

MEDICAID ADVISORY COMMITTEE
July 27th, 2016
9:00am-12pm
Oregon State Library, Room 103
250 Winter St. NE, Salem OR 97301

Webinar registration: <https://attendee.gotowebinar.com/register/274139403574292993>
 Conference number: 888.398.2342; Public listen-in only: 3732275

Time	Item	Presenter
9:00	Opening remarks	Co-Chairs
9:05	MAC membership <ul style="list-style-type: none"> • Co-Chair transition 	Co-Chairs
9:10	Oral Health Work Group presentation and discussion	Alyssa Franzen, MAC, Matt Sinnott, Willamette Dental Group
9:45	Public Health Modernization	Cara Biddlecom, OHA
10:15	Break	
10:25	CCO Metrics 2015 Performance Report	Sarah Bartelmann, OHA
10:55	General Assistance Program update	Erika Miller, DHS
11:10	OHA access monitoring <ul style="list-style-type: none"> • Presentation • Feedback 	Jamal Furqan, OHA
11:45	Public Comment – FFS Access Monitoring Plan and General	
11:55	Closing comments	Co-Chairs

Materials:

1. Agenda
2. Draft minutes, June 2016 (**committee only*)
3. OHP Monthly enrollment info
 - a. OHP Enrollment and Renewals – July 7th monthly update
 - b. OHP Monthly stoplight report – July 7th report
4. Oral Health Workgroup
 - a. Oral Health Work Group: Progress-to-date
 - b. Work Plan and timeline

- c. Guiding document
 - d. Oral Health Access – Key factors summary matrix
5. Public Health Modernization
 6. CCO Metrics 2015 Performance Report
 7. General Assistance Program Summary
 8. Oregon FFS Access Monitoring Plan (*forthcoming)

Next Meeting:

Wednesday, September 28th: 9:00 a.m. – 12:00 p.m.

Oregon State Library bldg. -Room #103

250 Winter St. NE, Salem, OR 97301



Oregon Health Plan **Enrollment and Renewals** ***Monthly Update***

July 7, 2016



Today's agenda

- Introduction
- Oregon Eligibility (ONE) System update
- Oregon Health Plan Operations update
- Questions collected

Introduction

Welcome to the sixth Oregon Health Plan: Enrollment and Renewals *Monthly Update* meeting.

Today's presenters:

Varsha Chauhan, Chief Health Systems Officer

Sarah Miller, Project Director, Oregon Eligibility (ONE)

ONE System Update

It has been 206 days since ONE launched

The last phase of implementation is to offer ONE directly to Oregonians through the Applicant Portal. The timeline for expanding the Applicant Portal has shifted to the fall due to high call and application volumes

The June 28 ONE build successfully implemented several updates, including:

- Improved search functionality
- Real-time MMIS eligibility transactions
- Improved way to upload documents

OHP Operations update

- Performance data
- Current goals
- Concerns we have heard
- Successes we have had
- Questions collected

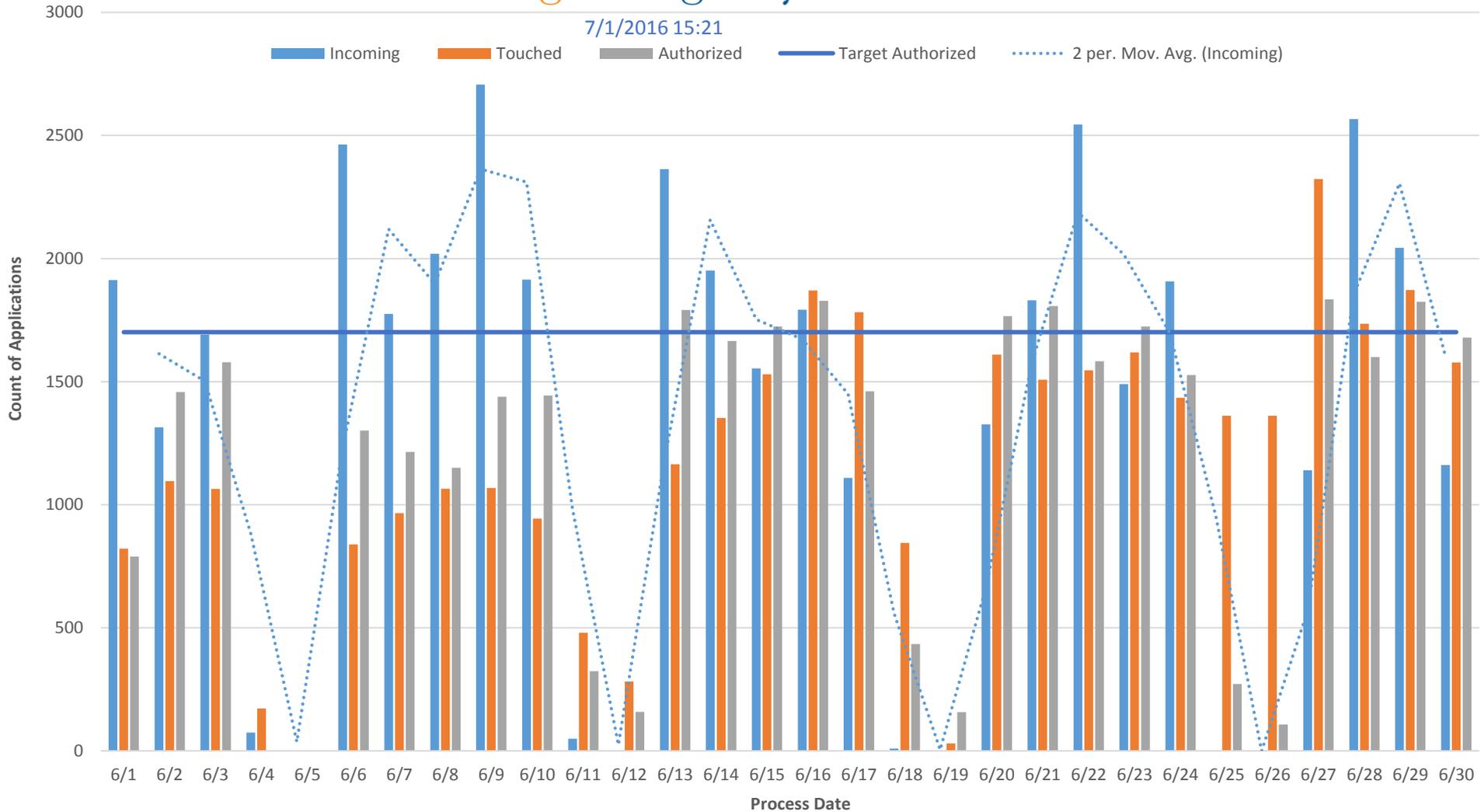
Member Services Performance Data

- June application processing performance
- June call performance
- 45-day application backlog
- Applicant Portal applications
- Overall Applications received

Member Services Monthly Application Processing Performance



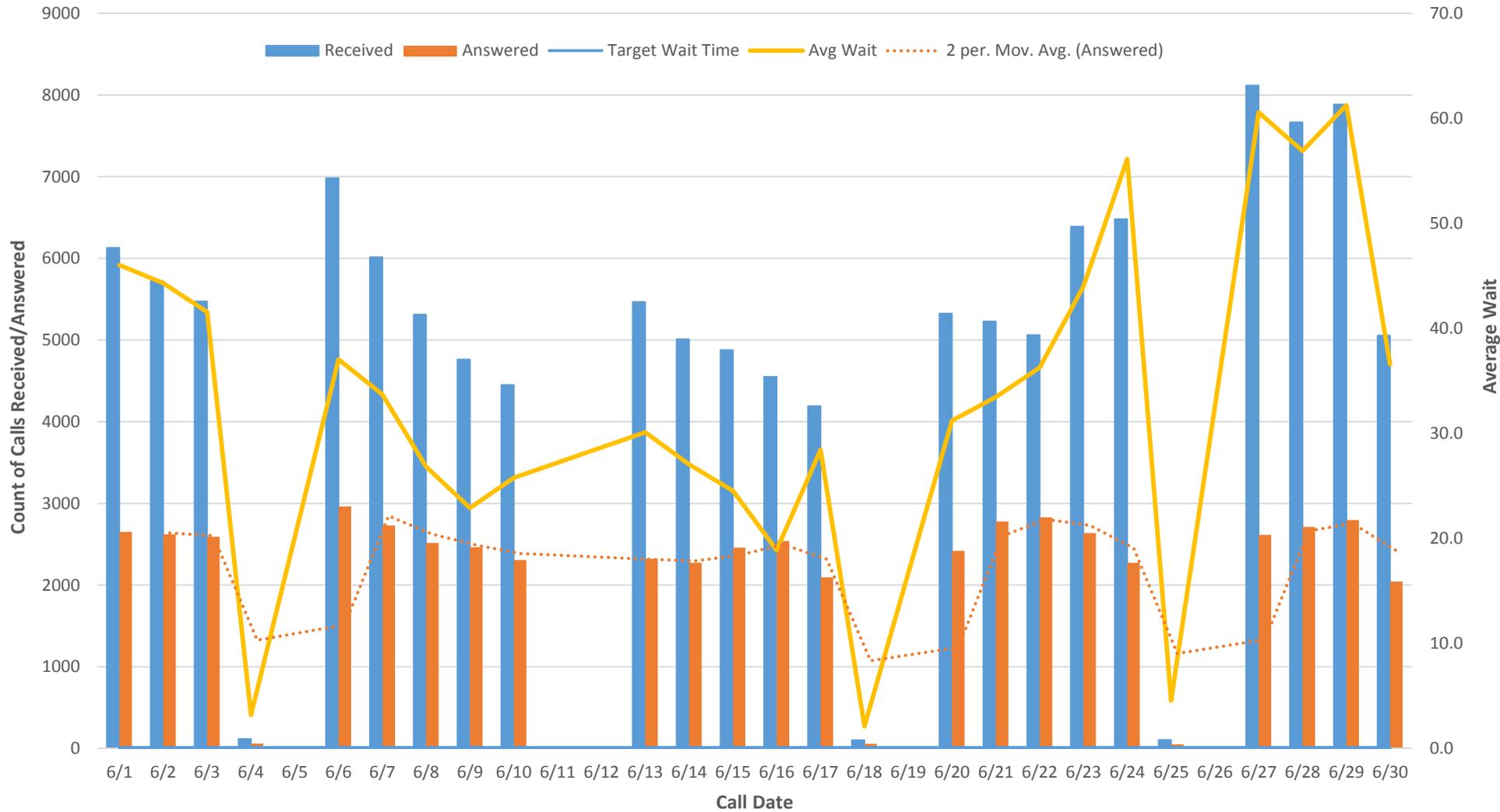
Data Sources:
Incoming = Deloitte Operational Metrics Report
Touched = Siebel Daily Report & Deloitte Operational Metrics Report & Phone Application Manual Count



In June, there were 40,706 incoming, 35,323 touched and 35,642 authorized applications

Member Services Monthly Call Performance

Data Source: Interactive Intelligence
housed in OHA OHP/Enrollment
SharePoint

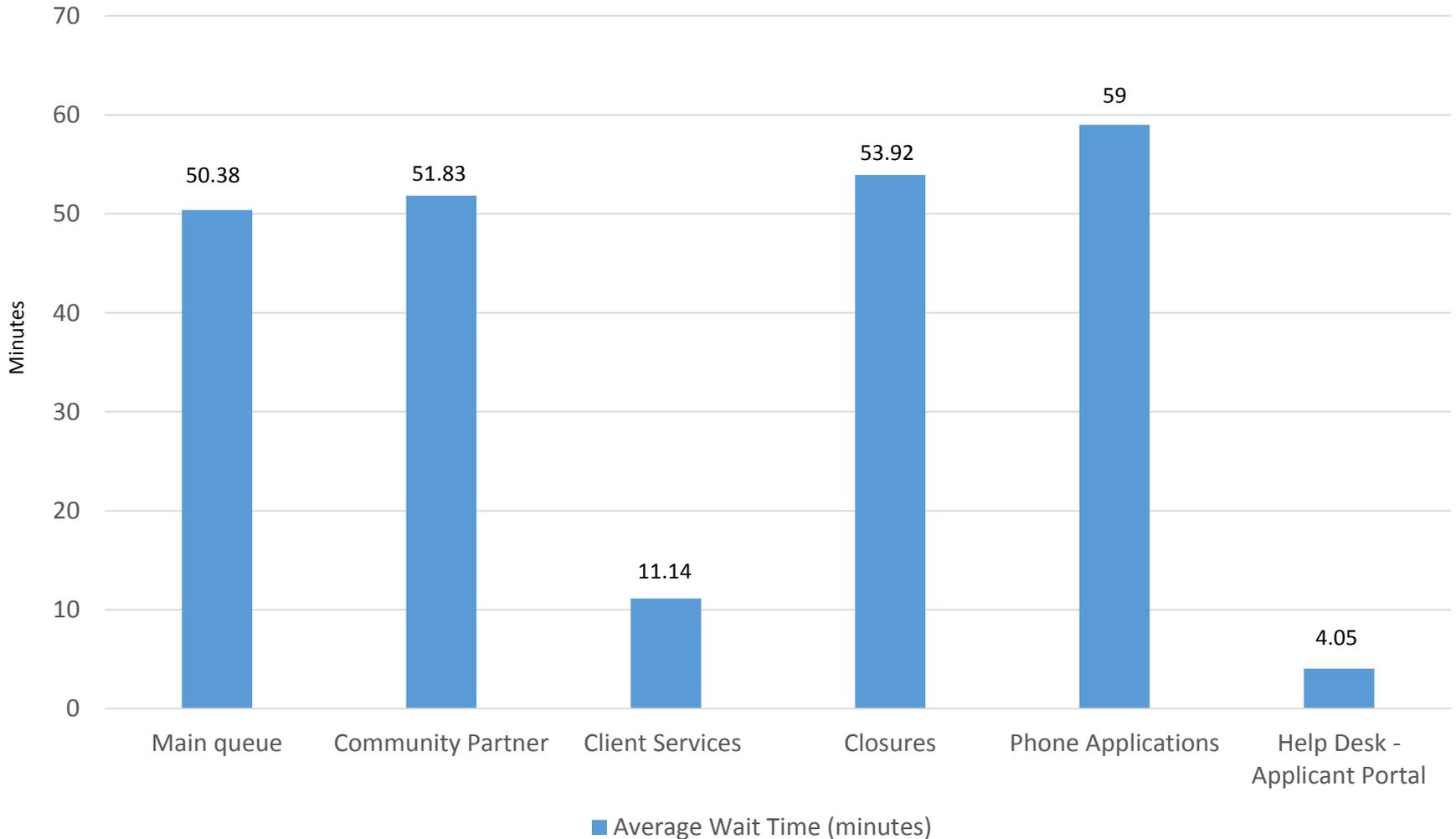


A total of 129,197 calls were received and 56,490 calls were answered in June

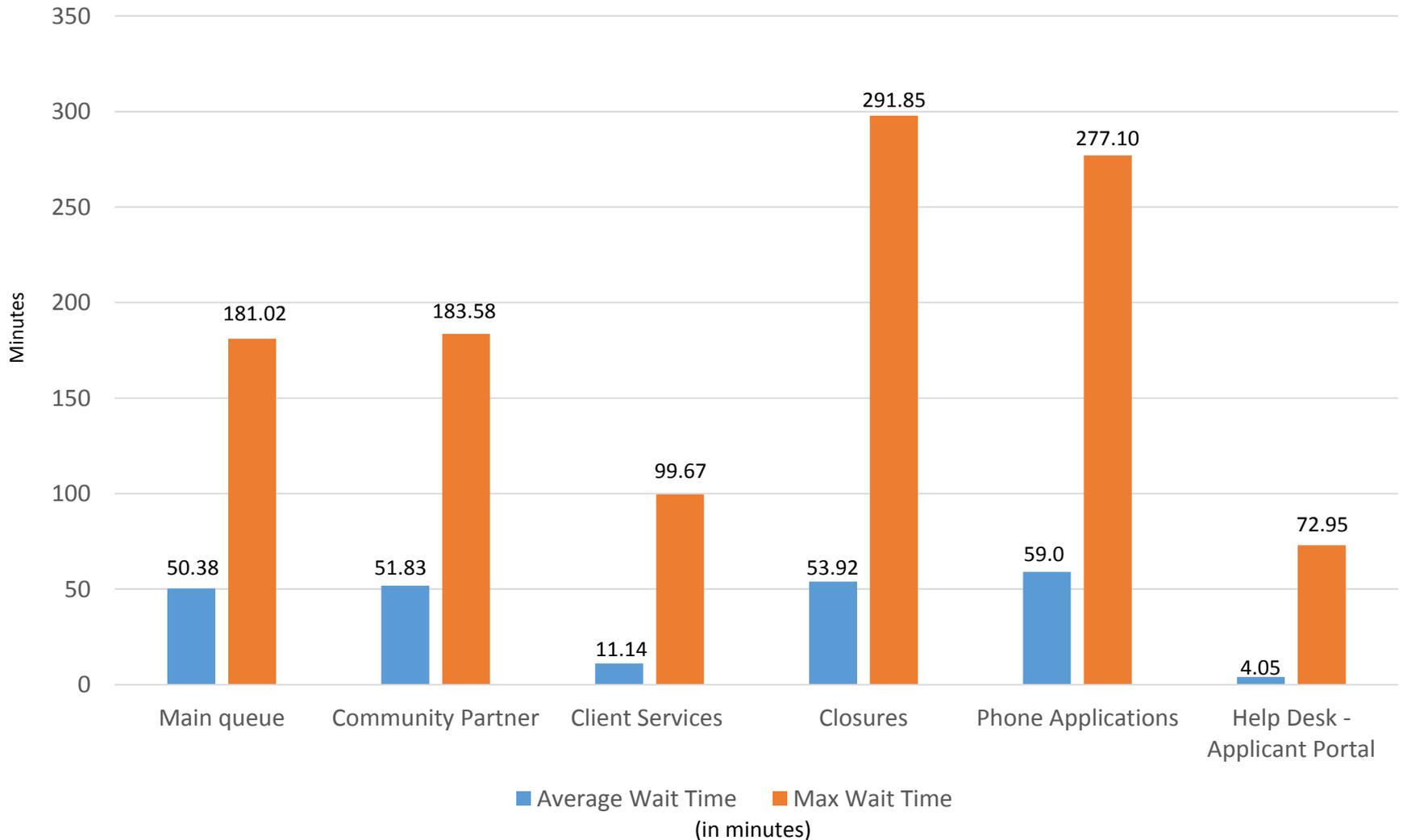
Phone queues

- When a member or partner dials OHP Customer Service, there are several menu options that transition into specific phone queues.
- Each phone queue has a dedicated team and its own reported stats, including average wait time.
- When we report our average wait time, it's important to note that it's the average of all queues.

Average Monthly Wait Time (per phone queue) – June 2016



Average Monthly Wait Time and Max Wait time – June 2016



Applicant Portal - Applications Created/Authorized

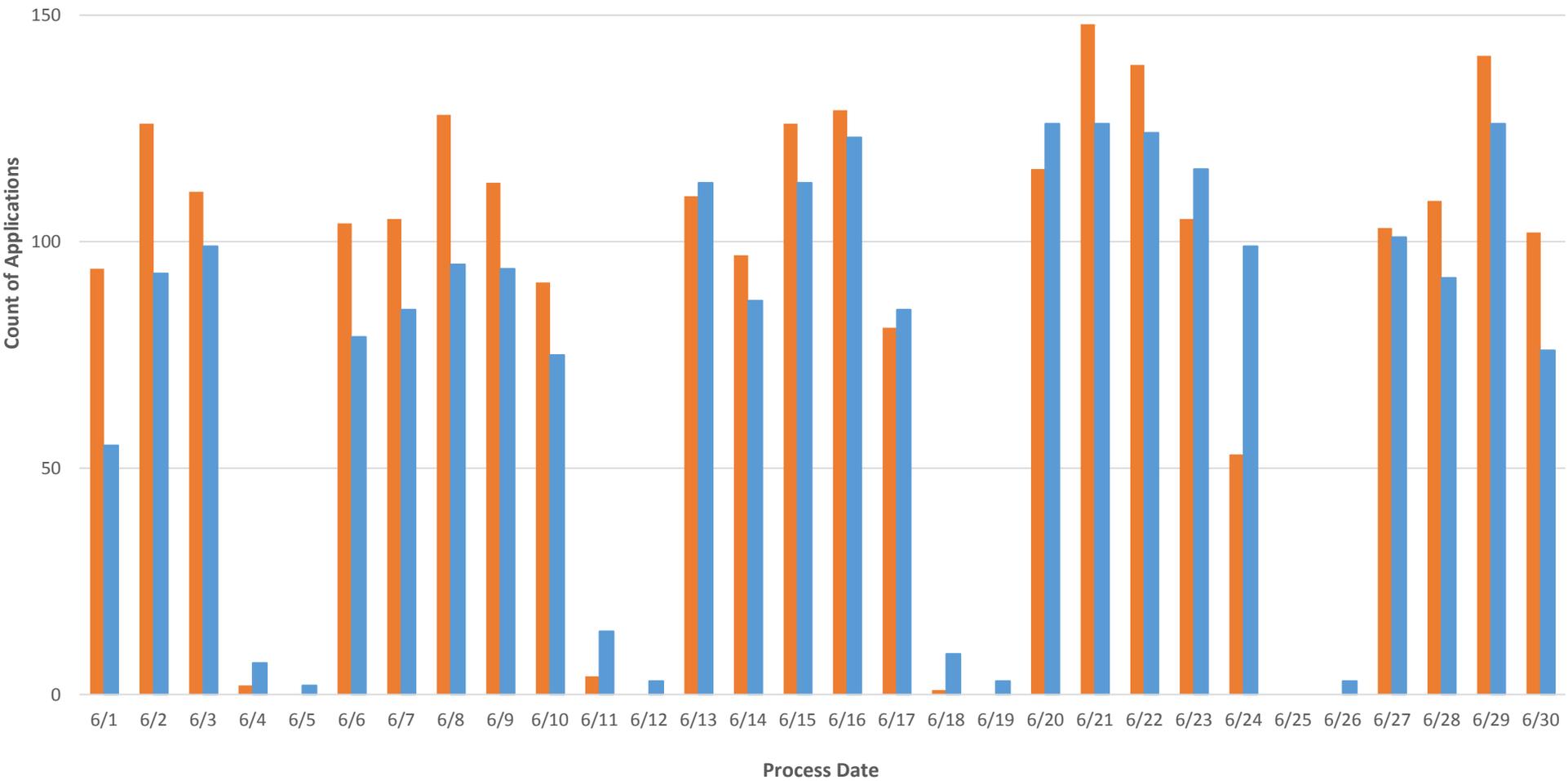
Source: Deloitte Report - Key Command Center Metrics



7/1/2016 13:02

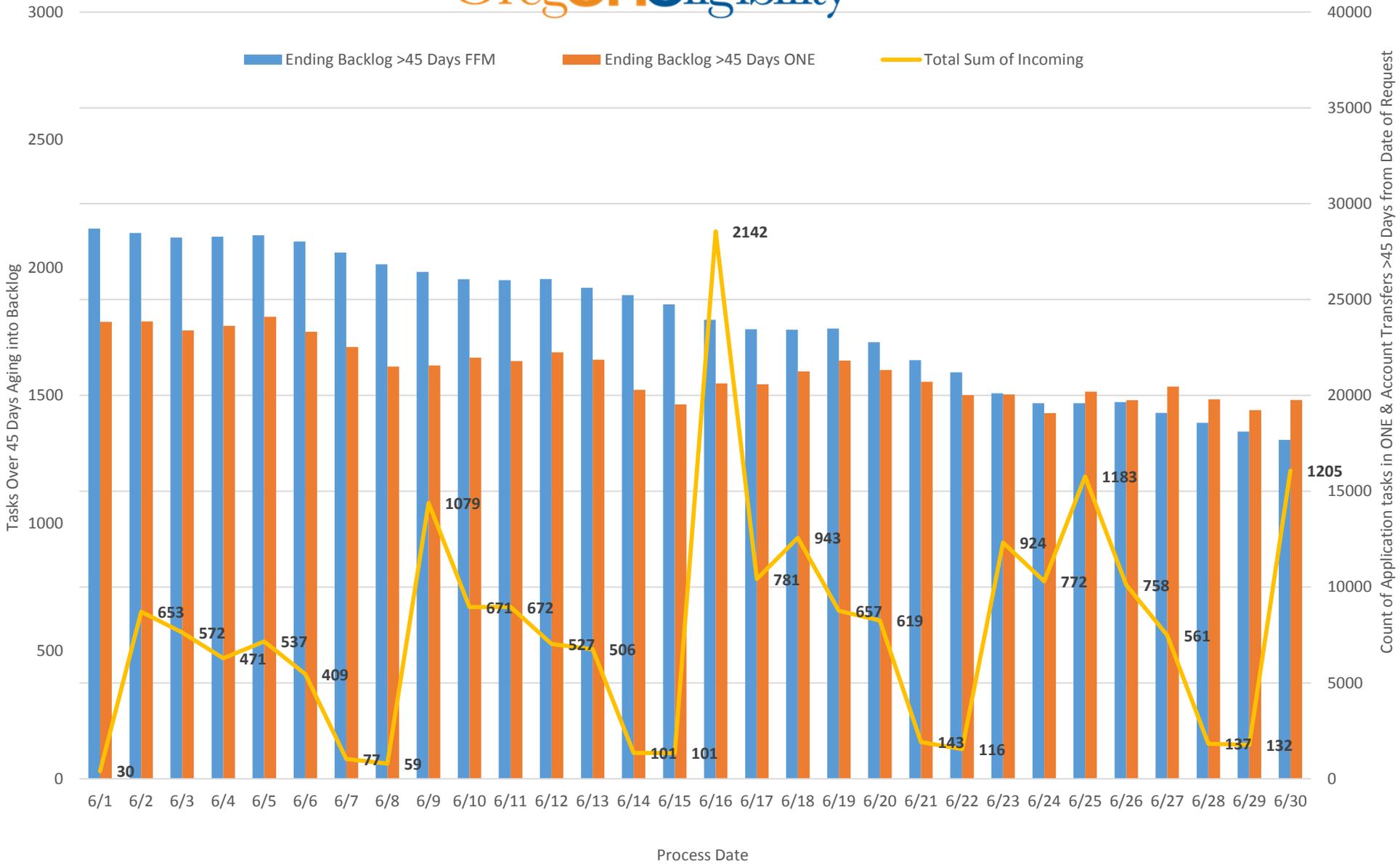
Total Applicant Portal Applications Created To Date: **7393**
Current Applicant Portal Hard Pends: **336**
Total Applicant Portal Applications Completed To Date: **6477**

Sum of Current Created AP Sum of Current Auth - AP



Member Services - Application Tasks >45 Days Monthly Report

Source: Deloitte "Daily Application Tasks" & Account Transfer Transaction Report

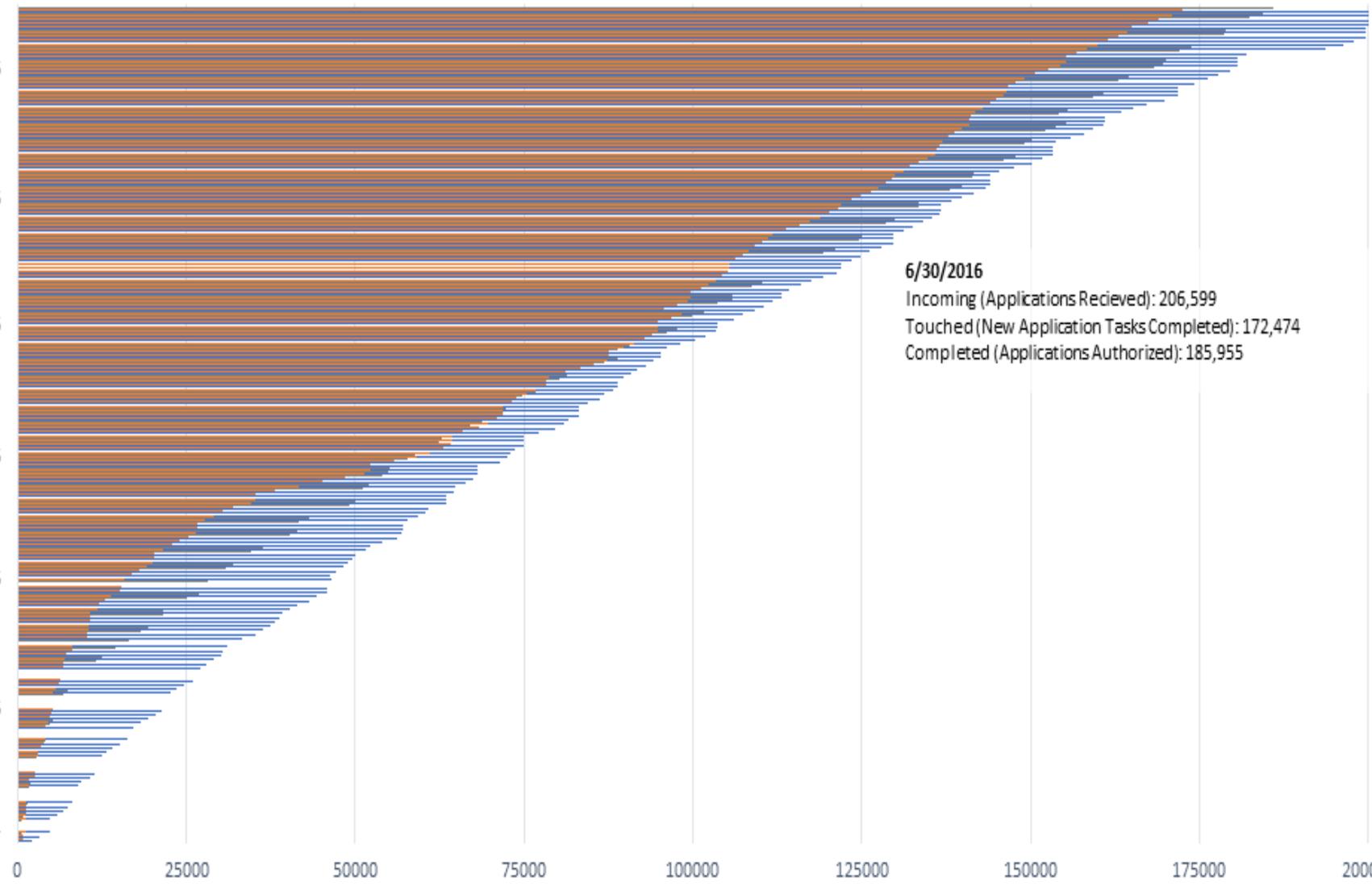


Member Services - Sum of Applications Received, Touched & Completed

7/1/2016 15:28

6/15/2016
5/15/2016
4/15/2016
3/15/2016
2/15/2016
1/15/2016
12/15/2015

6/30/2016
Incoming (Applications Received): 206,599
Touched (New Application Tasks Completed): 172,474
Completed (Applications Authorized): 185,955



Cumulative Touched Cumulative Incoming CC Sum Completed

Oregoneligibility

Current Goals

- **45-day backlog:** We have dedicated a team of 59 total staff working applications and tasks in the Account Transfer (FFM) backlog. These efforts have helped reduce the FFM backlog by 40% since June 1.
- **Staffing:** We are finalizing staffing and operations plans to meet our current need.
- **Training:** ONE Refresher training for staff continues through July. Targeted trainings are also being developed for processes outside of the ONE system.

Concerns we have heard

Processing time for urgent and pregnancy applications

- Our pregnancy, urgent and priority application queues are being worked same day/next day. However, there was a backlog with our imaging partners which caused a delay of up to five days in the process. At this time, the backlog has been eliminated and imaging is working same day/next day.

Backlog in imaging

- Imaging and Records Management Services (IRMS) has to complete its imaging process before we receive a fax, PDF or paper application. If there is a backlog in imaging, that impacts our ability to process within our goal time frame. Over the past few months, IRMS has had a backlog of up to seven days. However, that backlog has recently been reduced to 24 to 48 hours.

Clarification needed on address changes

- Clarification has been needed for best methods for submitting address and demographic changes. Members can call us at 1-800-699-9075 or email OregonHealthPlan.Changes@state.or.us. Member requests can also be submitted through community partners and CCOs.

Urgent address and demographic changes

- Previously, we had a very high volume of urgent address and demographic change requests that were a month out or older.
- As of this week, urgent address and demographic changes are being worked within 5 business days. Changes can be requested by calling us or by sending an email to OregonHealthPlan.Changes@state.or.us
- Changes cannot be made if a member's application is older than 12 months. If a member has not had an eligibility determination within the last year, they will need to submit a new application.

Successes we have had

- Concentrated processing efforts on our 45-day backlog, including paper applications and FFM applications
- Reduction of Imaging and Records Management Services (IRMS) backlog to processing within 24 to 48 hours.
- Quality Assurance implementation at our Veterans Building processing center
- More than 480 community partners and assisters registered for the Applicant Portal

Renewals and closures - June

May 2 – Renewal letters mailed to 48,542 households
(97,324 individuals)

June 20 – Closure notices mailed to 52,694 individuals

June 30 – Benefits close for members who did not respond.

June closure information will be posted by July 15 at:
www.oregon.gov/oha/healthplan/pages/ohp-update.aspx

What else would you like to hear?

Your feedback is important to us.

Please let us know what additional information we should present at our monthly meetings.

Questions

Via webinar: Please use the chat function to submit your questions.

Via email:

Please email ohp.customerservice@state.or.us.

FAQ and other materials can be found at:

www.oregon.gov/oha/healthplan/pages/ohp-update.aspx



Oregon Health Plan (OHP) Enrollment and Renewals Monthly Stoplight Report

The Monthly Stoplight Report is a compilation of concerns we have heard, issues we have addressed, and issues we are researching. It will help Oregon Health Plan operations ensure transparency of process and help eliminate duplication of efforts that result in multiple channels for issues resolution.

Concerns we have heard

- Processing time for urgent and pregnancy applications
- Document imaging backlog
- Clarification on how to submit address changes
- Clarification on the fastest way to submit an application

Issues completed

Clarification needed on submitting address changes

Changes can be requested by calling us at 1-800-699-9075 or by sending an email to OregonHealthPlan.Changes@state.or.us. Community partners and assisters can send an email to OHP.Outreach@state.or.us or use the ONE Applicant Portal.

Backlog in Imaging and Records Management Services (IRMS)

Before an application is processed, it must be imaged. Imaging and Records Management Services (IRMS) images all applications that have been submitted via fax, PDF or mail. If there is a backlog in imaging, that impacts our ability to process. Over the past few months, IRMS has had a backlog of up to seven days. However, due to staffing and process improvements, that backlog has recently been reduced to 24 to 48 hours.

Clarification on the fastest way to submit an application

The fastest way to submit an application is to call us at 1-800-699-9075 or get local help from a community partner. Processing time is the same for faxed applications and PDFs submitted electronically. Paper applications take the most time to process because of the extra time needed to mail an application.



Oregon Health Plan (OHP) Enrollment and Renewals Monthly Stoplight Report

Issues in progress (Research, validation, implementation)

Revise the renewal notice to include benefits closure date

The current OHP renewal notice includes a reply-by date but does not include a closure date. Operations is working with our communications and policy teams to revise the notice.

Revise the OHP Application to include more information about income verification

Application revision efforts are underway, including requests for feedback from members, community partners, CCOs, processing staff and other stakeholders. Our publication goal for the new application is November 2016.

Issues we are not able to complete at this time

No new issues at this time

Oral Health Work Group: Progress-to-Date

Alyssa Franzen, Care Oregon, MAC Liaison

Matt Sinnott, Willamette Dental Group, Oral
Health Work Group Co-chair

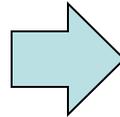


Oral Health Work Group Meeting #1

July 7, 2016

Meeting goals:

1. Introduce charge and goals for the work (see *Guiding Document*)
2. Develop a comprehensive list of barriers to oral health access
3. Identify key elements of an oral health care access framework



Desired products:

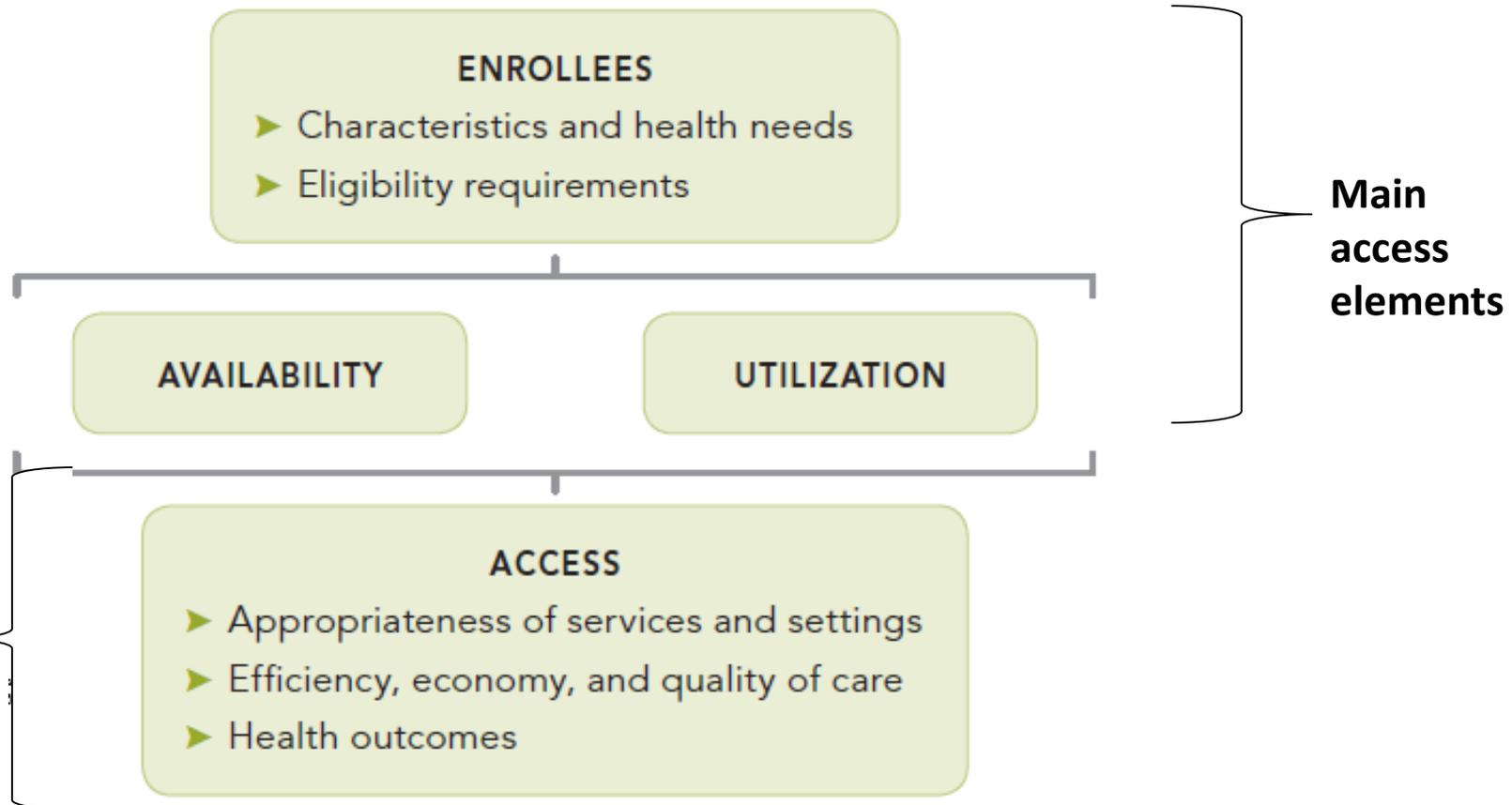
1. Draft oral health care access definition
2. Draft oral health care access framework model

Goal #2: barriers to oral health care access in OHP

We asked: What barriers do you know or imagine that may prevent Oregon Health Plan (OHP) members from accessing oral health services in OHP? Consider barriers from perspectives such as: consumer/family perspective, provider, and health care organization/delivery

- More than 50 barriers brainstormed
- Areas covered included:
 - Providers – supply, distribution, administrative barriers (e.g. credentialing process)
 - Enrollee/patient – knowledge/oral health literacy, attitudes (fear), cultural
 - Utilization – missed appointments, sites of care, patient experience of getting care
 - Structural/population health – state policy, disease burden in population

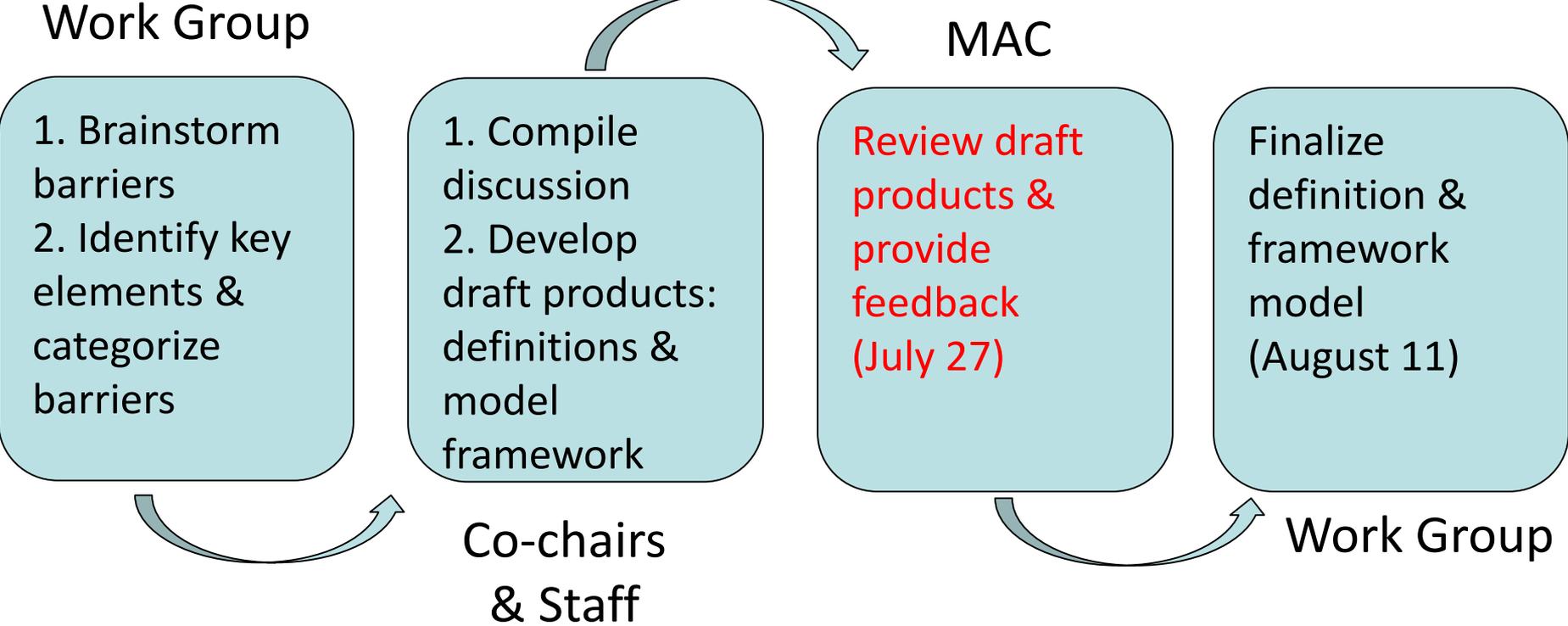
Key elements starting point: MACPAC Framework for Health Care Access in Medicaid



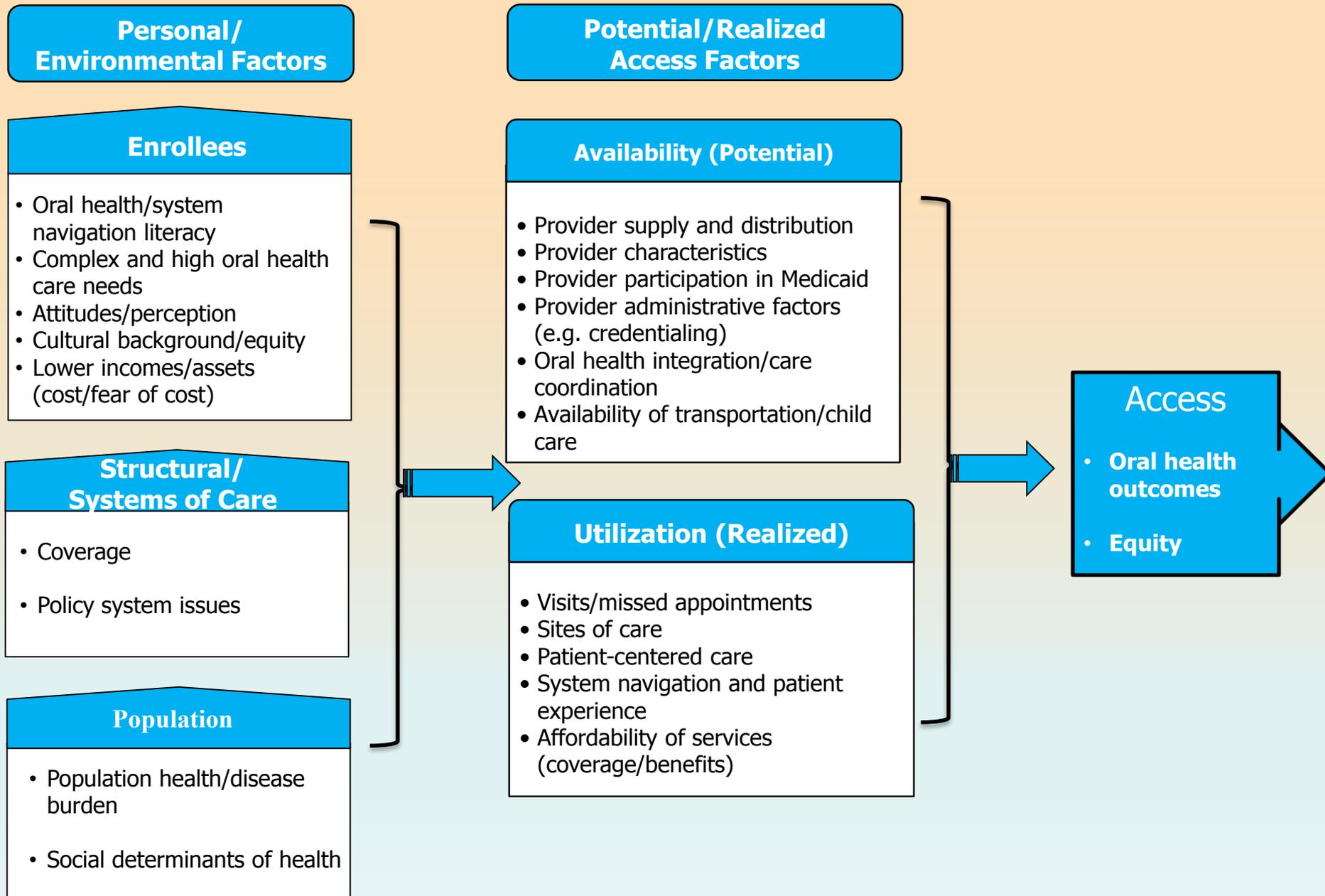
Goal #3: key elements of oral health care access framework

- Small group categorization activity: how do barriers reveal key elements of oral health care access?
- Many barriers can be categorized under multiple elements
 - For example, availability of transportation/child care can be seen as a barrier for individual enrollees, a factor in relative availability of services, and a factor in utilization of services
- MACPAC framework doesn't have everything we need
- Group identified new elements to encompass structural, systems of care, and population health barriers

Process: developing the products



Oral Health Care Access Framework DRAFT



Proposed definitions of oral health care access in the Oregon Health Plan

Option 1: Oral health care access in the Oregon Health Plan is the availability, affordability, member awareness, and timely use of quality oral health services, integrated within a plan for patient-centered overall care at appropriate sites and from qualified providers (including specialists) who meet the needs of individual patients, including oral disease preventive services at regular intervals and treatment services when needed, to reduce disparities and achieve the best possible health outcomes.

Option 2 (short version): Oral health care access in the Oregon Health Plan happens when members are aware of, seek, and successfully and equitably receive timely and quality oral health preventive services and needed treatment at appropriate sites and from providers who meet their needs, integrated into a plan for their overall health, in order to produce the best possible health outcomes.

Next Steps

Timing

MAC provide feedback on draft definitions and draft oral health access framework model

Today

MAC establish guidelines for Oral Health Work Group indicator prioritization and measure selection

Today

Work Group review and finalize recommended definition and framework model, incorporating MAC feedback

August 11

Work Group identify priority indicators of access and recommend measures, according to MAC guidelines

August 11

Work Group discuss and finalize recommendations to MAC

September 20

MAC discuss and finalize memo to OHA regarding a framework for access to oral health care in OHP

September 28

MAC feedback on draft products

- Does the model framework for oral health care access in OHP encompass every element/factor committee members feel should be included? Are there additional considerations committee members would like to raise?
- Is there anything missing from the oral health access definitions? Which definition does the committee prefer? Any other feedback on these?
- Other feedback on the progress to date?

