advocacy and family support organizations and programs for individuals with disabilities
- Youth development programs,
- Libraries with open access computers,
- Community service organizations,
- Education,
- Local governmental social service programs,
- Community based health education programs including for health professions/students,
- Family Support and training,
- NAMI,
- Individual Employment Support Services,
- Peer Supports (Recovery Coaches),
- Alternatives to Incarceration,

- Ryan White Programs,
- HIV Prevention/Outreach and Social Service Programs.

iii. Domain 2 Metrics

Domain 2 – System Transformation Metrics	
State-wide Measure	**Measure Name**
A. Create Integrated Delivery System	
Potentially Avoidable Services	
X	Potentially Avoidable Emergency Room Visits
X	Potentially Avoidable Readmissions
X	PQI Suite – Composite of all measures
X	PDI Suite – Composite of all measures
Provider Reimbursement	
	Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement
System Integration	
X	Percent of Eligible Providers with participating agreements with RHIO's; meeting MU Criteria and able to participate in bidirectional exchange
Primary Care	
X	Percent of PCP meeting PCMH (NCQA)/ Advance Primary Care (SHIP)
X	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?)
X	HEDIS Access/Availability of Care; Use of Services
X	CAHPS Measures: - Getting Care Quickly (routine and urgent care appointments as soon as member thought needed) - Getting Care Needed (access to specialists and getting care member thought needed) - Access to Information After Hours - Wait Time (days between call for appointment and getting appoint for urgent care)
Medicaid Spending for Projects Defined Population on a PMPM Basis	
	Medicaid spending on ER and Inpatient Services
	Medicaid spending on PC and community based behavioral health care
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	

Domain 2 – System Transformation Metrics	
State-wide Measure	**Measure Name**
A. Create Integrated Delivery System	
	H-CAHPS – Care Transition Metrics
X	CAHPS Measures – Care Coordination with provider up-to-date about care received from other providers
C. Connecting Settings	
Performing Provider Systems will be required to meet all of the above metrics for A and B.	

B. **Description of the community to be served.** While again relevant to all three Domains noted above, this information will be most useful in Domain 3 for the Medicaid and uninsured population and Domain 4 for the general population. The assessment may be broader than just the DSRIP priority areas. A broad assessment will help a PPS select the specific DSRIP priority areas in Domain 3 and 4 on which it should focus. The assessment should include a succinct narrative and graphical description of:

i. The demographics of the population served. Demographics should provide the PPS with an assessment of the Medicaid and uninsured population they are serving. This will include, but is not limited to, the usual distribution of data related to gender, race, ethnicity, age, income, disability status, mobility, educational attainment, housing status, employment status, Medicaid/insurance status, access to a regular source of care, language and health literacy, legal/illegal immigrant/migrant status, and urban/rural status. Population demographics should include those who are institutionalized as well as those involved in the criminal justice system.

ii. The health status of the population and the distribution of health issues, based on the analysis of demographic factors above, with particular attention and emphasis placed on identification of issues related to health disparities and high-risk populations within the Medicaid and uninsured population. Useful data for the whole population should also be assessed in alignment with Domain 4 project selection.

The population assessment should include the following:

- Leading causes of death and premature death by demographic and geographic groupings, and analysis of trends over time (demographic factors include age, sex, race/ethnicity and, where data are available, sexual orientation and disability status); ;
- Leading causes of hospitalization and preventable hospitalizations by demographic and geographic groupings and analysis of trends over time;
- Analysis of Medicaid data for the population proposed to be served;
- Rates of ambulatory care sensitive conditions, including chronic disease diagnoses such as hypertension, diabetes, obesity and asthma, and rates of risk factors that exacerbate health status;
- Disease prevalence such as diabetes, asthma, cardiovascular disease, hypertension, depression, HIV and STDs, etc.;
- Maternal and child health outcomes including infant mortality, low birth weight, high risk pregnancies, birth defects, as well as access and quality of prenatal care;
- Health risk factors such as obesity, smoking, drinking, drug overdose, physical inactivity, etc.;

- Access to healthcare such as uninsured population, availability of providers, population with regular health care providers, and population with costs or other barriers for getting proper health care, etc.;
- Quality of health care such as disease management for people with chronic conditions, managing medications, managing acute illnesses, and preventive care provided to children and adolescents, etc.

iii. Domain 3 and 4 Metrics

The Domain 3 and 4 Metrics are attached in Section VII.

