CCIP Metrics			
Comprehensive Care Management			
Goal	**Measurement**	**Type**	**Guidelines**
Increase use of Person Centered Assessments (PCAs) with complex patients	**% of high risk patients receiving PCA**	Process	***This measure will be determined using the definition of a person centered assessment from the CCIP standards. The threshold for "high risk" patients will be determined by each PE.*** ***For PEs that are unable to report on this measure, Qualidigm may use a validation survey as a supplement.***
Increase identification of social determinants of health (SDOH) needs among high risk patients	**% of high risk patients screened for SDOH needs**	Process	***Social determinants of health will be evaluated based on alignment with the CCIP standards.***
Increase use of CHW for navigation/linkage	**% of high risk patients with SDOH needs that receive CHW support**	Process	***Social determinants of health will be evaluated based on alignment with the CCIP standards.***
Increase use of comprehensive care team	**% of high risk patients that receive care team services with patient support roles/functions assigned to at least two non-PCP staff**	Process	***"Non-PCP" staff could include: a medical assistant, nurse, care coordinator, CHW, BH provider, nutritionist, pharmacist, chiropractor, etc. The two non-PCP staff that are used for this measure will vary between PEs.***

Goal	Measurement	Type	Guidelines
Decrease hospital admissions	Admissions per thousand/quarter	Outcome	*"Patients" refers to patients for which the provider is accountable under an ACO or MSSP contract agreement and for whom they are receiving Patient Ping alerts.*
Decrease hospital readmissions	Readmissions per thousand/quarter	Outcome	*"Patients" refers to patients for which the provider is accountable under an ACO or MSSP contract agreement and for whom they are receiving Patient Ping alerts.*
Decrease ED visits	ED visits per thousand/quarter	Outcome	*"Patients" refers to patients for which the provider is accountable under an ACO or MSSP contract agreement and for whom they are receiving Patient Ping alerts.*

Health Equity Improvement

Goal	Measurement	Type	Guidelines
Increase collection of CDC compliant race and ethnicity data documented in the EHRs	% of patients with complete CDC compliant race and	Process	*The CCIP Standards permit PEs to select a subset of CDC compliant race and ethnicity categories based on the patient population served in each region.*
Increase collection of sexual orientation and gender identity (SOGI) data	% of patients with SOGI data documented in the	Process	
Increase collection of preferred language data documented in the EHRs	% of patients with preferred language data documented in	Process	

Goal	Measurement	Type	Guidelines
Behavioral Health Integration			
Improve rate of depression screening	**% of patients greater than 12 years of age screened for**	Process	***The numerator and denominator exclude patients who already screened positive and have a diagnosis of depression.***
Improve rate of primary care follow-up for depression	**% screened positive with successful primary care-based**	Process	***Follow-up for depression is referring to patients who are newly screened as positive. This measure excludes patients who already screened positive and***
Improve rate of BH specialist follow-up for depression	**% screened positive with successful community BH**	Process	***Follow-up for depression is referring to patients who are newly screened as positive. This measure excludes patients who already screened positive and***
Depression remission	**Depression remission at 12 months (NQF 0710), MSSP measure**	Outcome	
Improve rate of substance use screening	**% of patients greater than 12 years of age screened for**	Process	***"Substance use" refers to screening for alcohol and drug use.***
Improve rate of primary care follow-up for substance use	**% screened positive with successful primary care-based**	Process	***"Substance use" refers to screening for alcohol and drug use.***
Improve rate of SU specialist follow-up for substance use	**% screened positive with successful community SU**	Process	***"Substance use" refers to screening for alcohol and drug use.***