Draft guidelines for Oral Health Work Group access indicator selection

- **Indicator prioritization:** Prioritize top five indicators for each framework element:



Draft considerations for prioritization/selection:

- (1) Consistency with recommendations of stakeholder groups (e.g. Dental Quality Metrics Work Group, CCO Oregon Dental Work Group)
- (2) Support of Triple Aim: importance of care coordination as a critical component of oral health care access
- (3) Health equity and access for vulnerable and underserved populations within OHP

Oral Health Access Framework: Overview and Committee Work Plan

The Oregon Health Authority is uniquely positioned to work with CCOs and across divisions (Health Policy and Analytics, Health Systems Delivery, and Public Health) to coordinate activities to improve oral health outcomes for Oregonians. Recently, OHA expanded the capacity of its cross-divisional oral health program, with the hire of its first Dental Director, Dr. Bruce Austin (2015).

During the summer of 2016, OHA will commence an oral health strategic planning process to develop a coordination and alignment roadmap for oral health work across the agency: the OHA Oral Health Strategic Plan (OHA Strategic Plan). The OHA Strategic Plan will incorporate and build on:

- OHA-specific priorities and strategies in existing internal/external oral health plans, including the statewide [Strategic Plan for Oral Health in Oregon: 2014-2020](#) (Oregon Oral Health Coalition/Oregon Health Authority/Oral Health Funders Collaborative) and the [State Health Improvement Plan: 2015-2019](#) (OHA Public Health Division); and
- Emerging oral health priorities and strategies in the context of Oregon's Health System Transformation 2.0 efforts and other broad agency priorities, such as OHA's 10 priority areas, and Oregon's renewal of its 1115 waiver.

Oregon's Medicaid Advisory Committee (MAC) has the opportunity to inform OHA's ongoing strategic planning efforts with regard to oral health. Specifically, OHA has asked MAC to recommend a **framework** for defining and assessing oral health access for OHP members by addressing two foundational questions:

1. What are the key factors that influence access to oral health care for OHP members (i.e. how should Oregon define access)?
2. What key data could be used to assess access to oral health services for OHP members (i.e. how should Oregon monitor access to oral health in Medicaid)?

The committee will review this issue in May-September of 2016 and will submit its recommendations to OHA by October 1st, 2016. The Committee's recommended framework around access to oral health for OHP enrollees will be incorporated into the OHA Oral Health Strategic Plan, which will be released by the end of 2016.

Date (2016)	Task Description
<p style="text-align: center;">May 25 (MAC Mtg.)</p>	<ul style="list-style-type: none"> • Introduce OHA request to develop the framework for assessing oral health access in OHP and committee work plan; present background on oral health for adults in Medicaid, summary of oral health delivery system in Medicaid, and summary of OHA strategic priorities and initiatives. <i>Committee approved creating an Oral Health Work Group to advise the committee on dental access framework.</i>

Oral Health Access Framework: Overview and Committee Work Plan

June	<ul style="list-style-type: none"> Recruitment for Oral Health Work Group.
June 22 (MAC Mtg.)	<ul style="list-style-type: none"> MAC approve <i>Oral Health Work Group</i> committee roster.
July 7 (Oral Health Work Group)	<ul style="list-style-type: none"> Presentations on national/state model definitions and factors. <i>Work Group</i> consider factors that help/hinder oral health access. Develop a working definition of access.
July 27 (MAC Mtg.)	<ul style="list-style-type: none"> <i>Work Group</i> present list of key factors influencing access for OHP members and working definition of access.
August 11 (Oral Health Work Group)	<ul style="list-style-type: none"> Presentations on model metrics/measures from dental work groups, strategic plans, national sources. <i>Work Group</i> Develop and prioritize list of key data influencing access for OHP members.
August/September	<ul style="list-style-type: none"> <i>Staff</i> draft memo on framework for oral health access in OHP per work group discussions.
September 20 (Oral Health Work Group)	<ul style="list-style-type: none"> <i>Work Group</i> review and discuss draft memo on framework for oral health access in OHP.
September 28 (MAC Mtg.)	<ul style="list-style-type: none"> MAC review and finalize draft committee memo on framework for oral health access in OHP for OHA.



Guiding Document Oral Health Work Group of the Medicaid Advisory Committee

Authority
<p>On behalf of the Oregon Health Authority (OHA), the Medicaid Advisory Committee formed the Oral Health Work Group. The work group is tasked with developing a framework to assess oral health access in the Oregon Health Plan (OHP). The Work Group is directed to develop a framework by answering two key questions:</p> <ol style="list-style-type: none">1. What are the <u>key factors</u> that influence access to oral health care for OHP members (i.e. how should Oregon define access)?2. What <u>key data</u> or <u>information</u> should be used to assess access to oral health services for OHP members (i.e. how should Oregon monitor access to oral health in Medicaid)?
Timeline
July – September, 2016
Roles, Responsibilities, and Scope of Work
<p>The purpose of the Oral Health Work Group is to develop a <u>high-level framework</u>, including a shared definition of oral health access in OHP and recommended data OHA can use to assess access to oral health services for members.</p> <p>Criteria for Developing a Definition of Oral Health Access: The Work Group will draw on existing federal and state definitions and frameworks regarding access to oral health and other health services. The definition and framework adopted by the Work Group should be tailored to Oregon’s unique health care delivery system; demographic characteristics, health needs and disparities among populations served by OHP; provider composition, and other Oregon-specific considerations.</p> <p>Key Data to Assess Oral Health Access: The Work Group will review, select, and prioritize measures on oral health access from existing local and federal sources, including local oral health advisory and work groups, existing oral health and oral-health-related strategic plans, and federal oral health access measures and metrics. Measures will be selected and prioritized for the purpose of OHA monitoring and evaluation of oral health access in OHP.</p> <p>The workgroup <u>is not tasked</u> with recommending incentive or accountability metrics for coordinated care organizations (CCOs). <u>The scope of work also does not include developing recommendations related to oral health access improvement strategies or solutions.</u> While critically important, these discussions are outside of the current scope and timeline for the Oral Health Work Group of the Medicaid Advisory Committee.</p>
Deliverables
<p>The Oral Health Work Group will be responsible for developing a memo that recommends a framework for assessing oral health access in the Oregon Health Plan. The memo will be presented for review and discussion at the Medicaid Advisory Committee meeting on September 29, 2016. The Medicaid Advisory Committee will approve and submit the final Oral Health Access Framework to OHA.</p>

Membership

OHA Leadership Sponsors:

David Simnitt, Oregon Health Authority
Dr. Bruce Austin, Oregon Health Authority

OHA Staff:

Oliver Droppers, Health Policy and Analytics (staff to the MAC)
Amanda Peden, Health Policy and Analytics (staff to the MAC)
Margie Fernando, Health Policy and Analytics (staff to the MAC)

MAC Liaisons

Alyssa Franzen, Care Oregon
Bob Diprete, Retired health policy professional

Work Group Members:

By MAC designation, the Oral Health Work Group is comprised of representatives from Coordinated Care Organizations (CCOs), Dental Care Organizations (DCOs), providers, consumer/consumer advocates, tribal, and members of the general public

Kelle Adamek-Little, Coquille Indian Tribe
Maria Ahrendt, NARA NW Clinic
Laura Bird, Northwest Portland Area Indian Health Board
Dr. Lisa Bozzetti, Virginia Garcia Memorial Health Center
Jim Connelly, Trillium Community Health Plan
Christina Coutts, ShelterCare Homeless Medical Recuperation Program
Susan Filkins, Oregon Center for Children and Youth with Special Health Care Needs
Tony Finch, Oregon Oral Health Coalition
Laura McKeane, AllCare Health
Kuulei Payne, Winding Waters Medical Clinic
Dr. Eli Schwarz, OHSU School of Dentistry, Department of Community Dentistry
Dr. Mike Shirtcliff, Advantage Dental
Heather Simmons, PacificSource Community Solutions
Matthew Sinnott, Willamette Dental Group (Co-Chair)
Dr. Jeffrey Sulitzer, InterDent/Capitol Dental
Dr. James Tyack, Tyack Dental (Co-Chair)

Meeting Schedule

Oral Health Work Group Meeting #1

Thursday, July 7, 9-11am
Lincoln Building, Suite 775, Transformation Center Training Room
421 SW Oak Street
Portland

Oral Health Work Group Meeting #2

Thursday, August 11, 3-5pm (please hold 2-5pm)
Oregon State Library, Room 103
250 Winter St., NE
Salem

Oral Health Work Group Meeting #3

Tuesday, September 20, 9-11am (please hold 9am-noon)

Wilsonville Training Center, Room 111/112

29353 SW Town Center Loop

Wilsonville

	Access Factors	Access Barriers	
Environmental/Personal Factors	Enrollees	Oral health/system navigation literacy: oral health literacy; knowledge/knowledge of patient; knowledge of benefits/availability of coverage; system navigation literacy	Oral Health Outcomes/Health Equity
		Complex and high oral health care needs: high burden of disease.	
		Attitudes/perception: Dental history of parents/caretakers (barriers for children); fear among patients.	
		Cultural background/equity: cultural background; health equity issues/race ethnicity	
	Lower incomes/assets: Culture of poverty/understanding cultural language of poverty and fear of costs		
	Structural/Systems of Care	Policy/system issues: discontinuous eligibility (churn), assignment of members, FQHCs may not be able to accept certain plans, requirement to go through general dentist before pediatric	
		Adult medicaid coverage	
Population	Population health/disease burden: disease in population trying to serve; root causes		
	Social determinants of health		
Potential/Realized Access Factors	Availability	Supply & distribution: provider availability/access, turnover/churn, mal-distribution of providers (rural vs. urban)	
		Characteristics: experience; different philosophies of care between DCOs	
		Participation in Medicaid: Reimbursement rates/funding, lack of providers accepting OHP; Availability - lack of open card provider/Low volume of FFS providers; incentive programs don't provide continuity; lack of incentives to work in rural communities	
		Oral health integration/care coordination: Need for coordination with mental and physical health, especially for chronic disease; oral health integration; need better care coordination and co-location	
		Administrative: Provider credentialing slow; Capacity setting structural (by DCO), reporting on access	
		Availability of transportation/child care	
	Utilization	Visits/missed appointments: missed/failed appointments; Accountability/responsibility	
		Sites of care: history of using emergency departments (ED); need to expand points of access; need more programs for children (preschool children)	
		Patient-centered care: need to meet patients where they are	
		Affordability of services (coverage/benefits): coverage for adults (loss potential barrier); coverage of adult dental - impact to children	

OREGON'S PATH TO PUBLIC HEALTH MODERNIZATION

Public health modernization will ensure basic public protections critical to the health of all in Oregon and future generations – these include protection from communicable disease and environmental risks, health promotion, prevention of diseases and injury, and responding to new health threats.

Where public health happens

Eighty percent of what shapes our health happens outside the doctor's office. Public health promotes the health of all people in Oregon where they live, work, learn and play by:

- protecting people from communicable disease,
- preparing for and responding to emergencies,
- limiting environmental risks to human health
- promoting health and countering the harmful impact of disease and injury,
- and, ensuring equitable access to quality health care.

Oregon's public health system works tirelessly to keep communities safe and healthy. Unfortunately, not every community in Oregon is equally equipped to provide these essential public protections. We need to upgrade our public health system in ways that recognize how our physical environment, social and economic conditions, and health behaviors affect us.

In every community

Public health in Oregon requires a full-system upgrade to ensure all people, no matter where they live, have access to essential public health protections. An assessment of the public health system found gaps between our current and modernized public health system—identifying that **most foundational public health programs are limited or minimal in over a third of Oregon communities.**

A modern system will enable every Oregon community to provide essential prevention programs and respond to emerging health threats, like Zika, Cascadia earthquake, air contaminants or lead in our water. Investing in these essential public programs is critical to the health of all people in Oregon now and for future generations.

Health within reach

Modernized public health is critical to Oregon's movement toward health system transformation. A modern public health system helps Oregon achieve the Triple Aim: better health and better care at a lower cost. But for people in Oregon, it is simpler than that: **a healthy life, within our reach.**

For more information, visit healthoregon.org/modernization.

Oregon's Health System Transformation: CCO Metrics 2015 Final Report

 June 2016

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EXECUTIVE SUMMARY

This report lays out the progress of Oregon's coordinated care organizations (CCOs) on quality measures in 2015. Measuring quality and access to care are key to moving health system transformation forward, to ensure high quality care for Oregon Health Plan members.

This is the third year of Oregon's pay for performance program, under which the Oregon Health Authority held back 4 percent of the monthly payments to CCOs, which were put into a 'quality pool.' To earn their full incentive payment, CCOs had to meet benchmarks or improvement targets on at least 12 of the 17 incentive measures and have at least 60 percent of their members enrolled in a patient-centered primary care home.

This is the first year Oregon has paid CCOs for two new incentive measures: improving the rates of dental sealants for children and providing effective contraceptives for women ages 18 – 50.

All CCOs showed improvements in some number of measures and 15 out of 16 CCOs earned 100 percent of their quality pool dollars.

The report indicates that through the coordinated care model, there have been continued improvements in a number of areas, such as reductions in emergency department visits, and increases in depression screening and enrollment in patient-centered primary care homes.

The coordinated care model shows improvements in the following areas:

- **Hospital readmissions have decreased:** The percent of adults who had a hospital stay and were readmitted for any reason within 30 days has improved by 33 percent since 2011. Fifteen of 16 CCOs have met or exceeded the benchmark. This measure is also shared with the Hospital Transformation Performance Program.
- **Decreased hospital admissions for short-term complications from diabetes:** decreased 29 percent since 2011. Admissions for chronic obstructive pulmonary disease (COPD), congestive heart failure, and asthma have all also decreased from 2011 baseline. Lower is better for these measures.
- **Increased access to primary care for children and adolescents:** The percent of children and adolescents who had a visit with their primary care provider in the past year has increased from 2014. Adolescent well-care visits have also increased 38 percent since 2011.
- **Increased rates of dental sealants:** The percent of children ages 6-14 who received a dental sealant on a permanent molar in the past year increased 65 percent since 2014.
- **Increased use of effective contraceptives:** The percent of women ages 15-50 who are using an effective contraceptive increased almost 9 percent since 2014, even with the addition of thousands of new OHP members in 2014.

EXECUTIVE SUMMARY

- **Increased blood sugar testing for adults with diabetes:** The percent of adults with diabetes who received at least one blood sugar test during the year has increased 6 percent since 2011.
- **Patient-centered primary care home enrollment continues to increase:** Coordinated care organizations continue to increase the proportion of members enrolled in patient-centered primary care homes. PCPCH enrollment has increased 69 percent since 2012.
- **Increased member satisfaction:** The percent of CCO members who report they received needed information or help and thought they were treated with courtesy and respect by customer service staff has increased almost 10 percent since 2011 baseline.

CCOs have also demonstrated promising improvements in providing health assessments for children in foster care. While these assessments should be occurring in a timely fashion for all children, the rate of assessments has increased 107 percent since 2014, when dental health assessments were added to the measure.

These improvements are attributable to positive changes toward better care coordination and integration of services. For example, one CCO has created a member navigator role for members with complex needs, has provided orientation to the health plan for new members, and instated a one call resolution approach for members who call with questions, which have all helped increase member satisfaction.

After several years of reporting declines in chlamydia screening and cervical cancer screening, both rates have improved slightly compared to 2014 (4 percent increase for chlamydia screening; 8 percent increase in cervical cancer screening), although there is still much room for improvement.

Measures in this report that highlight room for improvement include continued engagement in treatment for alcohol or drug dependence, and tobacco users receiving advice and supports to quit from their doctor.

OHA's Transformation Center: Support for CCOs through targeted technical assistance

- The health authority's Transformation Center has begun providing targeted technical assistance on specific measures to CCOs, including a focus on colorectal cancer screening, adolescent well care visits, childhood immunizations, and reducing tobacco use. This assistance includes trainings, consultation with experts and coordination of support across OHA to support workforce development and quality improvement. Highlights include:
 - Consultation with Oregon Rural Practice-based Research Network and the Kaiser Permanente Center for Health Research to improve colorectal cancer screenings. Nine CCOs are participating.
 - Upcoming trainings for CCOs and providers on how to provide youth-centered care from the Oregon-School Based Health Alliance.

EXECUTIVE SUMMARY

- Upcoming community meetings with public health, providers, and stakeholders to develop strategies to improve childhood immunization rates.
- Developing culturally-responsive and population-specific training for providers to support tobacco cessation strategies.

New in this report

This report is the first to provide more detailed demographic information about Medicaid members at the CCO level. Previous reports have only included demographic information at the state level. This expanded section helps illustrate diversity across the Oregon Health Plan population.

This is also the first report to provide overall summaries of performance across multiple measures in a graphic display. This new display offers an "at-a-glance" perspective on where performance is strong across CCOs or across populations, as well as potential areas for improvement (see next page).

This is the second report to show statewide performance on selected measures for members with disabilities, and members with mental health conditions and severe and persistent mental illness ([see page 157](#)).

Oregon is continuing its efforts to transform the health delivery system. By measuring our progress, sharing it publicly and learning from our successes and challenges, we can see clearly where we are and where we need to go next.

2015 PERFORMANCE OVERVIEW

CCO Incentive Measures

	AllCare	Cascade	Columbia Pacific	Eastern Oregon	FamilyCare	Health Share	IHN	Jackson	PacSource Central	PacSource Gorge	PrimaryHealth	Trillium	Umpqua	WOAH	WVCH	Yamhill
<ul style="list-style-type: none"> ■ CCO achieved BENCHMARK in 2015 ■ CCO achieved IMPROVEMENT TARGET in 2015 * Highest performing CCO in each measure 																
Access to care (CAHPS)	■	■						*		■	■	■				
Adolescent well care visits	■		■			■	■	■	■	■	■	■	■	■		*
Alcohol and drug misuse screening (SBIRT) 12+	■			■	■	■	■	■	■	■	■	■	■	■	*	■
Ambulatory care - Emergency department utilization	■	■	■		■	■		■	■	■	*		■	■	■	
Colorectal cancer screening	■		■		■	■	■	■	■	■	■		*	■	■	■
Controlling high blood pressure	■		■	■	■	■		*		■		■		■	■	■
Dental sealants for children	■	■	■	■	■	■	■	■	■	■	*	■	■	■	■	■
Depression screening and follow up	■		■	■	■	■	■	■	■	■	■	■	■	■	■	*
Developmental screening	■	■	■	■	■	■	■	■	■	■	*	■	■	■	■	■
Diabetes HbA1c poor control	■	*	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Effective contraceptive use (ages 18-50)				■					■	■	■	■	*	■	■	■
Electronic health record (EHR) adoption	■	■	■	■	■	■	■	■	■	■	*	■	■	■	■	■
Follow up after hospitalization for mental illness	■		■	■	■	■	■	■	■	*	■		■	■		■
Assessments for children in DHS custody	■	■	■	■	■	■	■	■	■	*	■	■	■		■	■
Patient-Centered Primary Care Home (PCPCH) enrollment†	■	■	■	■	■	■	■	■	■	■	*	■	■	■	■	■
Prenatal and postpartum care: Prenatal care	■	■	■	■	■	■	■	■	■	*	■	■	■	■	■	■
Satisfaction with care (CAHPS)	■	*		■	■		■		■	■				■		

†CCOs earn payment for this measure if at least 60 percent of members are enrolled in a patient-centered primary care home.

2015 QUALITY POOL DISTRIBUTION

2015 Quality Pool

The Oregon Health Authority has established the quality pool--Oregon's incentive payments to coordinated care organizations. Each CCO is being paid for reaching benchmarks or making improvements on incentive measures. This is the third time Oregon has paid CCOs for better care, rather than just the volume of services delivered.

The 2015 quality pool is almost \$168 million. This represents 4 percent of the total amount all CCOs were paid in 2014. The quality pool is divided among all CCOs, based on their size (number of members) and their performance on the 17 incentive metrics, which are denoted with an  icon throughout the report.

Quality Pool: Phase One Distribution

CCOs can earn 100 percent of their quality pool in the first phase of distribution by:

- Meeting the benchmark or improvement target on 12 of 16 measures; and
- Meeting the benchmark or improvement target for the electronic health record adoption measure (as one of the 12 measures above); and
- Having at least 60 percent of their members enrolled in a patient-centered primary care home (PCPCH)

CCOs must meet all three of these conditions to earn 100 percent of their quality pool.

Challenge Pool: Phase Two Distribution

The challenge pool includes funds remaining after quality pool funds are distributed in phase one. The 2015 challenge pool is \$1.25 million. Challenge pool funds are distributed to CCOs that meet the benchmark or improvement target on four measures:

- * Alcohol and drug misuse screening (SBIRT);
- * Diabetes HbA1c poor control;
- * Depression screening and follow-up plan;
- * PCPCH enrollment.

Through the challenge pool, some CCOs earn more than 100 percent of their maximum quality pool funds. The next page shows the percentage and dollar amounts earned by each CCO.

2015 QUALITY POOL DISTRIBUTION

CCO	Phase 1 distribution			Challenge pool		Total	
	Number of measures met (of 17 possible)	Payment earned in Phase 1*	Percent of quality pool funds earned	Number of challenge pool measures met (of 4 possible)	Challenge pool earned	Total payment (Phase 1 + Challenge pool)	Total quality pool earned
AllCare Health Plan	15.8	\$ 8,791,057	100%	4	\$ 68,621	\$ 8,859,678	100.8%
Cascade Health Alliance	9.8	\$ 1,881,680	60%	2	\$ 11,853	\$ 1,893,533	60.4%
Columbia Pacific	12.8	\$ 5,641,275	100%	3	\$ 27,450	\$ 5,668,725	100.5%
Eastern Oregon	12.7	\$ 10,160,105	100%	4	\$ 66,393	\$ 10,226,498	100.7%
FamilyCare	13.9	\$ 19,054,681	100%	4	\$ 170,320	\$ 19,225,001	100.9%
Health Share of Oregon	13.9	\$ 42,388,765	100%	4	\$ 326,518	\$ 42,715,283	100.8%
Intercommunity Health Network	12.9	\$ 10,938,166	100%	4	\$ 77,006	\$ 11,015,172	100.7%
Jackson Care Connect	14.8	\$ 5,223,448	100%	4	\$ 40,947	\$ 5,264,395	100.8%
PacificSource – Central Oregon	14.9	\$ 10,118,519	100%	4	\$ 73,973	\$ 10,192,492	100.7%
PacificSource – Gorge	16.9	\$ 2,473,127	100%	4	\$ 18,021	\$ 2,491,148	100.7%
PrimaryHealth of Josephine County	15.0	\$ 2,072,690	100%	4	\$ 15,764	\$ 2,088,454	100.8%
Trillium	12.8	\$ 17,470,578	100%	4	\$ 124,374	\$ 17,594,952	100.7%
Umpqua Health Alliance	13.9	\$ 4,834,093	100%	4	\$ 36,685	\$ 4,870,778	100.8%
Western Oregon Advanced Health	14.9	\$ 4,340,382	100%	4	\$ 28,081	\$ 4,368,463	100.6%
Willamette Valley Community Health	12.9	\$ 17,304,864	100%	4	\$ 137,128	\$ 17,441,992	100.8%
Yamhill CCO	13.7	\$ 4,038,860	100%	4	\$ 31,314	\$ 4,070,174	100.8%
Total		\$ 166,732,290			\$ 1,254,448	\$ 167,986,738	

*Quality pool distribution is based on number of measures met and CCO size (number of members). See page 33 for CCO enrollment.

INCENTIVE MEASURE SUMMARIES

The following dashboards show incentive measure results over time (2011 baseline through 2015) statewide, for each CCO, and for each race or ethnicity. **Light blue** shading indicates the CCO met its individual improvement target that year, and **dark blue** indicates the CCO met the benchmark.

The **light grey** column titled "2014 revised" shows updated results for several measures that are new or have revised specifications beginning in 2015. Note that these revised 2014 results were calculated to serve as a baseline for 2015 only; CCOs received payment in 2015 based on the original 2014 data compared to 2014 benchmark. Measures with 2014 baselines should not be compared to earlier years.

- Alcohol or drug misuse screening (SBIRT) - Added adolescents ages 12-17 (previously the measures only included adults ages 18+)
- Dental sealants on permanent molars for children - New in 2015
- Effective contraceptive use among women at risk of unintended pregnancy - New in 2015
- Follow-up after hospitalization for mental illness - Allowed follow-up services that occurred on the same day as the hospital discharge
- Assessments for children in DHS custody - Added dental health assessments (previously the measure only required mental and physical assessments)

Additional notes:

- Colorectal cancer screening - Specifications were updated beginning in 2014 to use medical record data. In 2011 and 2013, rates were calculated using administrative (claims) data and were reported per 1,000 members months. Performance in 2014 and 2015 is not comparable to earlier years, and 2014 performance was rewarded based on improvement target only.
- In 2014, CCOs earned payment for the three Clinical Quality Measures (Controlling hypertension, Depression screening and follow-up plan, and Diabetes care: HbA1c poor control) by submitting Year 2 Technology Plans and required data. These dashboards indicate achievement of that requirement in 2014 with **light blue**, while achievement of the benchmark is indicated in **dark blue**. In 2015, CCOs are held to a benchmark or improvement target for these measures.
- The baseline for Patient-centered primary care home (PCPCH) enrollment is 2012. Although PCPCH does not have a benchmark, CCOs earn incentive payment by having at least 60 percent of their members enrolled in a PCPCH. CCOs that met the goal are shaded dark blue in these dashboards.

Statewide

	2011 baseline	2013	2014	2014 revised	2015	2015 benchmark	# of CCOs met benchmark or improvement target		% change 2014-2015	
Access to care (CAHPS)	83.0%	83.6%	83.8%	83.0%	83.8%	87.2%	2	4	↑	0%
Adolescent well care visits	27.1%	29.2%	32.0%	n/a	37.5%	62.0%	0	12	↑	17%
Alcohol and drug misuse screening (SBIRT) 12+	0.1%	2.0%	7.3%	6.4%	12.7%	12.0%	9	5	↑	98%
Ambulatory care - ED utilization	61.0	50.5	47.3	-	43.1	39.4 (lower is better)	7	5	↓	-9%
Colorectal cancer screening	10.7	11.4	46.2%	-	46.6%	47.0%	10	3	↑	1%
Controlling high blood pressure	-	-	64.6%	-	64.7%	64.0%	10	1	↑	0%
Dental sealants for children	-	-	-	11.2%	18.5%	20.0%	4	12	↑	65%
Depression screening and follow-up plan	-	-	27.9%	-	37.4%	25.0%	13	2	↑	34%
Developmental screening	20.9%	33.1%	42.6%	-	54.7%	50.0%	12	4	↑	28%
Diabetes HbA1c poor control	-	-	21.8%	-	26.7%	34% (lower is better)	16	0	↓	22%
Effective contraceptive use (ages 18-50)	-	-	-	33.4%	36.3%	50.0%	0	9	↑	9%
Electronic health record (EHR) adoption	28.0%	53.7%	67.7%	-	76.5%	72.0%	14	2	↑	13%
Follow up after hospitalization for mental illness	65.2%	67.6%	66.7%	71.8%	75.3%	70.0%	13	0	↑	5%
Assessments for children in DHS custody	53.6%	63.5%	70.0%	27.9%	58.4%	90.0%	14	0	↑	109%
Patient-centered primary care home (PCPCH) enrollment	51.8%	78.6%	81.0%	-	87.5%	60.0%	16	0	↑	8%
Prenatal and postpartum care: Prenatal care	65.3%	67.3%	82.9%	75.0%	84.7%	90.0%	3	13	↑	2%
Satisfaction with care (CAHPS)	78.0%	83.1%	84.6%	84.4%	85.4%	89.6%	0	8	↑	1%

AllCare Health Plan

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	83.0%	85.0%	83.6%	82.5%	87.0%	87.2%	83.8%
Adolescent well care visits	22.8%	20.5%	22.1%	-	29.8%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	0.7%	3.8%	3.3%	9.9%	12.0%	12.7%
Ambulatory care - Emergency department utilization	56.9	45.0	41.4	-	34.8	39.4 (lower is better)	43.1
Colorectal cancer screening	11.0	7.4	29.7%	-	38.7%	47.0%	46.6%
Controlling hypertension	-	-	62.9%	-	65.3%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	12.0%	21.1%	20.0%	18.5%
Depression screening and follow-up plan	-	-	9.7%	-	32.1%	25.0%	37.4%
Developmental screening in the first 36 months of life	19.6%	30.0%	43.1%	-	55.1%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	27.9%	-	29.4%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	35.1%	35.1%	50.0%	36.3%
Electronic health record (EHR) adoption	21.3%	71.5%	84.0%	-	94.2%	72.0%	76.5%
Follow-up after hospitalization for mental illness	63.0%	51.2%	48.4%	59.8%	80.0%	70.0%	75.3%
Assessments for children in DHS custody	50.7%	40.0%	61.4%	21.4%	40.3%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	39.8%	59.0%	70.0%	-	78.1%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	74.8%	73.4%	85.4%	-	90.0%	90.0%	84.7%
Satisfaction with care (CAHPS)	78.0%	85.1%	83.5%	83.4%	86.7%	89.6%	85.4%

Cascade Health Alliance

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	81.0%	80.4%	80.1%	78.9%	83.2%	87.2%	83.8%
Adolescent well care visits	20.7%	24.2%	19.4%	-	22.3%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	1.6%	0.8%	0.7%	3.3%	12.0%	12.7%
Ambulatory care - Emergency department utilization	41.4	31.6	34.4	-	36.1	39.4 (lower is better)	43.1
Colorectal cancer screening	8.4	7.3	54.0%	-	43.8%	47.0%	46.6%
Controlling hypertension	-	-	58.1%	-	60.6%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	3.3%	13.3%	20.0%	18.5%
Depression screening and follow-up plan	-	-	28.6%	-	0.5%	25.0%	37.4%
Developmental screening in the first 36 months of life	60.1%	58.0%	63.7%	-	55.1%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	11.5%	-	11.4%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	40.3%	36.5%	50.0%	36.3%
Electronic health record (EHR) adoption	31.6%	64.9%	73.0%	-	72.8%	72.0%	76.5%
Follow-up after hospitalization for mental illness	66.7%	75.0%	75.0%	75.0%	60.0%	70.0%	75.3%
Assessments for children in DHS custody	67.7%	100.0%	60.8%	17.4%	47.6%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	56.0%	65.0%	70.6%	-	78.5%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	68.3%	70.2%	95.3%	-	87.0%	90.0%	84.7%
Satisfaction with care (CAHPS)	75.0%	81.6%	82.1%	82.6%	89.1%	89.6%	85.4%

Columbia Pacific CCO

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	83.0%	87.0%	83.4%	82.8%	84.2%	87.2%	83.8%
Adolescent well care visits	22.3%	21.3%	26.4%	-	31.5%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	2.8%	10.9%	9.3%	7.5%	12.0%	12.7%
Ambulatory care - Emergency department utilization	58.2	50.9	47.5	-	44.1	39.4 (lower is better)	43.1
Colorectal cancer screening	7.1	9.2	31.6%	-	46.6%	47.0%	46.6%
Controlling hypertension	-	-	63.1%	-	64.2%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	6.6%	16.1%	20.0%	18.5%
Depression screening and follow-up plan	-	-	45.0%	-	52.9%	25.0%	37.4%
Developmental screening in the first 36 months of life	22.2%	33.1%	41.0%	-	50.4%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	32.5%	-	33.5%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	34.4%	31.9%	50.0%	36.3%
Electronic health record (EHR) adoption	35.3%	65.6%	57.4%	-	81.7%	72.0%	76.5%
Follow-up after hospitalization for mental illness	57.1%	68.0%	69.6%	78.8%	75.3%	70.0%	75.3%
Assessments for children in DHS custody	44.9%	57.1%	63.0%	36.6%	55.2%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	47.3%	76.1%	85.4%	-	83.9%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	67.7%	64.8%	68.1%	-	72.3%	90.0%	84.7%
Satisfaction with care (CAHPS)	78.0%	86.6%	86.7%	86.2%	83.1%	89.6%	85.4%

Eastern Oregon CCO

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	84.0%	84.2%	84.8%	84.1%	82.3%	87.2%	83.8%
Adolescent well care visits	23.7%	22.3%	23.9%	-	25.5%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.2%	0.8%	5.5%	4.9%	8.8%	12.0%	12.7%
Ambulatory care - Emergency department utilization	65.7	59.2	54.0	-	53.1	39.4 (lower is better)	43.1
Colorectal cancer screening	4.5	9.0	35.3%	-	36.0%	47.0%	46.6%
Controlling hypertension	-	-	52.2%	-	59.1%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	4.9%	14.4%	20.0%	18.5%
Depression screening and follow-up plan	-	-	17.4%	-	33.0%	25.0%	37.4%
Developmental screening in the first 36 months of life	6.7%	30.0%	35.9%	-	44.7%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	21.6%	-	26.4%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	32.6%	39.7%	50.0%	36.3%
Electronic health record (EHR) adoption	12.0%	46.0%	60.0%	-	70.4%	72.0%	76.5%
Follow-up after hospitalization for mental illness	67.9%	55.3%	60.0%	63.6%	70.9%	70.0%	75.3%
Assessments for children in DHS custody	54.5%	100.0%	68.8%	32.4%	61.5%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	3.7%	63.3%	61.0%	-	73.5%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	68.3%	78.3%	96.9%	-	91.4%	90.0%	84.7%
Satisfaction with care (CAHPS)	71.0%	83.7%	83.3%	82.0%	87.4%	89.6%	85.4%

FamilyCare

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	81.0%	81.2%	84.9%	84.0%	84.3%	87.2%	83.8%
Adolescent well care visits	30.0%	43.4%	45.6%	-	43.9%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	2.0%	8.8%	7.7%	14.3%	12.0%	12.7%
Ambulatory care - Emergency department utilization	57.4	50.2	43.8	-	36.9	39.4 (lower is better)	43.1
Colorectal cancer screening	10.5	13.5	47.4%	-	48.8%	47.0%	46.6%
Controlling hypertension	-	-	64.9%	-	66.0%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	12.4%	18.3%	20.0%	18.5%
Depression screening and follow-up plan	-	-	58.7%	-	32.3%	25.0%	37.4%
Developmental screening in the first 36 months of life	39.5%	50.7%	53.6%	-	59.5%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	31.1%	-	27.6%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	31.4%	32.7%	50.0%	36.3%
Electronic health record (EHR) adoption	31.7%	69.8%	72.9%	-	88.4%	72.0%	76.5%
Follow-up after hospitalization for mental illness	57.6%	64.1%	58.1%	63.1%	71.7%	70.0%	75.3%
Assessments for children in DHS custody	53.4%	70.0%	67.5%	22.1%	62.5%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	16.0%	74.1%	80.1%	-	87.5%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	63.9%	69.8%	72.4%	-	79.0%	90.0%	84.7%
Satisfaction with care (CAHPS)	82.0%	83.8%	83.9%	83.2%	85.4%	89.6%	85.4%

Health Share of Oregon

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	83.0%	80.2%	85.6%	85.4%	82.4%	87.2%	83.8%
Adolescent well care visits	31.2%	33.5%	37.8%	-	45.1%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	1.0%	5.6%	4.9%	10.2%	12.0%	12.7%
Ambulatory care - Emergency department utilization	64.6	52.8	49.3	-	44.3	39.4 (lower is better)	43.1
Colorectal cancer screening	12.5	14.0	53.3%	-	51.7%	47.0%	46.6%
Controlling hypertension	-	-	67.0%	-	68.7%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	15.3%	20.9%	20.0%	18.5%
Depression screening and follow-up plan	-	-	48.5%	-	53.0%	25.0%	37.4%
Developmental screening in the first 36 months of life	19.3%	33.9%	44.2%	-	57.3%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	23.0%	-	25.2%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	32.3%	35.0%	50.0%	36.3%
Electronic health record (EHR) adoption	32.3%	59.2%	64.8%	-	74.4%	72.0%	76.5%
Follow-up after hospitalization for mental illness	65.6%	69.1%	69.3%	74.9%	78.3%	70.0%	75.3%
Assessments for children in DHS custody	51.4%	60.9%	64.4%	29.9%	66.1%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	50.3%	81.2%	84.9%	-	91.2%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	67.5%	68.5%	83.9%	-	85.1%	90.0%	84.7%
Satisfaction with care (CAHPS)	80.0%	79.5%	85.6%	86.7%	84.5%	89.6%	85.4%

Intercommunity Health Network

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	82.0%	85.8%	85.9%	85.1%	85.5%	87.2%	83.8%
Adolescent well care visits	23.7%	22.0%	24.1%	-	30.1%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	0.0%	2.8%	2.4%	13.7%	12.0%	12.7%
Ambulatory care - Emergency department utilization	58.2	48.0	48.6	-	48.2	39.4 (lower is better)	43.1
Colorectal cancer screening	10.2	9.5	51.8%	-	49.1%	47.0%	46.6%
Controlling hypertension	-	-	61.4%	-	61.2%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	9.9%	16.8%	20.0%	18.5%
Depression screening and follow-up plan	-	-	3.3%	-	38.6%	25.0%	37.4%
Developmental screening in the first 36 months of life	12.1%	24.9%	26.9%	-	36.2%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	18.9%	-	25.9%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	33.3%	35.8%	50.0%	36.3%
Electronic health record (EHR) adoption	34.3%	59.5%	72.7%	-	80.7%	72.0%	76.5%
Follow-up after hospitalization for mental illness	69.7%	62.9%	61.5%	67.9%	74.6%	70.0%	75.3%
Assessments for children in DHS custody	60.3%	23.1%	63.6%	25.7%	54.4%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	86.1%	87.6%	89.2%	-	94.0%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	62.1%	66.8%	76.0%	-	84.5%	90.0%	84.7%
Satisfaction with care (CAHPS)	76.0%	87.2%	84.3%	83.8%	87.7%	89.6%	85.4%

Jackson Care Connect

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	83.0%	87.5%	85.2%	84.4%	87.7%	87.2%	83.8%
Adolescent well care visits	24.9%	22.6%	27.7%	-	31.2%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	0.1%	4.4%	3.6%	9.4%	12.0%	12.7%
Ambulatory care - Emergency department utilization	58.1	49.2	48.0	-	44.6	39.4 (lower is better)	43.1
Colorectal cancer screening	9.7	8.9	47.0%	-	47.8%	47.0%	46.6%
Controlling hypertension	-	-	68.2%	-	71.3%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	11.7%	23.8%	20.0%	18.5%
Depression screening and follow-up plan	-	-	20.3%	-	42.2%	25.0%	37.4%
Developmental screening in the first 36 months of life	2.0%	23.5%	37.1%	-	48.1%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	32.9%	-	33.9%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	35.7%	37.2%	50.0%	36.3%
Electronic health record (EHR) adoption	16.1%	60.5%	67.7%	-	71.5%	72.0%	76.5%
Follow-up after hospitalization for mental illness	68.1%	63.4%	57.7%	65.0%	86.1%	70.0%	75.3%
Assessments for children in DHS custody	39.2%	44.4%	72.6%	24.7%	67.3%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	45.2%	41.8%	77.0%	-	76.7%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	71.2%	67.5%	80.3%	-	84.1%	90.0%	84.7%
Satisfaction with care (CAHPS)	78.0%	84.7%	87.2%	86.4%	86.7%	89.6%	85.4%

PacificSource—Central Oregon

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	81.0%	80.6%	79.3%	78.1%	78.1%	87.2%	83.8%
Adolescent well care visits	26.3%	29.3%	27.1%	-	31.6%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	3.0%	5.8%	5.1%	8.1%	12.0%	12.7%
Ambulatory care - Emergency department utilization	61.6	49.9	41.9	-	32.6	39.4 (lower is better)	43.1
Colorectal cancer screening	10.3	10.3	53.5%	-	49.0%	47.0%	46.6%
Controlling hypertension	-	-	64.0%	-	61.9%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	4.7%	11.3%	20.0%	18.5%
Depression screening and follow-up plan	-	-	28.0%	-	36.6%	25.0%	37.4%
Developmental screening in the first 36 months of life	21.0%	30.8%	52.1%	-	54.0%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	14.7%	-	18.4%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	35.0%	41.7%	50.0%	36.3%
Electronic health record (EHR) adoption	25.8%	57.8%	74.7%	-	83.4%	72.0%	76.5%
Follow-up after hospitalization for mental illness	67.9%	65.8%	73.2%	79.9%	81.2%	70.0%	75.3%
Assessments for children in DHS custody	47.9%	50.0%	82.4%	17.6%	59.0%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	73.9%	91.0%	92.6%	-	92.4%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	74.0%	75.9%	86.0%	-	89.6%	90.0%	84.7%
Satisfaction with care (CAHPS)	81.0%	83.5%	83.1%	83.3%	86.6%	89.6%	85.4%

PacificSource—Gorge

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	81.0%	80.6%	79.8%	79.1%	83.1%	87.2%	83.8%
Adolescent well care visits	26.3%	29.3%	32.2%	-	36.9%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	3.0%	19.8%	15.4%	16.1%	12.0%	12.7%
Ambulatory care - Emergency department utilization	61.6	49.9	42.0	-	38.2	39.4 (lower is better)	43.1
Colorectal cancer screening	10.3	10.3	46.7%	-	47.3%	47.0%	46.6%
Controlling hypertension	-	-	66.5%	-	67.2%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	5.6%	12.6%	20.0%	18.5%
Depression screening and follow-up plan	-	-	38.8%	-	53.2%	25.0%	37.4%
Developmental screening in the first 36 months of life	21.0%	30.8%	41.8%	-	58.0%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	18.0%	-	27.6%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	34.6%	40.3%	50.0%	36.3%
Electronic health record (EHR) adoption	25.8%	57.8%	84.7%	-	88.4%	72.0%	76.5%
Follow-up after hospitalization for mental illness	67.9%	65.8%	100.0%	100.0%	90.0%	70.0%	75.3%
Assessments for children in DHS custody	47.9%	50.0%	71.1%	31.8%	76.7%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	73.9%	91.0%	96.4%	-	93.7%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	74.0%	75.9%	90.1%	-	92.3%	90.0%	84.7%
Satisfaction with care (CAHPS)	81.0%	83.5%	83.9%	83.1%	88.4%	89.6%	85.4%

Primary Health of Josephine County

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	83.0%	88.0%	90.0%	89.2%	87.2%	87.2%	83.8%
Adolescent well care visits	23.4%	25.5%	29.1%	-	45.4%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	1.3%	8.5%	7.3%	16.8%	12.0%	12.7%
Ambulatory care - Emergency department utilization	57.2	40.5	38.0	-	29.2	39.4 (lower is better)	43.1
Colorectal cancer screening	8.7	7.5	40.5%	-	44.3%	47.0%	46.6%
Controlling hypertension	-	-	72.5%	-	59.1%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	14.1%	24.3%	20.0%	18.5%
Depression screening and follow-up plan	-	-	31.9%	-	46.8%	25.0%	37.4%
Developmental screening in the first 36 months of life	67.1%	62.7%	72.2%	-	84.1%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	26.4%	-	27.4%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	32.8%	37.5%	50.0%	36.3%
Electronic health record (EHR) adoption	27.6%	72.5%	100.0%	-	100.0%	72.0%	76.5%
Follow-up after hospitalization for mental illness	57.1%	66.7%	77.8%	80.0%	87.5%	70.0%	75.3%
Assessments for children in DHS custody	35.7%	75.0%	86.7%	33.3%	52.6%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	94.4%	95.6%	99.0%	-	99.9%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	65.1%	71.9%	94.3%	-	83.0%	90.0%	84.7%
Satisfaction with care (CAHPS)	81.0%	88.2%	89.2%	88.8%	88.2%	89.6%	85.4%

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	90.0%	84.7%	82.2%	81.2%	83.2%	87.2%	83.8%
Adolescent well care visits	23.8%	26.8%	28.7%	-	37.8%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	0.2%	7.8%	6.5%	12.2%	12.0%	12.7%
Ambulatory care - Emergency department utilization	55.5	51.3	50.6	-	50.1	39.4 (lower is better)	43.1
Colorectal cancer screening	8.8	8.6	50.1%	-	43.4%	47.0%	46.6%
Controlling hypertension	-	-	57.1%	-	66.3%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	10.8%	18.9%	20.0%	18.5%
Depression screening and follow-up plan	-	-	14.1%	-	23.5%	25.0%	37.4%
Developmental screening in the first 36 months of life	16.3%	28.3%	45.0%	-	67.2%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	26.3%	-	22.9%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	35.1%	38.6%	50.0%	36.3%
Electronic health record (EHR) adoption	16.4%	48.6%	67.5%	-	72.6%	72.0%	76.5%
Follow-up after hospitalization for mental illness	70.7%	69.9%	77.0%	75.7%	64.7%	70.0%	75.3%
Assessments for children in DHS custody	47.1%	92.9%	73.4%	28.3%	60.1%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	80.2%	85.3%	60.7%	-	82.4%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	59.1%	56.0%	79.7%	-	87.7%	90.0%	84.7%
Satisfaction with care (CAHPS)	80.0%	84.2%	86.2%	86.3%	83.8%	89.6%	85.4%

Umpqua Health Alliance

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	81.0%	82.4%	82.7%	82.1%	83.6%	87.2%	83.8%
Adolescent well care visits	21.2%	28.6%	30.8%	-	39.9%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	3.0%	9.3%	8.2%	17.5%	12.0%	12.7%
Ambulatory care - Emergency department utilization	86.4	74.6	64.7	-	57.6	39.4 (lower is better)	43.1
Colorectal cancer screening	11.7	10.3	51.7%	-	52.7%	47.0%	46.6%
Controlling hypertension	-	-	61.4%	-	62.4%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	4.7%	17.3%	20.0%	18.5%
Depression screening and follow-up plan	-	-	58.7%	-	59.0%	25.0%	37.4%
Developmental screening in the first 36 months of life	1.2%	27.2%	35.0%	-	63.2%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	26.3%	-	27.1%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	37.8%	45.4%	50.0%	36.3%
Electronic health record (EHR) adoption	35.2%	77.2%	84.1%	-	83.9%	72.0%	76.5%
Follow-up after hospitalization for mental illness	63.6%	68.0%	68.4%	76.3%	70.8%	70.0%	75.3%
Assessments for children in DHS custody	47.2%	75.0%	65.3%	11.8%	50.0%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	18.0%	73.5%	89.2%	-	92.2%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	65.5%	66.3%	87.6%	-	86.7%	90.0%	84.7%
Satisfaction with care (CAHPS)	83.0%	81.9%	83.1%	82.7%	84.1%	89.6%	85.4%

Western Oregon Advanced Health

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	82.0%	88.3%	85.0%	83.9%	82.2%	87.2%	83.8%
Adolescent well care visits	31.9%	35.8%	34.3%	-	44.2%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.2%	2.3%	6.5%	5.7%	15.9%	12.0%	12.7%
Ambulatory care - Emergency department utilization	59.7	49.7	44.2	-	34.7	39.4 (lower is better)	43.1
Colorectal cancer screening	10.7	7.2	52.1%	-	47.7%	47.0%	46.6%
Controlling hypertension	-	-	67.0%	-	64.9%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	5.2%	17.8%	20.0%	18.5%
Depression screening and follow-up plan	-	-	4.8%	-	17.2%	25.0%	37.4%
Developmental screening in the first 36 months of life	21.2%	57.1%	53.5%	-	61.8%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	28.4%	-	29.2%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	32.1%	36.6%	50.0%	36.3%
Electronic health record (EHR) adoption	17.9%	63.8%	83.8%	-	91.1%	72.0%	76.5%
Follow-up after hospitalization for mental illness	58.1%	68.3%	67.5%	74.1%	73.5%	70.0%	75.3%
Assessments for children in DHS custody	65.1%	100.0%	100.0%	49.3%	49.6%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	45.7%	67.6%	82.2%	-	88.2%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	47.7%	57.4%	96.9%	-	83.6%	90.0%	84.7%
Satisfaction with care (CAHPS)	77.0%	80.3%	83.9%	83.1%	87.3%	89.6%	85.4%

Willamette Valley Community Health

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	81.0%	83.1%	84.5%	84.3%	82.0%	87.2%	83.8%
Adolescent well care visits	25.9%	24.8%	28.7%	-	31.0%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	8.7%	15.2%	13.5%	23.7%	12.0%	12.7%
Ambulatory care - Emergency department utilization	55.4	41.3	42.2	-	39.7	39.4 (lower is better)	43.1
Colorectal cancer screening	10.7	14.0	48.4%	-	49.9%	47.0%	46.6%
Controlling hypertension	-	-	67.0%	-	66.8%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	12.5%	18.8%	20.0%	18.5%
Depression screening and follow-up plan	-	-	9.6%	-	27.9%	25.0%	37.4%
Developmental screening in the first 36 months of life	19.4%	23.9%	34.4%	-	48.0%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	17.7%	-	33.8%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	32.1%	36.0%	50.0%	36.3%
Electronic health record (EHR) adoption	25.6%	68.4%	81.9%	-	91.6%	72.0%	76.5%
Follow-up after hospitalization for mental illness	63.2%	73.0%	66.2%	67.6%	66.9%	70.0%	75.3%
Assessments for children in DHS custody	65.4%	72.2%	74.8%	28.0%	66.9%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	67.0%	90.1%	91.2%	-	93.9%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	57.1%	58.8%	78.1%	-	81.3%	90.0%	84.7%
Satisfaction with care (CAHPS)	70.0%	83.5%	86.9%	86.9%	80.2%	89.6%	85.4%