C. Identification of the main health and health service challenges facing the community,

This includes a discussion of the contributing causes of poor health status, including the broad determinants of health. This description should include:

a. behavioral risk factors,
b. environmental risk factors (the natural and built environment, including geography),
c. socioeconomic factors,
d. basic necessity resources including housing and access to affordable food
e. barrier free access deficiencies
f. policy environment (e.g., smoke-free parks, menu labeling, zoning for walkable communities, etc.);
g. service gaps related to primary care and/or other specific types of service applicable to the DSRIP project or strategy,
h. factors related to access to health insurance and health services,
i. transportation barriers
j. other unique characteristics of the community that contribute to health status.

D. Succinct summary of the assets and resources that can be mobilized and employed to address the DSRIP strategies and projects and those that are needed to be developed

These may include populations as well as services, including those provided by the local health department, hospitals and health care providers and community-based organizations; businesses; academia; the media; and resources available through other sectors of government.

E. Summary Chart of Projects to be Implemented

Each PPS should prepare from the above information an Excel document that lists by Domain the projects chosen for implementation with a clear summary of the assessment findings such that the reviewers of the Project Plan will fully understand the rationale for these choices. The information will need to be submitted in the following summary format in an Excel document:

Domain	Project	DSRIP Measure	DSRIP Measure Preliminary Baseline Finding	Other Population Findings	Rationale for Choice	Plan Goal
2	2.a					
	2. b or c					
3	3.a					
	3. b etc.					
4	4. a etc					

Column Explanation:

Domain – Domain which includes project

Project – Project number and name of those projects identified by the PPS to be most likely impactful on transforming the current health care system.

DSRIP Measure – Each DSRIP measure associated with that project in the document

DSRIP Measure Preliminary Baseline Finding – This will concisely document the baseline information on this measure that resulted in the PPS choosing this project for its project plan. The final baseline data will be provided when available.

Other Population Findings – This will again concisely document any other population findings that were used to choose this particular project.

Rationale for Choice – Summary documentation supporting the choice of the listed project for the project plan.

Plan Goal – A brief summary of what the system will look like in 5 years if the PPS undertakes this project. This will need to be specific and concise.

F. Documentation of the process and methods used to conduct the assessment, the sources and time periods of data used, and information on how the preliminary findings of the assessment were shared with collaborating organizations and how their input was sought

This section will assist in understanding the comprehensiveness of this community assessment. It is critical that all groups affected by DSRIP have an opportunity to have input into the plan. This is most particularly important to address disparities that affect racial, cultural and disabled populations. Methods to seek input include: community/town forums and listening sessions; community focus groups; presentations and discussions at other organizations' local meetings; publication of a summary of the findings in the local press with feedback or comment forms; publication on the organization's web page with a website comment form, etc. Additionally, the Project Advisory Committee (PAC) should provide input and review of the developing project plan.

V. Background on NYS DOH Requirements for Local Health Department Community Health Assessments and Health Improvement Plans and Hospital Community Service Plans tied to Prevention Agenda 2013-2017

Article 6 and Article 28 of the Public Health Law require local health departments (LHDs) and hospitals to complete periodic community health assessments and community service plans. In recent years, the DOH has required that LHDs and hospitals collaborate to develop these assessments and plans. The DOH has tied the planning process to its state health improvement plan, known as the *Prevention Agenda*. The DOH has requested that LHDs and hospitals work together with others in the community to identify and take action on local priorities from the state's *Prevention Agenda* priorities. In November, 2013, LHDs and hospitals submitted these documents to the DOH. The recently completed CHA/CHIPs and CSPs by local health departments (LHDs) and hospitals in each community are valuable to PPSs as they perform their DSRIP-required community assessments, understanding that DSRIP is focused on the Medicaid and uninsured population, not the full community population, and that the DSRIP community health assessment should focus specifically on this population. A chart identifying the priorities selected by each organization, and the link to the report or the contact person responsible for developing each report will be posted on the Prevention Agenda home page. http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/
Good examples of such plans are here: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/implementation/examples.htm

New York State's health improvement plan, the *Prevention Agenda 2013-17*, was released at the end of 2012. It is a call to action to local health departments, health care providers, health plans, schools, employers, governmental and non governmental agencies and businesses to collaborate at the community level to identify local health priorities and plan and implement a strategy for local health improvement that will contribute to improving the health status of New Yorkers and reducing health disparities through increased emphasis on prevention. The Plan identifies five priorities for improving the health of all New Yorkers and asks communities to work together to address them.

