ALLIANCE for Better Health

14 Columbia Circle Drive, Suite 201
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Proxy Measure Examples

Purpose:

The purpose of this document is to provide six examples of proxy measures that could be used to inform the progress towards achieving the DSRIP performance measures by 6/30/2018. The proxy measures selected by partners will need to align with their areas of operational focus. For example, the proxy measures created by a Community Based Organization should not be the same as those created for a Primary Care Physician.

Potentially Preventable ED Visits

- **Method:**
  - Establish a base line of the monthly volume of potentially preventable ED visits
  - Track monthly rate each time the data available on the Medicaid Analytics Performance Portal is refreshed.
  - Rate defined as '(*number of potentially preventable ED visits / Partner specific Medicaid Patient list) x 100'*
- **Expectation:** Observe a decrease equivalent to the gap to goal when comparing rates across a comparable cohort from year prior to rates observed in Medicaid Analytics Performance Portal.
- **Data Sources:**
  - Partner Medicaid Patient Lists
  - Potentially Preventable ED visits provided on the Medicaid Analytics Performance Portal
- **What does this mean for the partner?**
  - Partners submit Medicaid Patient Lists
  - Work with Alliance to establish baseline and interpret results with end goal of working towards value based payments
- **Notes:**
  - Potentially preventable ED visits provided on the Medicaid Analytics Performance Portal do not directly align with the 3M Potentially Preventable ED Visit algorithm. Instead, it identifies instances that may be considered preventable when the algorithm is run.
  - Data provided on the Portal is only representative of Alliance attributed patients. Therefore, if a partner's Medicaid List contains patients attributed to another PPS, they will not be included in the proxy measure.

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Potentially Preventable Admissions

- **Method:**
  - Establish a base line of the monthly volume of potentially preventable admissions
  - Track monthly rate each time the data available on the Medicaid Analytics Performance Portal is refreshed.
  - Rate defined as '(*number of potentially preventable admissions / Partner specific Medicaid Patient list) x 100*'
- **Expectation:** Observe a decrease equivalent to the gap to goal when comparing rates across a comparable cohort from year prior to rates observed in Medicaid Analytics Performance Portal.
- **Data Sources:**
  - Partner Medicaid Patient Lists
  - Potentially Preventable admissions provided on the Medicaid Analytics Performance Portal
- **What does this mean for the partner?**
  - Partners submit Medicaid Patient Lists
  - Work with Alliance to establish baseline and interpret results with end goal of working towards value based payments
- **Notes:** the potentially preventable admissions provided on the Medicaid Analytics Performance Portal do not directly align with the Agency for Healthcare Research and Quality algorithm. Instead, it identifies instances that may be considered preventable when the algorithm is run.

Well-Child Visits / Primary Care Visits: Example 1

- **Method:**
  - Segment Partner Medicaid Patient List by age cohort (1-2, 2-6, 7-11, 12-19, 20-44, 45-64, 65+) and establish a base line
  - Identify of the Medicaid Patient List, who has not had a Well-Child Visits / Primary Care Visits in the last year
  - Determine target percent increase for identified population
- **Expectation:** For Partners that are at 100%, maintain current percent of population with Well-Child Visits / Primary Care Visits. For Partners below 100%, measure against previously determined percent increase. Percent will be determined at a later time.
- **Data Sources:**
  - Partner Medicaid Patient Lists
  - Partner EHR systems
- **What does this mean for the partner?**
  - Partners submit Medicaid Patient Lists
  - Work with Alliance to identify of the partner's Medicaid population, who has not had a well-child visit / primary care visit in the last year

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Well-Child Visits / Primary Care Visits: Example 2

- **Method:**
  - Indicate on Medicaid Patient List the number of newly active Medicaid patients that receive well-child visits
- **Expectation:** Observe a percent increase in the newly active Medicaid patient population. Percent would be determined at a later time.
- **Data Sources:**
  - Partner Medicaid Patient Lists
  - Partner EHR systems
- **What does this mean for the partner?**
  - Partners submit Medicaid Patient Lists
  - Work with Alliance to identify who has not had a well-child visit / primary care visit in the last year
- **Notes**
  - Newly active is defined as those that have received Well-Child Visits / Primary Care Visits for the first time in 2 years.

Mental Health Follow Up: 7 Day and 30 Day

- **Method:**
  - Establish a base line of the monthly volume of number of individuals who did not receive a Mental Health Follow Up 7/30 days after discharge
  - Track monthly percent of individuals each time the data available on the Medicaid Analytics Performance Portal is refreshed.
  - Percent defined as '(*Number of individuals who did not have a Mental Health Follow Up 7/30 days after discharge / Number of individuals with a Mental Health admission)*'
- **Expectation:** Observe a decrease in the percent of the population. Percent decrease will be determined at a later time.
- **Data Sources:**
  - Partner Medicaid Patient Lists
  - Number of individuals with an admission which qualified for Mental Health Follow Up 7/30 on the Medicaid Analytics Performance Portal
- **What does this mean for the partner?**
  - Partners submit Medicaid Patient Lists
  - Work with Alliance to establish baseline and interpret results with end goal of working towards value based payments