Yamhill CCO

■ CCO achieved **BENCHMARK**

■ CCO achieved **IMPROVEMENT TARGET**

	2011 baseline	2013	2014	2014 revised	2015	2015 Benchmark	2015 Statewide
Access to care (CAHPS)	83.0%	81.6%	84.4%	83.0%	83.9%	87.2%	83.8%
Adolescent well care visits	24.8%	28.9%	31.6%	-	46.2%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	1.7%	5.0%	4.1%	14.1%	12.0%	12.7%
Ambulatory care - Emergency department utilization	77.7	58.9	61.1	-	61.8	39.4 (lower is better)	43.1
Colorectal cancer screening	6.1	15.7	46.7%	-	49.4%	47.0%	46.6%
Controlling hypertension	-	-	61.3%	-	65.4%	64.0%	64.7%
Dental sealants on permanent molars for children	-	-	-	6.0%	19.5%	20.0%	18.5%
Depression screening and follow-up plan	-	-	68.1%	-	62.8%	25.0%	37.4%
Developmental screening in the first 36 months of life	9.4%	16.8%	23.9%	-	51.1%	50.0%	54.7%
Diabetes care: HbA1c poor control	-	-	23.7%	-	22.6%	34.0% (lower is better)	26.7%
Effective contraceptive use (ages 18-50)	-	-	-	35.0%	38.7%	50.0%	36.3%
Electronic health record (EHR) adoption	28.1%	53.9%	68.2%	-	76.9%	72.0%	76.5%
Follow-up after hospitalization for mental illness	70.6%	81.0%	74.3%	77.1%	77.8%	70.0%	75.3%
Assessments for children in DHS custody	52.3%	80.0%	33.3%	33.3%	41.7%	90.0%	58.4%
Patient-centered primary care home (PCPCH) enrollment	38.7%	75.5%	67.3%	-	74.7%	60.0%	87.5%
Prenatal and postpartum care: Timeliness of prenatal care	66.5%	70.3%	73.6%	-	79.5%	90.0%	84.7%
Satisfaction with care (CAHPS)	78.0%	81.0%	82.6%	82.8%	84.7%	89.6%	85.4%

African American / Black

	2011 baseline	2013	2014	2014 revised	2015	2015 CCO Benchmark	2015 Statewide
Access to care (CAHPS) - Adults	82.0%	76.5%	74.0%	n/a	80.5%	87.2%	83.8%
Access to care (CAHPS) - Children	83.0%	88.2%	87.7%	n/a	89.6%	87.2%	88.7%
Adolescent well care visits	33.2%	36.6%	37.8%	n/a	43.4%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	1.7%	7.2%	6.2%	11.2%	12.0%	12.7%
Ambulatory care - Emergency department utilization	80.2	68.5	66.6	-	61.1	39.4 (lower is better)	43.1
Dental sealants on permanent molars for children	-	-	-	12.8%	19.0%	20.0%	18.5%
Developmental screening in the first 36 months of life	22.6%	35.2%	41.9%	-	54.8%	50.0%	54.7%
Effective contraceptive use (ages 18-50)	-	-	-	35.7%	37.2%	50.0%	36.3%
Follow-up after hospitalization for mental illness	51.9%	52.2%	57.4%	61.4%	76.5%	70.0%	75.3%
Assessments for children in DHS custody	43.2%	~	62.3%	28.2%	57.9%	90.0%	58.4%
Satisfaction with care (CAHPS) - Adult	73.0%	73.5%	87.0%	-	85.1%	89.6%	84.8%
Satisfaction with care (CAHPS) - Child	75.0%	69.6%	85.7%	-	94.4%	89.6%	85.4%

(Not all CCO incentive measures are available by race/ethnicity)

~ Results suppressed (N<30)

American Indian / Alaska Native

	2011 baseline	2013	2014	2014 revised	2015	2015 CCO Benchmark	2015 Statewide
Access to care (CAHPS) - Adults	81.0%	81.3%	87.5%	n/a	82.3%	87.2%	83.8%
Access to care (CAHPS) - Children	81.0%	88.3%	90.5%	n/a	89.0%	87.2%	88.7%
Adolescent well care visits	24.5%	27.2%	31.3%	n/a	36.5%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	2.2%	5.9%	6.0%	12.2%	12.0%	12.7%
Ambulatory care - Emergency department utilization	74.0	62.0	63.7	-	58.8	39.4 (lower is better)	43.1
Dental sealants on permanent molars for children	-	-	-	8.6%	14.2%	20.0%	18.5%
Developmental screening in the first 36 months of life	17.1%	36.0%	37.4%	-	48.6%	50.0%	54.7%
Effective contraceptive use (ages 18-50)	-	-	-	32.9%	37.3%	50.0%	36.3%
Follow-up after hospitalization for mental illness	72.3%	~	~	~	72.7%	70.0%	75.3%
Assessments for children in DHS custody	46.8%	~	69.2%	20.3%	54.5%	90.0%	58.4%
Satisfaction with care (CAHPS) - Adult	72.0%	89.5%	81.3%	-	83.6%	89.6%	84.8%
Satisfaction with care (CAHPS) - Child	72.0%	89.6%	68.8%	-	91.5%	89.6%	85.4%

(Not all CCO incentive measures are available by race/ethnicity)

~ Results suppressed (N<30)

Asian American

	2011 baseline	2013	2014	2014 revised	2015	2015 CCO Benchmark	2015 Statewide
Access to care (CAHPS) - Adults	70.0%	61.0%	72.5%	n/a	65.8%	87.2%	83.8%
Access to care (CAHPS) - Children	72.0%	69.8%	96.1%	n/a	81.9%	87.2%	88.7%
Adolescent well care visits	31.6%	34.8%	41.6%	n/a	45.6%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	0.6%	3.8%	3.9%	9.5%	12.0%	12.7%
Ambulatory care - Emergency department utilization	25.1	22.3	20.7	-	18.8	39.4 (lower is better)	43.1
Dental sealants on permanent molars for children	-	-	-	15.0%	21.0%	20.0%	18.5%
Developmental screening in the first 36 months of life	22.8%	31.2%	41.9%	-	51.9%	50.0%	54.7%
Effective contraceptive use (ages 18-50)	-	-	-	25.5%	29.0%	50.0%	36.3%
Follow-up after hospitalization for mental illness	65.2%	74.3%	~	67.4%	~	70.0%	75.3%
Assessments for children in DHS custody	~	~	~	~	~	90.0%	58.4%
Satisfaction with care (CAHPS) - Adult	73.0%	70.0%	74.1%	-	85.4%	89.6%	84.8%
Satisfaction with care (CAHPS) - Child	73.0%	80.8%	79.7%	-	84.7%	89.6%	85.4%

(Not all CCO incentive measures are available by race/ethnicity)

~ Results suppressed (N<30)

Hawaiian / Pacific Islander

	2011 baseline	2013	2014	2014 revised	2015	2015 CCO Benchmark	2015 Statewide
Access to care (CAHPS) - Adults	83.0%	78.2%	78.3%	n/a	80.3%	87.2%	83.8%
Access to care (CAHPS) - Children	82.0%	87.8%	88.8%	n/a	84.1%	87.2%	88.7%
Adolescent well care visits	24.5%	26.3%	32.9%	n/a	33.6%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	1.3%	5.6%	6.0%	13.3%	12.0%	12.7%
Ambulatory care - Emergency department utilization	52.7	41.1	37.9	-	37.8	39.4 (lower is better)	43.1
Dental sealants on permanent molars for children	-	-	-	9.4%	17.0%	20.0%	18.5%
Developmental screening in the first 36 months of life	26.6%	32.0%	37.1%	-	42.5%	50.0%	54.7%
Effective contraceptive use (ages 18-50)	-	-	-	31.1%	30.7%	50.0%	36.3%
Follow-up after hospitalization for mental illness	~	~	~	~	78.8%	70.0%	75.3%
Assessments for children in DHS custody	~	~	~	~	~	90.0%	58.4%
Satisfaction with care (CAHPS) - Adult	83.0%	85.0%	87.5%	-	83.6%	89.6%	84.8%
Satisfaction with care (CAHPS) - Child	83.0%	85.7%	94.5%	-	~	89.6%	85.4%

(Not all CCO incentive measures are available by race/ethnicity)

~ Results suppressed (N<30)

Hispanic / Latino

	2011 baseline	2013	2014	2014 revised	2015	2015 CCO Benchmark	2015 Statewide
Access to care (CAHPS) - Adults	81.0%	73.4%	79.0%	n/a	79.4%	87.2%	83.8%
Access to care (CAHPS) - Children	81.0%	84.0%	82.6%	n/a	84.5%	87.2%	88.7%
Adolescent well care visits	29.2%	31.9%	35.6%	n/a	40.9%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	1.9%	7.1%	6.1%	13.0%	12.0%	12.7%
Ambulatory care - Emergency department utilization	42.0	36.6	35.2	-	34.7	39.4 (lower is better)	43.1
Dental sealants on permanent molars for children	-	-	-	13.3%	21.2%	20.0%	18.5%
Developmental screening in the first 36 months of life	18.7%	28.7%	41.1%	-	56.0%	50.0%	54.7%
Effective contraceptive use (ages 18-50)	-	-	-	34.7%	37.2%	50.0%	36.3%
Follow-up after hospitalization for mental illness	63.3%	67.6%	66.3%	70.1%	69.7%	70.0%	75.3%
Assessments for children in DHS custody	56.4%	~	65.2%	32.1%	64.8%	90.0%	58.4%
Satisfaction with care (CAHPS) - Adult	76.0%	82.8%	81.9%	-	85.9%	89.6%	84.8%
Satisfaction with care (CAHPS) - Child	77.0%	85.4%	87.0%	-	85.1%	89.6%	85.4%

(Not all CCO incentive measures are available by race/ethnicity)

~ Results suppressed (N<30)

White

	2011 baseline	2013	2014	2014 revised	2015	2015 CCO Benchmark	2015 Statewide
Access to care (CAHPS) - Adults	84.0%	83.1%	81.3%	n/a	83.1%	87.2%	83.8%
Access to care (CAHPS) - Children	84.0%	92.7%	91.2%	n/a	92.2%	87.2%	88.7%
Adolescent well care visits	25.2%	27.2%	29.3%	n/a	35.3%	62.0%	37.5%
Alcohol and drug misuse screening (SBIRT)	0.0%	2.0%	7.3%	6.6%	12.8%	12.0%	12.7%
Ambulatory care - Emergency department utilization	67.4	54.9	53.3	-	48.6	39.4 (lower is better)	43.1
Dental sealants on permanent molars for children	-	-	-	9.8%	16.8%	20.0%	18.5%
Developmental screening in the first 36 months of life	22.0%	35.6%	43.7%	-	55.0%	50.0%	54.7%
Effective contraceptive use (ages 18-50)	-	-	-	33.9%	36.6%	50.0%	36.3%
Follow-up after hospitalization for mental illness	66.1%	68.9%	68.3%	72.1%	69.0%	70.0%	75.3%
Assessments for children in DHS custody	53.6%	63.1%	70.8%	27.5%	57.7%	90.0%	58.4%
Satisfaction with care (CAHPS) - Adult	76.0%	84.6%	83.9%	-	84.4%	89.6%	84.8%
Satisfaction with care (CAHPS) - Child	76.0%	80.8%	84.0%	-	88.0%	89.6%	85.4%

(Not all CCO incentive measures are available by race/ethnicity)

OREGON HEALTH PLAN POPULATION

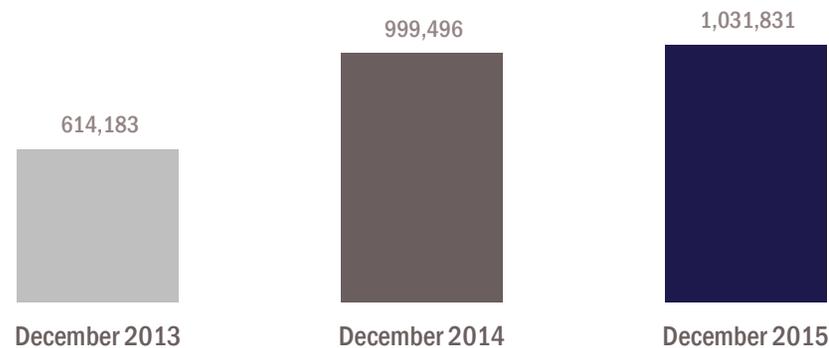
Medicaid demographics

With the Affordable Care Act (ACA) coverage expansion, an increasing number of Oregonians receive health insurance through the Oregon Health Plan (Medicaid). More than 385,313 Oregonians gained coverage in 2014. Enrollment has continued to increase since then, with an additional 32,335 members enrolled in 2015, for a total of 1,031,831 members by December 2015.

Despite this influx of new members, the racial and ethnic makeup of the Medicaid population has remained largely consistent. The age distribution has shifted: in 2013 and earlier, the majority of the population were children and adolescents; with the enrollment expansion in 2014, more adults were eligible for Medicaid and the proportion of members ages 19-64 increased, with the greatest increase being members ages 19-35.

This section of the report has been expanded this year to include racial/ethnic and age distribution at the CCO level, as well as enrollment stratified by members with disability.

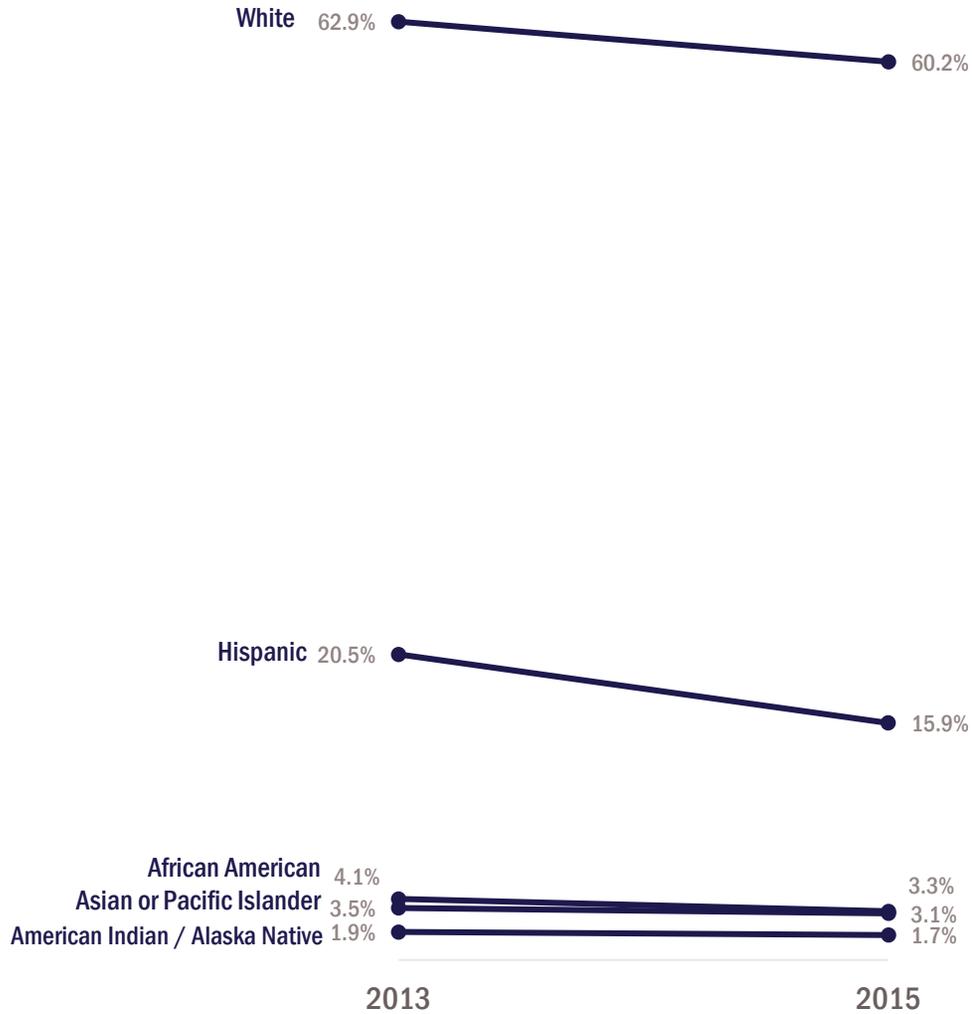
Total Medicaid enrollment has increased 68 percent since 2013.



OREGON HEALTH PLAN POPULATION

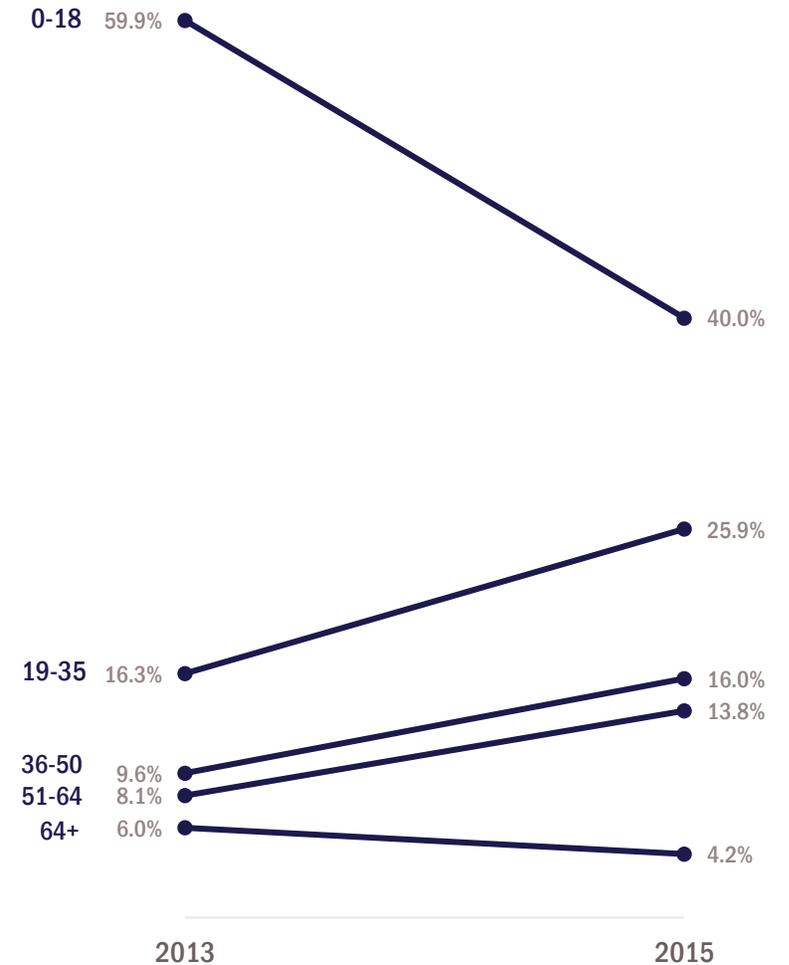
Racial and ethnic distribution of Oregon's Medicaid population between 2013 and 2015.

Data missing for 8% of respondents in 2013 and 10% of respondents in 2015

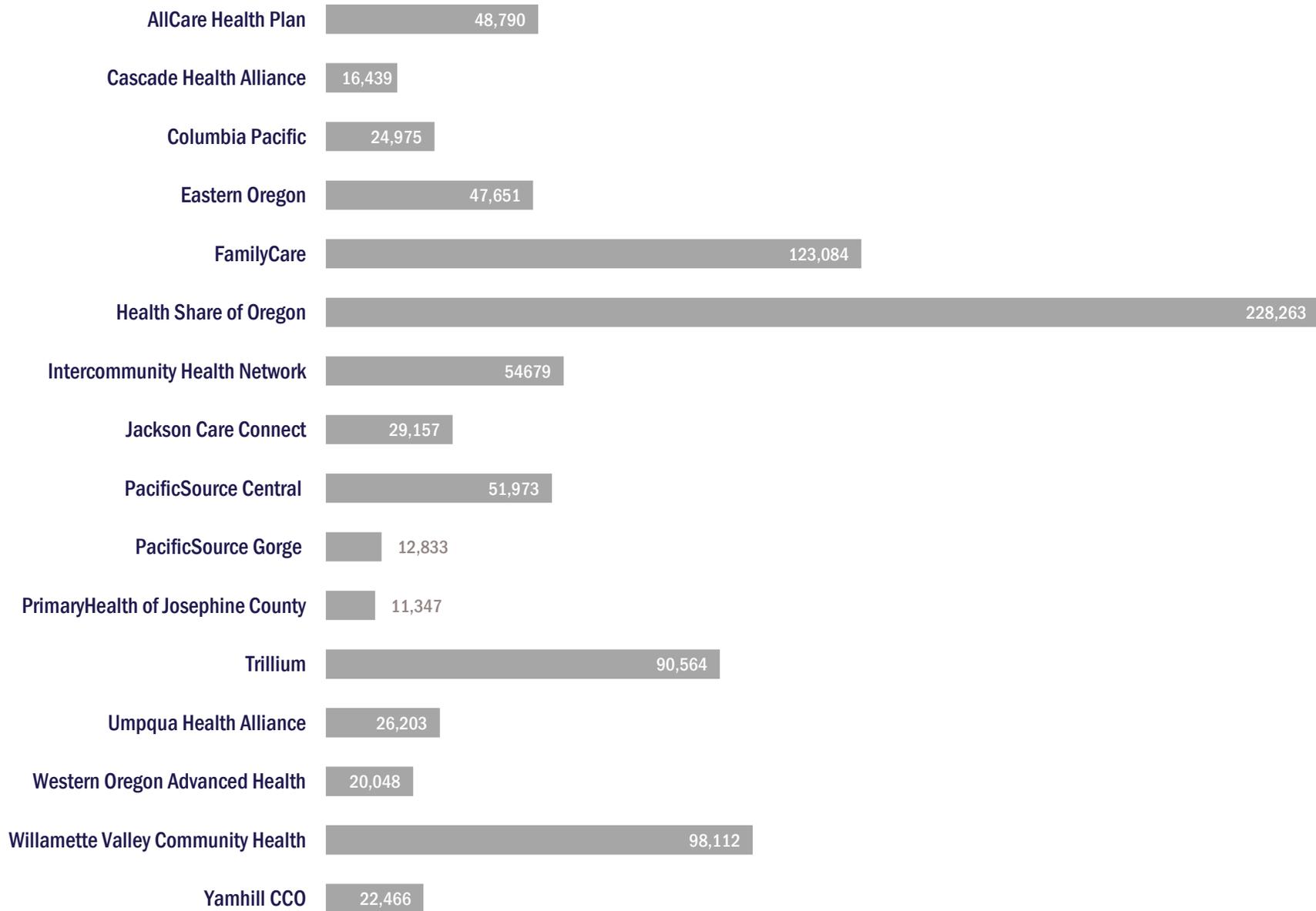


Age distribution of Oregon's Medicaid population between 2013 and 2015.

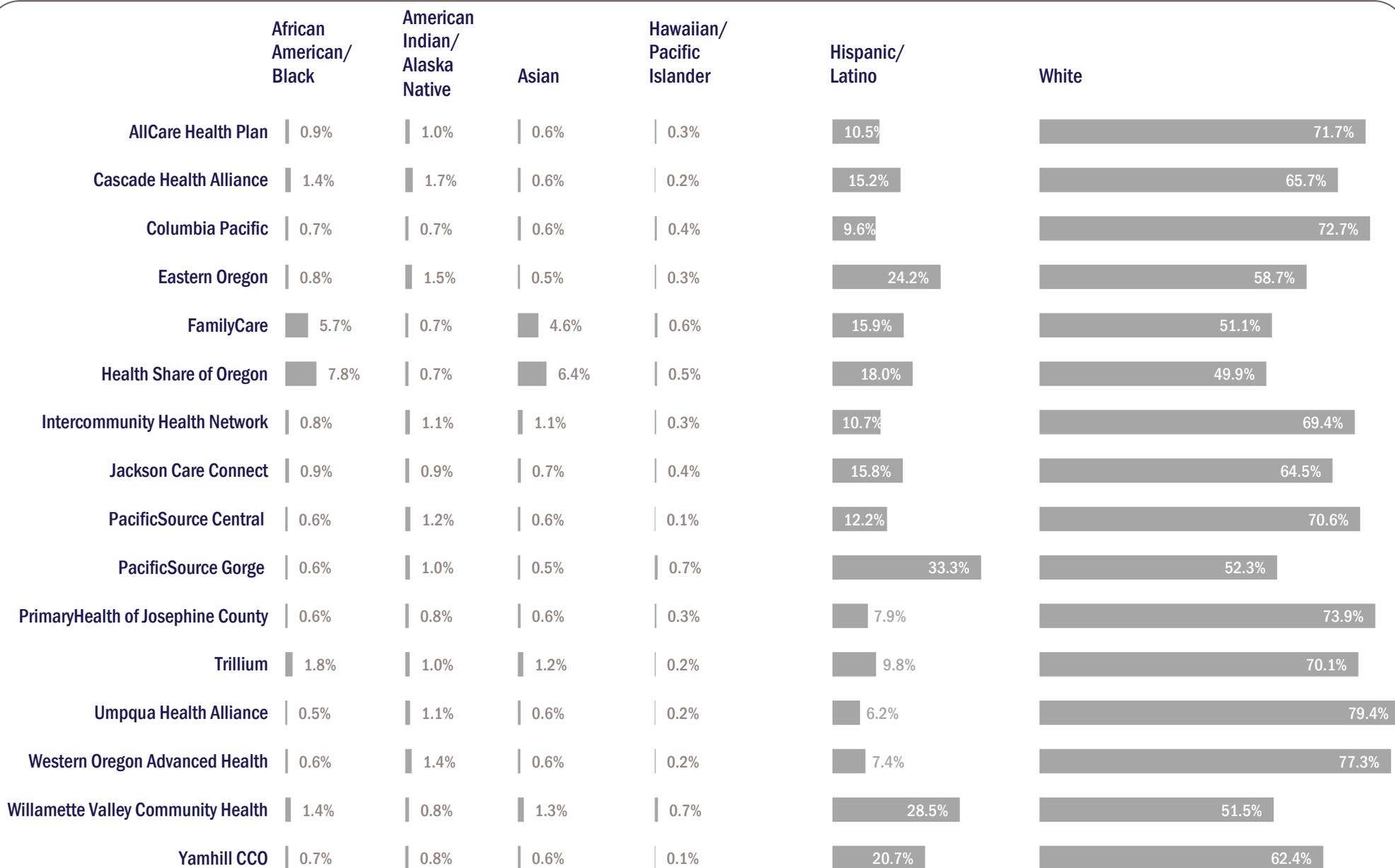
Children make up a smaller share of Medicaid members in 2015.



TOTAL CCO ENROLLMENT (DECEMBER 2015)

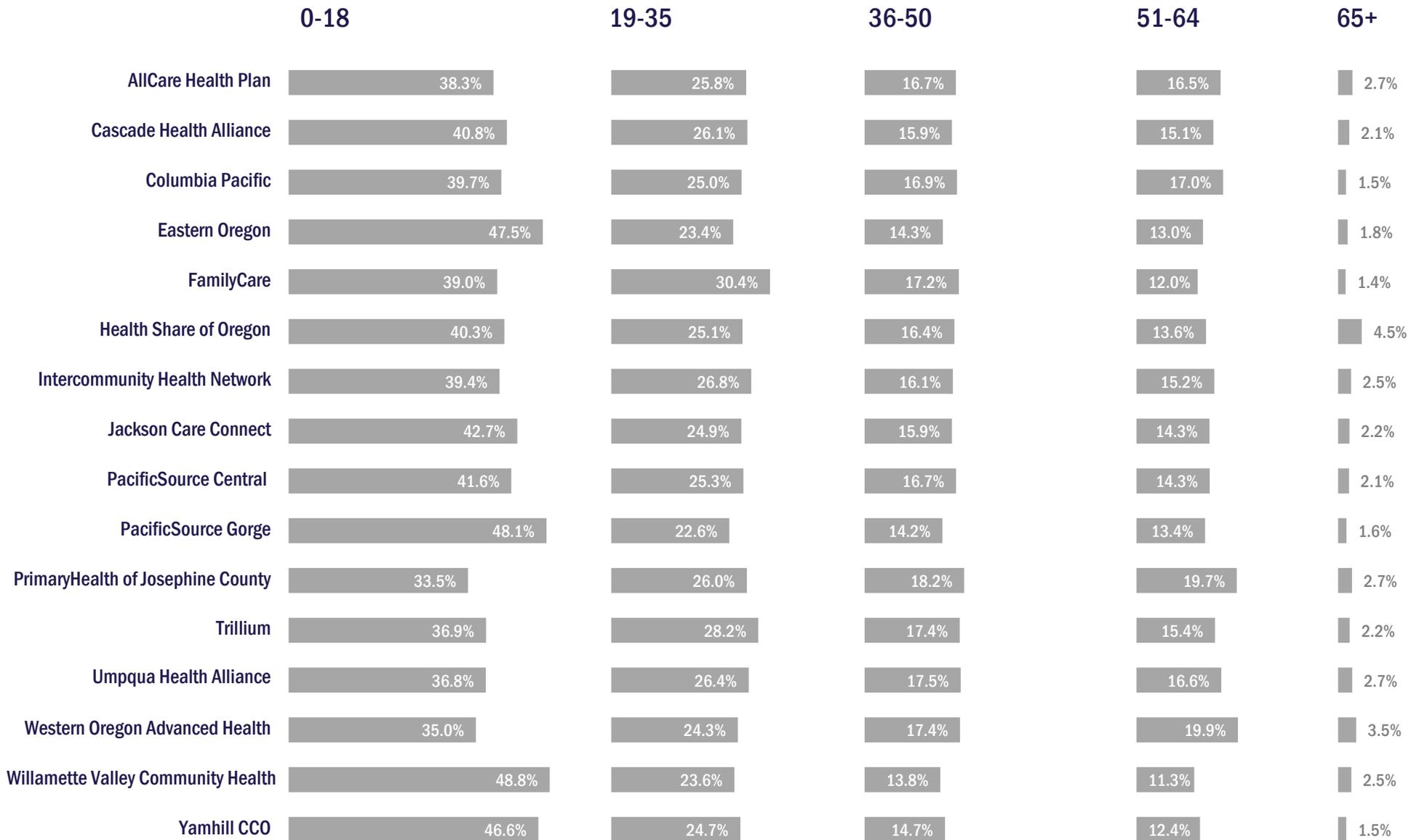


RACE AND ETHNICITY DISTRIBUTION BY CCO (DECEMBER 2015)



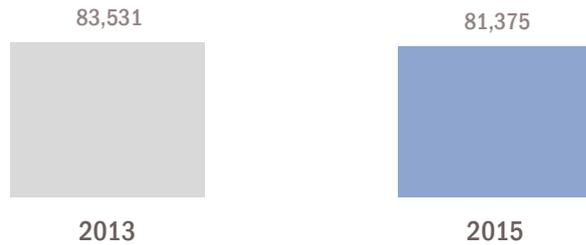
Values do not add to 100% because race and ethnicity data are missing for some members.

AGE DISTRIBUTION BY CCO (DECEMBER 2015)

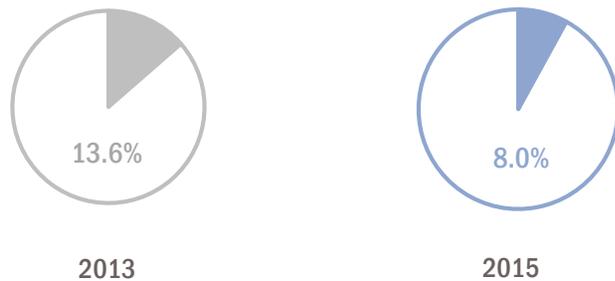


OREGON HEALTH PLAN POPULATION WITH DISABILITY

Although the total number of members with disability has remained fairly steady since 2013....



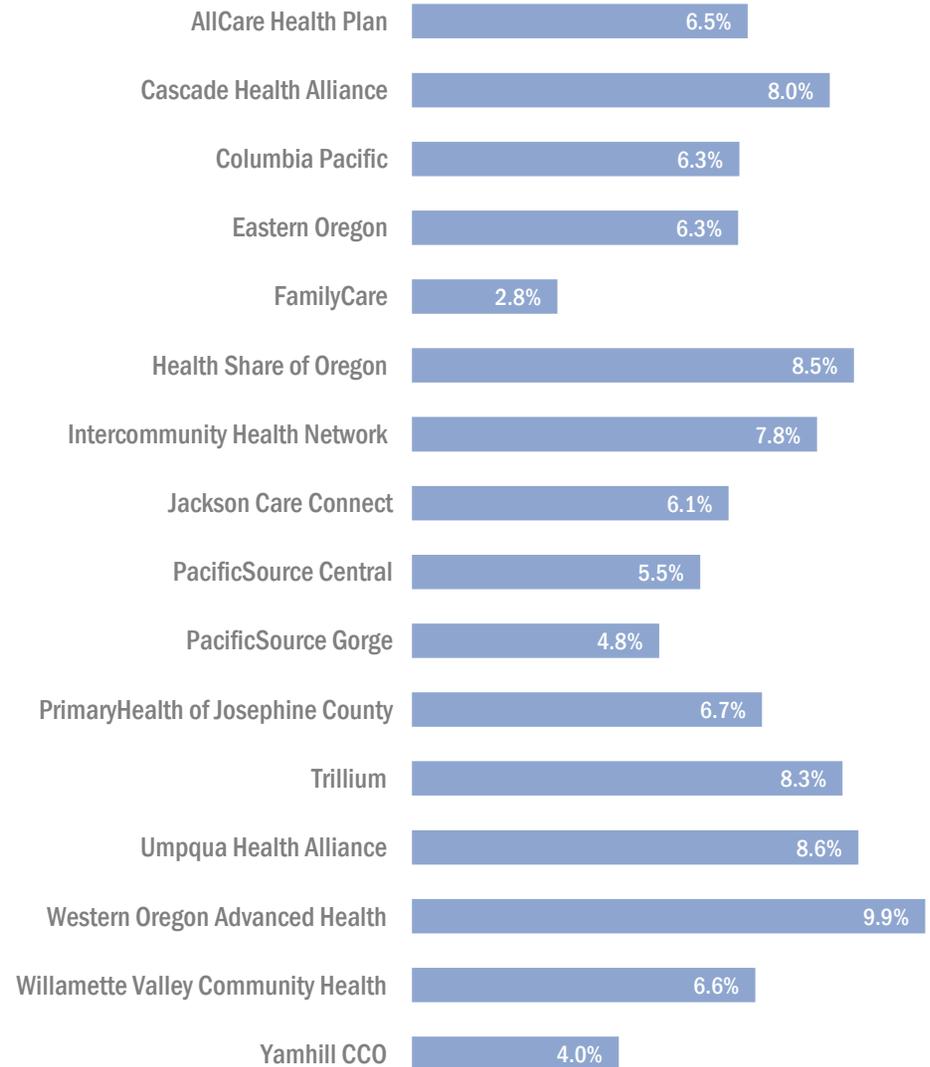
...members with disability now make up a smaller share of total enrollment.



With disability means people who qualify for Medicaid based on an impairment that has prevented them from performing substantial gainful activity for at least one year, or is expected to prevent them from performing substantial gainful activity for at least one year. This may include physical, mental, emotional, learning, developmental or other disabilities. These individuals may or may not also be qualified for Medicare. Eligibility codes include: 3, 4, B3, and D4.

See pages [158-163](#) for a subset of incentive metrics stratified by members with disability.

Percent of members with disability in December 2015, by CCO.



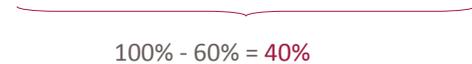
ABOUT BENCHMARKS AND IMPROVEMENT TARGETS

Incentive measure benchmarks are selected by the Metrics and Scoring Committee and are meant to be aspirational goals. CCOs are not expected to meet the benchmark each year but rather to *make improvement toward* the benchmark. To demonstrate this, CCOs can earn quality pool payment for a) achieving the benchmark or b) achieving their individual *improvement target*. Improvement targets require at least a 10 percent reduction in the gap between the CCO's prior year's performance ("baseline") and the benchmark to qualify for incentive payments.

Suppose CCO A's performance in **2014** (i.e. baseline) on Measure 1 was 60.0%



The gap between CCO A's baseline and the benchmark is 40%



Ten percent of that gap is 4%



**CCO A must improve by 4 percentage points in 2015 to meet their improvement target.
(60% + 4% = improvement target)**

CCO A's performance in **2015** is 65%. They achieved their improvement target.

Even though CCO A did not meet the aspirational benchmark, they are considered to have "achieved the measure" and will earn incentive payment.



Note that in some cases, the Metrics and Scoring Committee will establish an "improvement target floor," meaning that an improvement target cannot be less than X% above baseline. In the example above, if the floor was 6 percentage points, CCO A would need to earn at least [baseline + 6% =] 66% in 2015 to earn incentive payment.

HOW TO READ THESE GRAPHS

Icons

To help readers identify which metrics belong in which measure set, each metric is accompanied by up to three icons that denote the measure set:

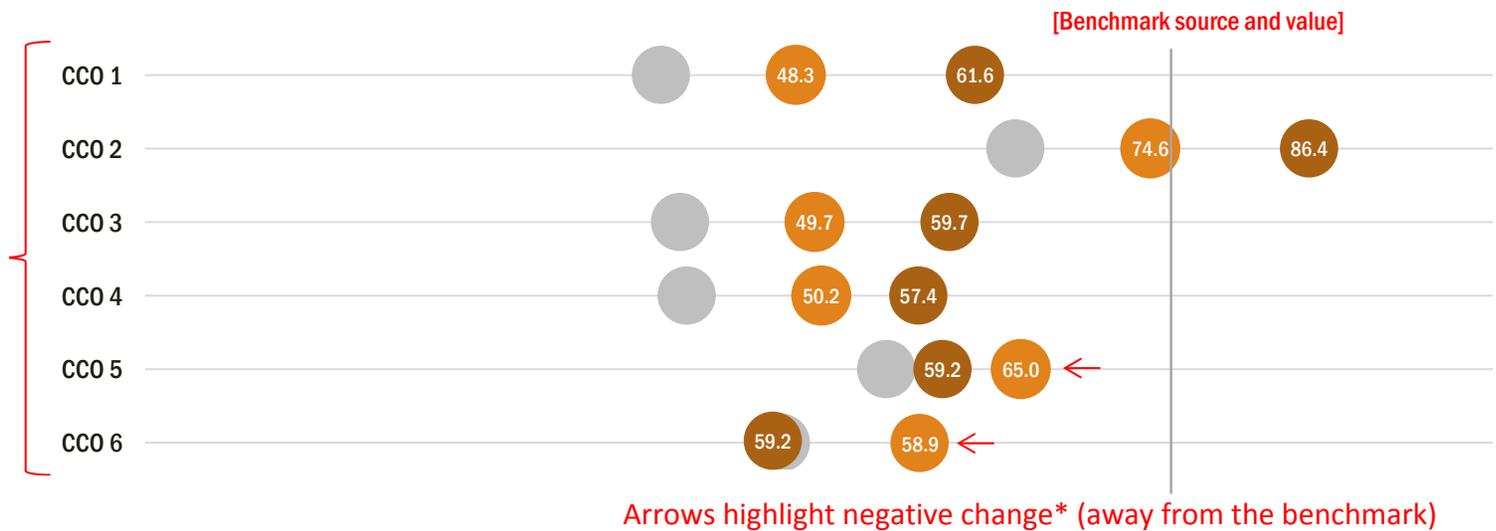
 This icon indicates the measure is one of the 17 CCO incentive metrics. CCOs receive quality pool funding based on their 2015 performance on these measures.

 This icon indicates the measure is one of the 33 state performance metrics (also known as quality and access metrics). OHA is accountable to the Centers for Medicare and Medicaid Services (CMS) for statewide performance on these metrics.

 This icon indicates the measure is one of the core performance metrics. There are no financial incentives or penalties for performance on these measures.

[Descriptive title] between 2014 & 2015.

Categories are sorted by amount of change between 2014 and 2015. That is, the CCOs or racial/ethnic groups with the **most improvement*** in 2015 are listed first.



* Please note that changes between years have not been tested for statistical significance.



ACCESS TO CARE (CAHPS SURVEY)

Access to care (CAHPS survey)

Percentage of members (adults and children) who received appointments and care when they needed them.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2015 data

Statewide change since 2014: **+1%**

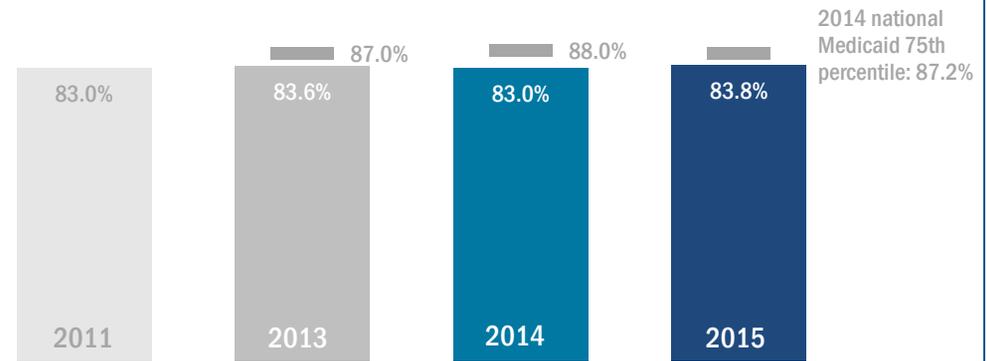
Number of CCOs that improved: **10**

Number of CCOs achieving benchmark or improvement target: **6**

[Back to table of contents.](#)

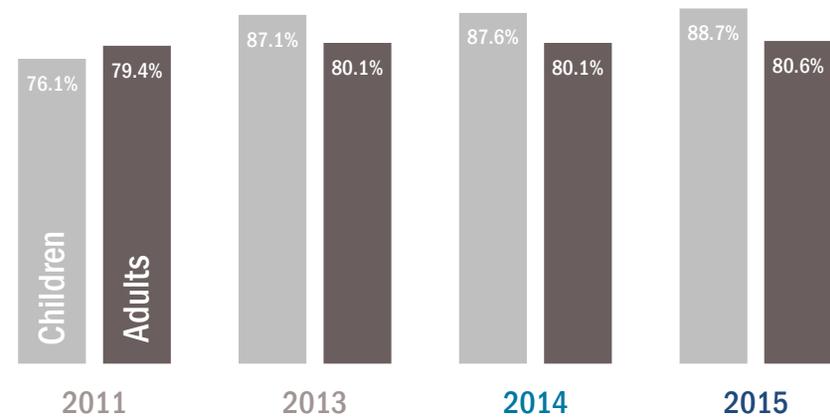
Statewide, access to care has increased slightly.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Access to care among children and adults, statewide.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)

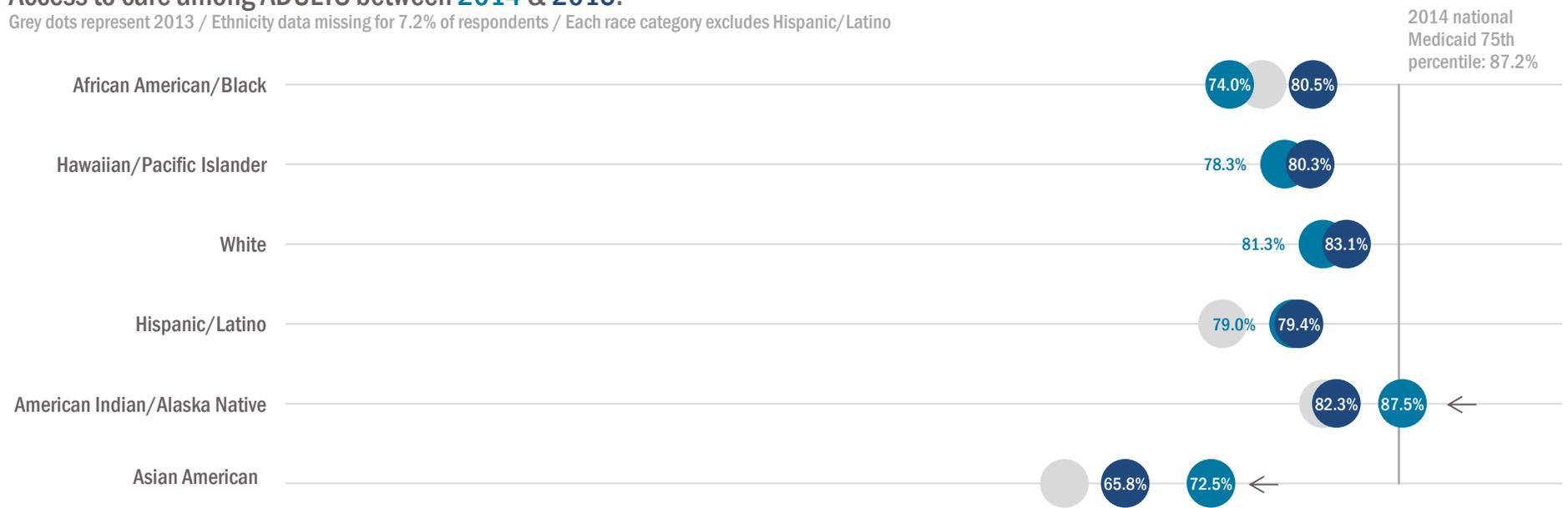




ACCESS TO CARE (CAHPS SURVEY)

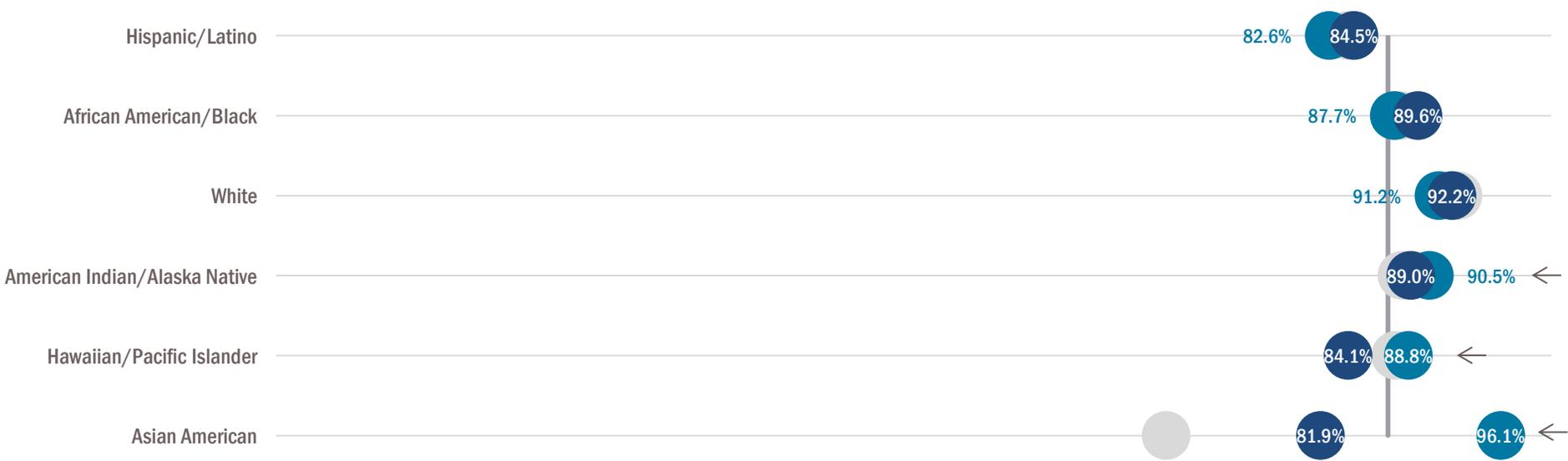
Access to care among ADULTS between 2014 & 2015.

Grey dots represent 2013 / Ethnicity data missing for 7.2% of respondents / Each race category excludes Hispanic/Latino



Access to care among CHILDREN between 2014 & 2015.