The five Prevention Agenda priorities for 2013-2017 are:

- Prevent Chronic Diseases
- Promote a Healthy and Safe Environment
- Promote Healthy Women, Infants and Children
- Promote Mental Health and Prevent Substance Abuse
- Prevent HIV, STDs, Vaccine-Preventable Diseases and Healthcare-Associated Infections

For each priority, the *Prevention Agenda* identifies specific goals and evidence-based and best-practice interventions for action that can be implemented by various sectors within the public health and health care system to meet the goals. It provides measurable objectives that can be used to track progress, including progress on reducing health disparities. The Prevention Agenda priority specific action plans identify evidence based interventions and may serve as a resource to PPSs where they align with DSRIP projects.

VI. Background on NYS OMH Requirements for Directors of Community Services and Community Planning for Mental Services

PART 102 DIRECTORS OF COMMUNITY SERVICES (Statutory authority: Mental Hygiene Law, 7.09, 41.04) establishes minimum requirements for directors of community services in order to ensure the effective direction and administration by each local governmental unit of a local comprehensive service system. This Part applies to all local governmental units which contract for and/or provide services, licensed in accordance with the provisions of the Mental Hygiene Law, for persons diagnosed with mental illness, persons with mental retardation, persons with developmental disabilities, persons with alcoholism and persons who abuse substances. The following are defined in the statute:

102.4 Definitions.
(a) Board means a community services board which plans for services to persons diagnosed with mental illness, persons with mental retardation, persons with developmental disabilities, persons with alcoholism and persons who abuse substances.

(b) Local governmental unit means the unit of a local government given authority by local government to contract for and/or provide local or unified mental health, mental retardation and development disabilities, alcohol abuse and substance abuse services.

(c) "Director of community services" means the chief executive officer of a local governmental unit, by whatever title known.

(d) "Inter-Office Coordinating Council" means a council constituted by the Commissioner of the Office of Mental Health, Commissioner of the Office of Mental Retardation and Developmental Disabilities, the Commissioner of the Office of Alcoholism and Substance Abuse Services which shall ensure that the state policy for the prevention, care, treatment and rehabilitation of mental illness, mental retardation and developmental disability, alcoholism and substance abuse is comprehensively planned, developed, implemented and regulated.

The Director of community services has the following responsibilities related to local behavioral health planning:

- exercise general supervision and program monitoring over local services and local facilities;
- exercise general supervision over the treatment of patients who are receiving local or unified services or who are in local facilities;
- make recommendations to the board for the provision of services and the establishment of facilities, including contracts and other matters necessary as desirable to ensure the effective direction and administration of a local comprehensive service system;
- encourage the development and expansion of preventive, rehabilitation and treatment programs in the field of mental illness, mental retardation and developmental disabilities, alcoholism, and substance abuse;

The Director of community services and board in a region should be consulted and involved in the DSRIP PPS's planning process.

VII. Domain 3 and 4 Metrics

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 BIPNH project. These providers will include the additional behavioral health measures below in A-2.								
	PPV (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./BPD Using Antipsychotic Med.	NCQA	1932	Claims	Process	Performance		Performance
	Cardiovascular Monitoring for People with CVD 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
	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 (IET)	NCQA	0004	Claims	Process	Performance		Performance
A – 2. Additional behavioral health measures for provider systems implementing the Behavioral Interventions Paradigm in Nursing Homes (BIPNH) project								
	PPR for SNF patients	3M		Claims	Outcome	Performance		Performance
	Percent of Long Stay Residents who have Depressive Symptoms	CMS		MDS 3.0	Process	Performance		Performance
B. Cardiovascular Disease								
	PQI # 7 (HTN)	AHRQ		Claims	Outcome	Performance		Performance
	PQI # 13 (Angina without procedure)	AHRQ		Claims	Outcome	Performance		Performance
	Cholesterol Management for Patients with CV Conditions	NCQA		Medical Record	Outcome	Reporting		Performance
	Controlling High Blood Pressure (Provider	NCQA	0018	Medical	Outcome	Reporting		Performance