Grey dots represent 2013 / Race and ethnicity data missing for 8.9% of respondents / Each race category excludes Hispanic/Latino



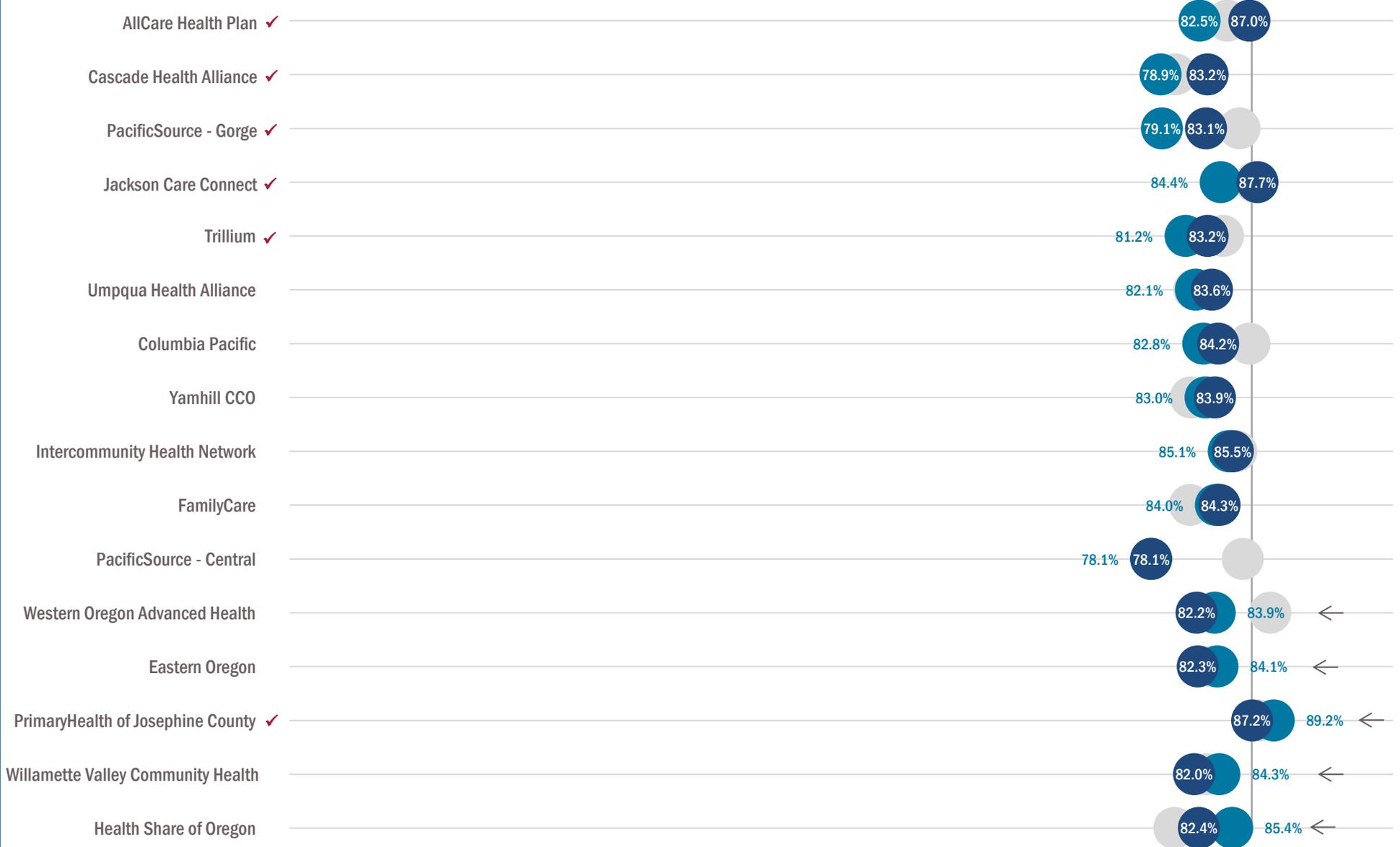


ACCESS TO CARE (CAHPS SURVEY)

Access to care by CCO between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2013

2014 national Medicaid 75th percentile: 87.2%





ADOLESCENT WELL CARE VISITS

Adolescent well-care visits

Percentage of adolescents and young adults (ages 12-21) who had at least one well-care visit during the measurement year.

2015 data (n=114,953)

Statewide change since 2014: **+17%**

Number of CCOs that improved: **15**

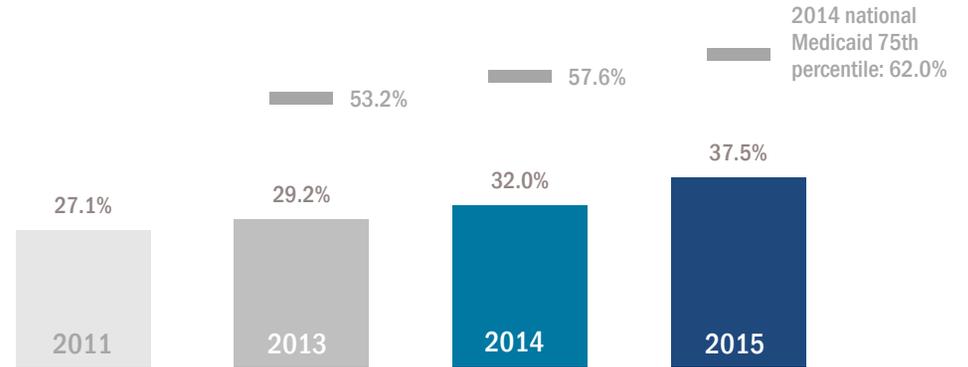
Number of CCOs achieving benchmark or improvement target: **12**

See pages [163](#) and [170](#) for results stratified by members with disability and mental health diagnoses.

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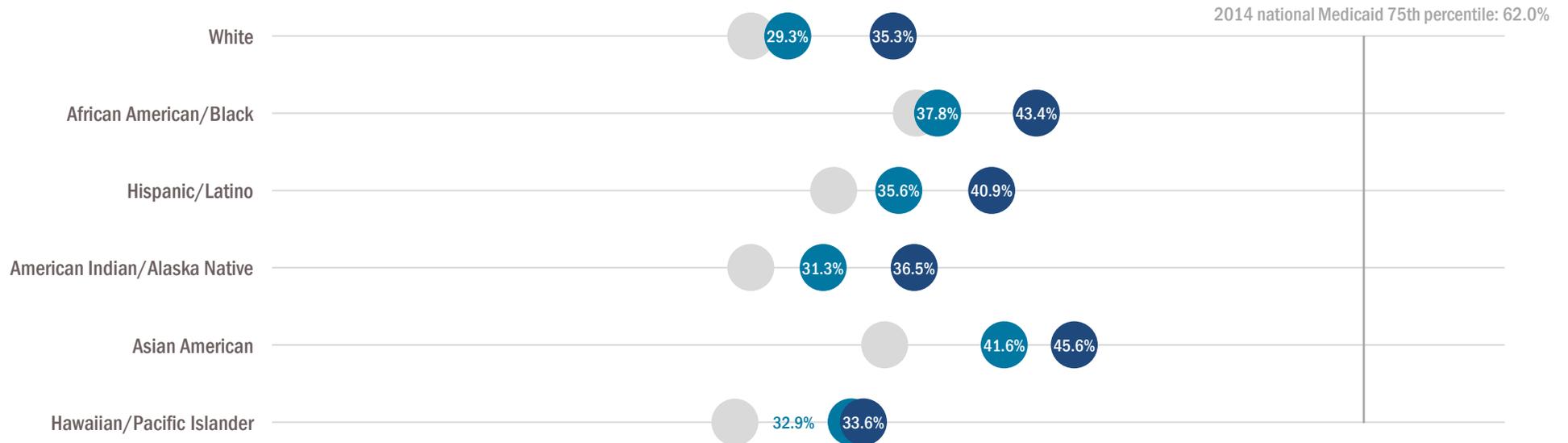
Statewide, adolescent well-care visits continue to increase but remain well below the benchmark.

Data source: Administrative (billing) claims



Adolescent well-care visits between 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 19.4% of respondents / Each race category excludes Hispanic/Latino

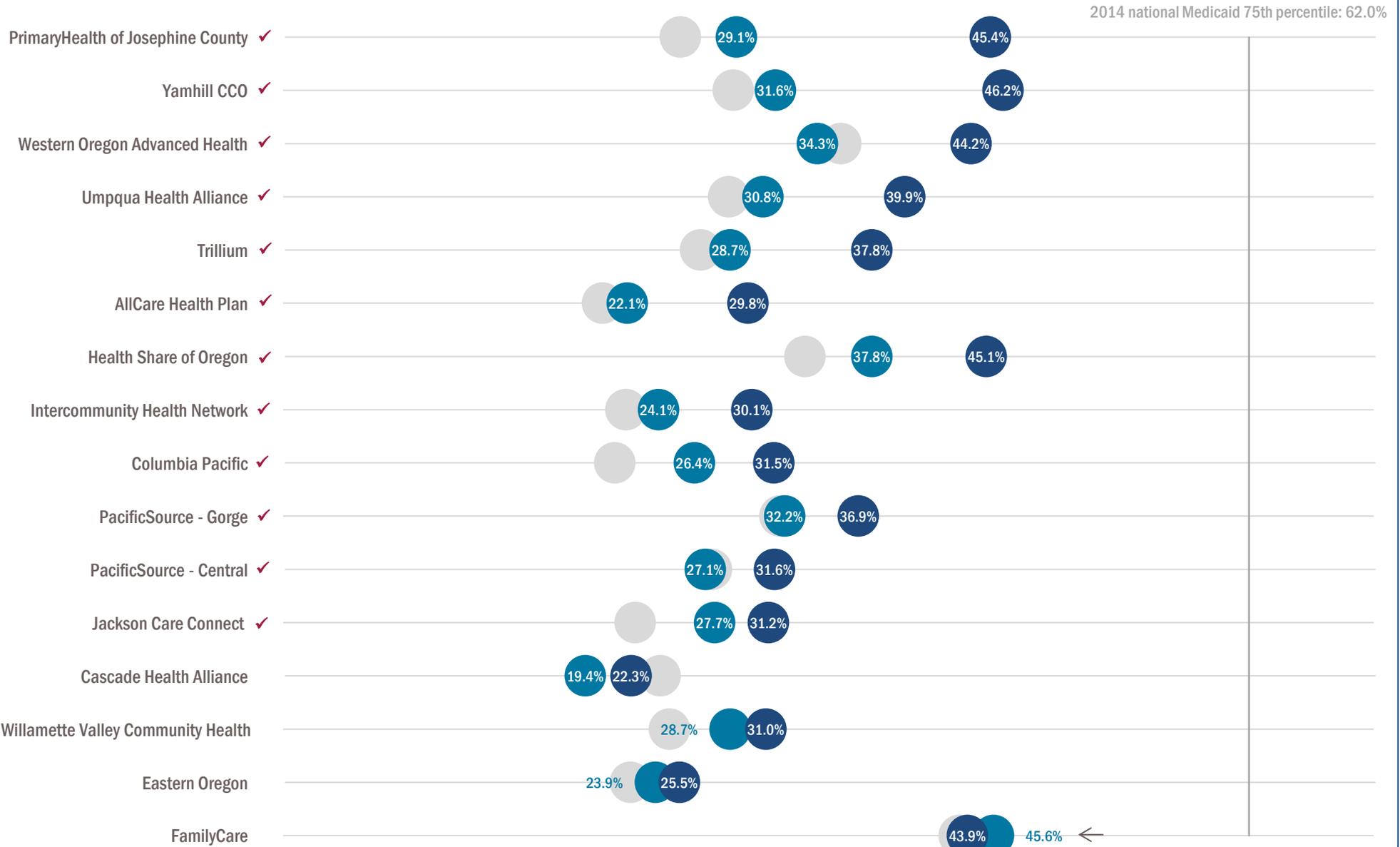




ADOLESCENT WELL CARE VISITS

Twelve CCOs achieved their improvement target for adolescent well-care visits between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2013



\$ ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (all ages)

Alcohol or other substance misuse screening (SBIRT) (all ages)

The SBIRT measure, or Screening, Brief Intervention, and Referral to Treatment, measures the percentage of members (ages 12 and older) who had appropriate screening and intervention for alcohol or other substance misuse.

2015 data (n=511,413)

Statewide change since 2014: **+98%**

Number of CCOs that improved: **15**

Number of CCOs achieving benchmark or improvement target: **14**

Adolescents ages 12-17 were added to the SBIRT measure in 2015.

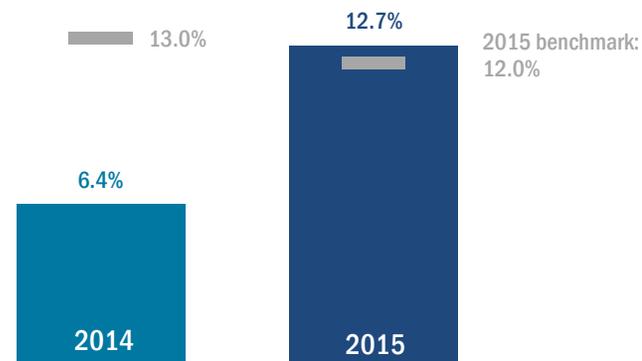
See pages [160](#) and [167](#) for results stratified by members with disability and mental health diagnoses.

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Statewide, SBIRT for all ages surpassed the benchmark in 2015.

Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



Alcohol or other substance misuse screening between 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 19.4% of respondents / Each race category excludes Hispanic/Latino



\$ ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (all ages)

Fourteen CCOs achieved benchmark or improvement target between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2013
 2014 CCO results have been slightly revised and may differ from previously published reports



ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ages 12-17)

Alcohol or other substance misuse screening (SBIRT) (ages 12-17)

The SBIRT measure, or Screening, Brief Intervention, and Referral to Treatment, measures the percentage of members (ages 12-17) who had appropriate screening and intervention for alcohol or other substance abuse.

2015 data (n=83,323)

Statewide change since 2014: **+595%**

Number of CCOs that improved: **all 16**

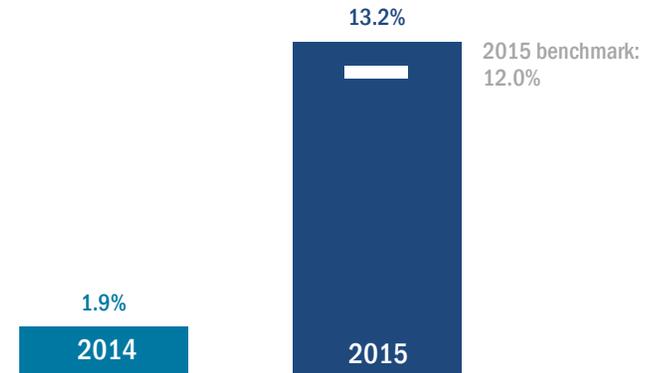
Adolescents ages 12-17 were added to the SBIRT measure in 2015. Incentive payments are based on all ages combined (see page [44](#)); Results are stratified by age group for reporting and monitoring purposes only.

See pages [160](#) and [167](#) for results stratified by members with disability and mental health diagnoses.

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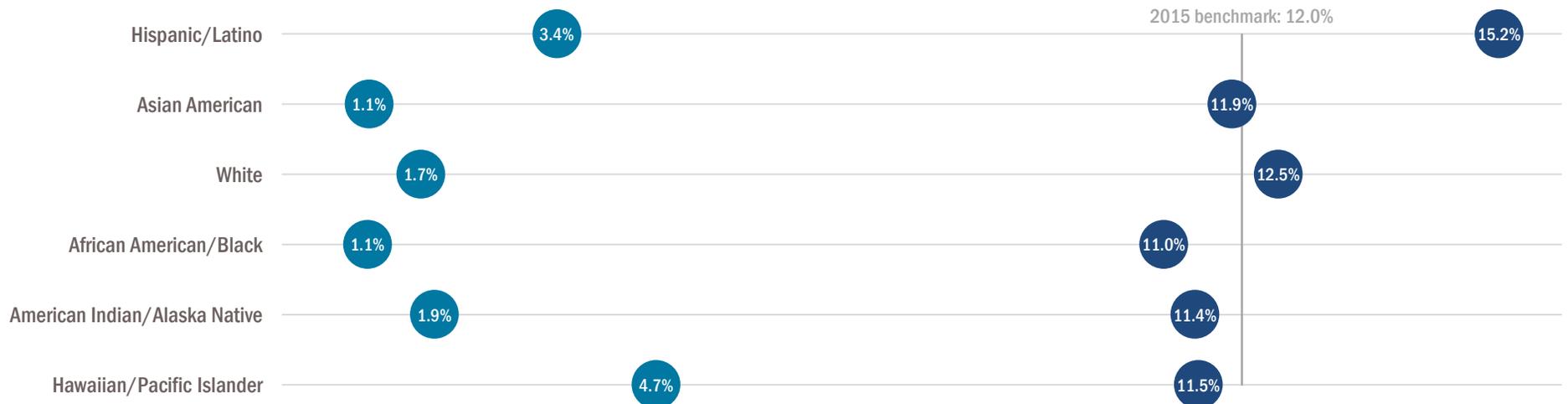
Statewide, SBIRT among adolescents increased and surpassed the benchmark in 2015.

Data source: Administrative (billing) claims
Benchmark source: Metrics and Scoring Committee consensus



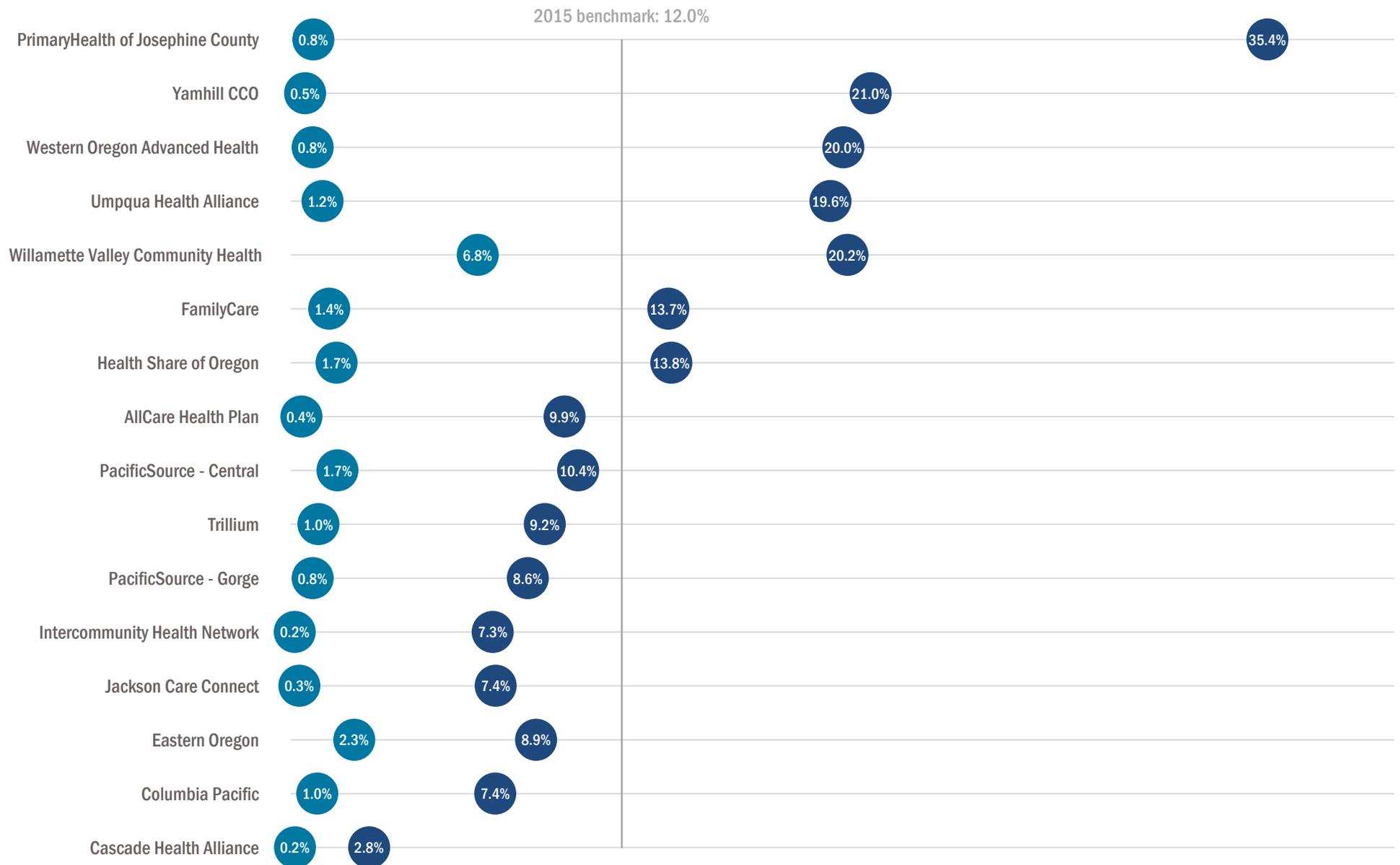
SBIRT among adolescents between 2014 & 2015, by race and ethnicity.

Race and ethnicity data missing for 20.0% of respondents / Each race category excludes Hispanic/Latino



ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ages 12-17)

SBIRT among adolescents between 2014 & 2015, by CCO.





ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ages 18+)

Alcohol or other substance misuse screening (SBIRT) (ages 18+)

The SBIRT measure, or Screening, Brief Intervention, and Referral to Treatment, measures the percentage of members (ages 18 and older) who had appropriate screening and intervention for alcohol or other substance abuse.

2015 data (n=428,090)

Statewide change since 2014: **+73%**

Number of CCOs that improved: **14**

Adolescents ages 12-17 were added to the SBIRT measure in 2015. Incentive payments are based on all ages combined (see page 44); Results are stratified by age group for reporting and monitoring purposes only.

See pages 160, 167, and 172 for results stratified by members with disability, mental health diagnoses, and severe and persistent mental illness

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SBIRT among adults between 2014 & 2015, by race and ethnicity.

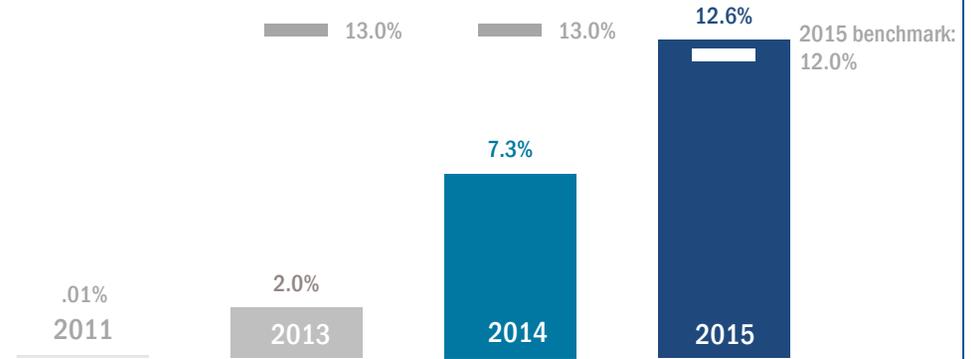
Race and ethnicity data missing for 16.6% of respondents / Each race category excludes Hispanic/Latino



Statewide, SBIRT among adults surpassed the benchmark for the first time in 2015.

Data source: Administrative (billing) claims

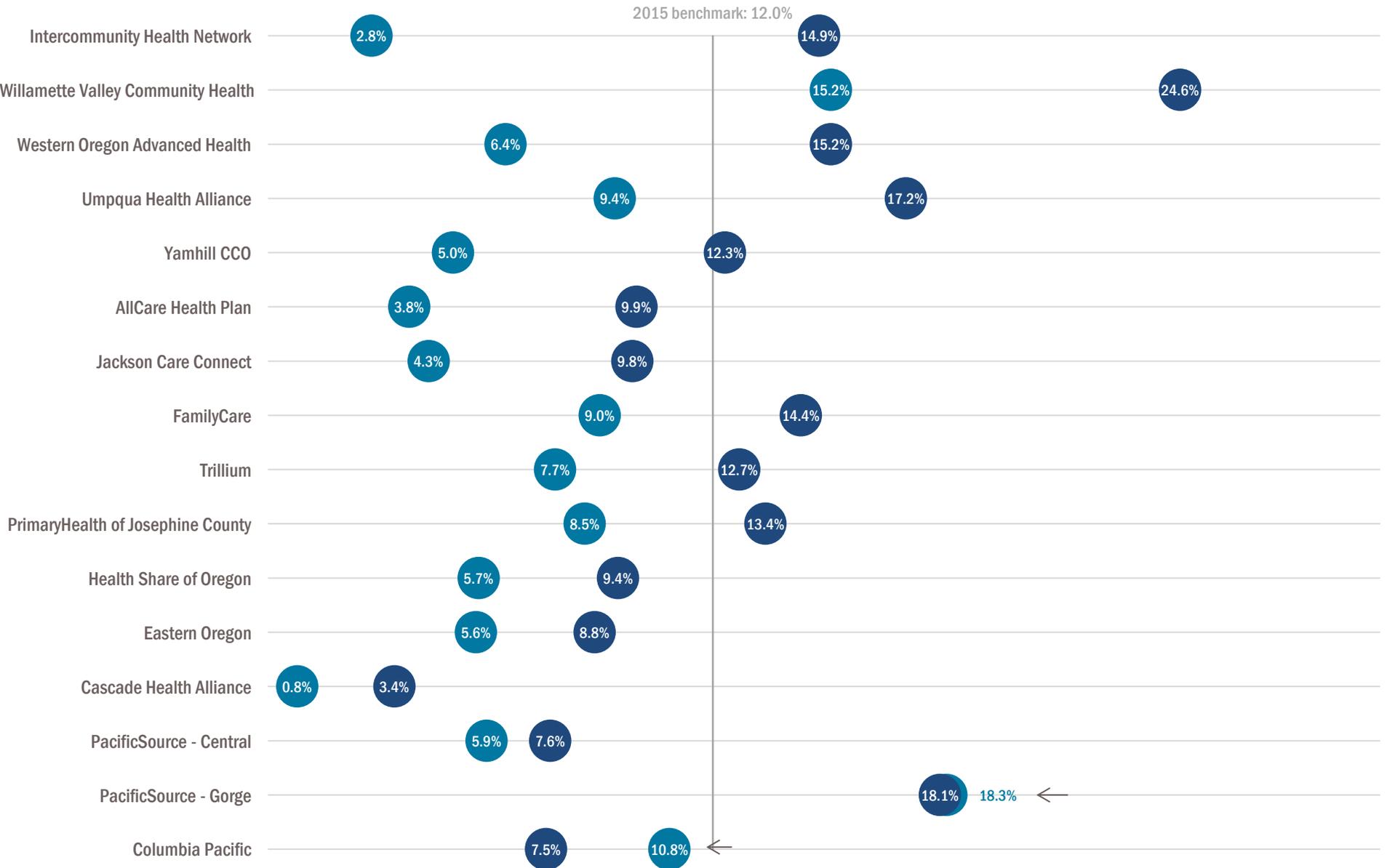
Benchmark source: Metrics and Scoring Committee consensus





ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ages 18+)

SBIRT among adults between 2014 & 2015, by CCO.





ALL-CAUSE READMISSIONS

All-cause readmissions

Percentage of adult members (ages 18 and older) who had a hospital stay and were readmitted for any reason within 30 days of discharge. A lower score for this measure is better.

2015 data (n=29,075)

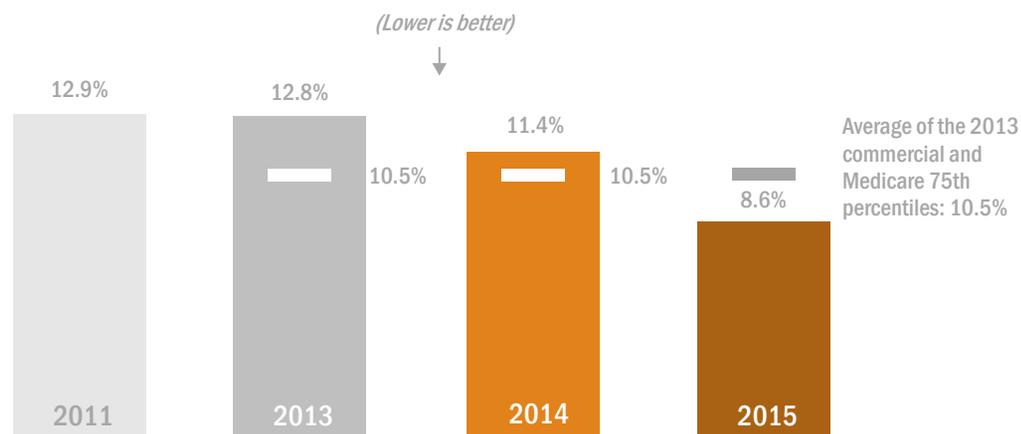
Statewide change since 2014: **-24%** (lower is better)

Number of CCOs that improved: **13**

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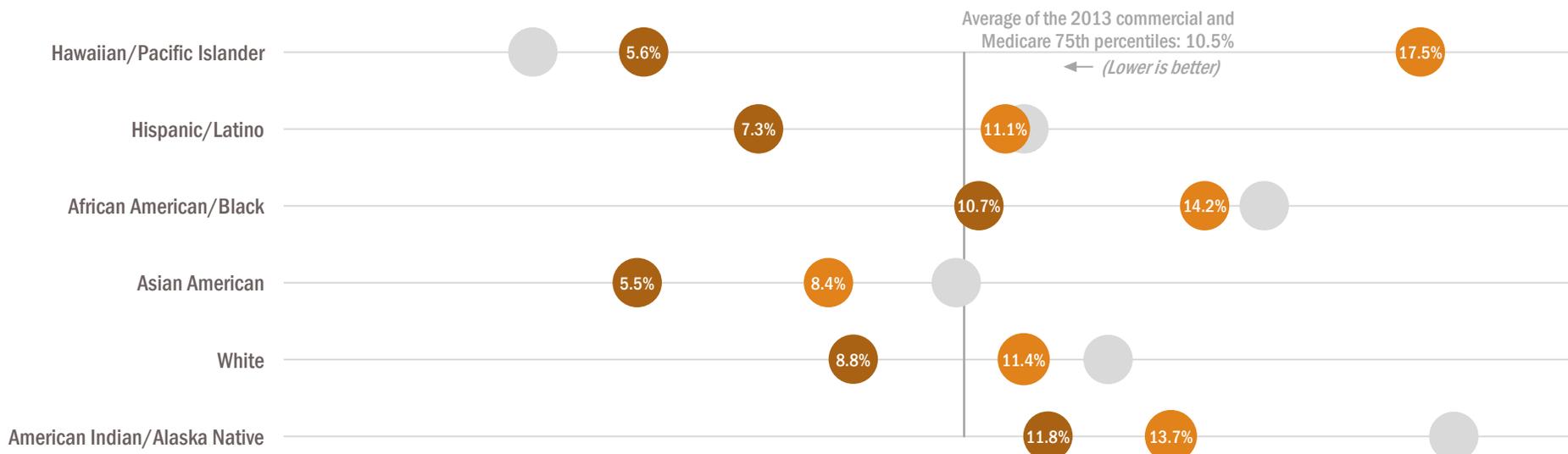
All-cause readmissions, statewide.

Data source: Administrative (billing) claims



All-cause readmissions in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 9.4% of respondents / Each race category excludes Hispanic/Latino

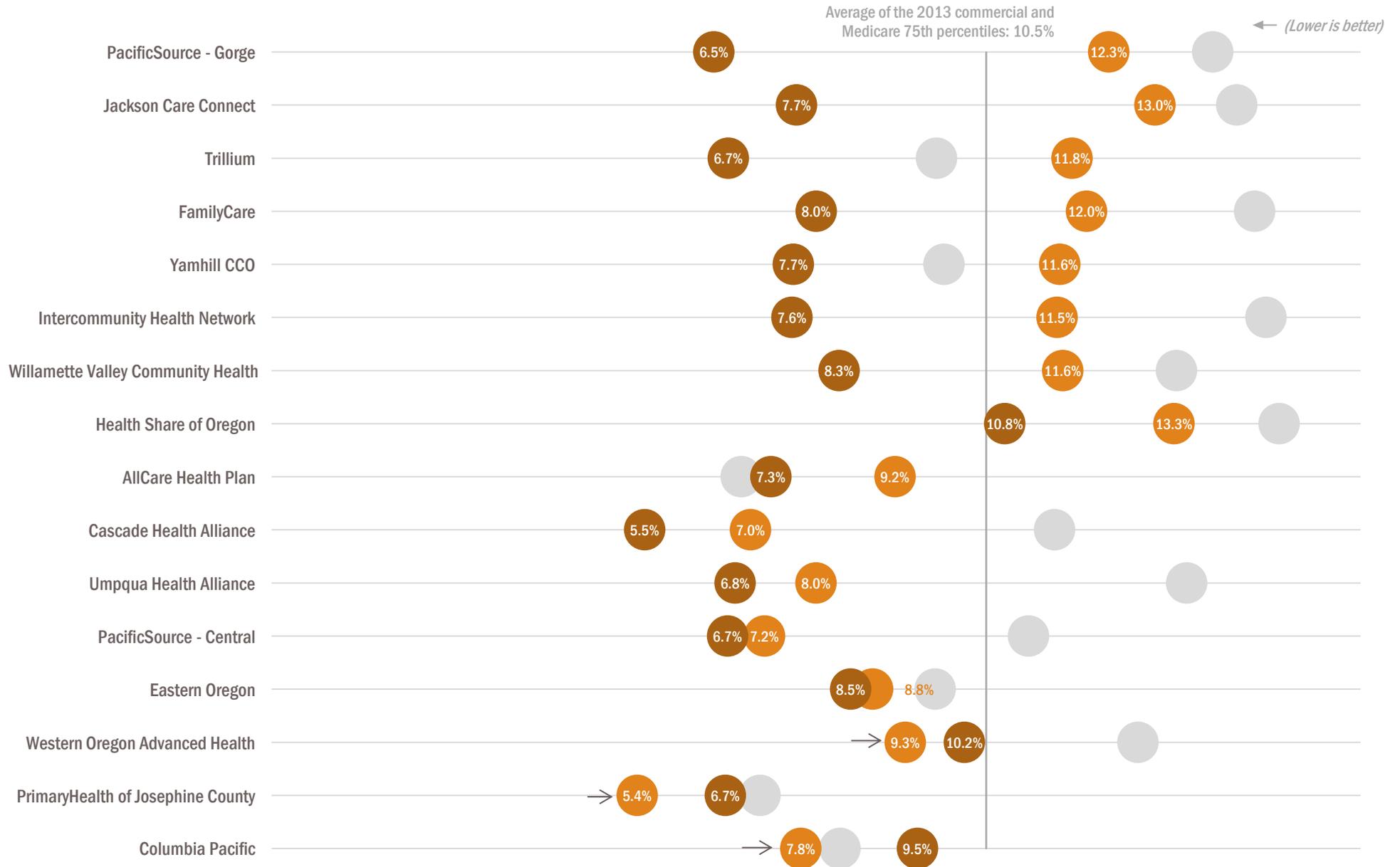




ALL-CAUSE READMISSIONS

All-cause readmissions in 2014 & 2015, by CCO.

Grey dots represent 2013





AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

Ambulatory care: Emergency department utilization

Rate of patient visits to an emergency department (ED). Rates are reported per 1,000 member months and a lower number represents a decrease in ED usage.

2015 data (n=10,895,454 member months)

Statewide change since 2014: **-2%** (lower is better)

Number of CCOs that improved: **14**

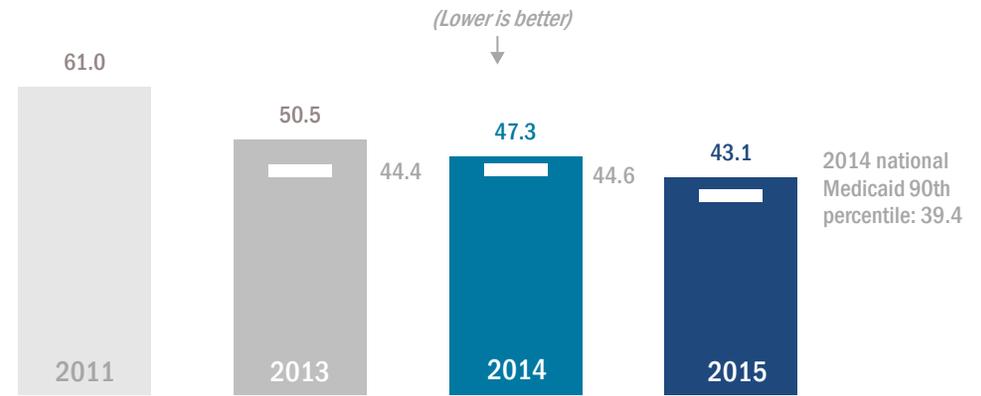
Number of CCOs achieving benchmark or improvement target: **12**

See pages [159](#), [165](#), and [171](#) for results stratified by members with disability, mental health diagnoses, and severe and persistent mental illness.

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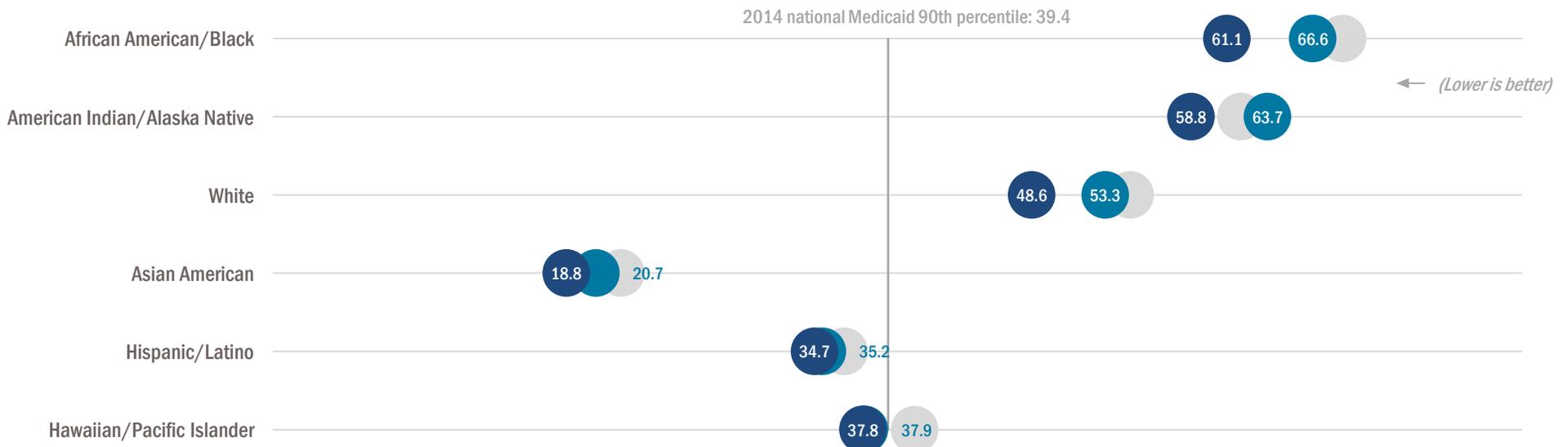
Statewide, the rate of emergency department use continues to improve.

Data source: Administrative (billing) claims
Rates are reported per 1,000 member months



Emergency department utilization by race and ethnicity between 2014 & 2015.

Grey dots represent 2013 / Race and ethnicity data missing for 19.4% of respondents / Each race category excludes Hispanic/Latino / Rates are reported per 1,000 member months

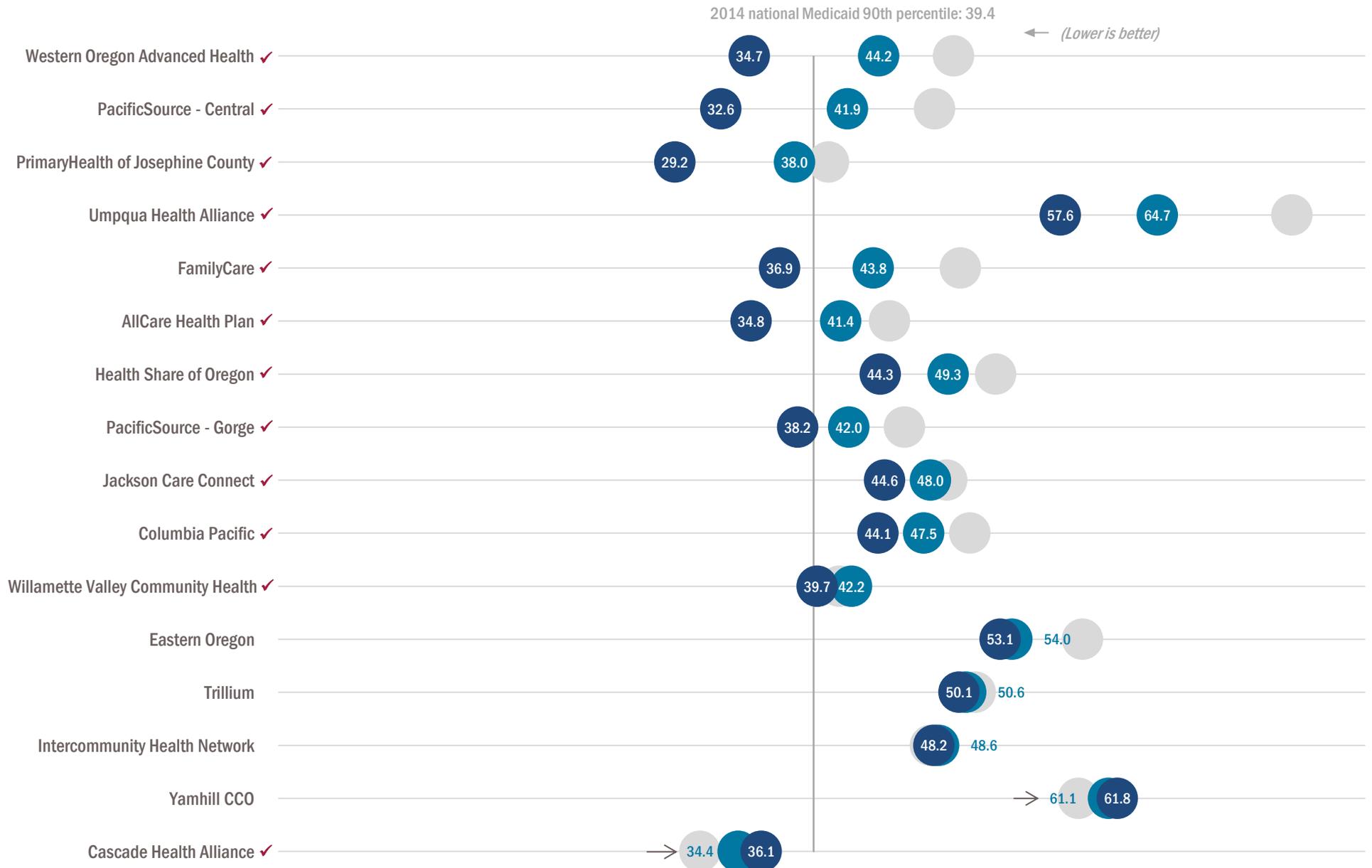




AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

Twelve CCOs achieved benchmark or improvement target for emergency department utilization between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2013 / Rates are reported per 1,000 member months





AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

Avoidable emergency department utilization

Rate of patient visits to an emergency department for conditions that could have been more appropriately managed by or referred to a primary care provider in an office or clinic setting.

Rates are derived from the ambulatory care: emergency department utilization measure and are reported per 1,000 member months. A lower number suggests more appropriate emergency department utilization.

2015 data (n=10,895,864 member months)

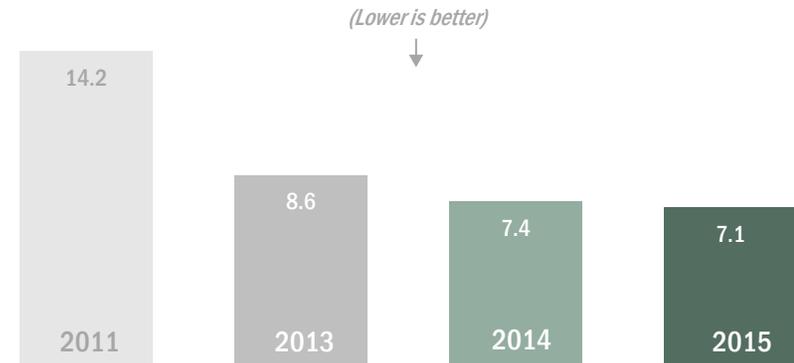
Statewide change since 2014: **-4%** (lower is better)

Number of CCOs that improved: **11**

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Avoidable emergency department utilization, statewide.

Data source: Administrative (billing) claims
Rates are per 1,000 member months



Avoidable emergency department utilization in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 16.5% of respondents / Each race category excludes Hispanic/Latino / Rates are per 1,000 member months





AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

Avoidable emergency department utilization in 2014 & 2015, by CCO.

Grey dots represent 2013 / Rates are per 1,000 member months





AMBULATORY CARE: OUTPATIENT UTILIZATION

Outpatient utilization

Rate of outpatient services, such as office visits, home visits, nursing home care, urgent care and counseling or screening services. Rates are reported per 1,000 member months.

2015 data (n=10,895,864 member months)

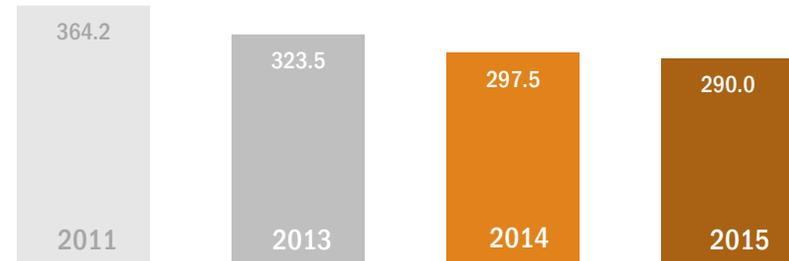
Statewide change since 2014: **-3%**

Number of CCOs that increased: **8**

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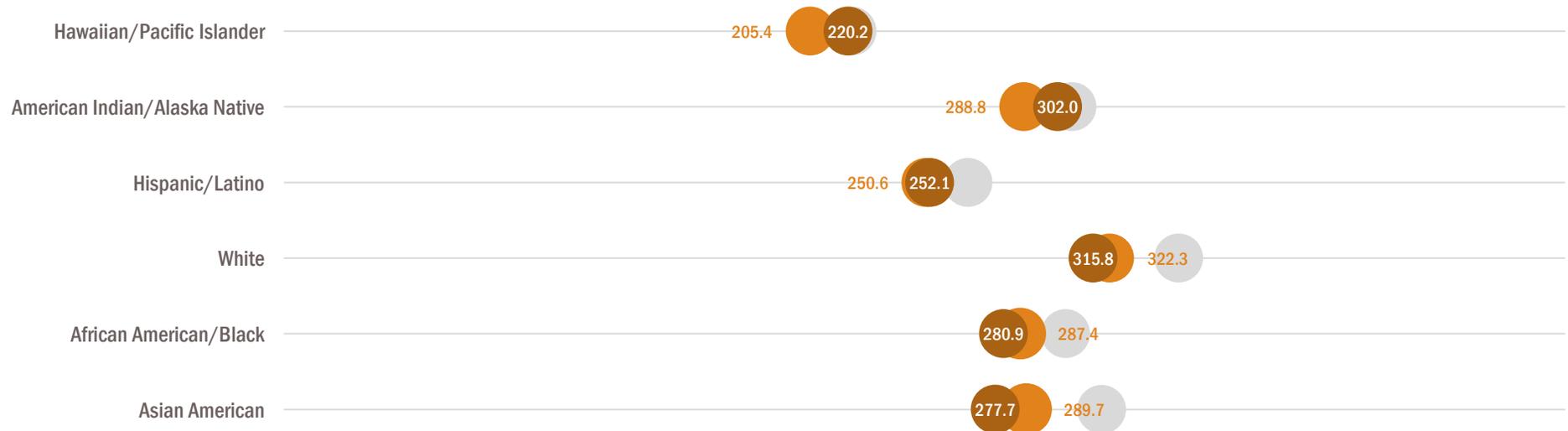
Outpatient utilization, statewide.

Data source: Administrative (billing) claims
Rates are per 1,000 member months



Outpatient utilization in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 16.5% of respondents / Each race category excludes Hispanic/Latino / Rates are per 1,000 member months

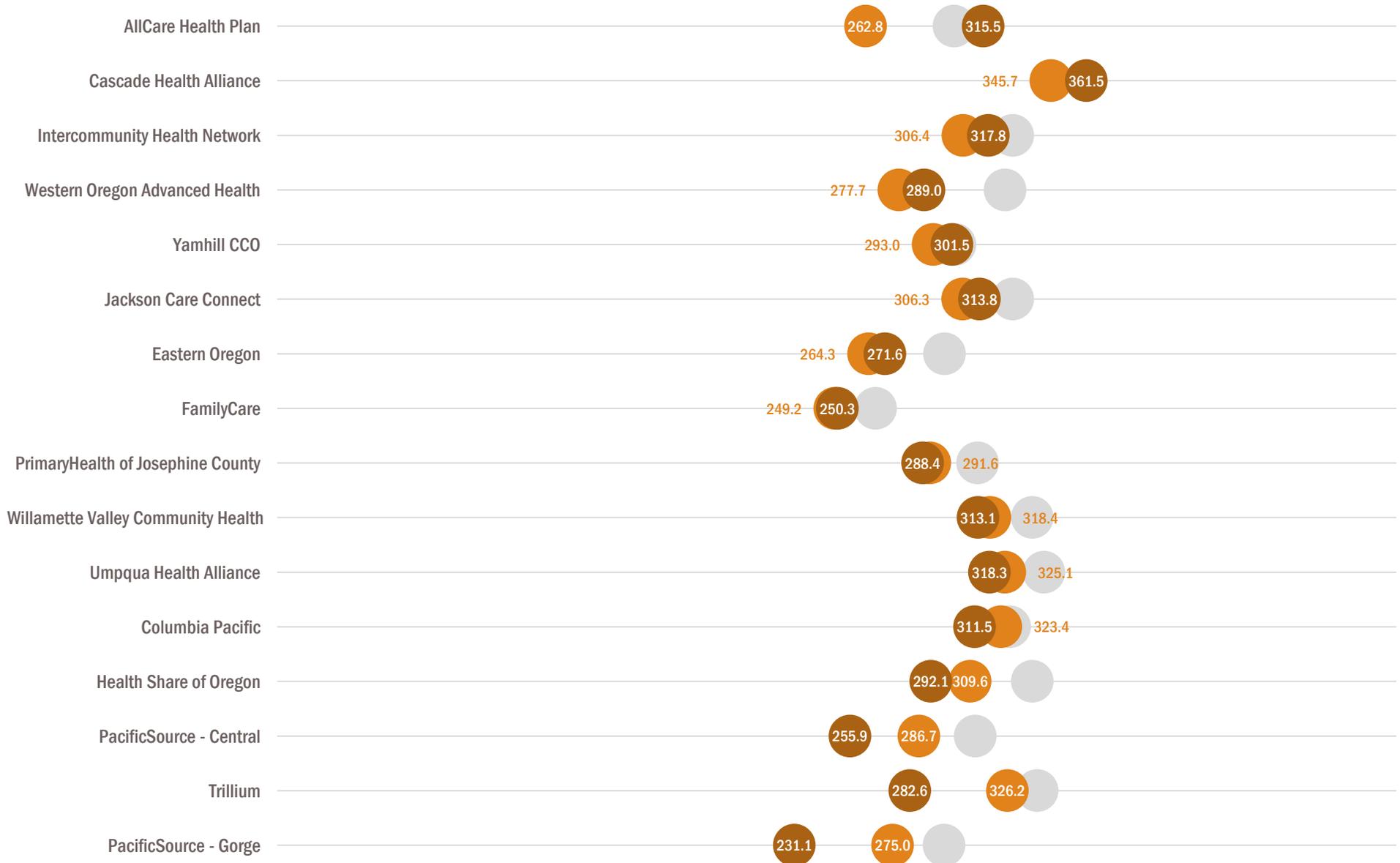




AMBULATORY CARE: OUTPATIENT UTILIZATION

Outpatient utilization in 2014 & 2015, by CCO.

Grey dots represent 2013 / Rates are per 1,000 member months





APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Appropriate testing for children with pharyngitis

Percentage of children with a sore throat (pharyngitis) who were given a strep test before getting an antibiotic.

2015 data (n=9,031)

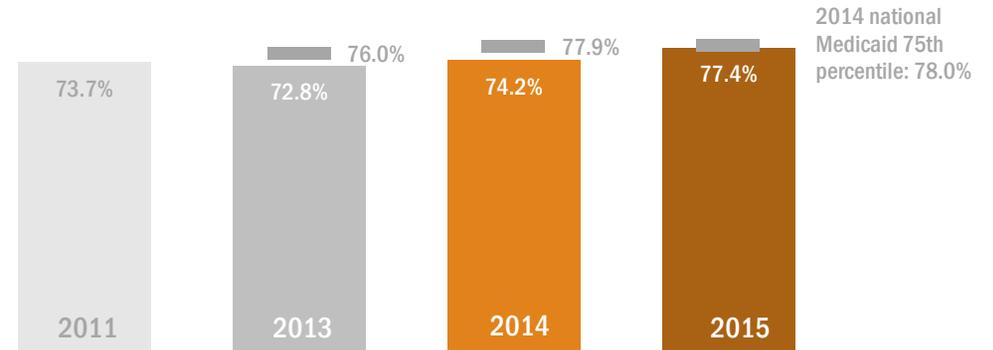
Statewide change since 2014: **+4%**

Number of CCOs that improved: **14**

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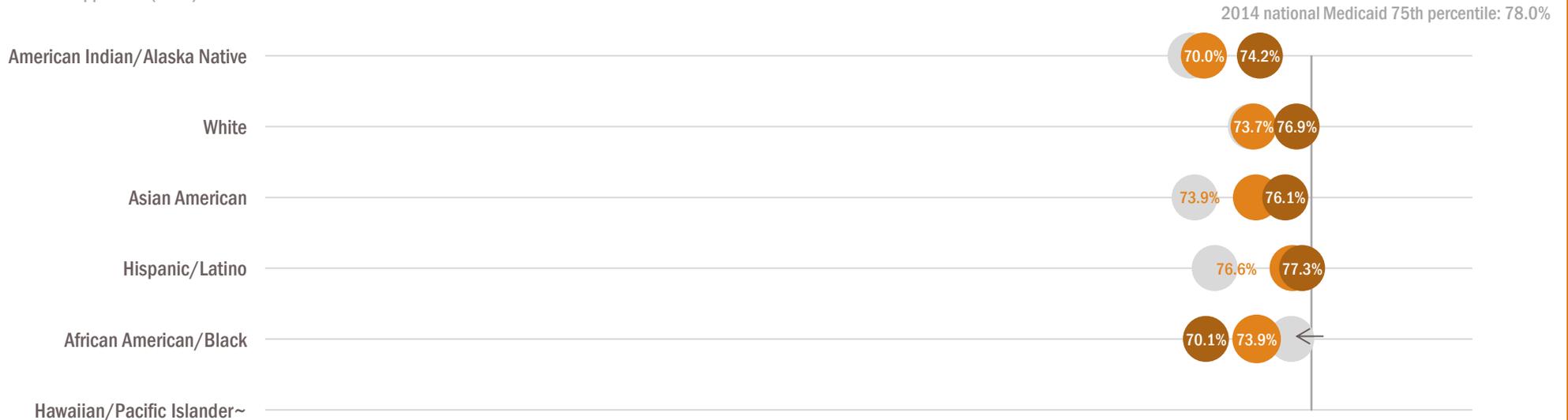
Appropriate testing for children with pharyngitis, statewide.

Data source: Administrative (billing) claims



Appropriate testing for children with pharyngitis in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 20.4% of respondents / Each race category excludes Hispanic/Latino
~ Data suppressed (n<30)

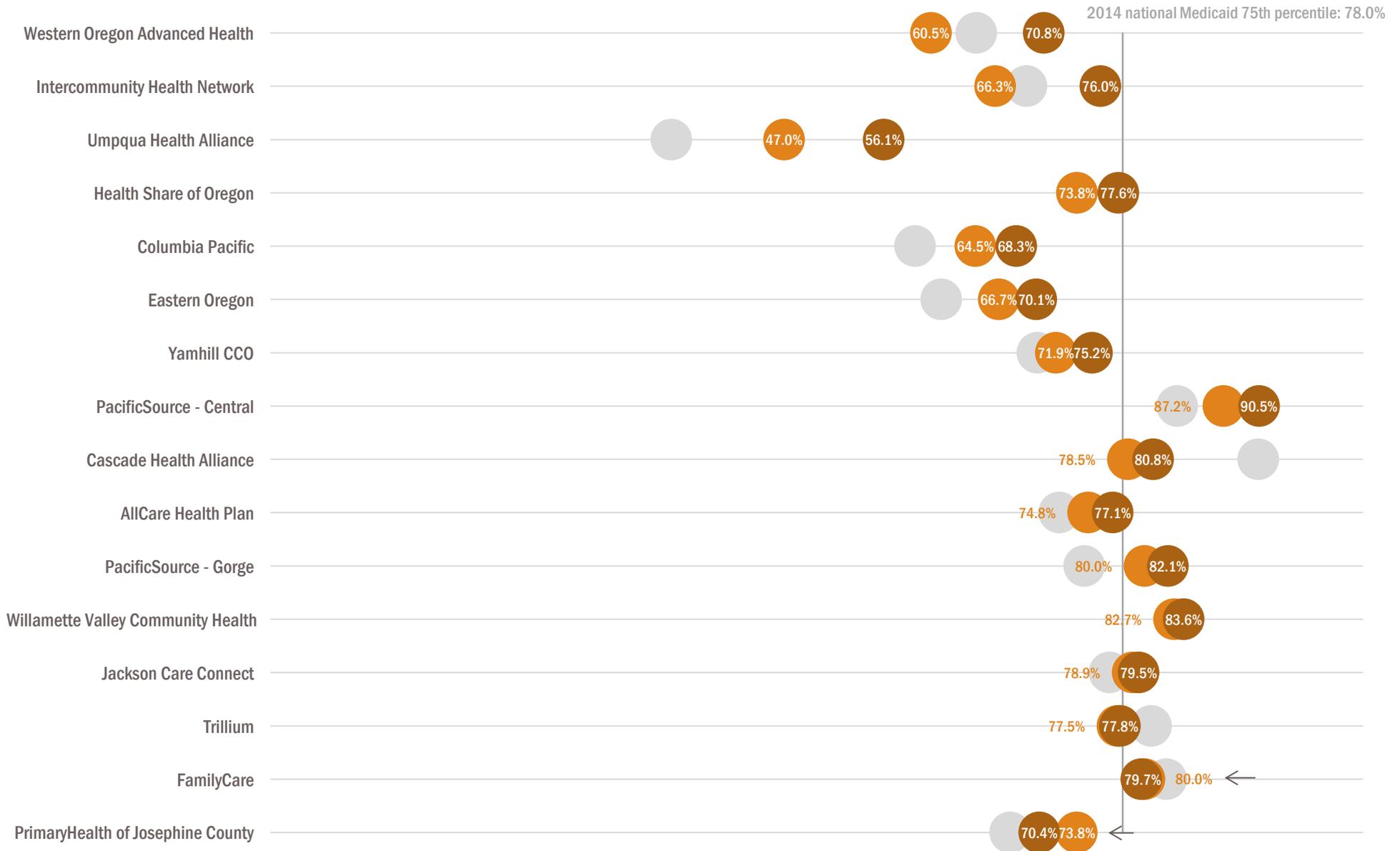




APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Appropriate testing for children with pharyngitis in 2014 & 2015, by CCO.

Grey dots represent 2013





CERVICAL CANCER SCREENING

Cervical cancer screening

Percentage of women (ages 21 to 64) who received one or more Pap tests for cervical cancer during the past three years.

Cervical cancer screening, statewide.

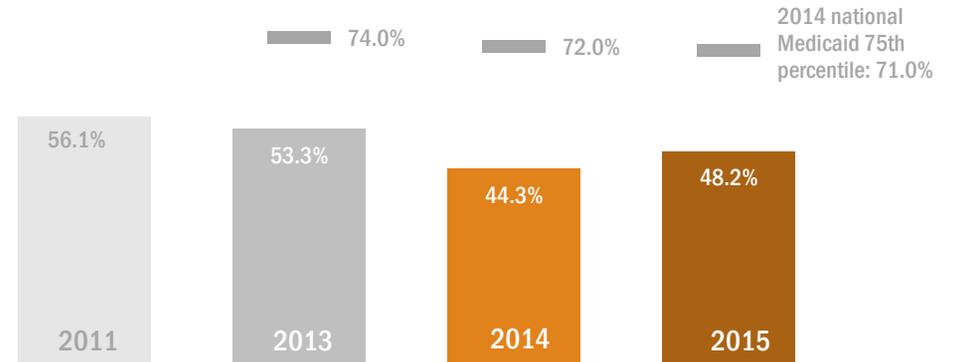
Data source: Administrative (billing) claims

2015 data (n=158,762)

Statewide change since 2014: **+9%**

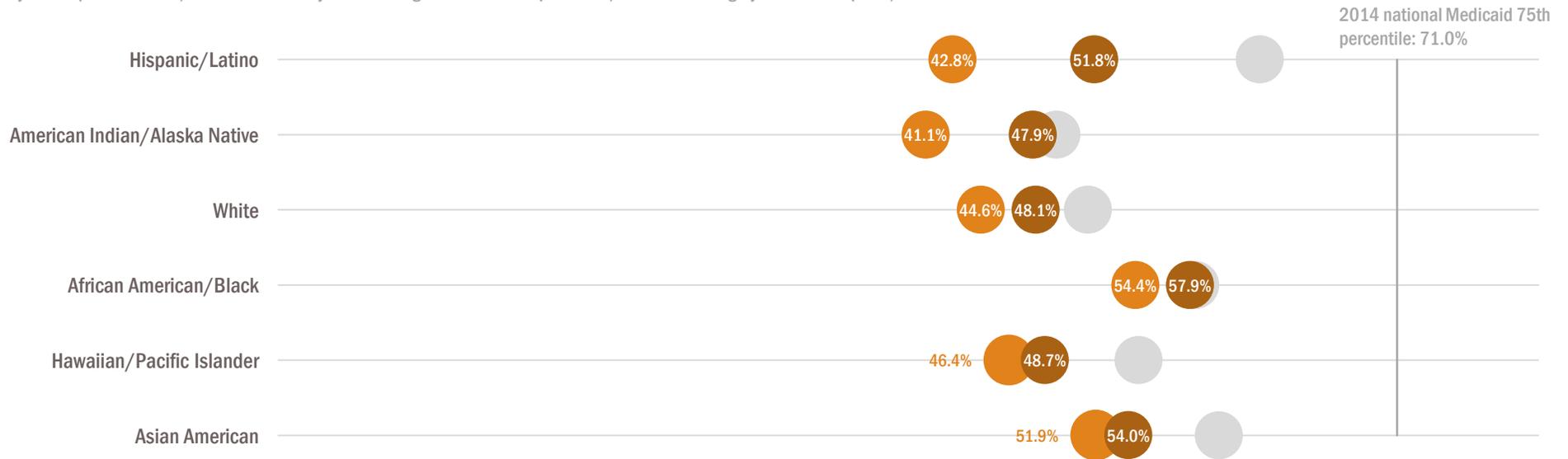
Number of CCOs that improved: **15**

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Cervical cancer screening in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 15.8% of respondents / Each race category excludes Hispanic/Latino

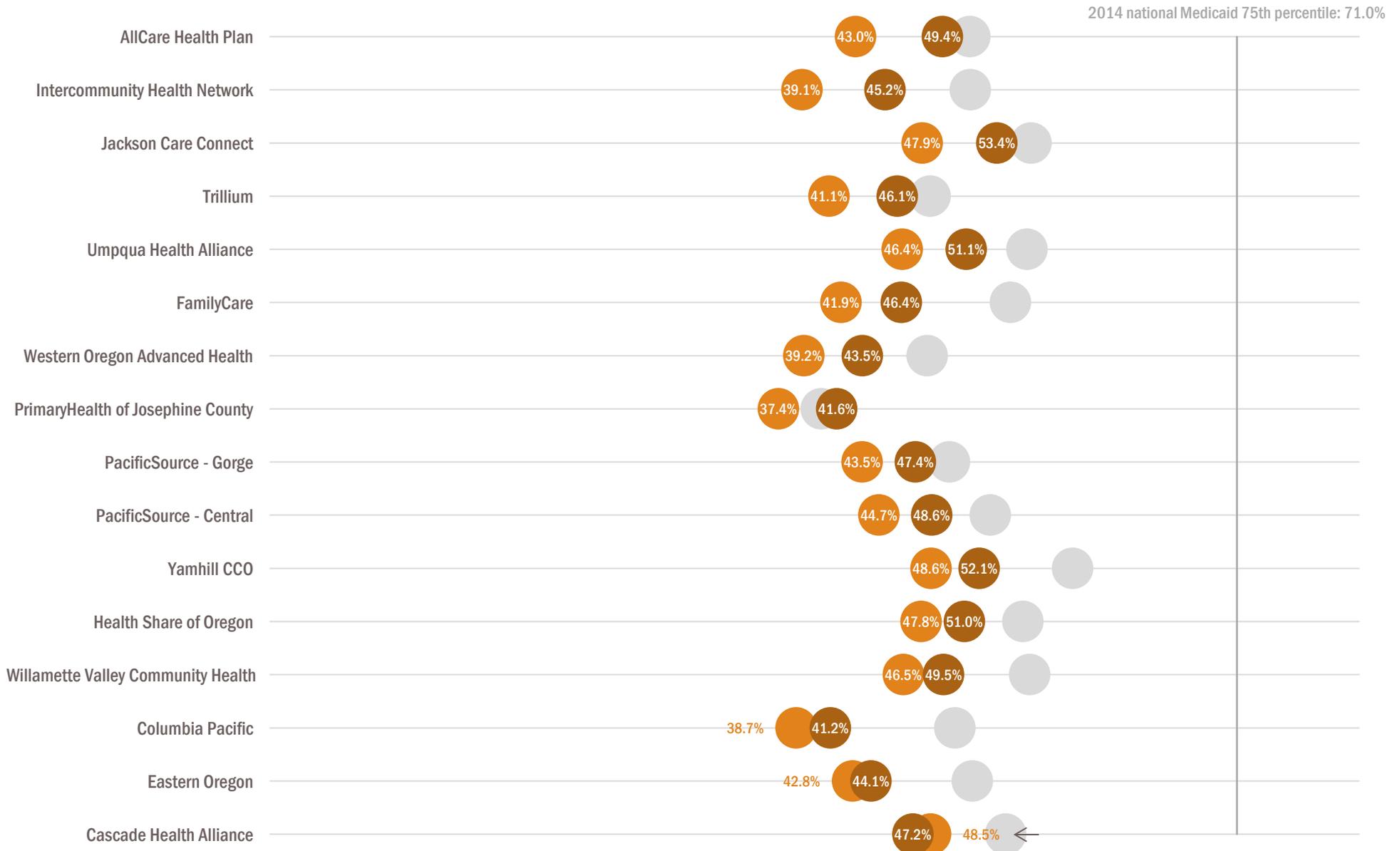




CERVICAL CANCER SCREENING

Cervical cancer screening in 2014 & 2015, by CCO.

Grey dots represent 2013





CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (ALL AGES)

Childhood and adolescent access to primary care providers (all ages)

Percentage of children and adolescents (ages 12 months - 19 years) who had a visit with a primary care provider.

See the following pages for results stratified by age groups.

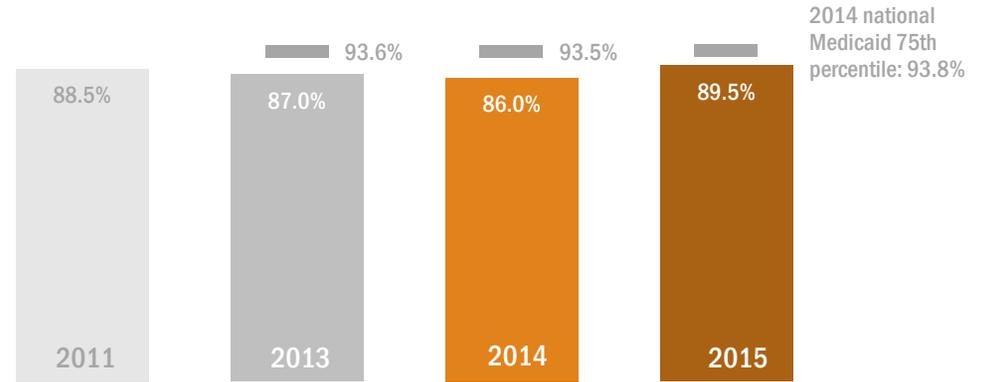
2015 data (n=229,835)

Statewide change since 2014: **+4%**

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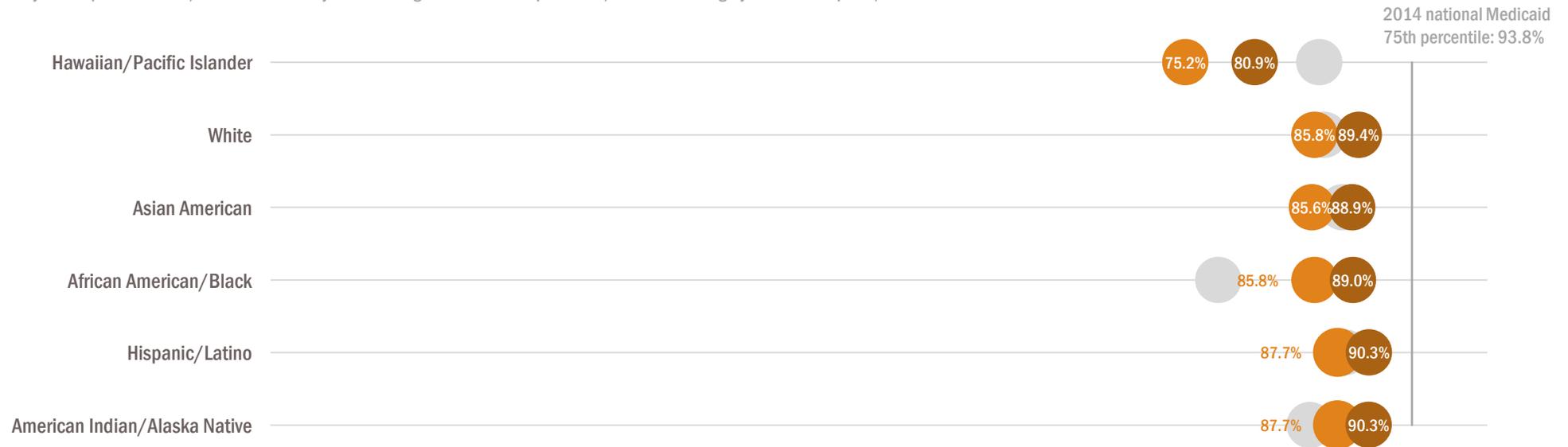
Percentage of children and adolescents who had a visit with a primary care provider, statewide.

Data source: Administrative (billing) claims



Percentage of children and adolescents who had a visit with a primary care provider in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 19.5% of respondents / Each race category excludes Hispanic/Latino





CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (12-24 months)

Childhood and adolescent access to primary care providers (12–24 months)

Percentage of children (ages 12-24 months) who had a visit with a primary care provider.

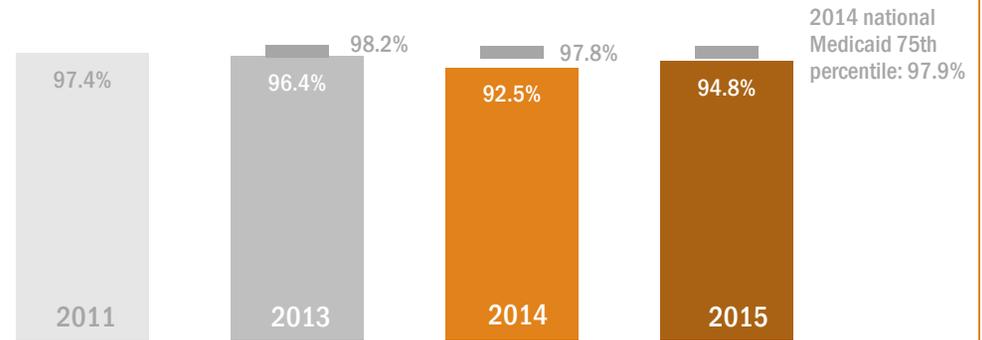
2015 data (n=17,685)

Statewide change since 2014: **+2%**

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Percentage of children (ages 12-24 months) who had a visit with a primary care provider, statewide.

Data source: Administrative (billing) claims



Percentage of children (ages 12-24 months) who had a visit with a primary care provider in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 20.3% of respondents / Each race category excludes Hispanic/Latino



CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (25 months-6 years)

Childhood and adolescent access to primary care providers (25 months–6 years)

Percentage of children (ages 25 months - 6 years) who had a visit with a primary care provider.

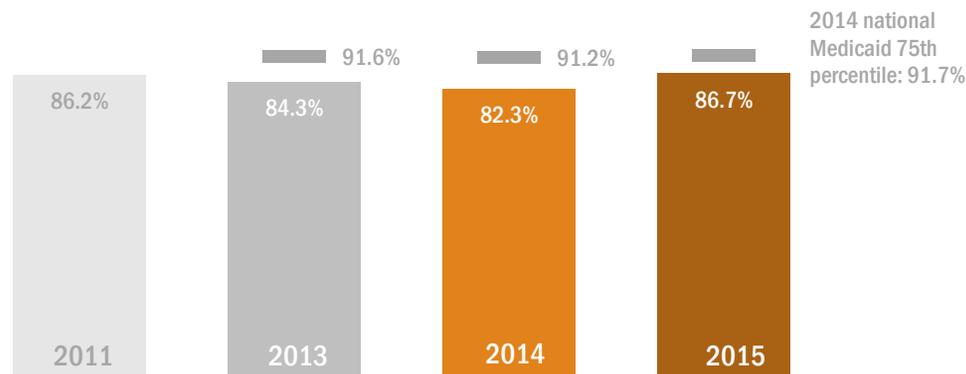
2015 data (n=73,942)

Statewide change since 2014: **+5%**

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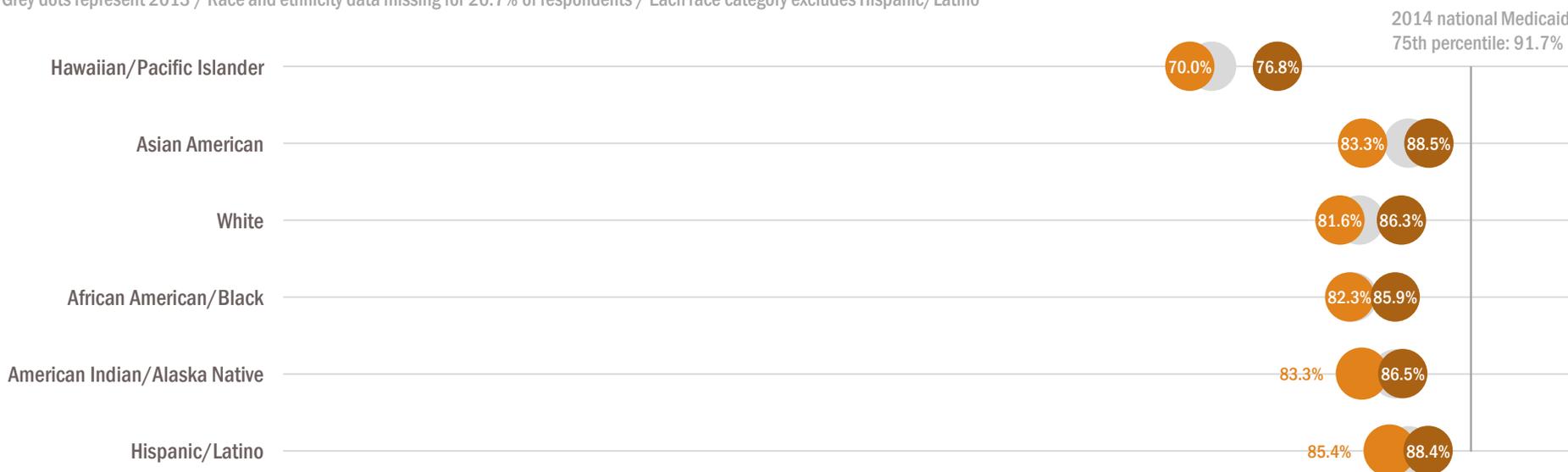
Percentage of children (ages 25 months - 6 years) who had a visit with a primary care provider, statewide.

Data source: Administrative (billing) claims



Percentage of children (ages 25 months - 6 years) who had a visit with a primary care provider in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 20.7% of respondents / Each race category excludes Hispanic/Latino





CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (7–11 years)

Childhood and adolescent access to primary care providers (7–11 years)

Percentage of children and adolescents (ages 7-11 years) who had a visit with a primary care provider.

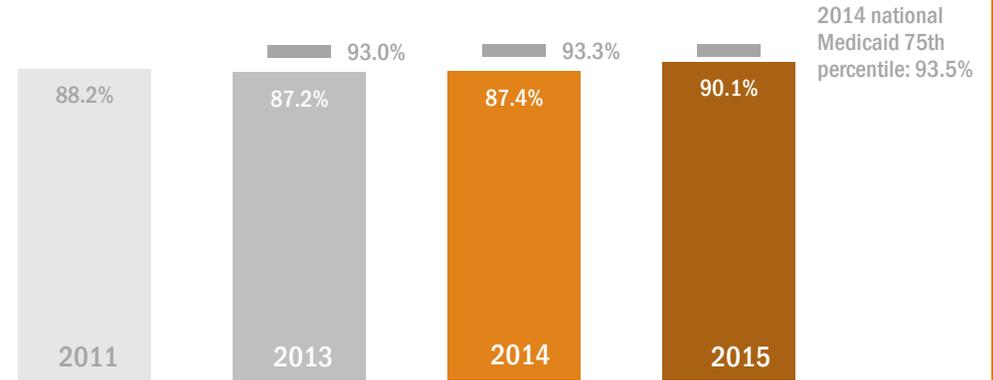
2015 data (n=61,156)

Statewide change since 2014: **+3%**

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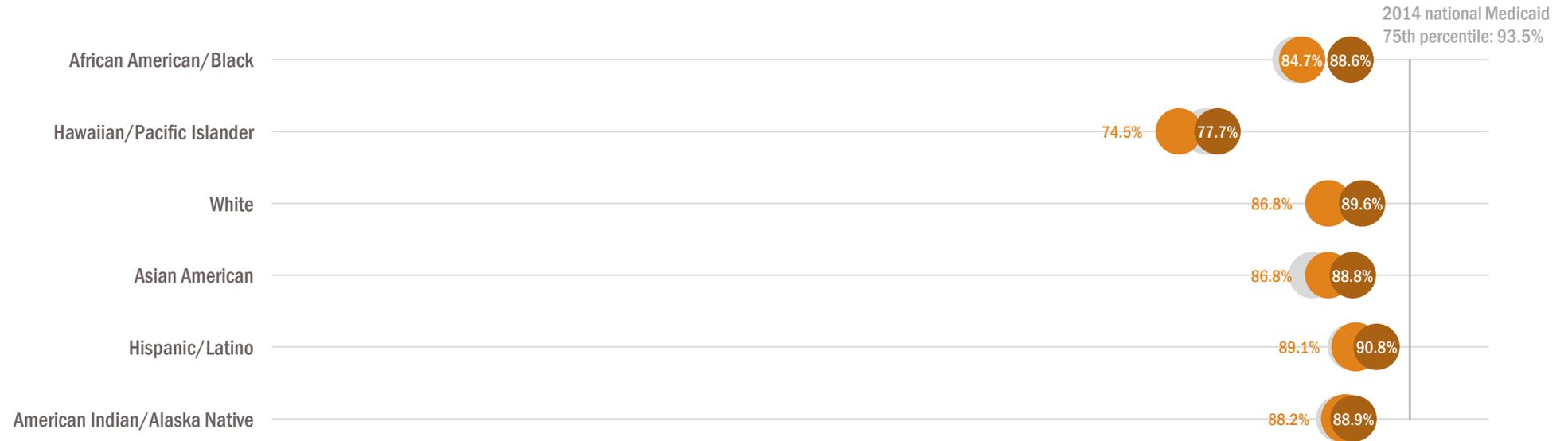
Percentage of children (ages 7-11 years) who had a visit with a primary care provider, statewide.

Data source: Administrative (billing) claims



Percentage of children (ages 7-11 years) who had a visit with a primary care provider in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 19.4% of respondents / Each race category excludes Hispanic/Latino





CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (12-19 years)

Childhood and adolescent access to primary care providers (12–19 years)

Percentage of adolescents (ages 12-19 years) who had a visit with a primary care provider.

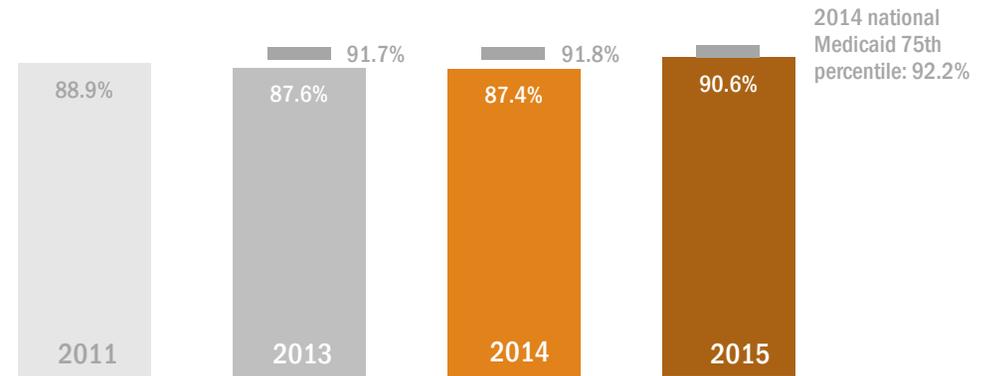
2015 data (n=77,052)

Statewide change since 2014: **+4%**

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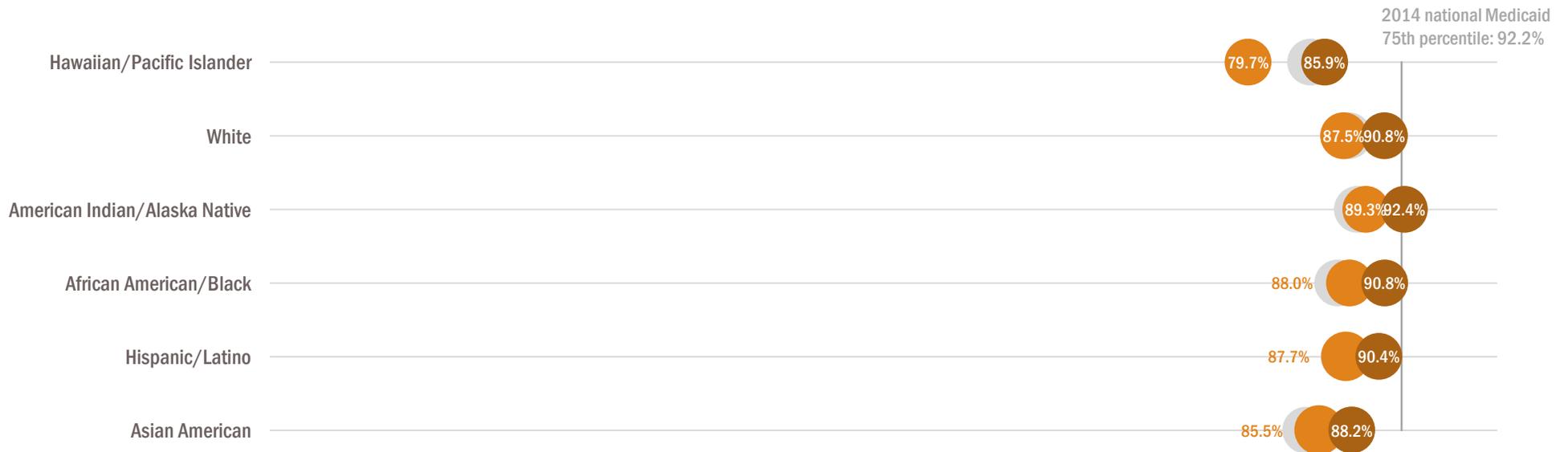
Percentage of adolescents (ages 12-19 years) who had a visit with a primary care provider, statewide.

Data source: Administrative (billing) claims



Percentage of adolescents (ages 12-19 years) who had a visit with a primary care provider in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 18.2% of respondents / Each race category excludes Hispanic/Latino





CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS - by CCO

Percentage of children and adolescents who had a visit with a primary care provider in 2015, by CCO.

Benchmark source: 2014 Medicaid national 75th percentile for each age group





CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS - by CCO

Percentage of children and adolescents who had a visit with a primary care provider in 2015, by CCO.

Benchmark source: 2014 Medicaid national 75th percentile for each age group





CHILDHOOD IMMUNIZATION STATUS

Childhood immunization status

Percentage of children who received recommended vaccines (DTaP, IPV, MMR, HiB, Hepatitis B, VZV) before their second birthday.

2015 data (n=15,984)

Statewide change since 2014: **+4%**

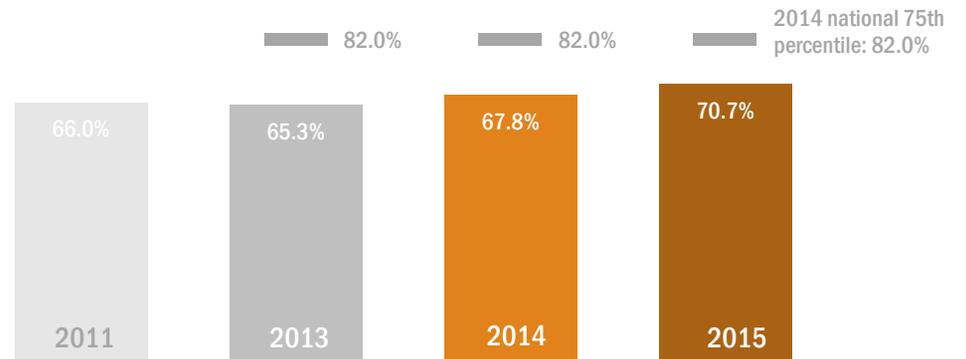
Number of CCOs that improved: **14**

Childhood immunization status will be a CCO incentive measure beginning in 2016.

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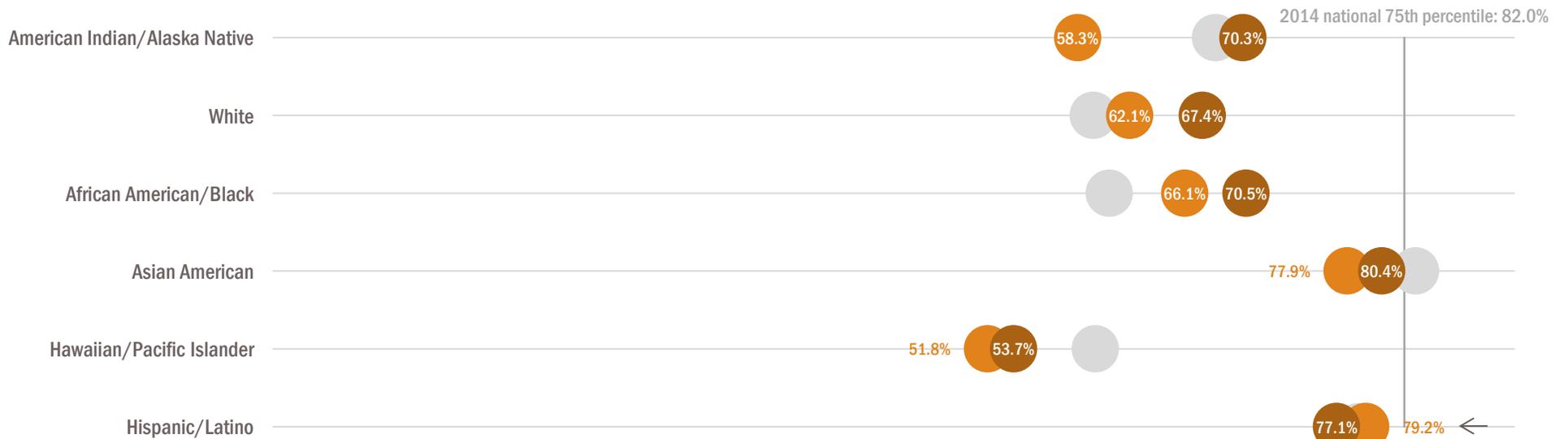
Percentage of children who received recommended vaccines before their second birthday, statewide.

Data source: Administrative (billing) claims + ALERT immunization data



Percentage of children who received recommended vaccines before their second birthday in 2014 & 2015, by race and ethnicity

Grey dots represent 2013 / Race and ethnicity data missing for 15.2% of respondents / Each race category excludes Hispanic/Latino

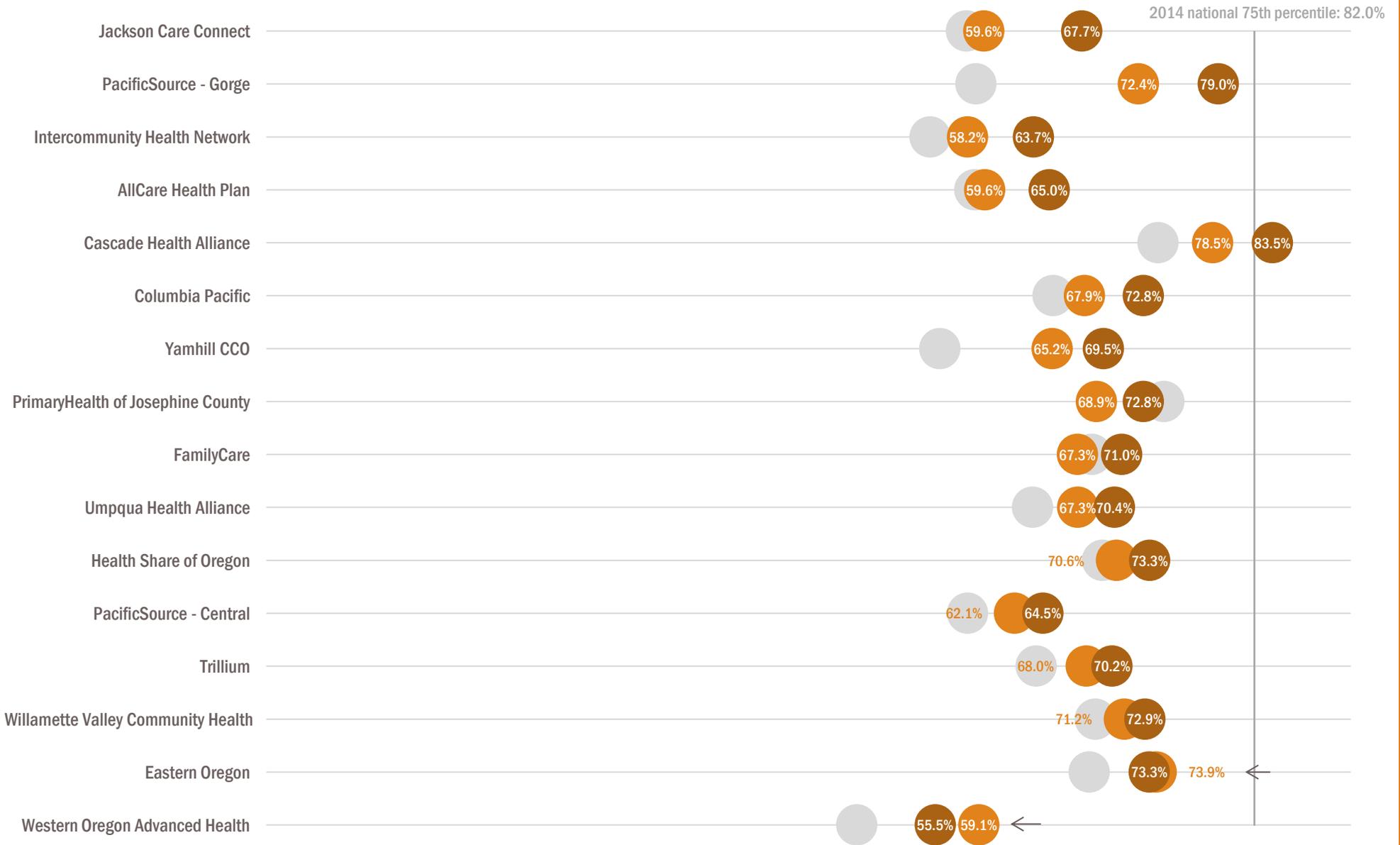




CHILDHOOD IMMUNIZATION STATUS

Percentage of children who received recommended vaccines before their second birthday in 2014 & 2015, by CCO.

Grey dots represent 2013





CHLAMYDIA SCREENING

Chlamydia screening

Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection

2015 data (n=26,074)

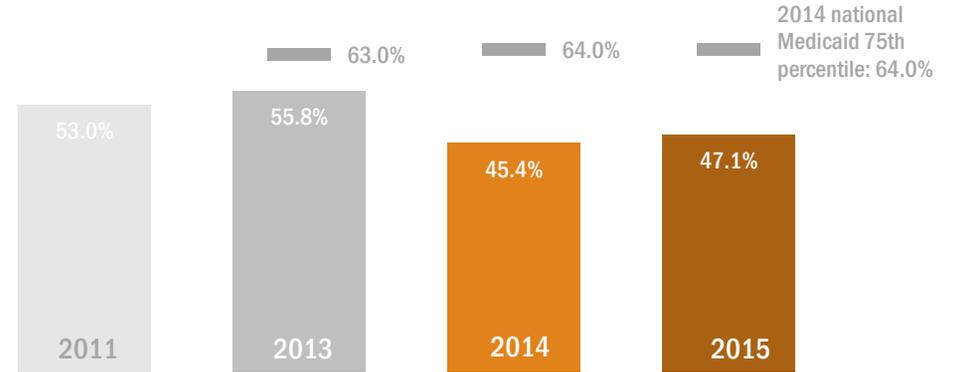
Statewide change since 2014: **+4%**

Number of CCOs that improved: **11**

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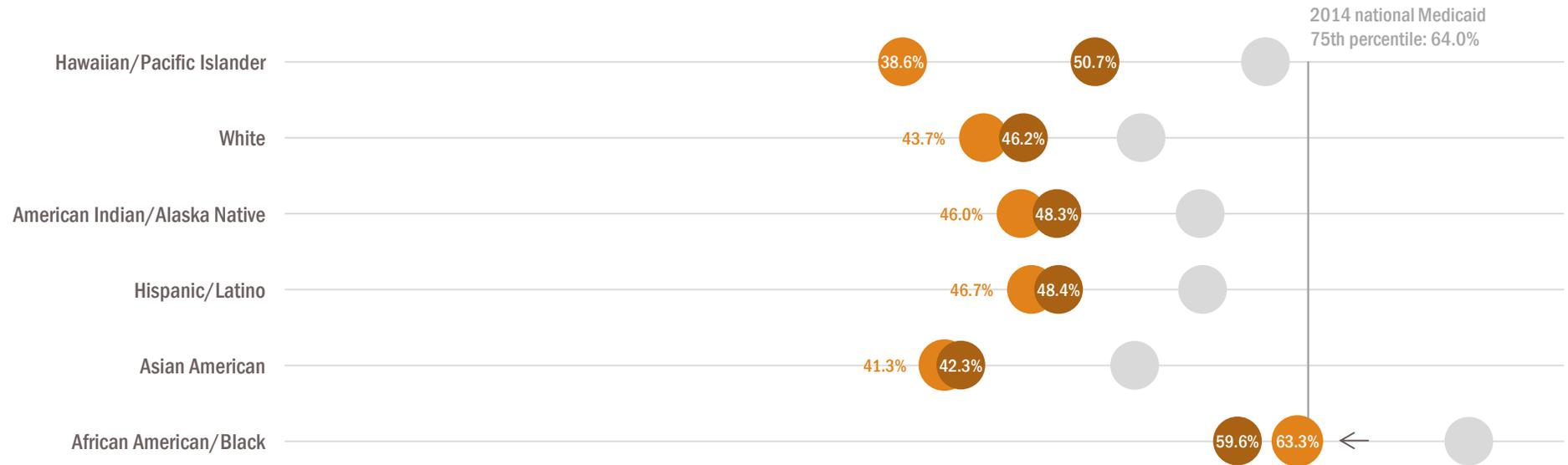
Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection, statewide.

Data source: Administrative (billing) claims



Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 14.1% of respondents / Each race category excludes Hispanic/Latino



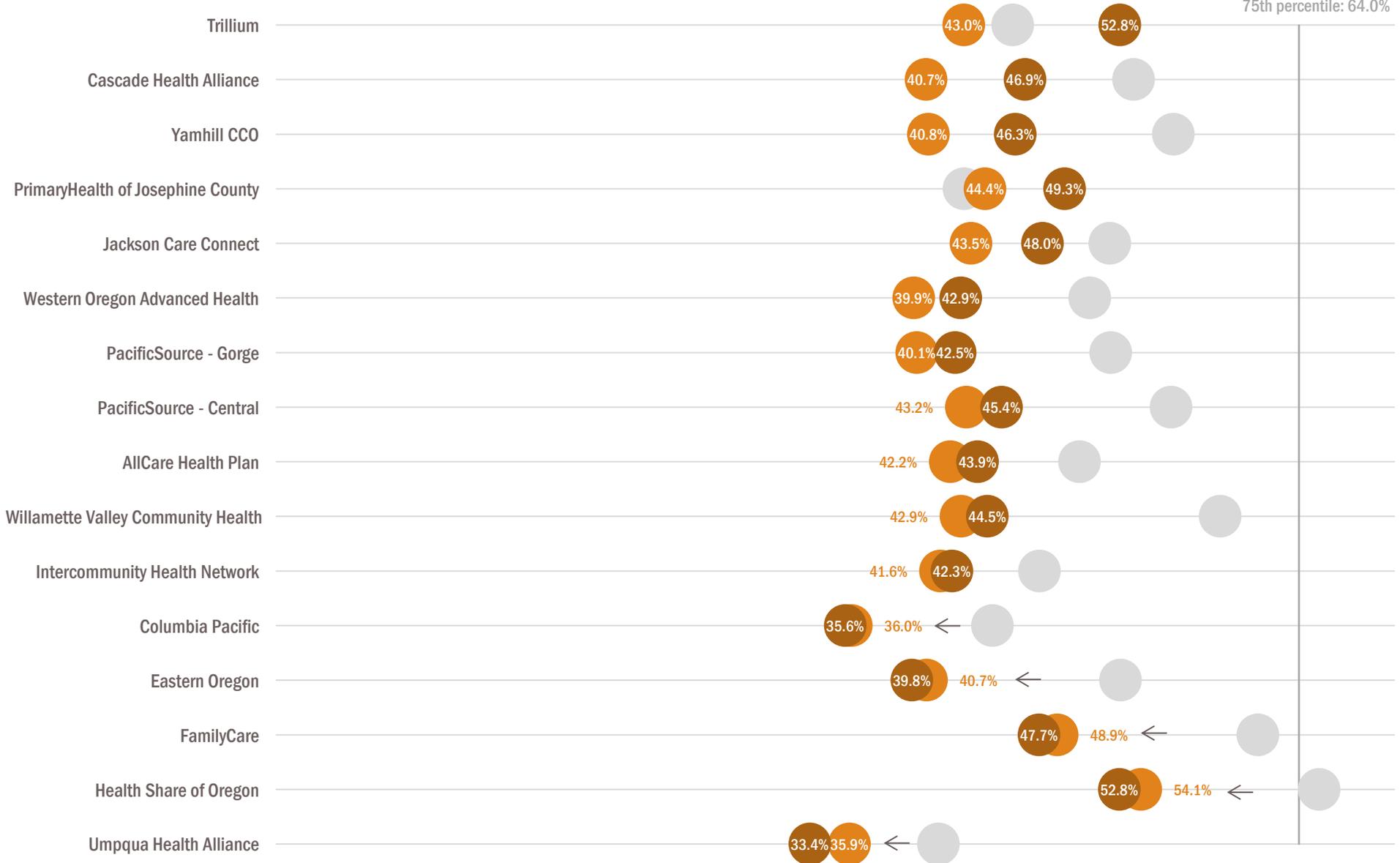


CHLAMYDIA SCREENING

Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection in 2014 & 2015, by CCO.