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**
	responsible for medical record reporting)			Record				
	Aspirin Discussion and Use	CAHPS		Survey	Process	Reporting		Performance
	Medical Assistance with Smoking 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 condition gets worse	CAHPS		Survey	Process	Reporting		Performance
C. Diabetes Mellitus								
	PQI # 1 (DM Short term complications)	AHRQ	0274	Claims	Outcome	Performance		Performance
	Comprehensive Diabetes screening (HbA1c, lipid profile, 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
	Comprehensive diabetes care - LDL-c control (<100mg/dL)	NCQA	0064	Medical Record	Outcome	Reporting		Performance
	Medical Assistance with Smoking 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 condition gets worse)	CAHPS		Survey	Process	Reporting		Performance
D. Asthma								
	PQI # 15 Adult Asthma	AHRQ	0283	Claims	Outcome	Performance		Performance
	PDI # 14 Pediatric Asthma	AHRQ	0638	Claims	Outcome	Performance		Performance
	Asthma Medication Ratio	NCQA	1800	Claims	Process	Performance		Performance

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**
	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 Cessation	NCQA/	0027	Survey	Process	Reporting		Performance
	Viral Load Suppression	HRSA	2082	Medical Record	Outcome	Reporting		Performance
F. Perinatal Care								
	PQI # 9 Low Birth Weight	AHRQ	0278	Claims	Outcome	Performance		Performance
	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.								
	Risk-Adjusted percentage of members who remained stable or demonstrated improvement in pain.	NYS		UAS	Process	Reporting		Performance

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**
	Risk-Adjusted percentage of members who had severe or more intense daily pain	NYS		UAS	Process	Reporting		Performance
	Risk-adjusted percentage of members whose pain was not controlled.	NYS		UAS	Process	Reporting		Performance
	Advanced Directives – Talked about Appointing for Health Decisions	NYS		UAS	Process	Reporting		Performance
	Depressive feelings - percentage of members who experienced some depression feeling	NYS		UAS	Process	Reporting		Performance
H. Renal Care								
	Comprehensive Diabetes screening (HbA1c, lipid profile, 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
	Comprehensive diabetes care - LDL-c control (<100mg/dL)	NCQA	0064	Medical Record	Outcome	Reporting		Performance
	Annual Monitoring for Patients on Persistent Medications – ACE/ARB	NCQA		Claims	Process	Reporting		Performance

Domain 4:

		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	BRFSS	Statewide NYC/ROS County
Promote Mental Health and Prevention Substance Abuse			
66.	Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month	BRFSS	Statewide NYC/ROS County
67.	Age-adjusted percentage of adult binge drinking during the past month	BRFSS	Statewide NYC/ROS County
68.	Age-adjusted suicide death rate per 100,000	NYS NYSDOH Vital Statistics	State, county
Prevent Chronic Diseases			
21.	Percentage of adults who are obese	BRFSS	Statewide NYC/ROS County
22.	Percentage of children and adolescents who are obese	BRFSS	Statewide NYC/ROS County
23.	Percentage of cigarette smoking among adults	BRFSS	Statewide NYC/ROS County
24.	Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years	BRFSS	Statewide
25.	Asthma emergency department visit rate per 10,000	SPARCS	Statewide

			Region County
26.	Asthma emergency department visit rate per 10,000 - Aged 0-4 years	SPARCS	Statewide Region County
27.	Age-adjusted heart attack hospitalization rate per 10,000	SPARCS	Statewide Region County
28.	Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years	SPARCS	Statewide Region County
29.	Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years	SPARCS	Statewide Region County
Prevent HIV/STDs			
33.	Newly diagnosed HIV case rate per 100,000	NYS HIV Surveillance System	
34.	***Difference in rates (Black and White) of new HIV diagnoses***		
35.	***Difference in rates (Hispanic and White) of new HIV diagnoses***		
36.	Gonorrhea case rate per 100,000 women - Aged 15-44 years	NYS STD Surveillance System	
37.	Gonorrhea case rate per 100,000 men - Aged 15-44 years	NYS STD Surveillance System	
38.	Chlamydia case rate per 100,000 women - Aged 15-44 years	NYS STD Surveillance System	
39.	Primary and secondary syphilis case rate per 100,000 males	NYS STD Surveillance	

		System	
40.	Primary and secondary syphilis case rate per 100,000 females	NYS STD Surveillance System	
Promote Healthy Women, Infants, and Children			
41.	Percentage of preterm births	NYS NYSDOH Vital Statistics	State, County
42.	***Ratio of Black non-Hispanics to White non-Hispanics***		
43.	***Ratio of Hispanics to White non-Hispanics***		

VIII. Major Resources for Conducting Community Health Needs Assessment and Data Sources

Community Health Improvement including the Assessment Process
Healthy People 2020: MAP-IT: A Guide to Using Healthy People 2020 in your Community
http://www.healthypeople.gov/2020/Implement/default.aspx
http://www.healthypeople.gov/2020/implement/MapIt.aspx)