Grey dots represent 2013

2014 national Medicaid
75th percentile: 64.0%





COLORECTAL CANCER SCREENING

Colorectal cancer screening

Percent of adult members (ages 50-75) who had appropriate screening for colorectal cancer.

2015 data (n=6,506)

Statewide change since 2014: **+1%**

Number of CCOs that improved: **10**

Number of CCOs achieving benchmark or improvement target: **13**

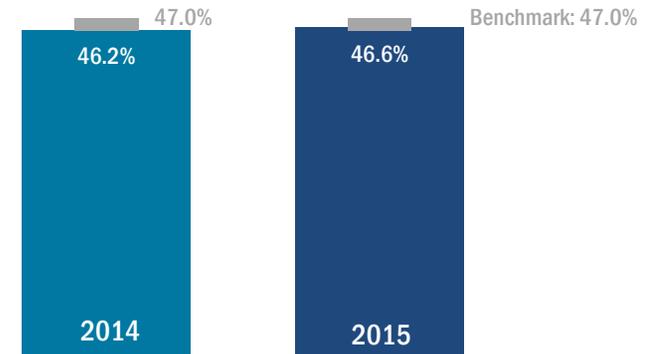
The measure specifications for colorectal cancer screening were updated in 2014 to use medical record data. Previously, rates were calculated using administrative (claims) data and were reported per 1,000 member months.

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Results for this measure are not available by race and ethnicity.

Percentage of adult members who had appropriate screening for colorectal cancer.

Data source: Administrative (billing) claims and medical record review
Benchmark source: Metrics and Scoring Committee consensus

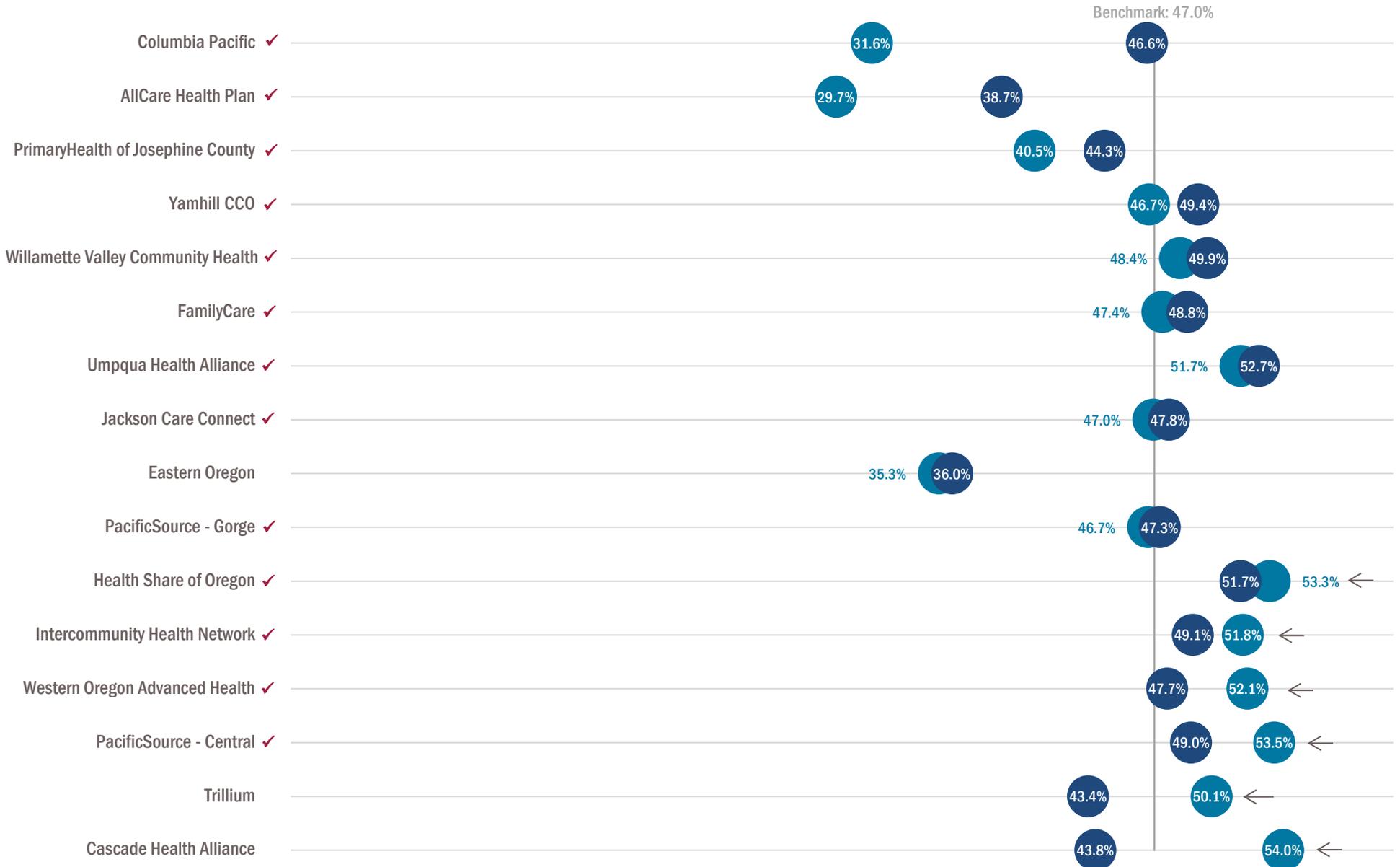




COLORECTAL CANCER SCREENING

Thirteen CCOs achieved benchmark or improvement target for colorectal cancer screening between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target





COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

Comprehensive diabetes care: HbA1c testing

Percentage of adult patients (ages 18-75) with diabetes who received at least one A1c blood sugar test during the year.

2015 data (n=33,546)

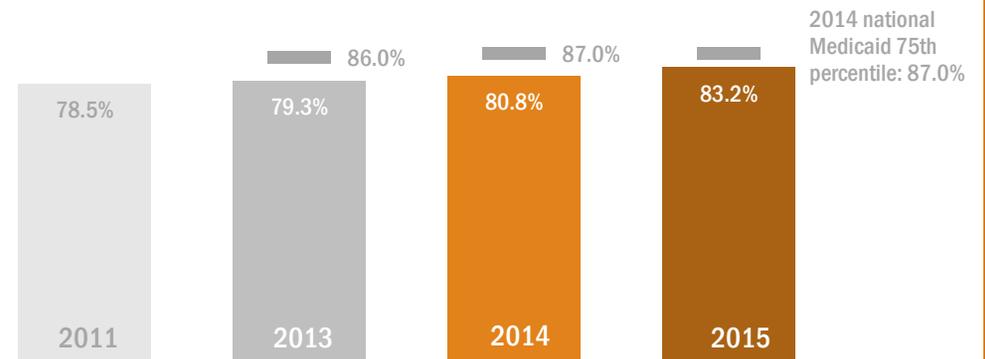
Statewide change since 2014: **+3%**

Number of CCOs that improved: **12**

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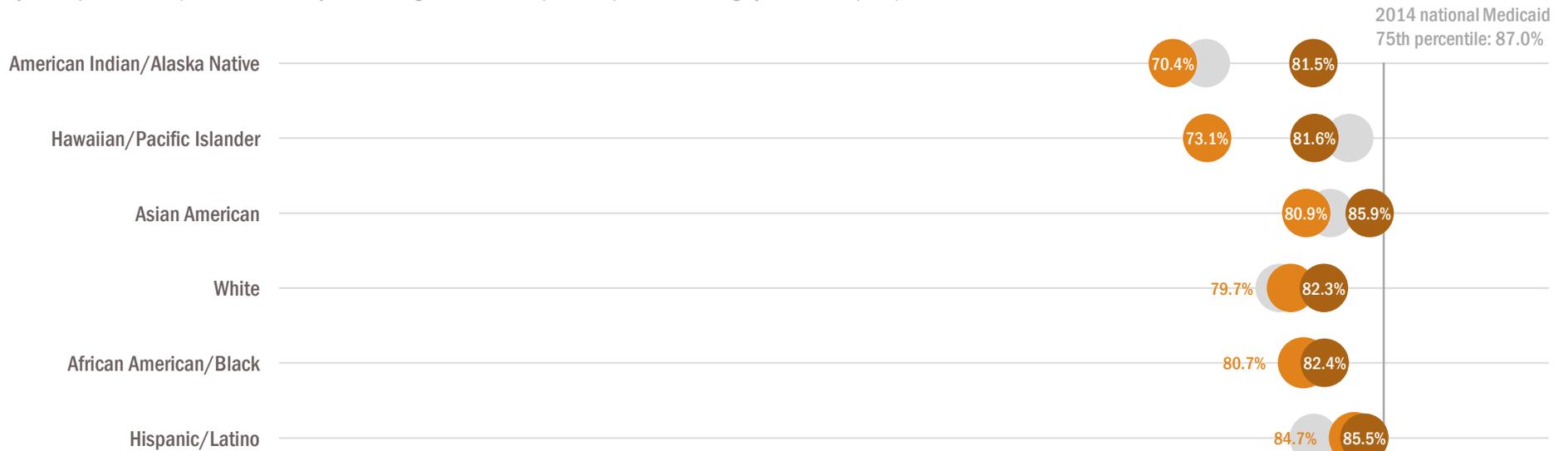
Percentage of adults with diabetes who received an A1c blood sugar test, statewide.

Data source: Administrative (billing) claims



Percentage of adults with diabetes who received an A1c blood sugar test in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 10.5% of respondents / Each race category excludes Hispanic/Latino



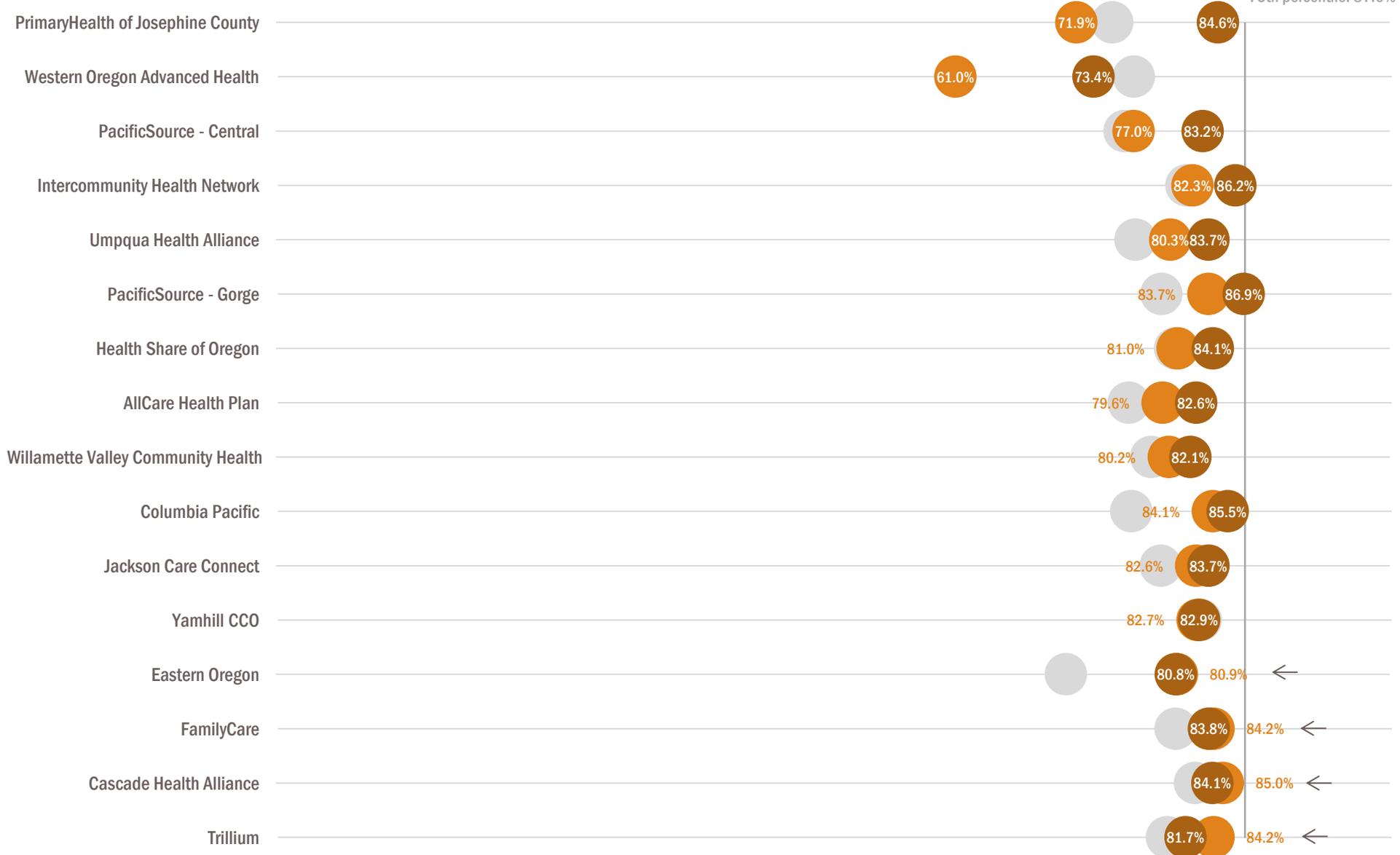


COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

Percentage of adults with diabetes who received an A1c blood sugar test in 2014 & 2015, by CCO.

Grey dots represent 2013

2014 national Medicaid
75th percentile: 87.0%





COMPREHENSIVE DIABETES CARE: LDL-C SCREENING

Comprehensive diabetes care: LDL-C screening

Percentage of adult patients (ages 18-75) with diabetes who received an LDL-C (cholesterol) test during the year.

2015 data (n=33,546)

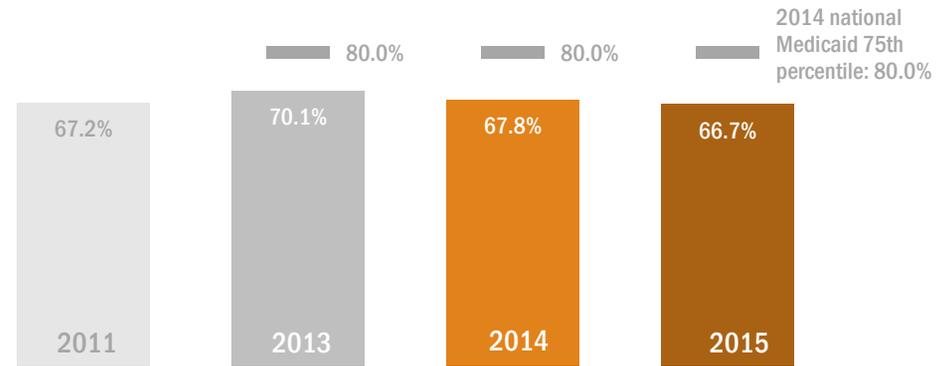
Statewide change since 2014: **-2%**

Number of CCOs that improved: **7**

LDL-C (cholesterol) testing among members with diabetes declined slightly in 2014 and 2015, while HbA1c blood sugar testing among the same population increased. This may be because the American College of Cardiology / American Heart Association released updated guidelines in 2013 that removed treatment targets for LDL-C for primary or secondary prevention of arteriosclerotic cardiovascular disease and recommended statin therapy instead. LDL-C screening and control measures were removed from the healthcare effectiveness data and information set (HEDIS) measures in 2015.

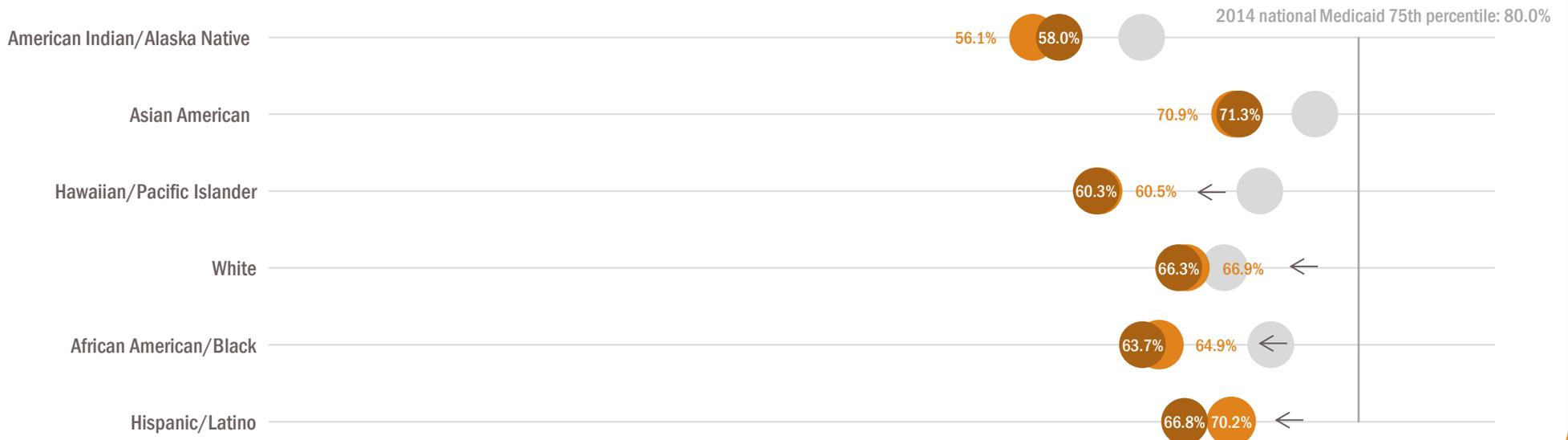
Percentage of adults with diabetes who received an LDL-C (cholesterol) test, statewide.

Data source: Administrative (billing) claims



Percentage of adults with diabetes who received an LDL-C (cholesterol) test in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 10.5% of respondents / Each race category excludes Hispanic/Latino

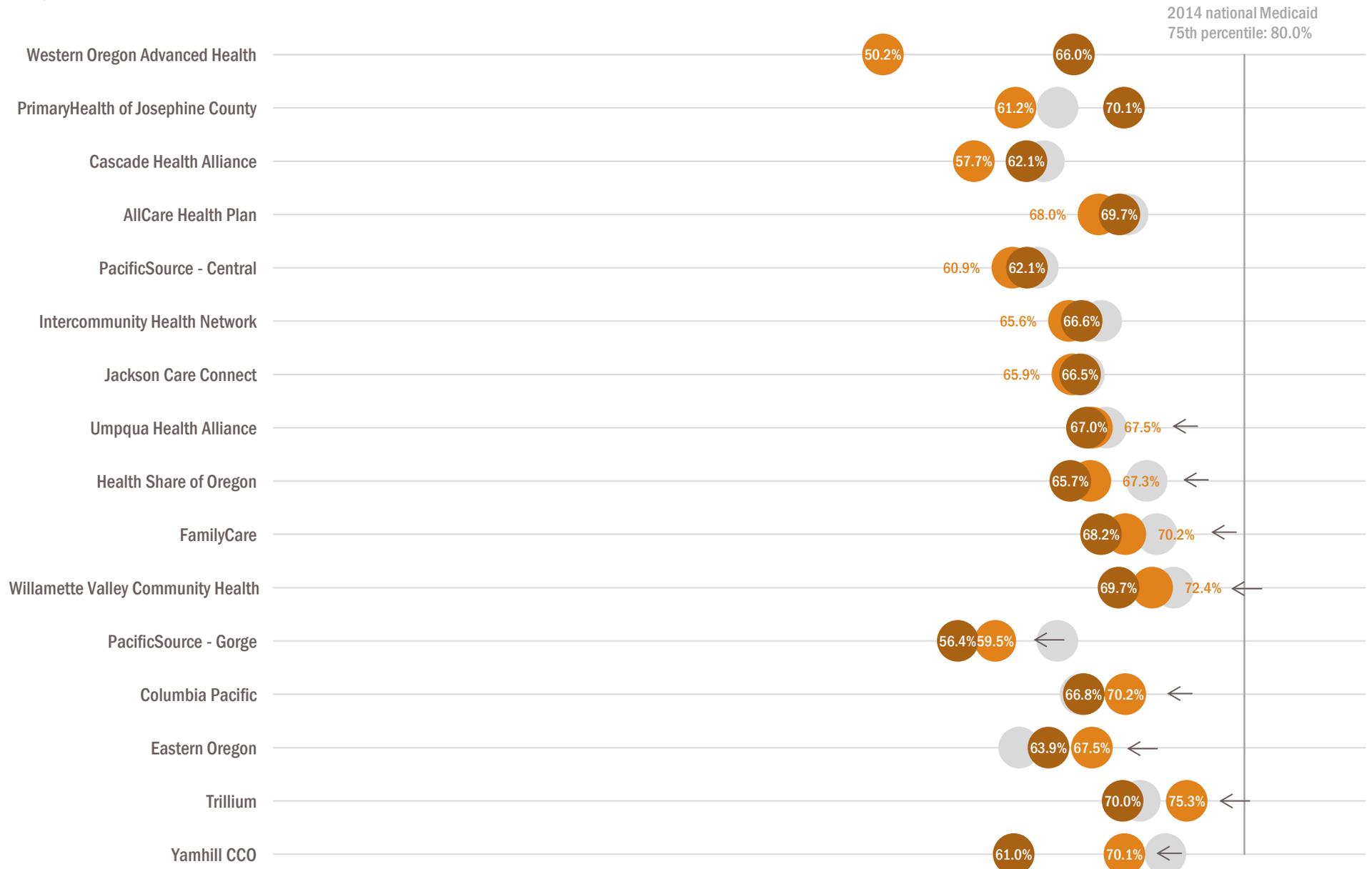




COMPREHENSIVE DIABETES CARE: LDL-C SCREENING

Percentage of adults with diabetes who received an LDL-C (cholesterol) test in 2014 & 2015, by CCO.

Grey dots represent 2013





CONTROLLING HIGH BLOOD PRESSURE

Controlling high blood pressure

Percentage of adult patients (ages 18–85) with a diagnosis of hypertension (high blood pressure) whose condition was adequately controlled.

2015 data (n=140,420)

Statewide change since 2014: **0%**

Number of CCOs that improved: **11**

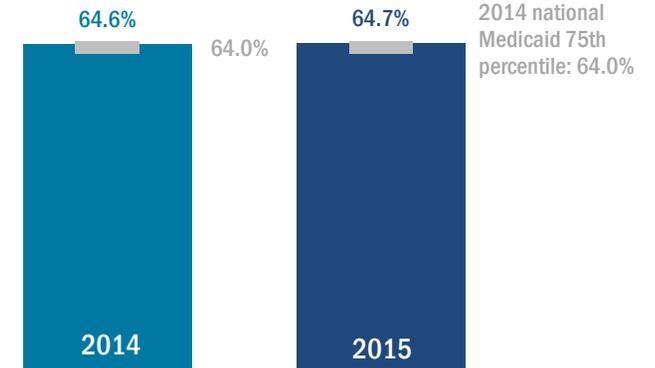
Number of CCOs achieving benchmark or improvement target: **11**

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Results for this measure are not available by race and ethnicity.

Percentage of adults with high blood pressure whose condition was adequately controlled, statewide.

Data source: Electronic Health Records

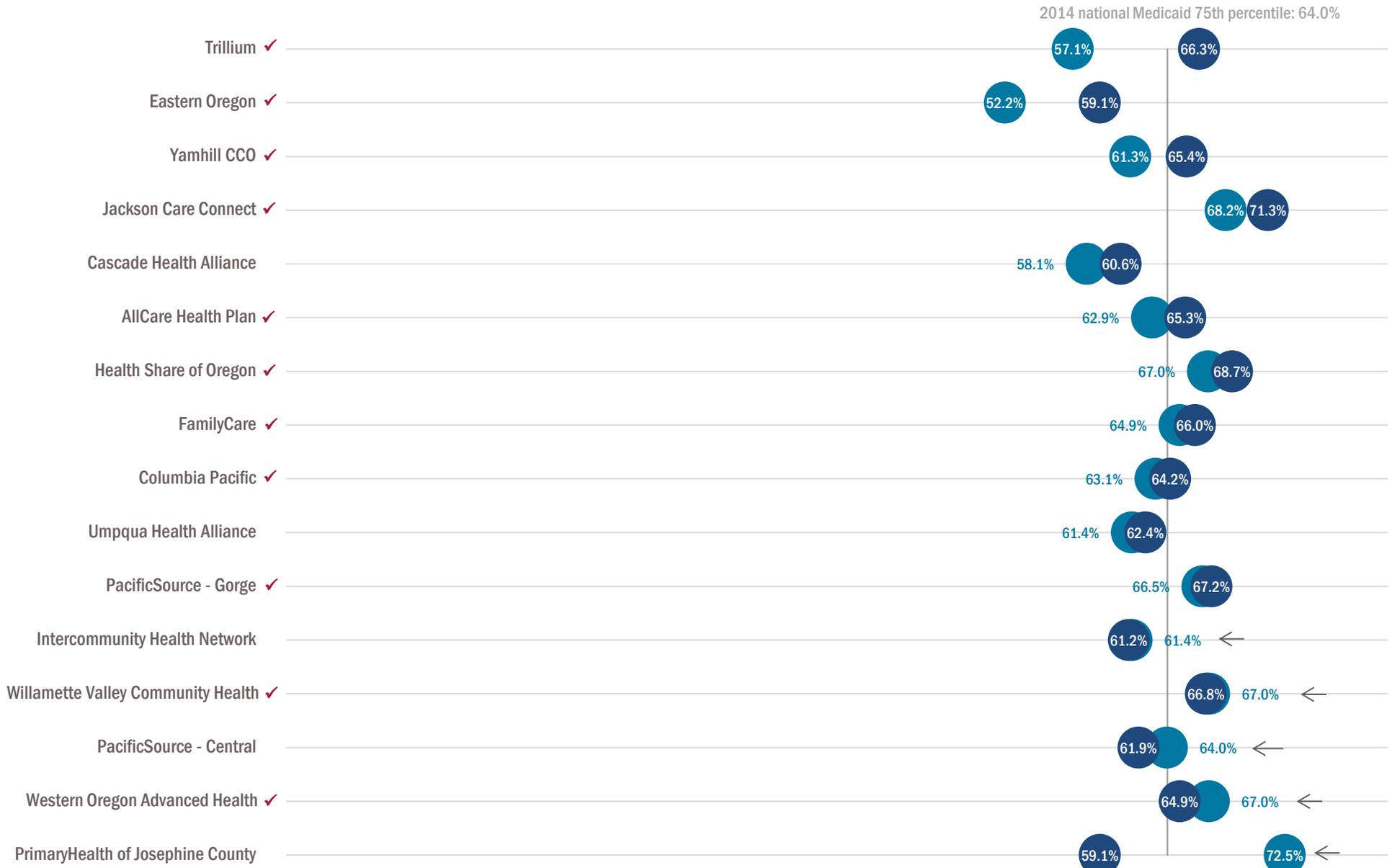




CONTROLLING HIGH BLOOD PRESSURE

Eleven CCOs achieved benchmark or improvement target for controlling high blood pressure between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target



\$ DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (all ages)

Dental sealants on permanent molars for children (all ages)

Percentage of children ages 6-14 who received a dental sealant during the measurement year.

2015 data (n=132,569)

Statewide change since 2014: **+65%**

Number of CCOs that improved: **all 16**

Number of CCOs achieving benchmark or improvement target: **all 16**

Dental sealants is a new incentive measure beginning in 2015. A benchmark of 100 percent for this measure is not realistic, due to the limitations of administrative data in identifying teeth that are not candidates for sealants (e.g., those already sealed, not yet erupted, or with active decay).

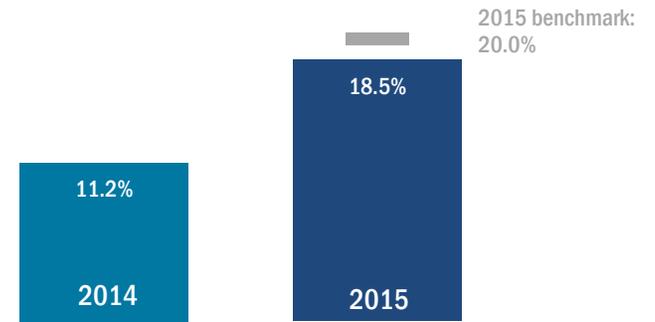
See pages [161](#) and [168](#) for results stratified by members with disability and mental health diagnoses.

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Statewide, dental sealants for children ages 6-14 have increased.

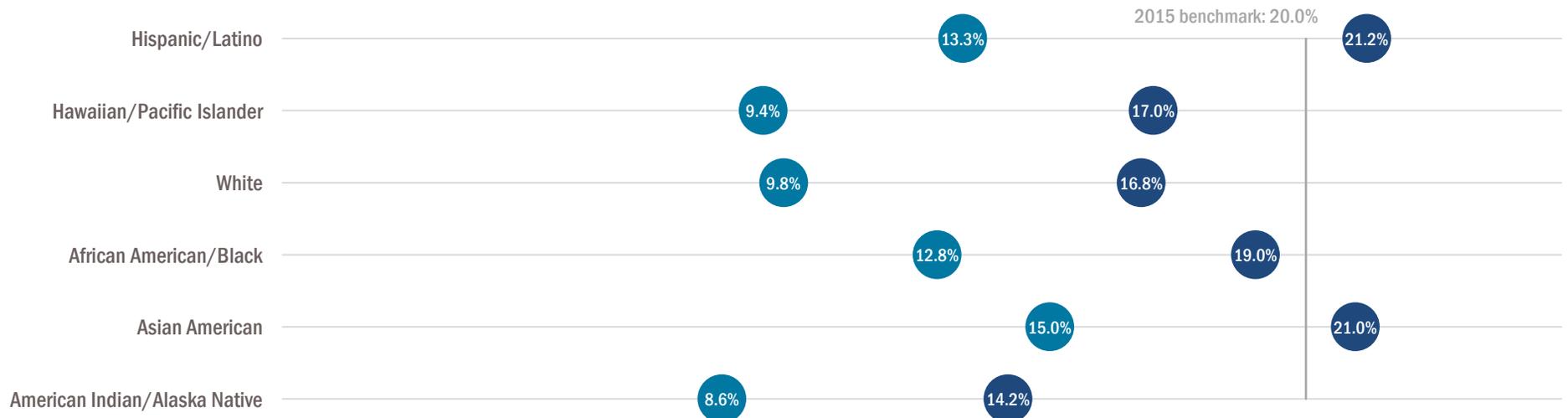
Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



Dental sealants for children ages 6-14 increased across all racial and ethnic groups between 2014 & 2015.

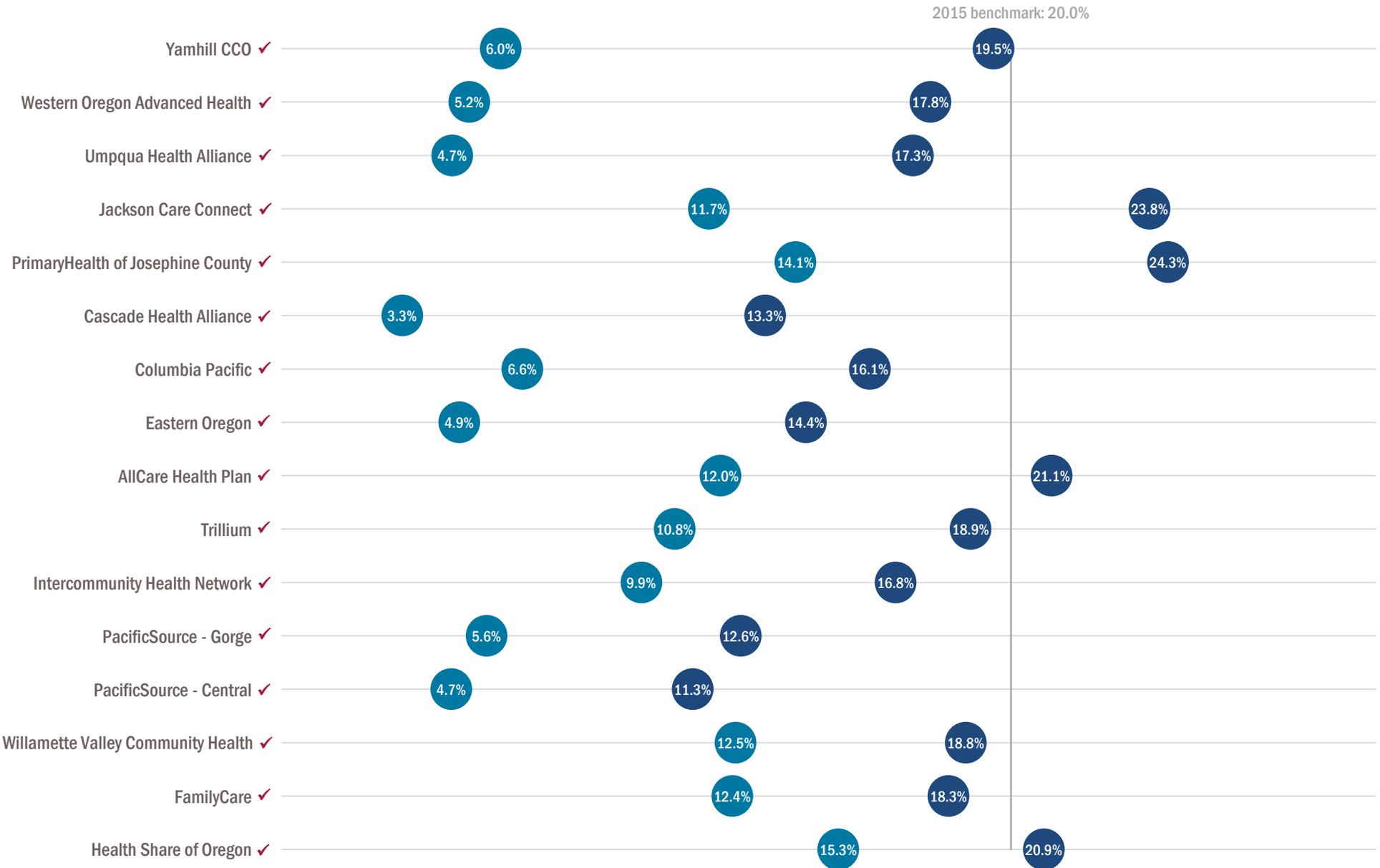
Race and ethnicity data missing for 20.2% of respondents / Each race category excludes Hispanic/Latino



\$ DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (all ages)

All 16 CCOs achieved benchmark or improvement target for dental sealants between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 6-9)

Dental sealants on permanent molars for children (ages 6-9)

Percentage of children ages 6-9 who received a dental sealant during the measurement year.

2015 data (n=63,329)

Statewide change since 2014: **+58%**

Number of CCOs that improved: **all 16**

Dental sealants is a new incentive measure beginning in 2015. Results are stratified by age group for reporting and monitoring purposes only; incentive payments are based on all ages combined (see page [81](#)).

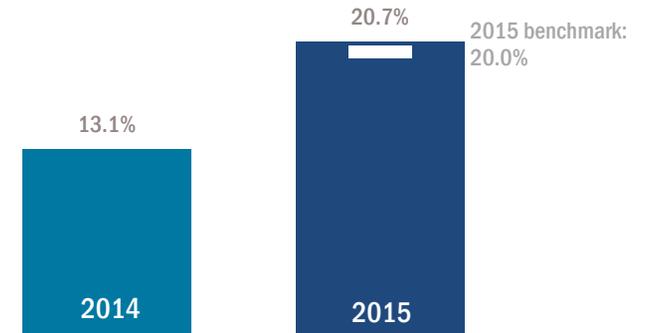
See pages [161](#) and [168](#) for results stratified by members with disability and mental health diagnoses.

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Dental sealants for children ages 6-9, statewide.

Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



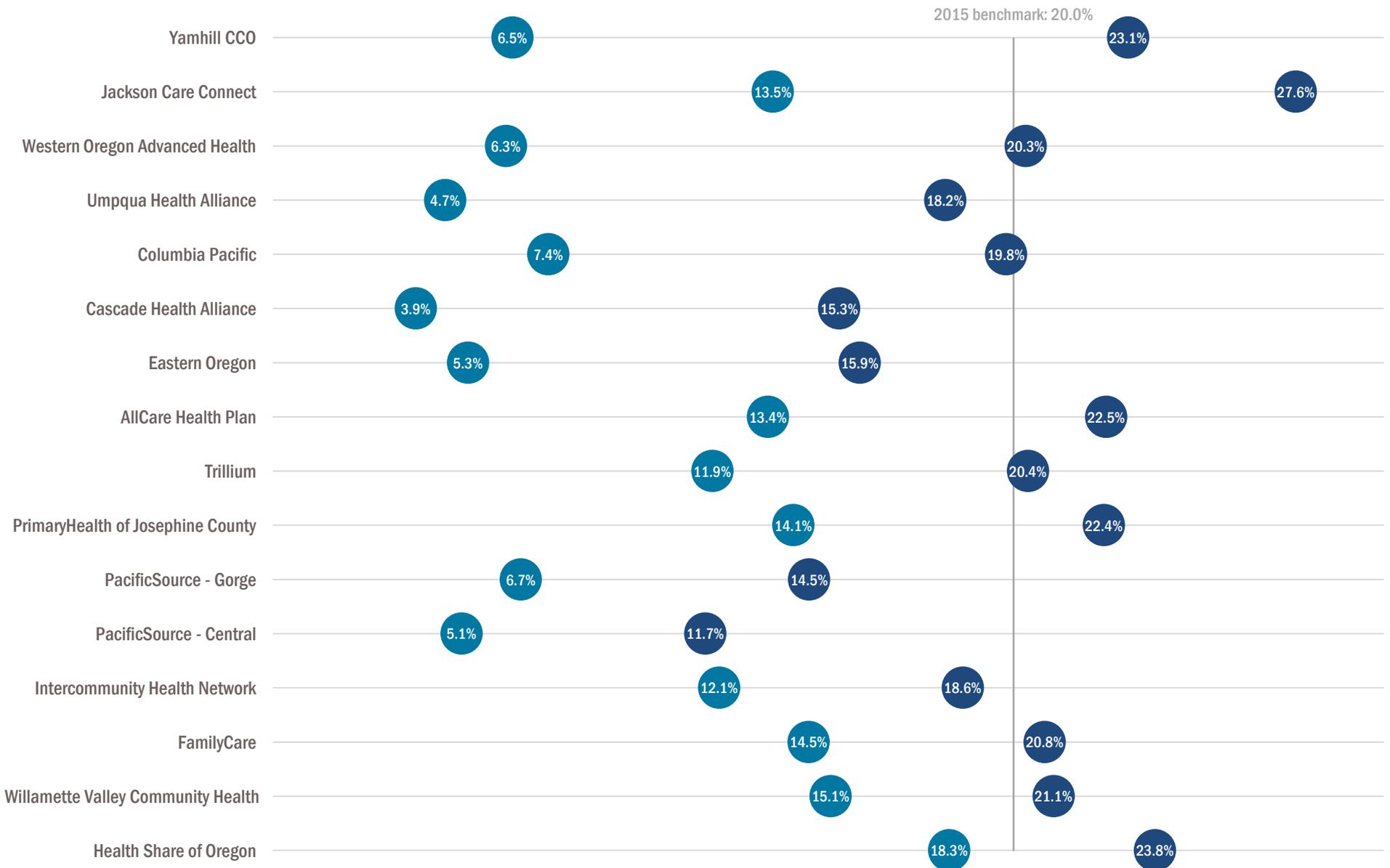
Dental sealants for children ages 6-9 between 2014 & 2015, by race and ethnicity.

Race and ethnicity data missing for 20.3% of respondents / Each race category excludes Hispanic/Latino



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 6-9)

Dental sealants for children ages 6-9 between 2014 & 2015, by CCO.



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 10-14)

Dental sealants on permanent molars for children (ages 10-14)

Percentage of children ages 10-14 who received a dental sealant during the measurement year.

2015 data (n=69,240)

Statewide change since 2014: **+76%**

Number of CCOs that improved: **all 16**

Dental sealants is a new incentive measure beginning in 2015. Results are stratified by age group for reporting and monitoring purposes only; incentive payments are based on all ages combined (see page [81](#)).

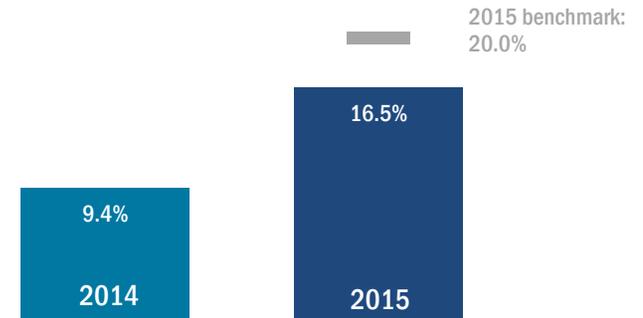
See pages [161](#) and [168](#) for results stratified by members with disability and mental health diagnoses.

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Dental sealants for children ages 10-14, statewide.

Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



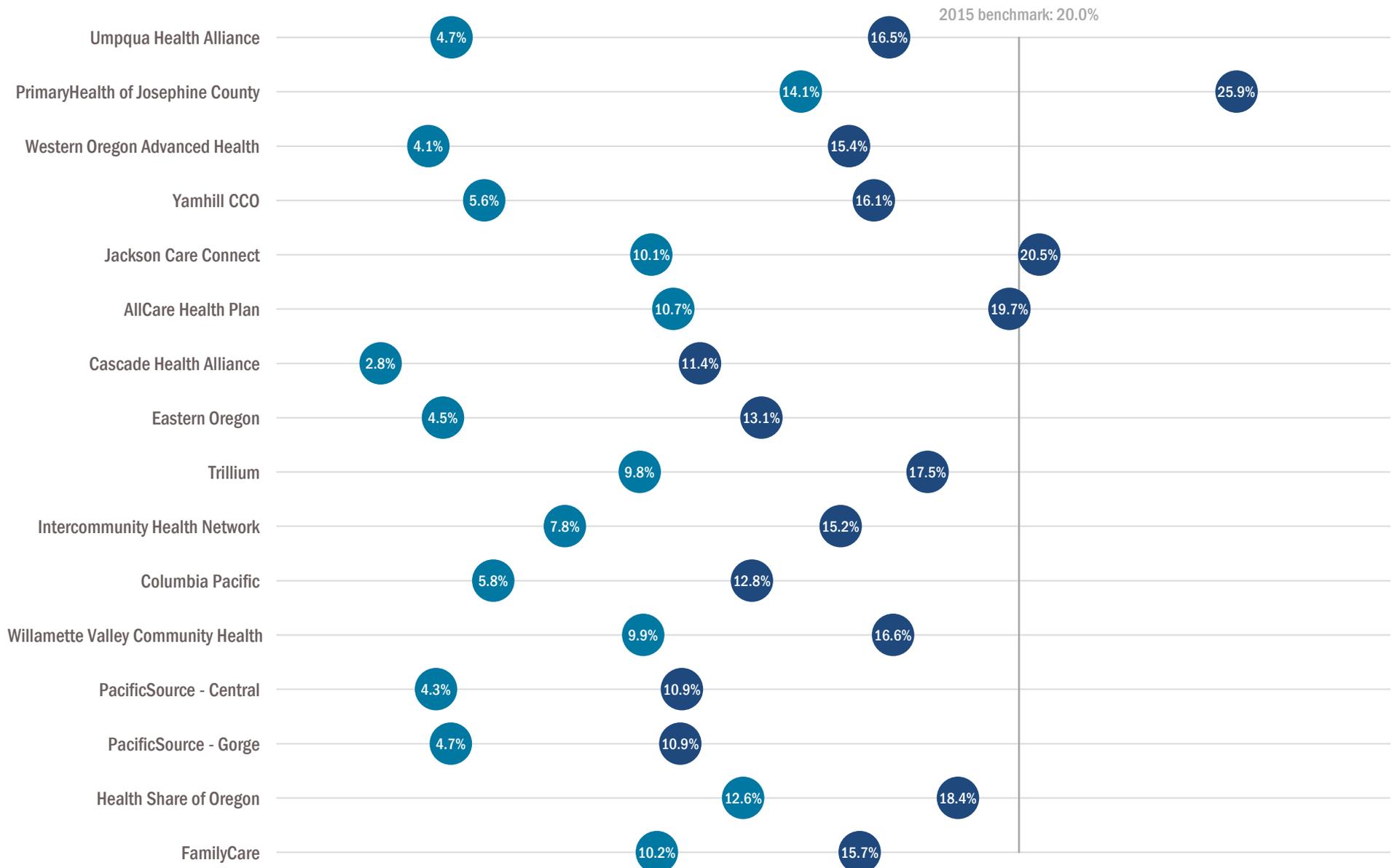
Dental sealants for children ages 10-14 between 2014 & 2015, by race and ethnicity.

Race and ethnicity data missing for 20.1% of respondents / Each race category excludes Hispanic/Latino



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 10-14)

Dental sealants for children ages 10-14 between 2014 & 2015, by CCO.





DEPRESSION SCREENING AND FOLLOW-UP PLAN

Depression screening and follow-up plan

Percentage of patients (ages 12 and older) who had appropriate screening and follow-up planning for depression.

2015 data (n=345,771)

Statewide change since 2014: **+34%**

Number of CCOs that improved: **13**

Number of CCOs achieving benchmark or improvement target: **15**

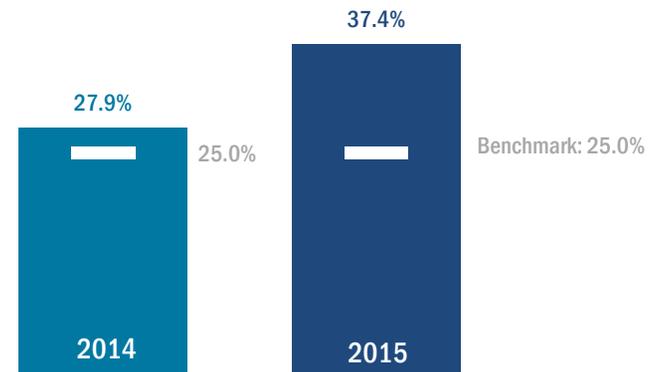
The range in performance on this measure in part reflects the challenges of adopting and implementing electronic health record functionality that enables the reporting of all data elements required for this measure.

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Results for this measure are not available by race and ethnicity.

Statewide, the percentage of adult patients who were screened for depression and had an appropriate follow-up plan increased.

Data source: Electronic Health Records
Benchmark source: Metrics and Scoring Committee consensus

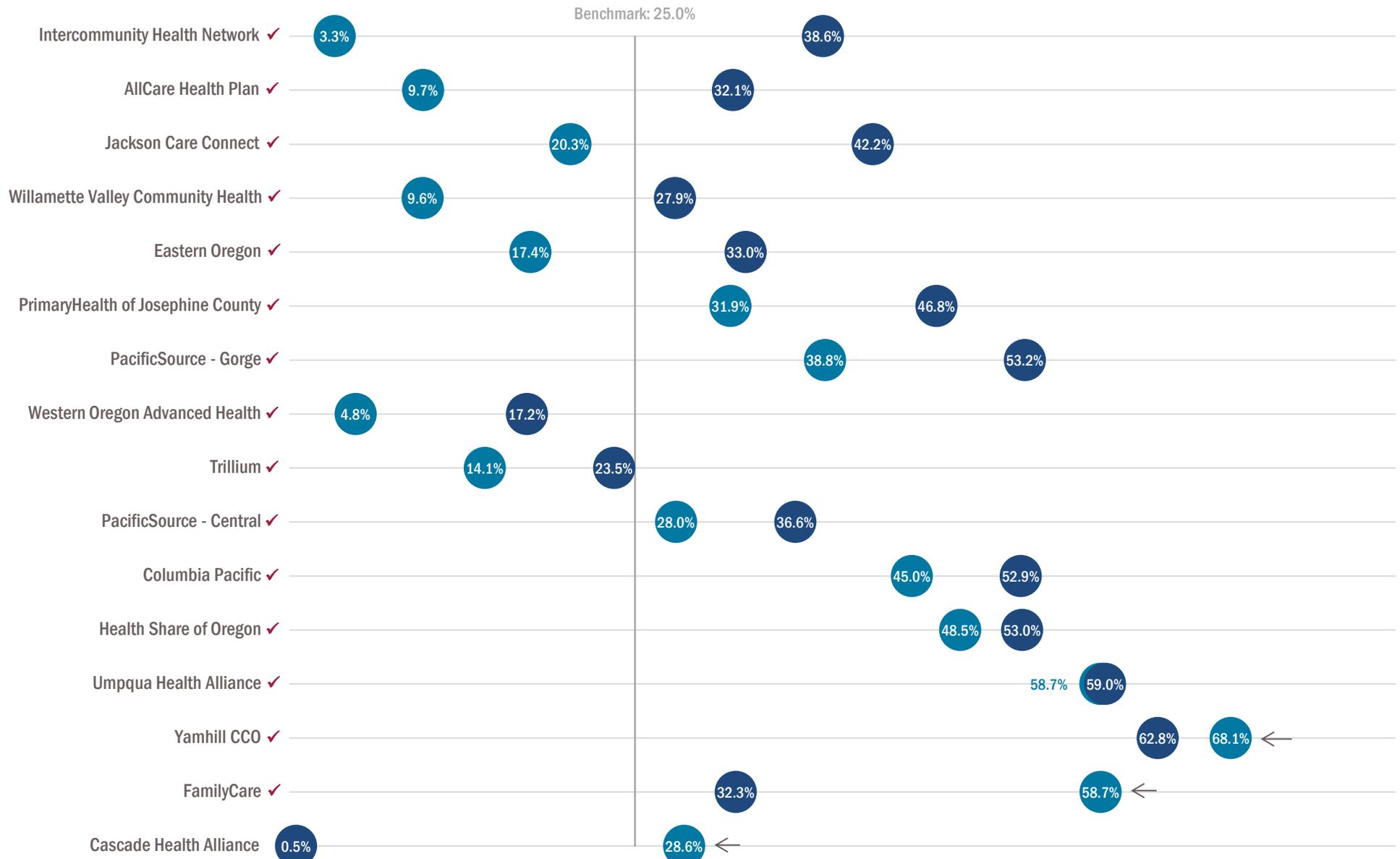




DEPRESSION SCREENING AND FOLLOW-UP PLAN

Fifteen CCOs achieved benchmark or improvement target for depression screening and follow-up plan between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target





DEVELOPMENTAL SCREENING IN THE FIRST 36 MONTHS OF LIFE

Developmental screening in the first 36 months of life

Percentage of children who were screened for risks of developmental, behavioral and social delays using standardized screening tools in the 12 months preceding their first, second or third birthday.

2015 data (n=51,093)

Statewide change since 2014: **+28%**

Number of CCOs that improved: **15**

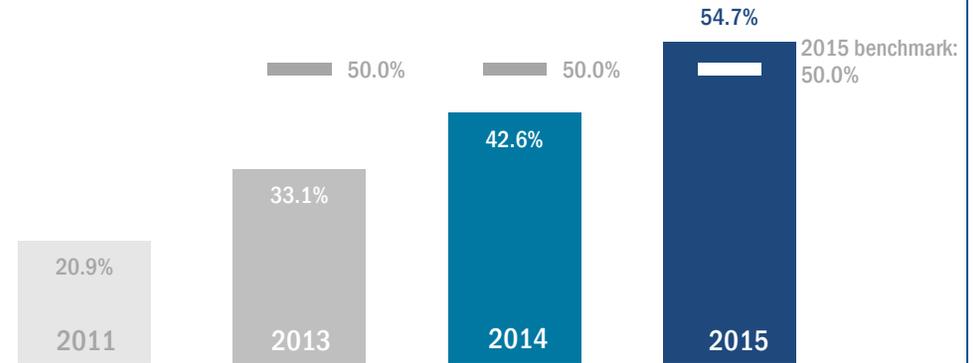
Number of CCOs achieving benchmark or improvement target: **all 16**

See pages [158](#) and [164](#) for results stratified by member with disability and mental health diagnoses.

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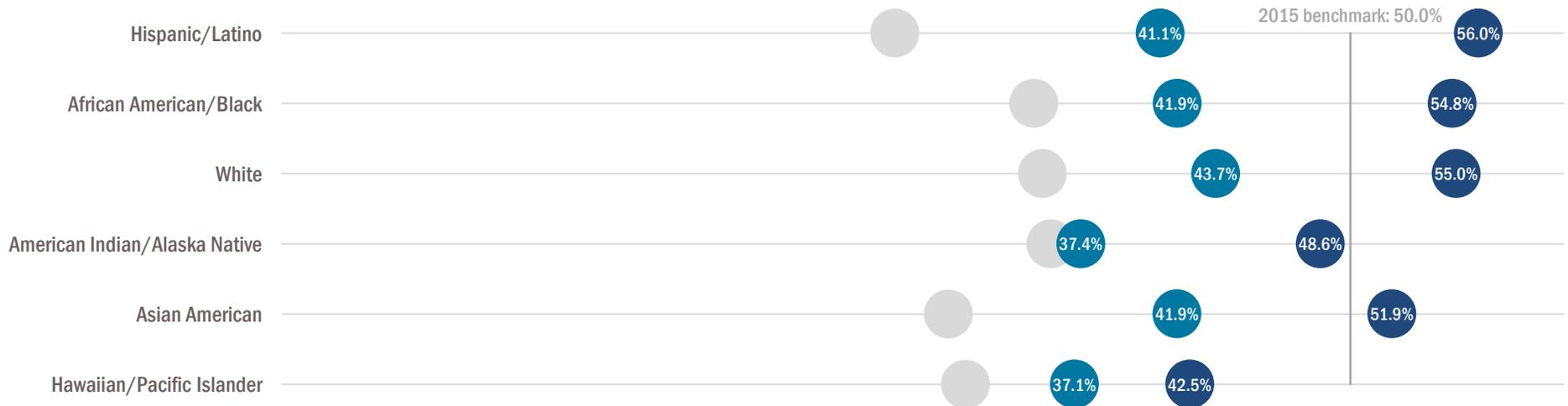
Statewide, developmental screening continues to improve and surpassed the benchmark for the first time in 2015.

Data source: Administrative (billing) claims
Benchmark source: Metrics and Scoring Committee consensus



Developmental screening improved for all racial and ethnic groups between 2014 & 2015.

Grey dots represent 2013 / Race and ethnicity data missing for 21.7% of respondents / Each race category excludes Hispanic/Latino

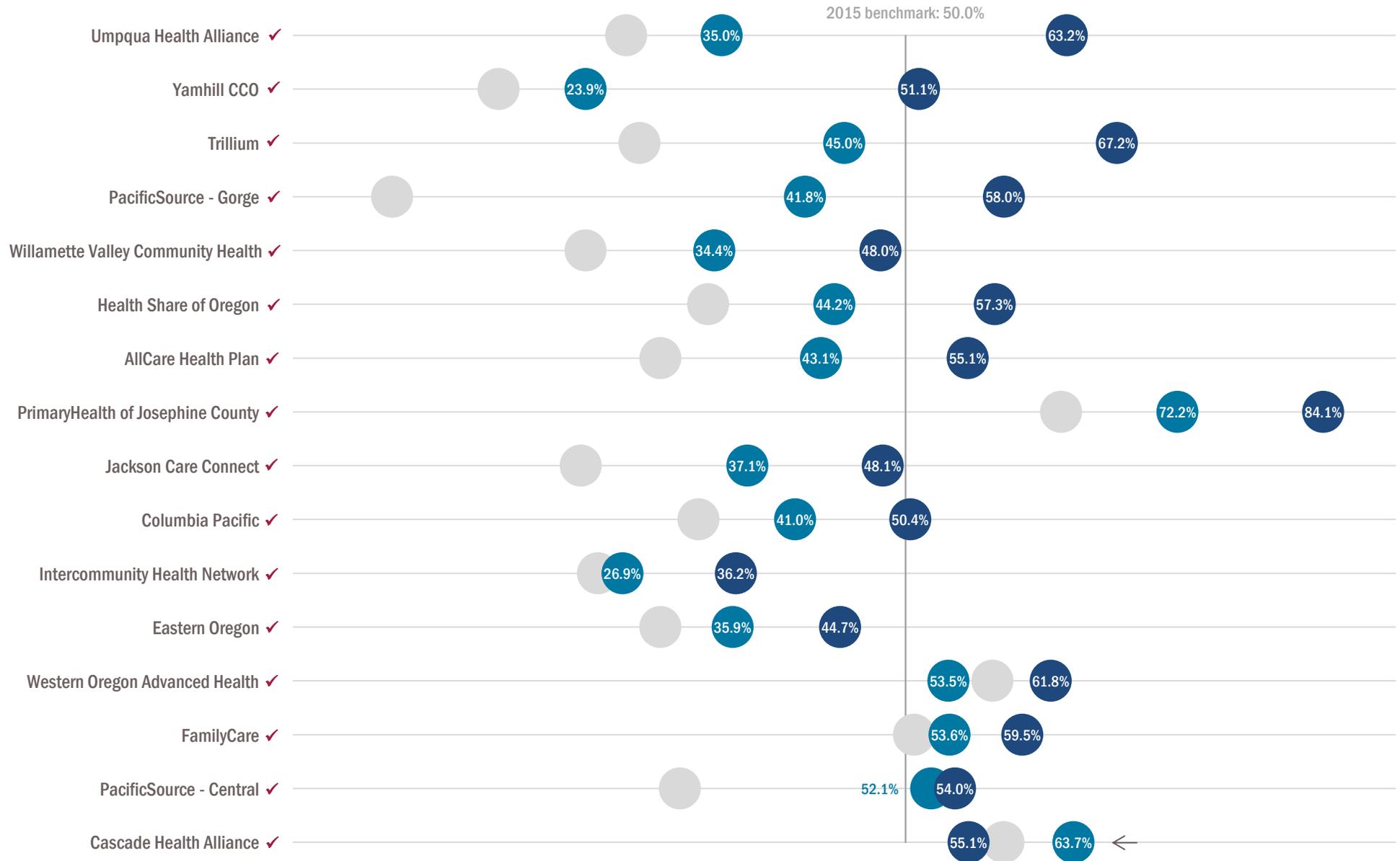




DEVELOPMENTAL SCREENING IN THE FIRST 36 MONTHS OF LIFE

All 16 CCOs achieved benchmark or improvement target for developmental screening between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2013





DIABETES CARE: HbA1c POOR CONTROL

Diabetes care: HbA1c poor control

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. A lower score is better.

2015 data (n=53,620)

Statewide change since 2014: **+22%** (lower is better)

Number of CCOs that improved: **4**

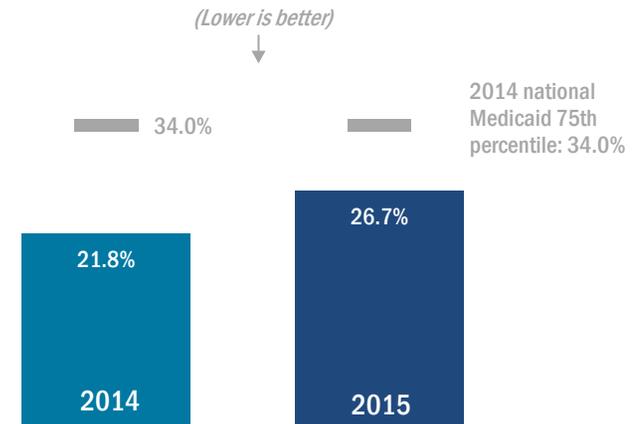
Number of CCOs achieving benchmark or improvement target: **all 16**

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Results for this measure are not available by race and ethnicity.

Statewide, the percentage of members with diabetes who had poor control of hemoglobin A1c has increased.

Data source: Electronic Health Records

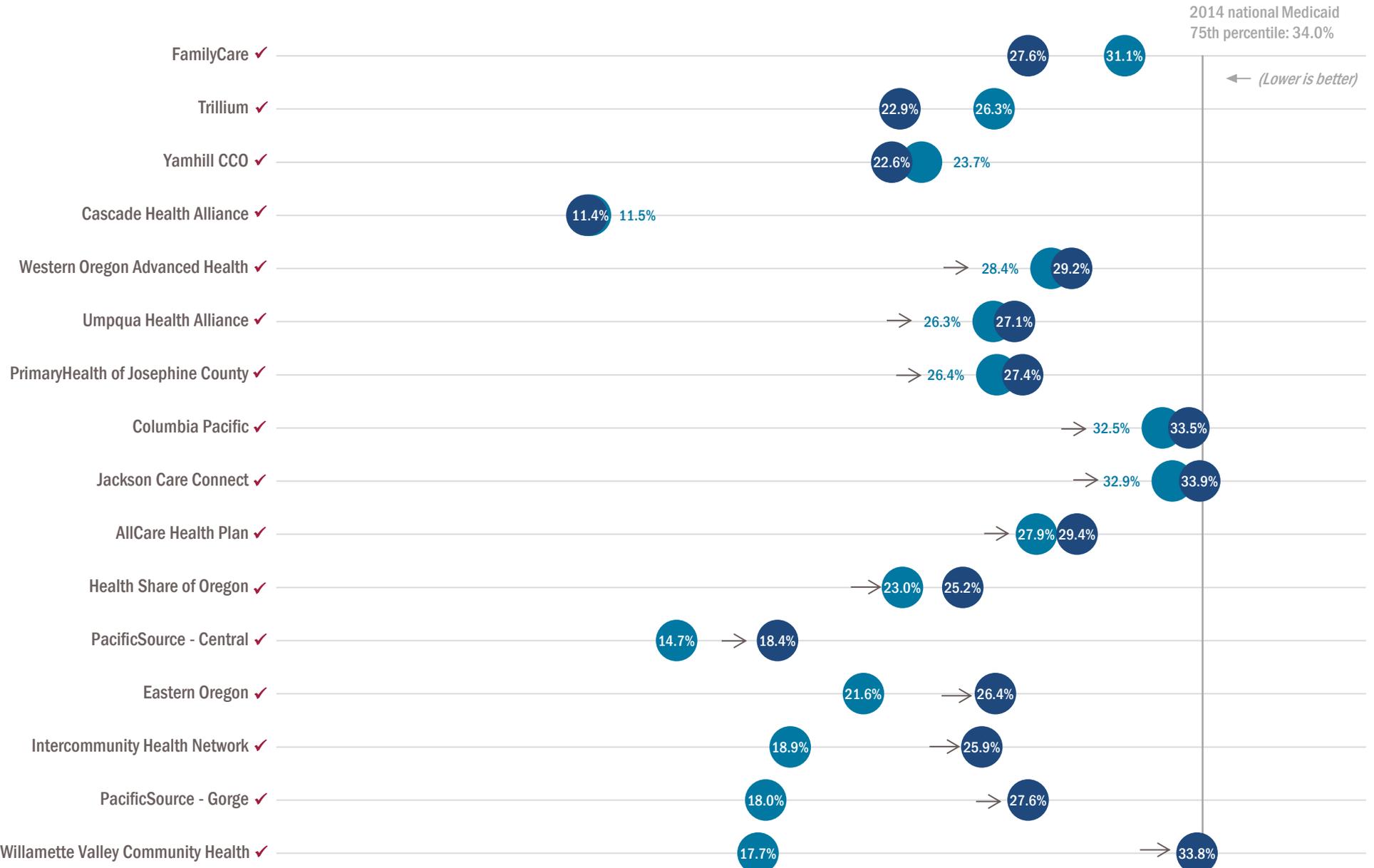




DIABETES CARE: HbA1c POOR CONTROL

All 16 CCOs met the benchmark for HbA1c poor control in both 2014 & 2015.

✓ indicates CCO met benchmark or improvement target





EARLY ELECTIVE DELIVERY

Early elective delivery

Percentage of women delivering a newborn who had an elective delivery between 37 and 39 weeks of gestation (lower score is better).

2015 data (n=2,939)

Statewide change since 2014: **-17%** (lower is better)

Number of CCOs that improved: **10**

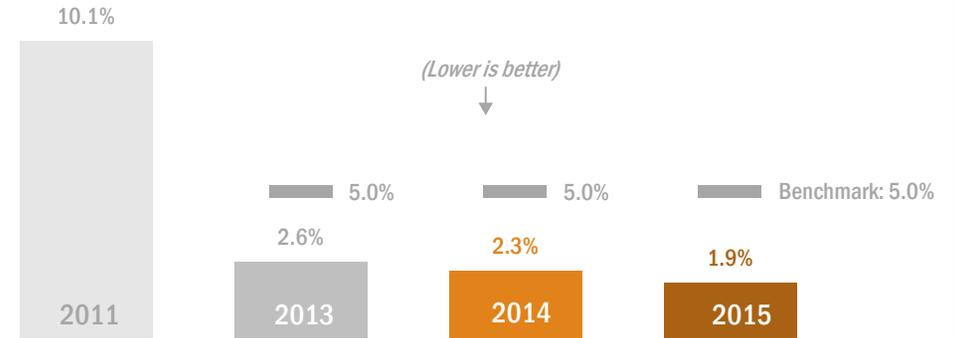
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Results for this measure are not available by race and ethnicity.

Early elective delivery, statewide.

Data source: Administrative (billing) claims, Vital Records, and hospitals

Benchmark source: Metrics and Scoring Committee consensus

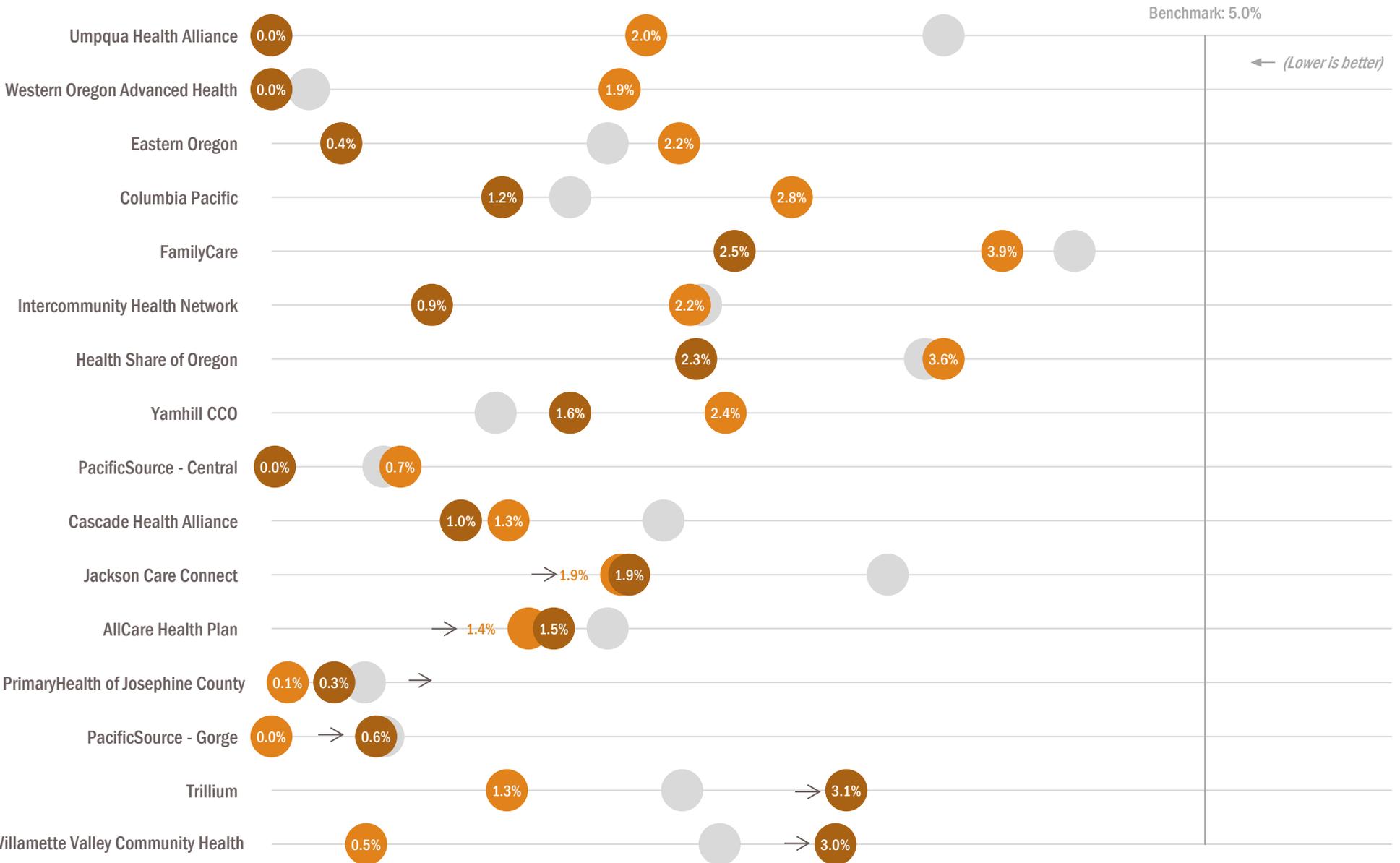




EARLY ELECTIVE DELIVERY

Early elective delivery in 2014 & 2015, by CCO.

Grey dots represent 2013





EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 18-50)

Effective contraceptive use among women at risk of unintended pregnancy (ages 18-50)

Percentage of adult women (ages 18-50) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

2015 data (n=127,643)

Statewide change since 2014: **+9%**

Number of CCOs that improved: **14**

Number of CCOs achieving benchmark or improvement target: **9**

Effective contraceptive use among women at risk of unintended pregnancy is a new incentive measure in 2015.

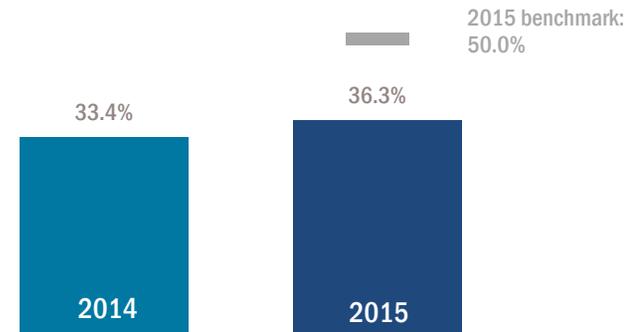
See pages [162](#), [169](#), and [172](#) for results stratified by members with disability, mental health diagnoses, and severe and persistent mental illness.

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Statewide, effective contraceptive use among adults increased slightly.

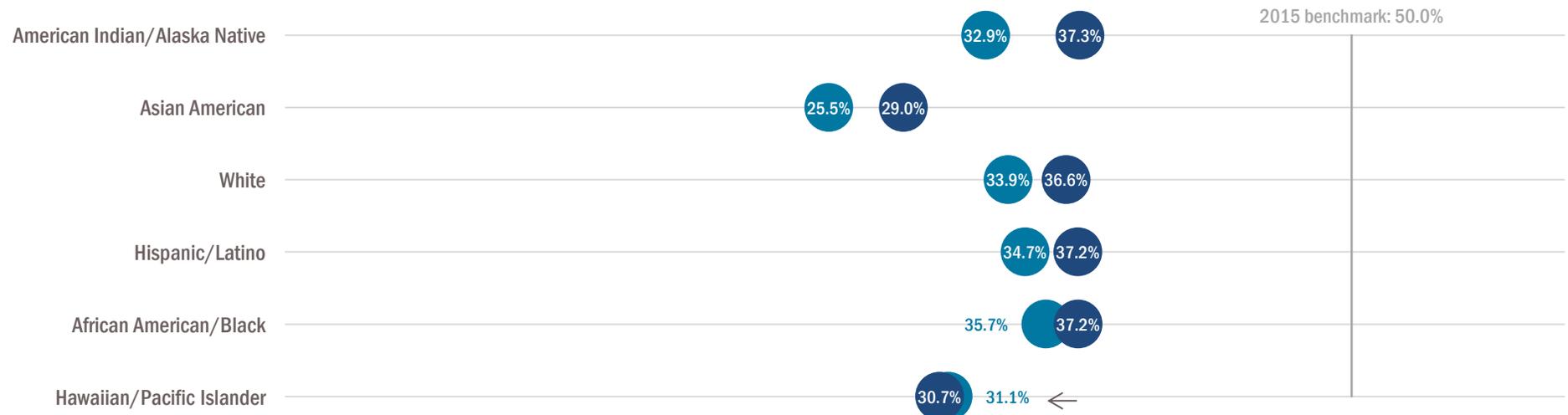
Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



Effective contraceptive use among adults between 2014 & 2015, by race and ethnicity.

Race and ethnicity data missing for 18.8% of respondents / Each race category excludes Hispanic/Latino

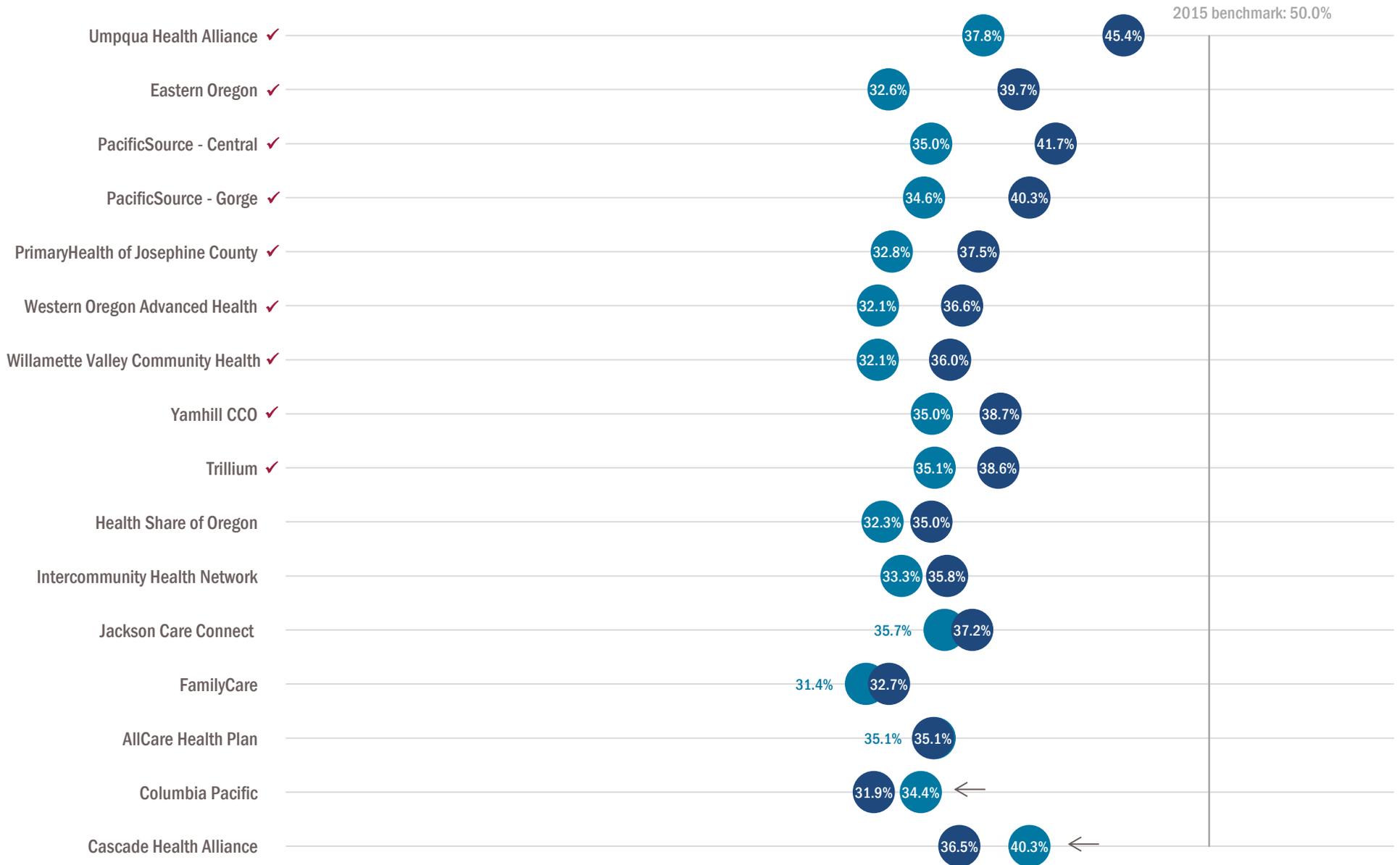




EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 18-50)

Nine CCOs achieved their improvement target for effective contraceptive use between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 15-17)

Effective contraceptive use among women at risk of unintended pregnancy (ages 15-17).

Percentage of adolescent women (ages 15-17) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

2015 data (n=18,247)

Statewide change since 2014: **+4%**

Number of CCOs that improved: **13**

Effective contraceptive use among adolescents (ages 15-17) at risk of unintended pregnancy is reported for monitoring purposes only; Incentive payments are based on all adults only (see page [95](#)).

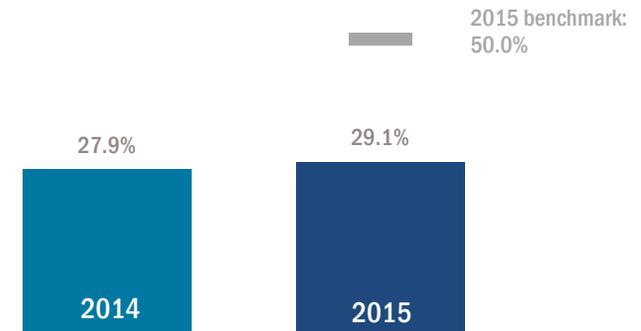
See pages [162](#) and [169](#) for results stratified by members with disability and mental health diagnoses.

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Effective contraceptive use among adolescents at risk of unintended pregnancy, statewide.

Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



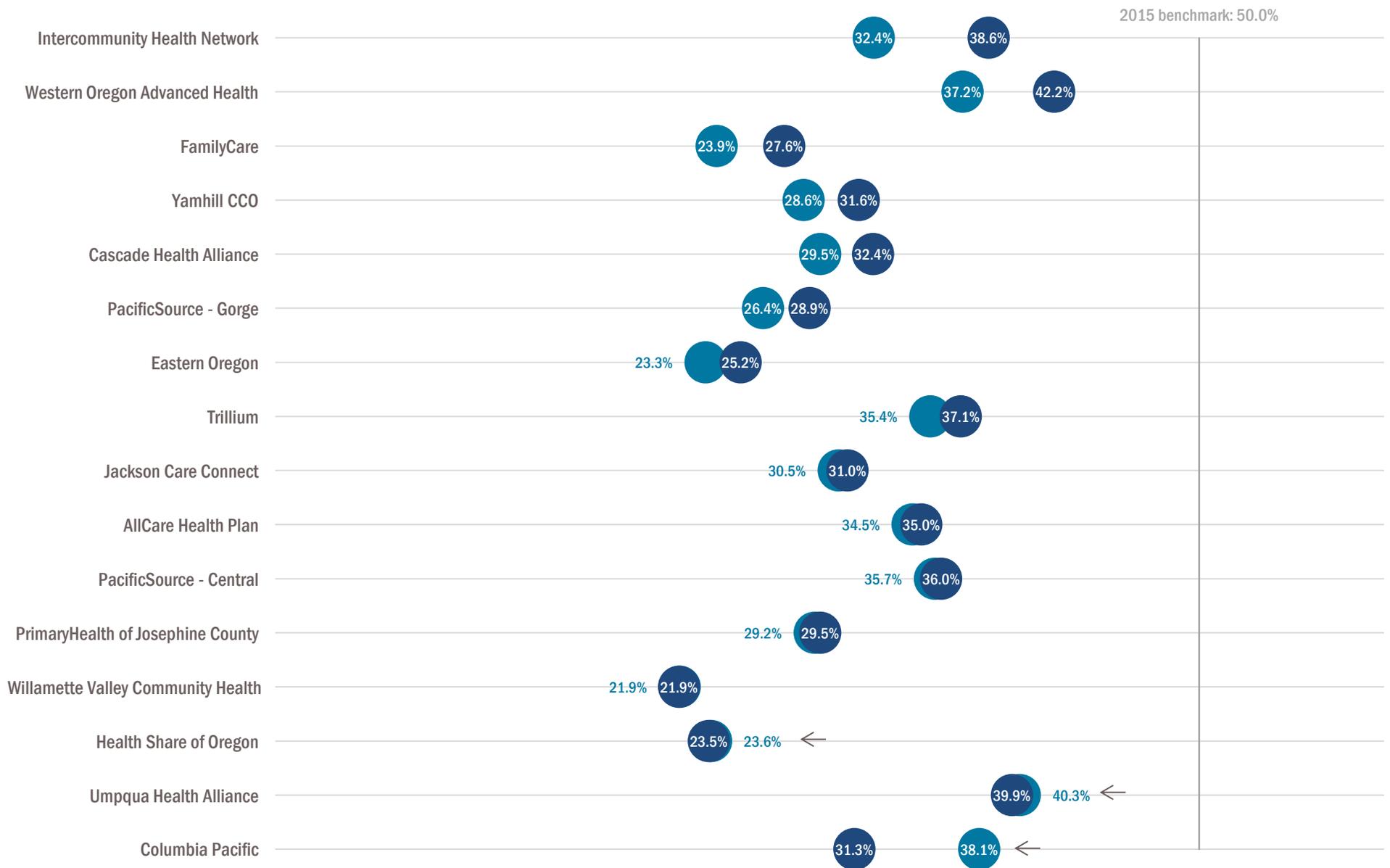
Effective contraceptive use among adolescents between 2014 & 2015, by race and ethnicity.

Race and ethnicity data missing for 19.4% of respondents / Each race category excludes Hispanic/Latino



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 15-17)

Effective contraceptive use among adolescents at risk of unintended pregnancy between 2014 & 2015, by CCO.



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (all ages 15-50)

Effective contraceptive use among women at risk of unintended pregnancy (ages 15-50).

Percentage of women (ages 15-50) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

2015 data (n=145,890)

Statewide change since 2014: **+9%**

Number of CCOs that improved: **14**

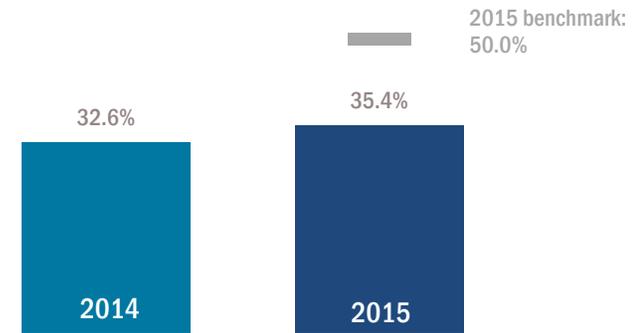
Effective contraceptive use among women all ages (15-50) at risk of unintended pregnancy is reported for monitoring purposes only; Incentive payments are based on all adults only (see page [95](#)).

See pages [162](#) and [169](#) for results stratified by members with disability and mental health diagnoses.

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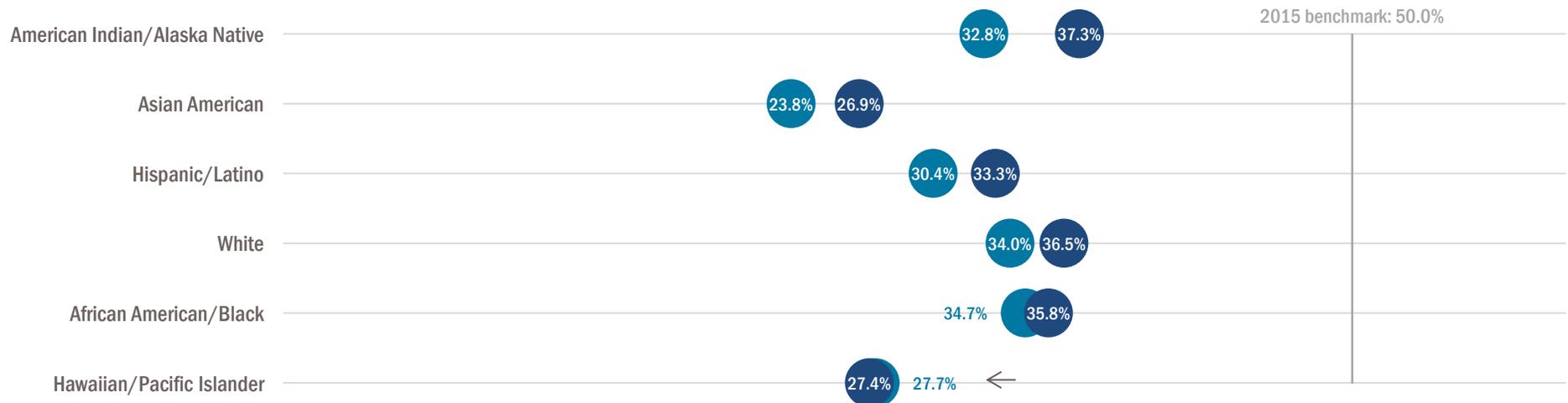
Effective contraceptive use among women (ages 15-50) at risk of unintended pregnancy, statewide.

Data source: Administrative (billing) claims
Benchmark source: Metrics and Scoring Committee consensus



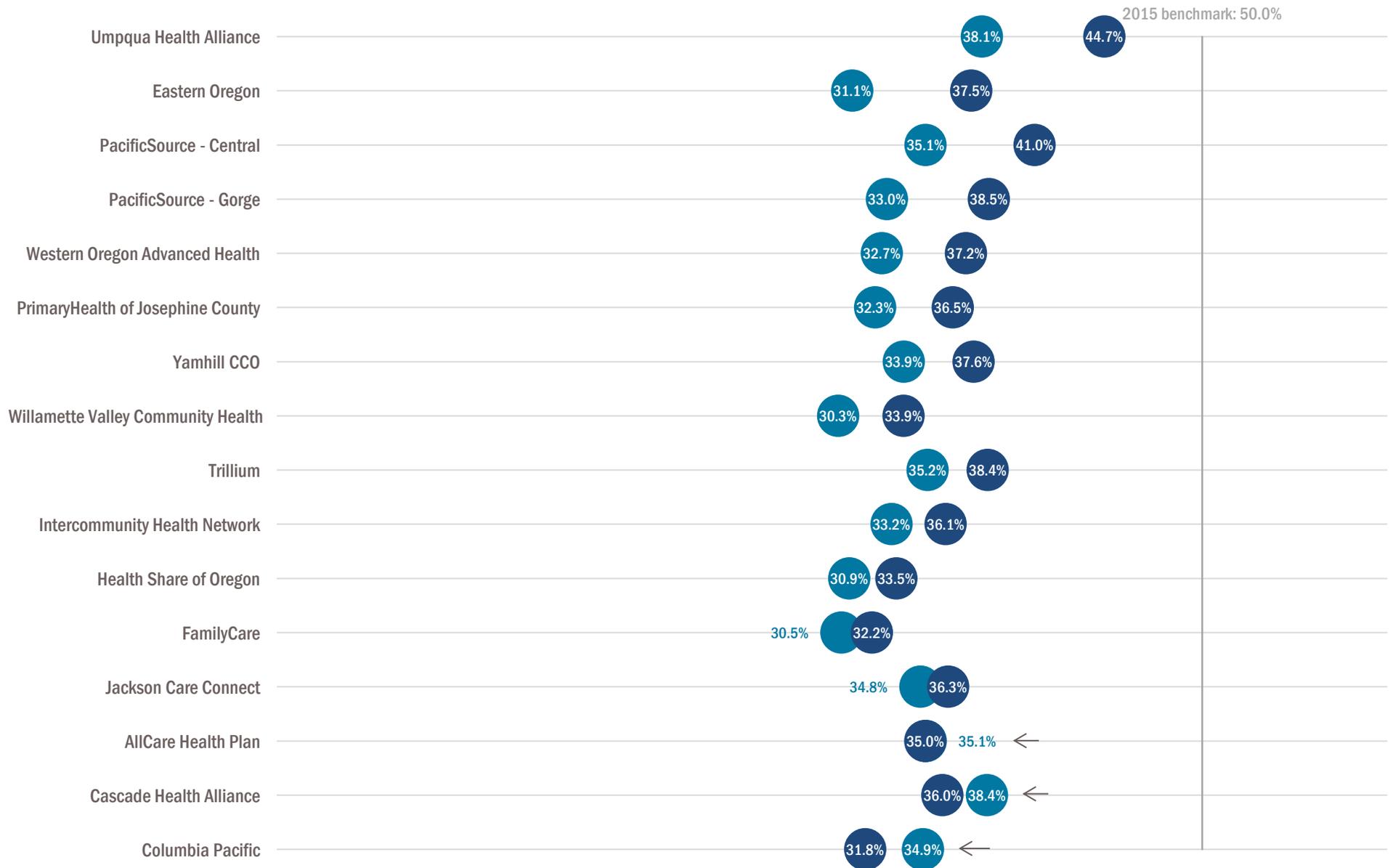
Effective contraceptive use among women at risk of unintended pregnancy between 2014 & 2015, by race and ethnicity.

Race and ethnicity data missing for 18.8% of respondents / Each race category excludes Hispanic/Latino



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (all ages 15-50)

Effective contraceptive use among women at risk of unintended pregnancy between 2014 & 2015, by CCO.





ELECTRONIC HEALTH RECORD ADOPTION

Electronic health record adoption

Percentage of eligible providers within a CCO’s network and service area who qualified for a “meaningful use” incentive payment during the measurement year through the Medicaid, Medicare, or Medicare Advantage EHR Incentive Programs.

2015 data (n=9,118, total number of eligible providers)

Statewide change since 2014: **+13%**

Number of CCOs that improved: **14**

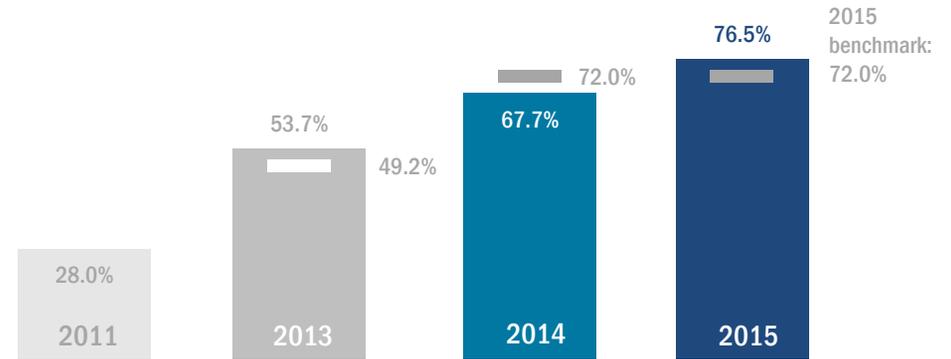
Number of CCOs achieving benchmark or improvement target: **all 16**

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Results for this measure are not available by race and ethnicity.

Statewide, electronic health record adoption surpassed the benchmark.

Data source: State and Federal EHR Incentive Program
Benchmark source: Metrics and Scoring Committee consensus

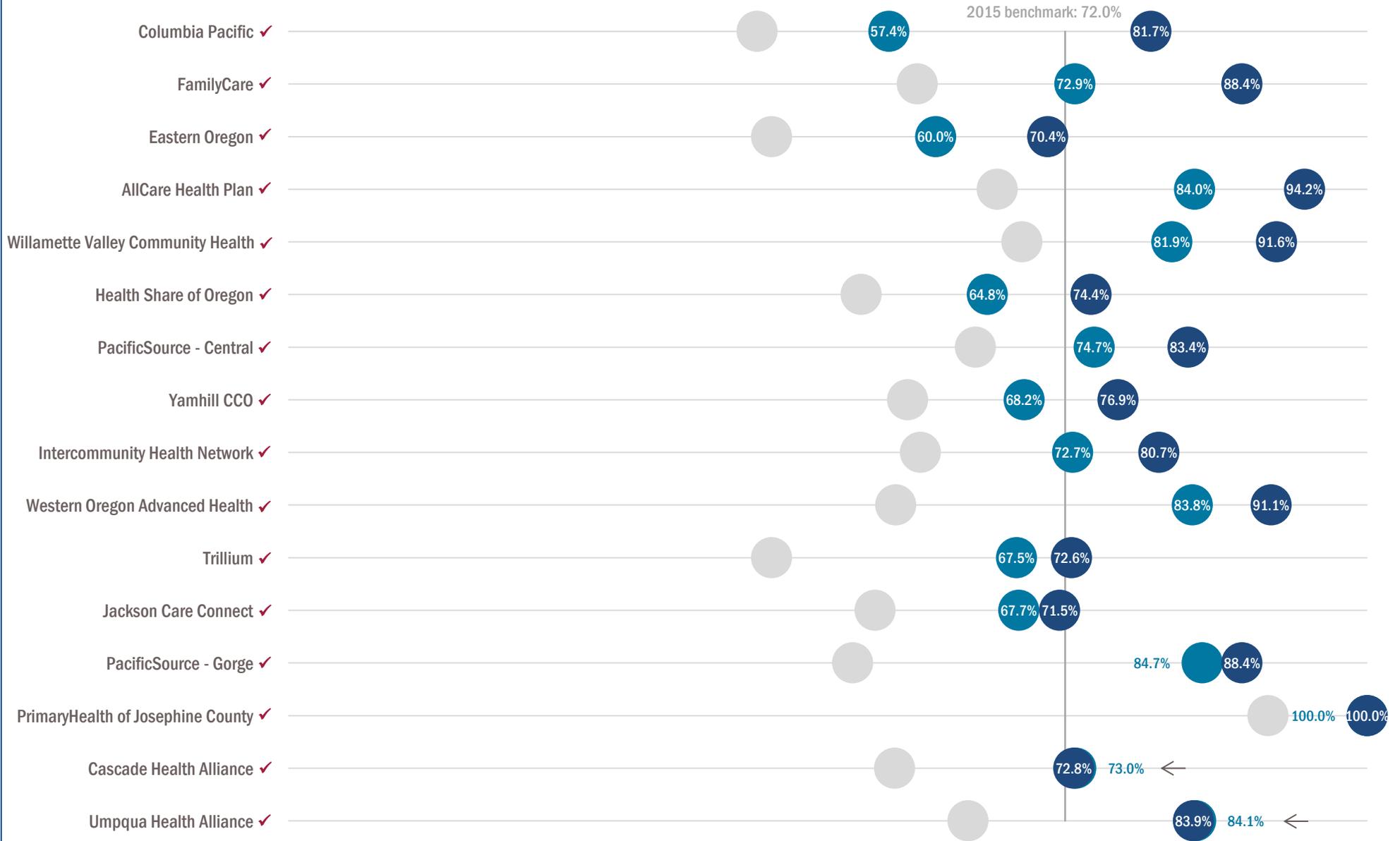




ELECTRONIC HEALTH RECORD ADOPTION

All 16 CCOs achieved benchmark or improvement target for electronic health record adoption between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2013





FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Follow-up after hospitalization for mental illness

Percentage of members (ages 6 and older) who received a follow-up visit with a health care provider within seven days of being discharged from the hospital for mental illness.

2015 data (n=2,845)

Statewide change since 2014: **+13%**

Number of CCOs that improved: **9**

Number of CCOs achieving benchmark or improvement target: **13**

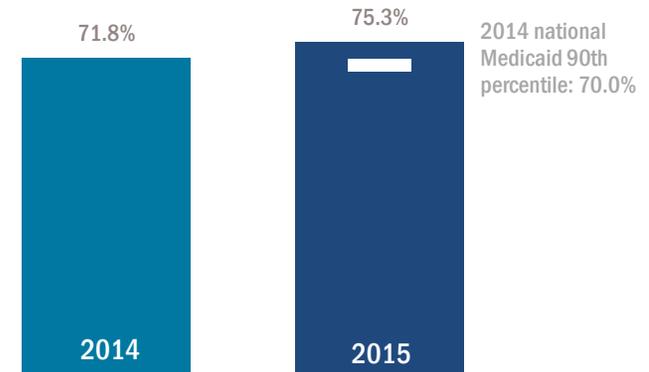
Beginning in 2015, follow-up visits on the day of discharge are included in this measure.

See pages [159](#) and [166](#) for results stratified by members with disability and mental health diagnoses.

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Statewide, follow-up after hospitalization for mental illness increased.

Data source: Administrative (billing) claims
2014 results have been recalculated according to updated measure specifications and differ from previously published reports



Follow-up after hospitalization for mental illness between 2014 & 2015, by race and ethnicity.