County Health Rankings: Tools and Resources related to Assessing Needs and Resources
http://www.countyhealthrankings.org/resources?f[0]=field_resource_type%3A108&f[1]=field_global_action_steps%3A18389

Catholic Health Association, Assessing and Addressing Community Health Needs:
http://www.chausa.org/Pages/Our_Work/Community_Benefit/Assessing_and_Addressing_Community_Health_Needs/

Association for Community Health Improvement:
http://www.communityhlth.org/communityhlth/resources/communitybenefit.html

Mobilizing for Action through Planning and Partnerships (MAPP)
http://www.naccho.org/topics/infrastructure/mapp/

Community Health Assessment Clearinghouse
http://www.health.ny.gov/statistics/chac/

NACCHO Community Health Assessment and Improvement Planning
http://www.naccho.org/topics/infrastructure/CHAIP/index.cfm

Prevention Agenda 2013-2017 state and county dashboard
https://health.ny.gov/preventionagendadashboard
The New York State Prevention Agenda Dashboard is an interactive visual presentation of the Prevention Agenda tracking indicator data at state and county levels. It serves as a key source for monitoring progress that communities around the state have made with regard to meeting the Prevention Agenda 2017 objectives. The state dashboard homepage displays a quick view of the most current data for New York State and the Prevention Agenda 2017 objectives for approximately 100 tracking indicators. The most current data are compared to data from previous time periods to assess the annual progress for each indicator. Historical (trend) data can be easily accessed and county data (maps and bar charts) are also available for each Prevention Agenda tracking indicator. Each county in the state has its own dashboard. The county dashboard homepage includes the most current data available for 68 tracking indicators.

New York State Prevention Quality Indicators (PQI) Data
(https://apps.health.ny.gov/statistics/prevention/quality_indicators/start.map)
Use this site to examine Prevention Quality Indicators (PQIs) at the ZIP code level in New York State. The PQIs are rates of admission to the hospital for conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

New York State Hospital Profiles
(http://hospitals.nyhealth.gov/)
Use this site to find information about hospitals in New York State, and the quality of care they provide. Please be mindful that while we believe these quality measures are among the most reliable, measuring quality is difficult because of the variation among hospitals in the complexity of patients that they treat.

Community Health Indicator Reports (CHIRS)
http://www.health.ny.gov/statistics/chac/indicators/
New York State Community Health Indicator Reports (CHIRS) were developed in 2012, and annually updated to consolidate and improve data linkage for the provided health indicators in the County Health Assessment Indicators (CHAI) for all communities in New York. The CHIRS provide data for over 300 health indicators, organized by 15 health topic and data tables with links to trend graphs and maps.

Expanded Behavioral Risk Factor Surveillance System
(http://www.health.ny.gov/statistics/brfss/expanded/)
The Expanded Risk Factor Surveillance System (Expanded BRFSS) augments the CDC Behavioral Risk Factor Surveillance System (BRFSS), which is conducted annually in New York State. The Expanded BRFSS collected county-specific data on preventive health practices, risk behaviors, injuries and preventable chronic and infectious diseases. This survey was conducted in New York State during 2002-2003 and 2008-2009.

Managed Care Reports
http://www.health.ny.gov/health_care/managed_care/reports/
Website offers links to reports on health plan performance. The reports provide easy-to-read information on health plan performance with respect to primary and preventive health care, access to health care, behavioral health and enrollee satisfaction. Data is provided for commercial and government-sponsored managed care. Enrollment reports show the level of consumer participation in various types of managed care plans.

Statewide Planning and Research Cooperative System (SPARCS)
http://www.health.ny.gov/statistics/sparcs/
The Statewide Planning and Research Cooperative System (SPARCS) is a comprehensive data reporting system. SPARCS collects patient level detail on patient characteristics, diagnoses and treatments, services, and charges for every hospital discharge, ambulatory surgery patient, and emergency department admission in New York State.

Leading Causes of Death and Premature Death in New York State
http://www.health.ny.gov/statistics/leadingcauses_death/
This site presents the five leading causes of death in New York State in the past ten years by age, gender, race, ethnicity, region, and county. Statistics on the leading causes of premature death among New York residents are also provided.

County Health Indicators by Race/Ethnicity (CHIRE)
http://www.health.ny.gov/statistics/community/minority/county/
CHIRE provides selected public health indicators by race/ethnicity for New York State and counties. Data related to births, deaths, cancer and hospitalizations are presented.

County/ZIP Code Perinatal Data Profile
http://www.health.ny.gov/statistics/chac/perinatal/
Vital statistics data for a three-year period are used to create ZIP code based tables of commonly requested perinatal data: Premature Births, Low Birth Weight, Out-of-Wedlock Births, Medicaid or Self-pay, Late or No Prenatal care, Infant Deaths, Neonatal Deaths, Teen Birth Rate, and Teen Pregnancy Rate. Tables for individual counties are provided.

Asthma Surveillance Data (http://www.health.ny.gov/statistics/ny_asthma/**)**
This site provides asthma prevalence data among all adults and among the Medicaid and State Child Health Plus programs by county and for the entire New York State. Hospital discharge and emergency department (ED) visit data from the Statewide Planning and Research Cooperative System (SPARCS) are also available at the state, county and ZIP code level. Furthermore, data on county-specific asthma death rates, both crude and age-adjusted are also available.

Sexually Transmitted Diseases Data and Statistics
(http://www.health.ny.gov/statistics/diseases/communicable/std/)
This site provides state and county level data on HIV/AIDS and STDs: Chlamydia, Gonorrhea and Syphilis.

Vital Statistics (births, pregnancies, deaths) (http://devweb.health.ny.gov/statistics/vital_statistics/)
This site provides annual reports containing data tables and charts presenting information extracted from birth, death and fetal death certificates. Data such as pregnancies and births by age, race/ethnicity, educational attainment and birthweight as well as deaths by selected causes, race and age are included. Data are presented for New York State by county. Limited statistics are available for school districts and cities and villages with populations of 10,000 or more.

Health Data NY (https://health.data.ny.gov/)
This site provides access to electronic datasets that are collected and analyzed from variety programs within the New York State Department of Health. Some of the relevant datasets includes Hospital Inpatient Prevention Quality Indicators and Hospital Inpatient Cost and Charge data.

New York State Office of Mental Health: Behavioral Health Planning Data for DSRIP Project
(http://www.omh.ny.gov/omhweb/special-projects/dsrip/index.html)
This site contains relevant behavioral health data sources compiled by the New York State Office of Mental Health (OMH) regarding the provision of behavioral health services.

County Health Rankings (www.countyhealthrankings.org/)
The County Health Rankings website provides access to 50 state reports, ranking each county within the 50 states according to its health outcomes and the multiple health factors that determine a county's health.

EpiQuery: New York City Interactive Health Data (https://a816-healthpsi.nyc.gov/epiquery/)
EpiQuery is a web-based, user-friendly system designed to provide users with health data from a variety of sources. EpiQuery Modules are based on health datasets with varying topics and indicators for different NYC populations and the system runs real-time analyses for users at the click of the mouse. EpiQuery offers prevalence estimates with confidence intervals, rates over time, bar charts and neighborhood maps, and much more:

- Survey data
    - Community Health Survey (http://www.nyc.gov/html/doh/html/data/survey.shtml)
    - Child Community Health Survey (https://a816-healthpsi.nyc.gov/SASStoredProcess/guest?_PROGRAM=%2FEpiQuery%2Fchild%2Fchildindex)
    - Youth Risk Behavior Survey (http://www.nyc.gov/html/doh/html/data/youth-risk-behavior.shtml)
    - Health and Nutrition Examination Survey (http://www.nyc.gov/html/doh/html/data/nyc-hanes.shtml)
- Surveillance data:
    - Communicable Disease Surveillance Data (https://a816-healthpsi.nyc.gov/epiquery/CDSS/index.html)
    - HIV/AIDS Surveillance Data (https://a816-healthpsi.nyc.gov/epiquery/HIV/index.html)
    - Sexually Transmitted Diseases Query (https://a816-healthpsi.nyc.gov/epiquery/STD/index.html)
- Vital Statistics data (http://www.nyc.gov/html/doh/html/data/vs-epiquery.shtml)
- Agency reports - Health Data Publications (http://www.nyc.gov/html/doh/html/data/data-publications.shtml)
    - Community Health Profiles (http://www.nyc.gov/html/doh/html/data/nyc-health-profiles.shtml)
- Environmental Public Health Tracking portal (http://a816-dohbesp.nyc.gov/IndicatorPublic/)
- Rat maps and data (http://www.nyc.gov/html/doh/html/environmental/disclaimer.shtml)
- Pregnancy Risk Assessment Monitoring System data tables (http://www.nyc.gov/html/doh/html/data/ms-prams.shtml)