Race and ethnicity data missing for 12.7% of respondents / Each race category excludes Hispanic/Latino
2014 results have been recalculated according to updated measure specifications and differ from previously published reports
~ Data suppressed (n<30)



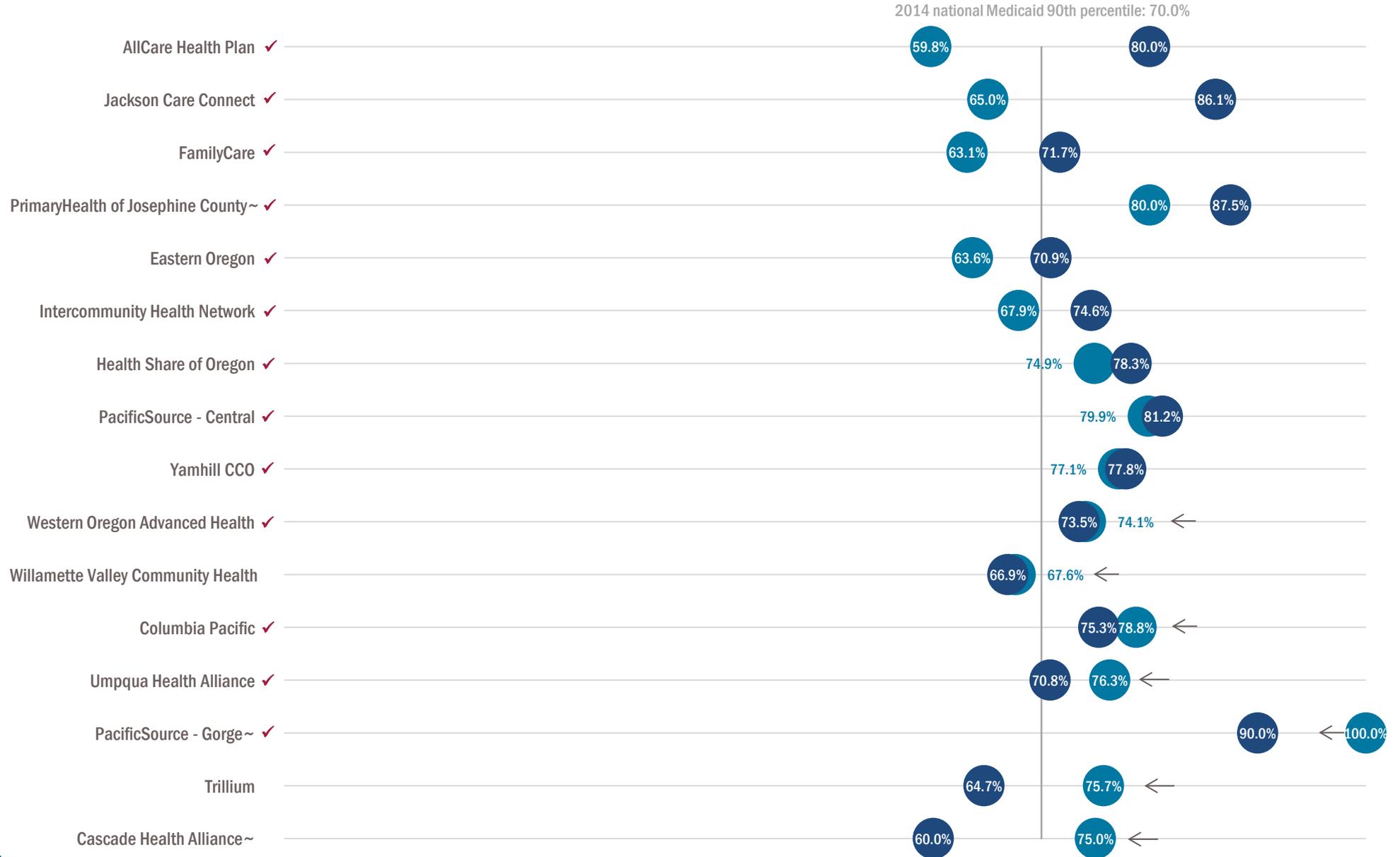


FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Thirteen CCOs achieved benchmark for follow-up after hospitalization for mental illness between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target / 2014 results have been recalculated according to updated measure specifications and differ from previously published reports

~ Note small denominator (n<30)





FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (INITIATION PHASE)

Follow-up care for children prescribed ADHD medication (initiation phase)

Percentage of children (ages 6-12) who had one follow-up visit with a provider during the 30 days after receiving a new prescription for attention deficit hyperactivity disorder (ADHD) medication.

2015 data (n=2,337)

Statewide change since 2014: **+6%**

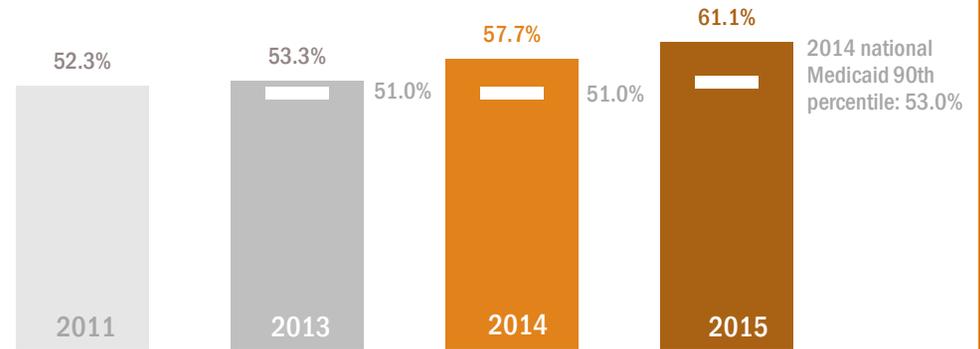
Number of CCOs that improved: **14**

See pages [163](#) and [170](#) for results stratified by members with disability and mental health diagnoses.

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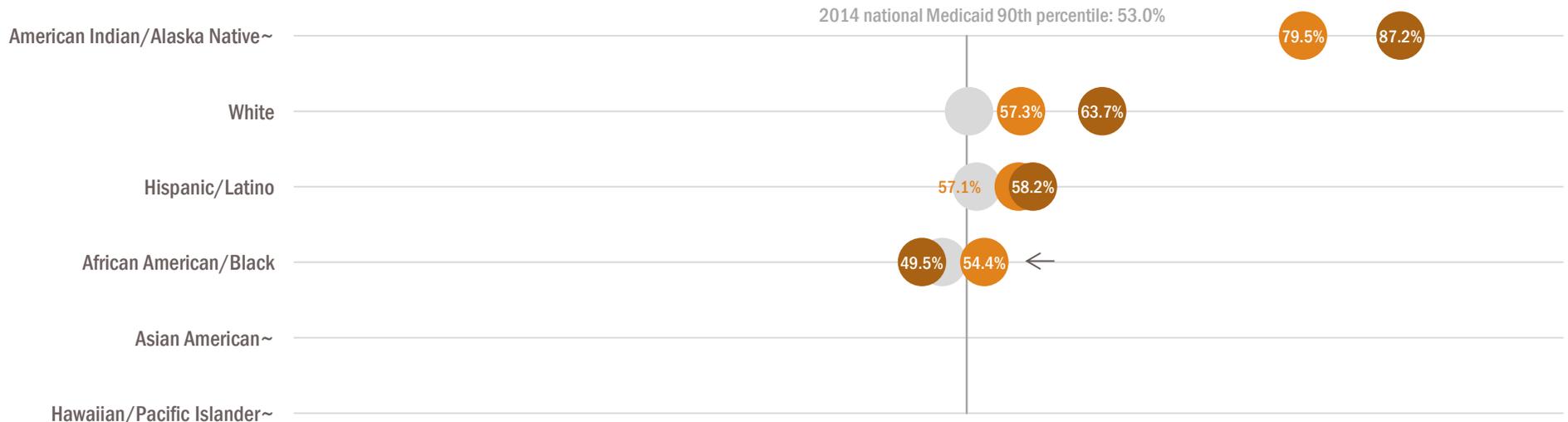
Initiation of follow-up care for children prescribed ADHD medication, statewide.

Data source: Administrative (billing) claims



Initiation of follow-up care for children prescribed ADHD medication between 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 19.4% of respondents / Each race category excludes Hispanic/Latino
~Data suppressed (n<30)



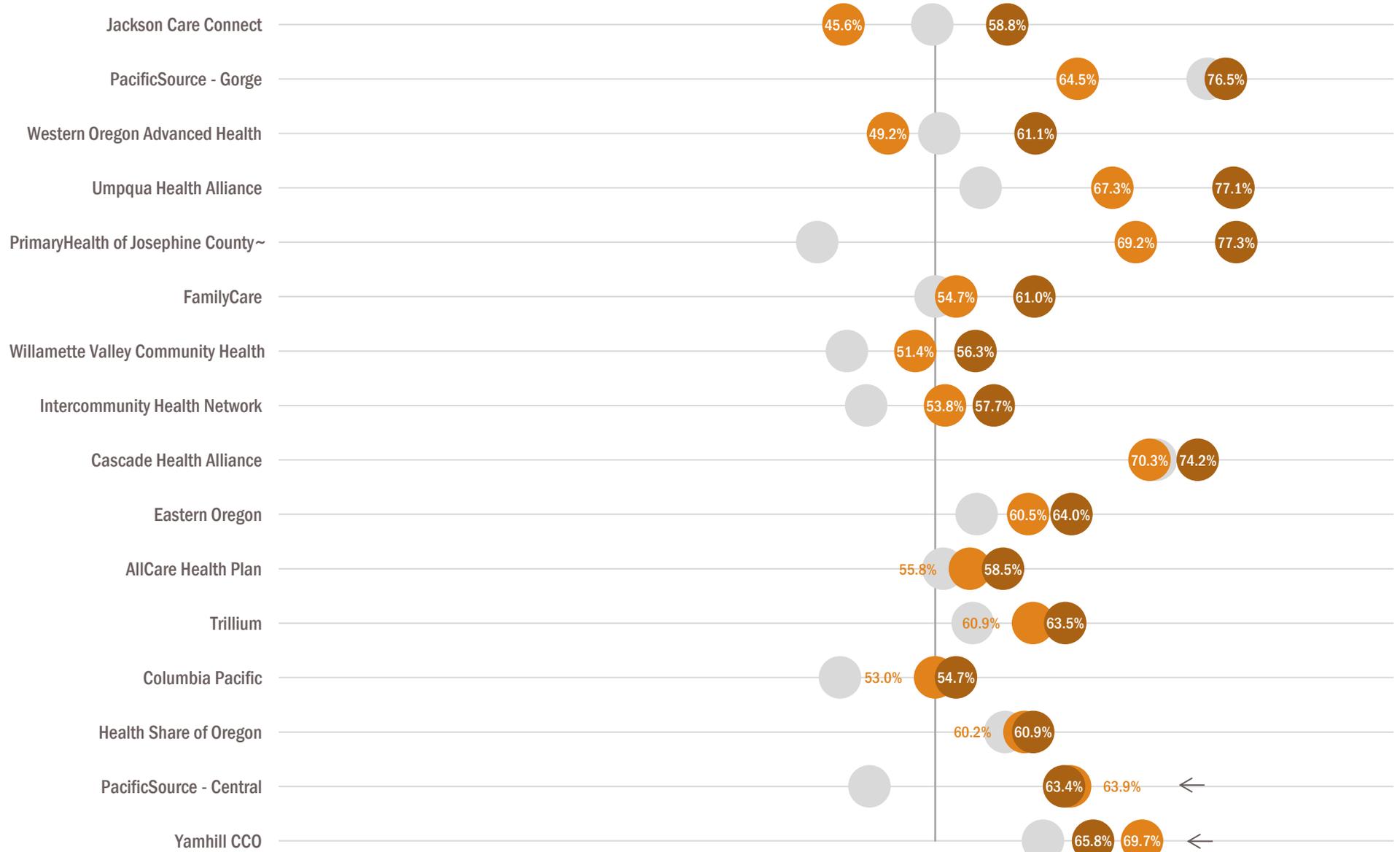


FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (INITIATION PHASE)

Initiation of follow-up care for children prescribed ADHD medication between 2014 & 2015, by CCO.

Grey dots represent 2013

~ Note small denominator (n<30)





FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (CONTINUATION AND MAINTENANCE PHASE)

Follow-up care for children prescribed ADHD medication (continuation and maintenance phase)

Percentage of children (ages 6-12) who remained on attention deficit hyperactivity disorder (ADHD) medication for 210 days after receiving a new prescription and who had at least two follow-up visits with a provider within 270 days after the initiation phase ([see page 105](#)).

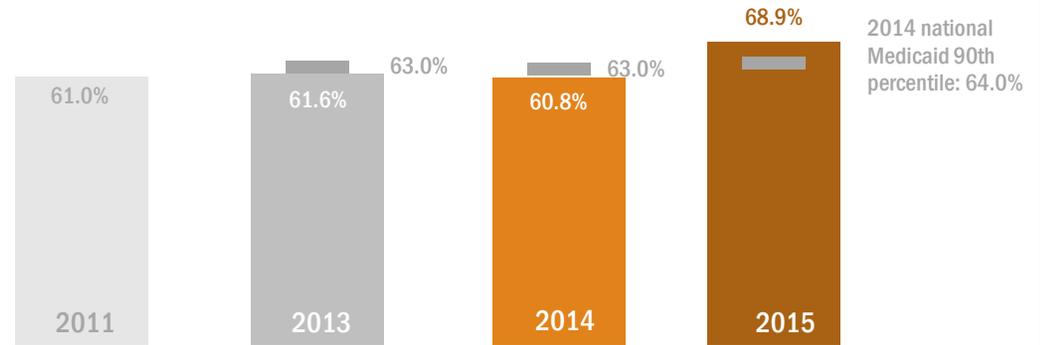
2015 data (n=765)

Statewide change since 2014: **+13%**

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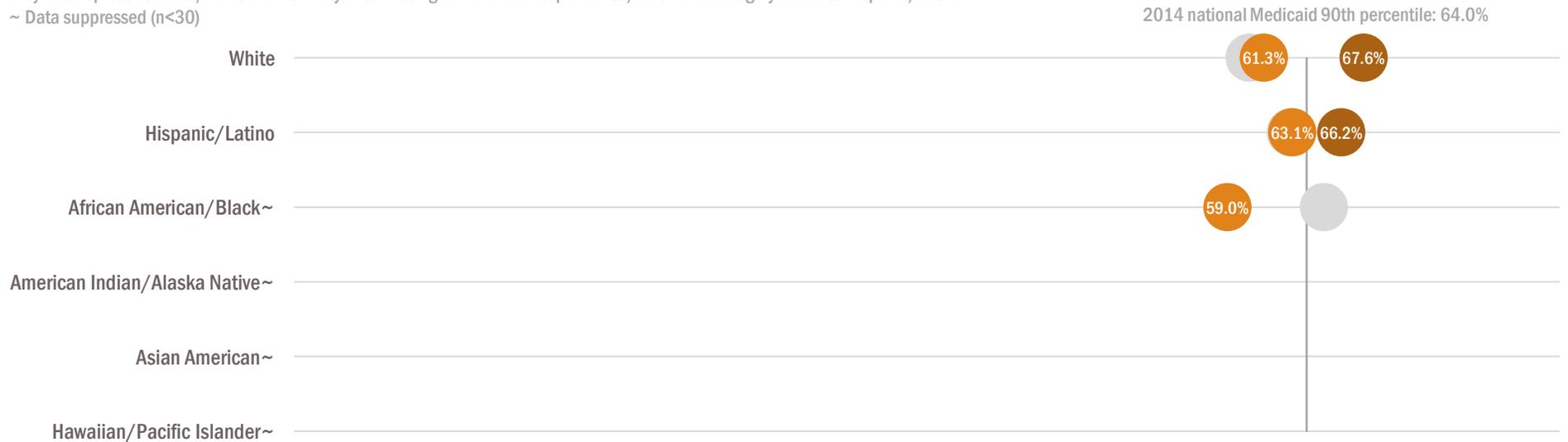
Ongoing follow-up care for children prescribed ADHD medication, statewide.

Data source: Administrative (billing) claims



Ongoing follow-up care for children prescribed ADHD medication in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 19.2% of respondents / Each race category excludes Hispanic/Latino
~ Data suppressed (n<30)



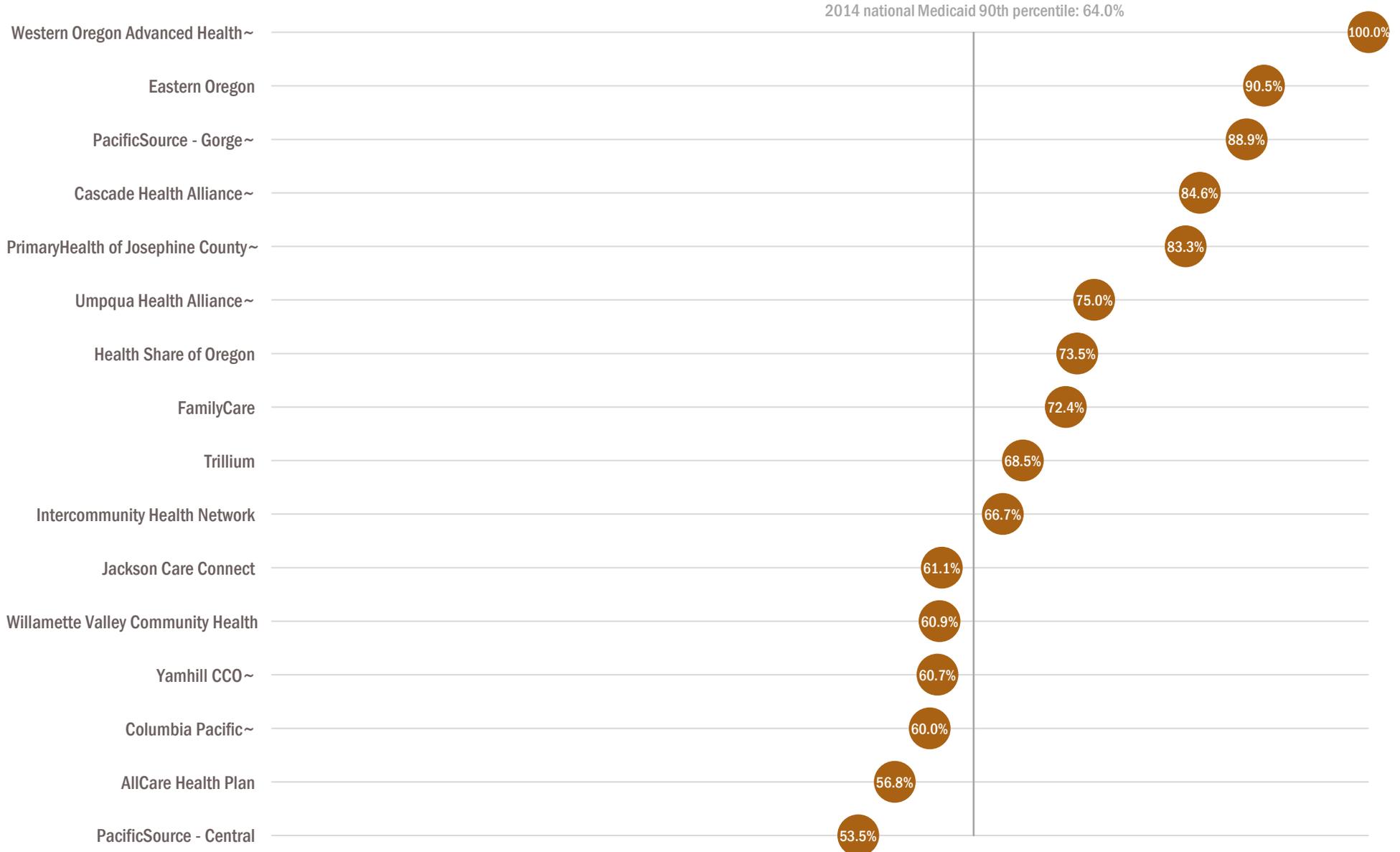


FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (CONTINUATION AND MAINTENANCE PHASE)

Ongoing follow-up care for children prescribed ADHD medication in 2015, by CCO.

2013 and 2014 results for this measure are not available by CCO

~ Note small denominator (n<30)





HEALTH STATUS (CAHPS SURVEY)

Health status (CAHPS survey)

Percentage of Medicaid members (adults and children) who report their overall health as good, very good, or excellent.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

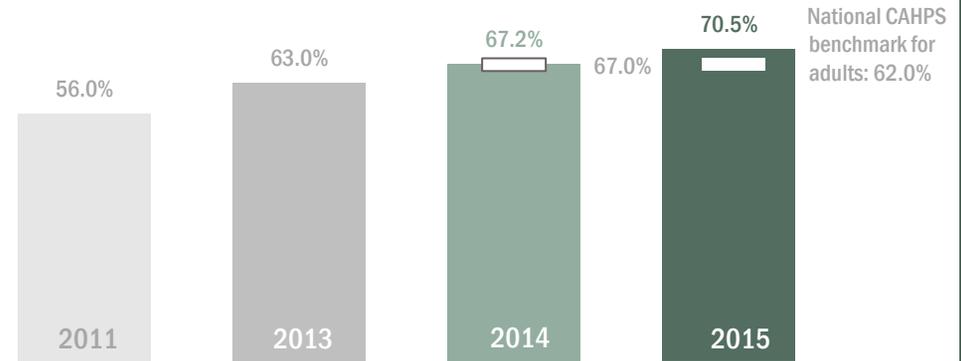
2015 data

Statewide change since 2014: **adults: +5%; children: +1%**

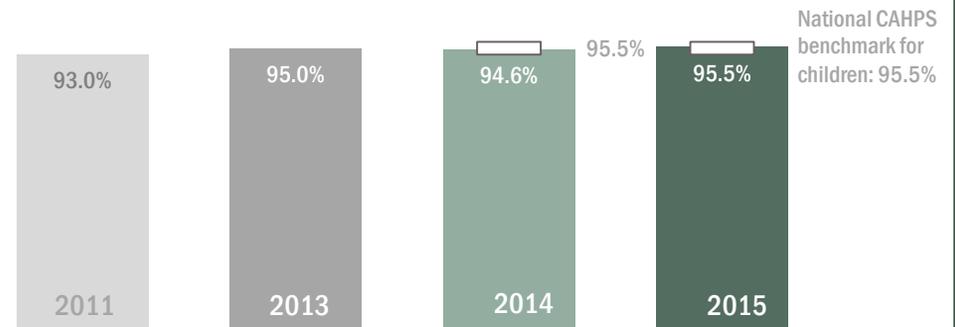
Number of CCOs that improved: **adults: 12; children: 11**

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Health status among ADULTS, statewide. Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Health status among CHILDREN, statewide. Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)

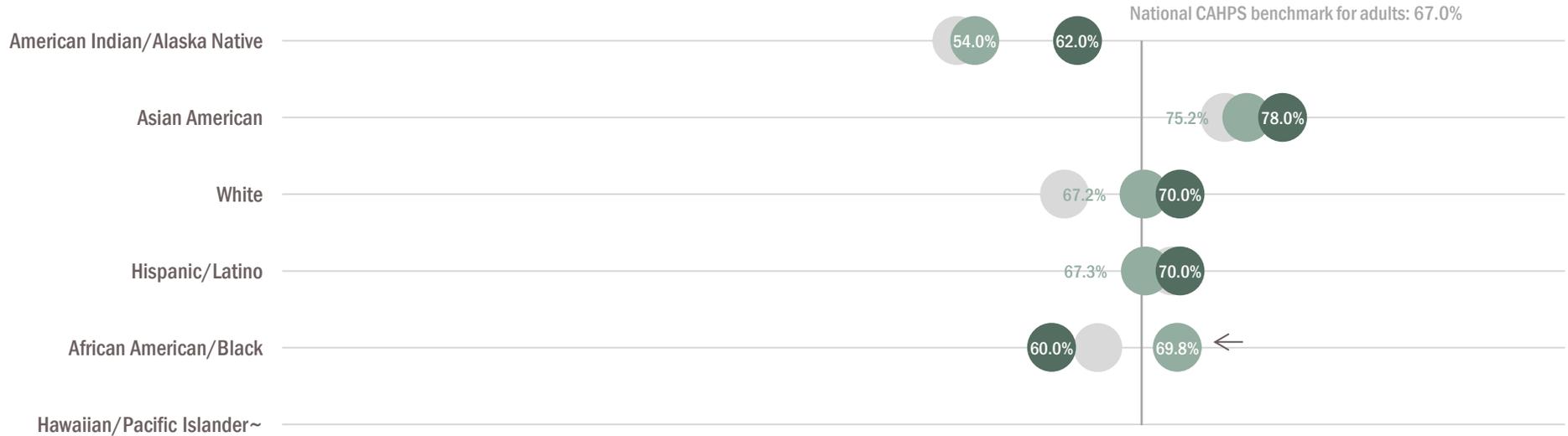




HEALTH STATUS (CAHPS SURVEY)

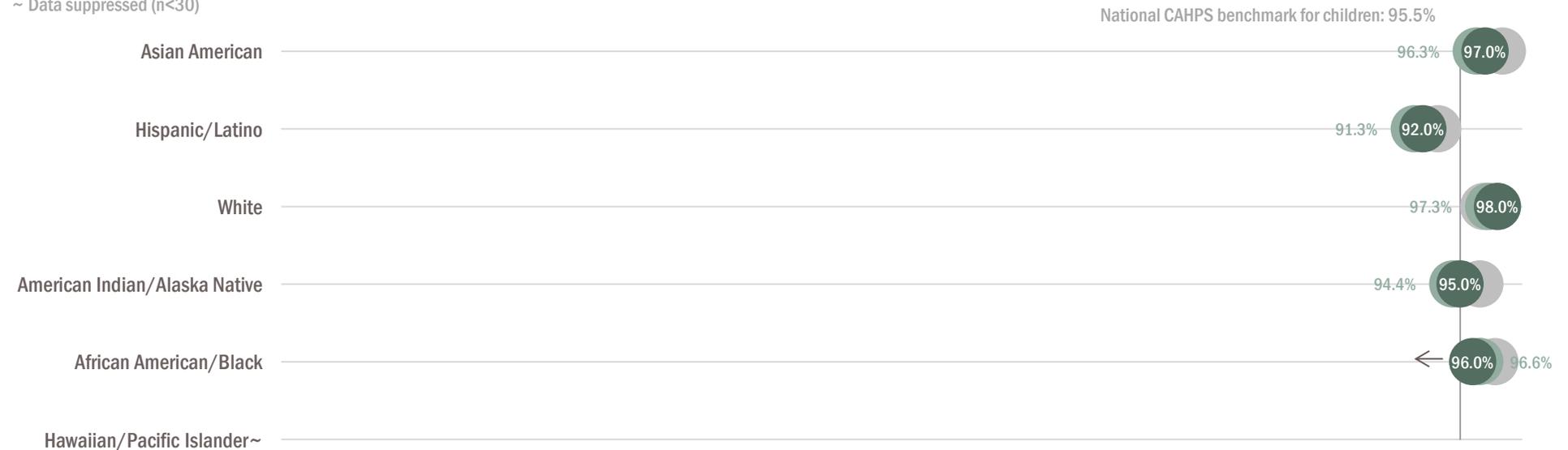
Health status among ADULTS between 2014 & 2015.

Grey dots represent 2013 / Ethnicity data missing for 7.2% of respondents / Each race category excludes Hispanic/Latino
~ Data suppressed (n<30)



Health status among CHILDREN between 2014 & 2015.

Grey dots represent 2013 / Ethnicity data missing for 8.9% of respondents / Each race category excludes Hispanic/Latino
~ Data suppressed (n<30)



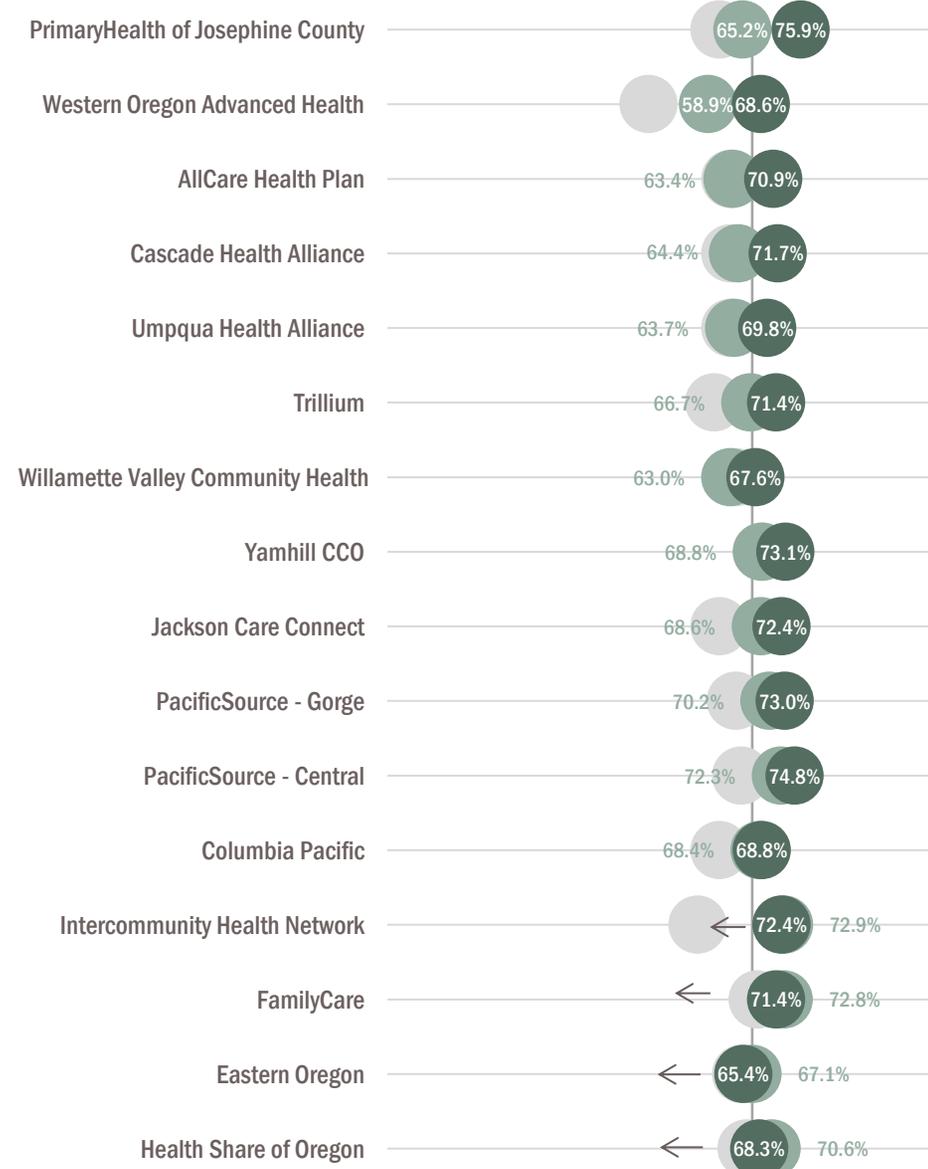


HEALTH STATUS (CAHPS SURVEY)

Health status among ADULTS between 2014 & 2015, by CCO.

Grey dots represent 2013

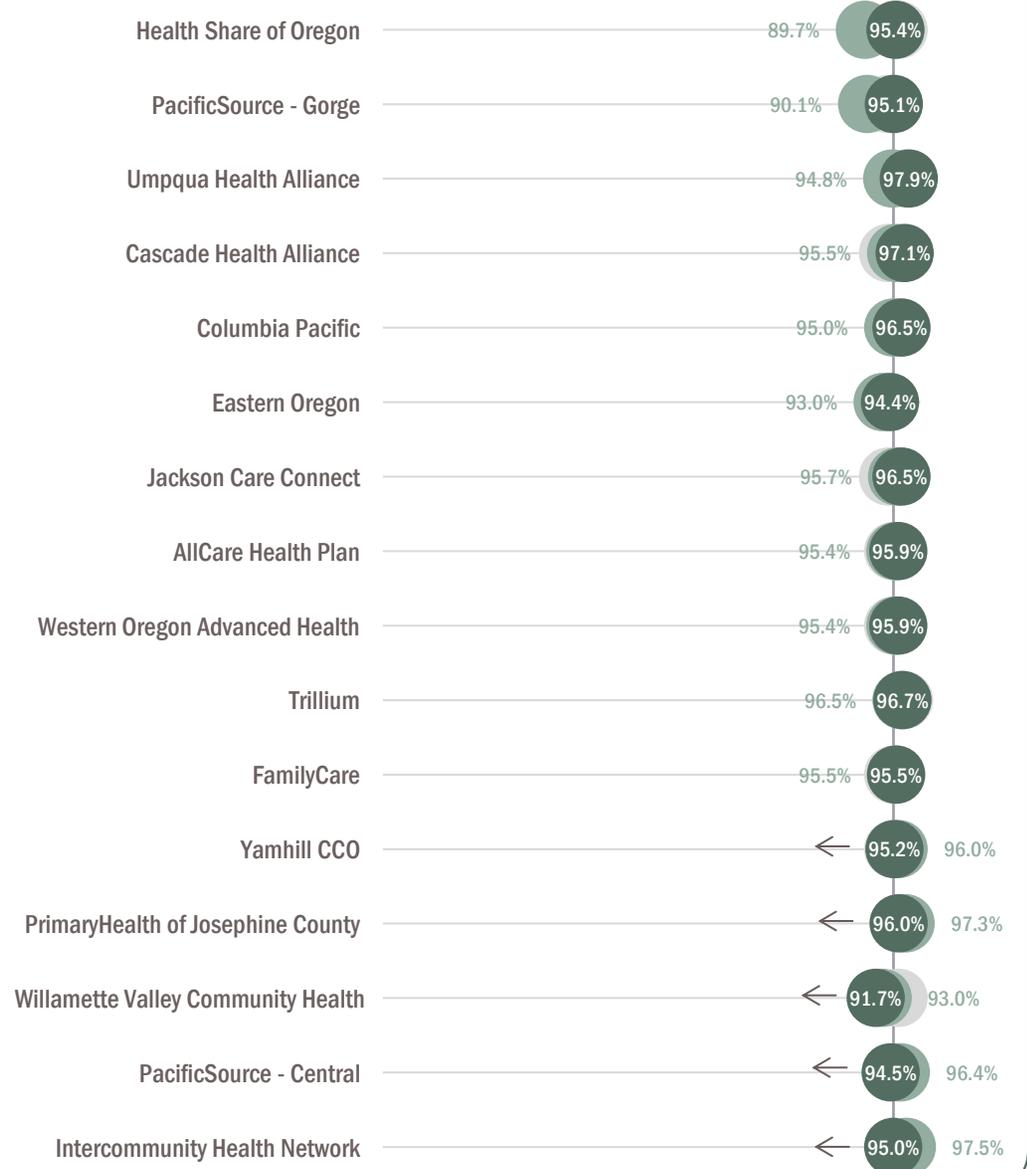
National CAHPS benchmark for adults: 67.0%



Health status among CHILDREN between 2014 & 2015, by CCO.

Grey dots represent 2013

National CAHPS benchmark for children: 95.5%





IMMUNIZATION FOR ADOLESCENTS

Immunization for adolescents

Percentage of adolescents who received recommended vaccines (Meningococcal and Tdap/TD) before their 13th birthday.

2015 data (n=14,731)

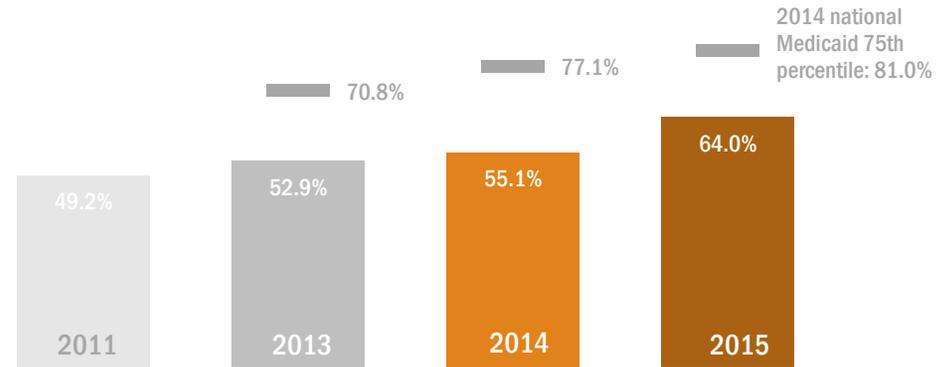
Statewide change since 2014: **+16%**

Number of CCOs that improved: **all 16**

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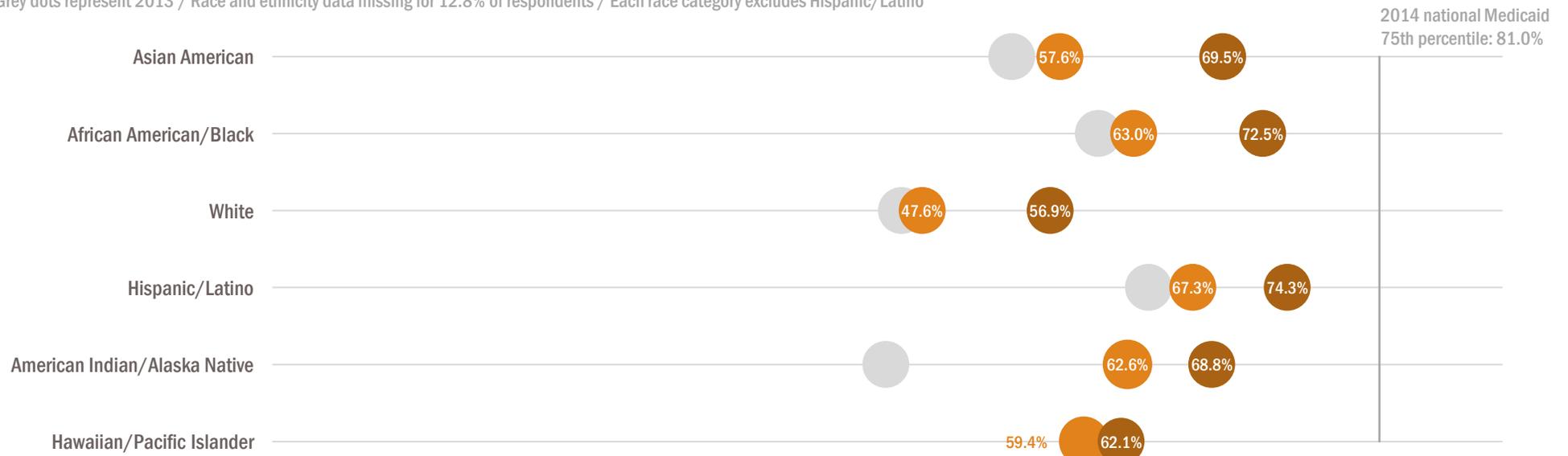
Percentage of adolescents who received recommended vaccines, statewide.

Data source: Administrative (billing) claims & ALERT immunization data



Percentage of adolescents who received recommended vaccines in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 12.8% of respondents / Each race category excludes Hispanic/Latino

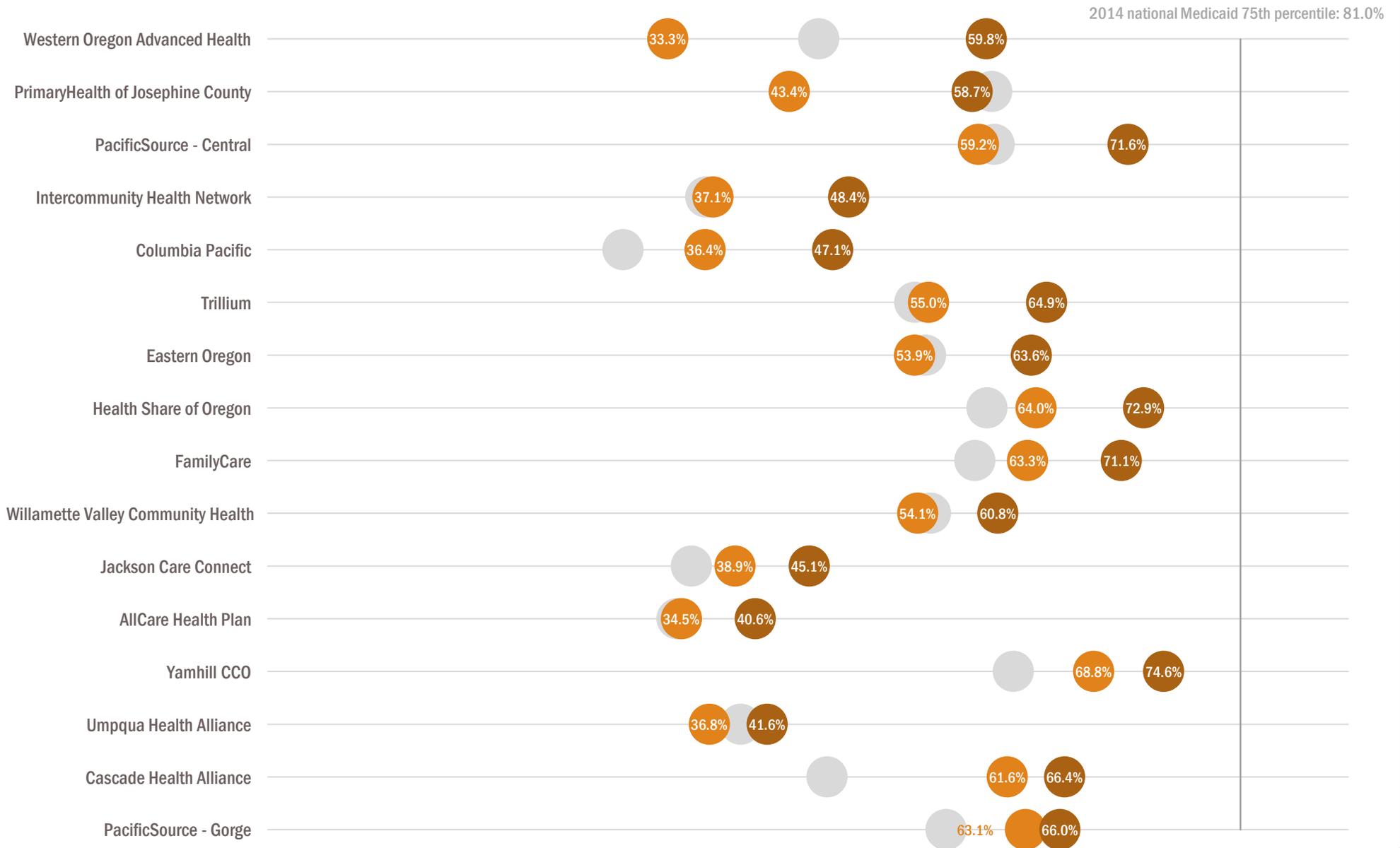




IMMUNIZATION FOR ADOLESCENTS

Percentage of adolescents who received recommended vaccines in 2014 & 2015, by CCO.

Grey dots represent 2013





INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (INITIATION PHASE)

Initiation and engagement of alcohol or other drug treatment (initiation phase)

Percentage of members (ages 13 and older) newly diagnosed with alcohol or other drug dependence and who began treatment within 14 days of the initial diagnosis.

2015 data (n=19,047)

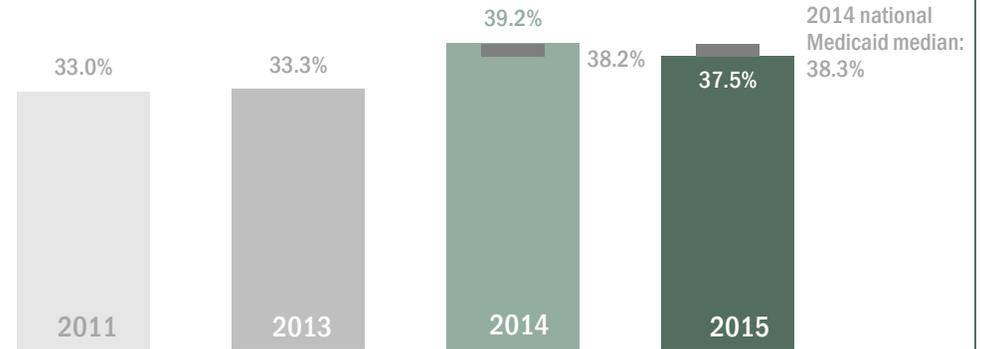
Statewide change since 2014: **-4%**

Number of CCOs that improved: **6**

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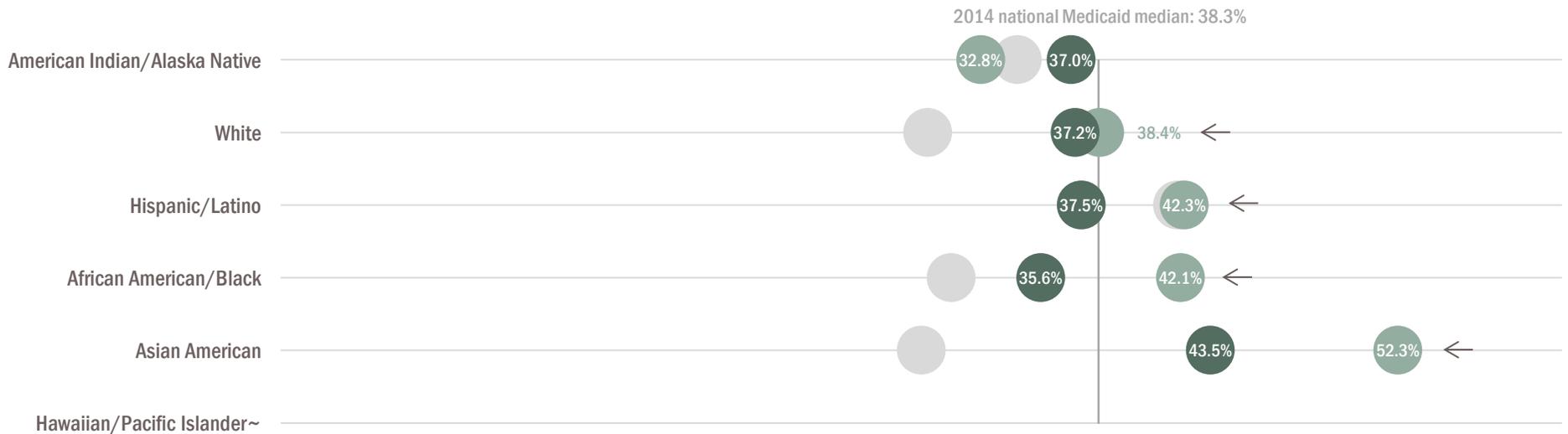
Initiation of treatment for members diagnosed with alcohol or other drug dependence, statewide.

Data source: Administrative (billing) claims



Initiation of treatment for members diagnosed with alcohol or other drug dependence in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 10.5% of respondents / Each race category excludes Hispanic/Latino
~ Data suppressed (n<30)

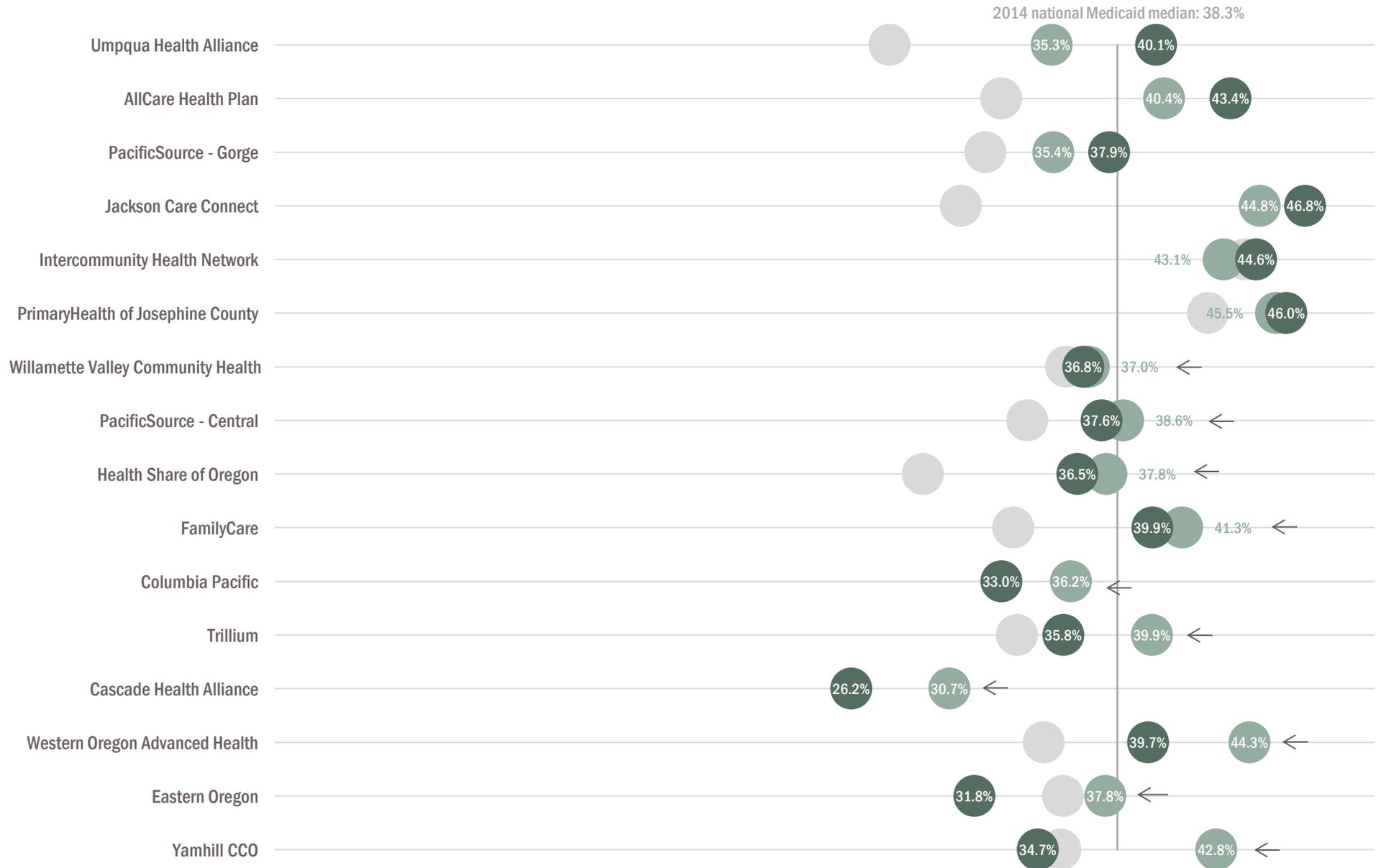




INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (INITIATION PHASE)

Initiation of treatment for members diagnosed with alcohol or other drug dependence in 2014 & 2015, by CCO.

Grey dots represent 2013





INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (ENGAGEMENT PHASE)

Initiation and engagement of alcohol or other drug treatment (engagement phase)

Percentage of members (ages 13 and older) who had two or more additional services for alcohol or other drug dependence within 30 days of their initial treatment.

2015 data (n=19,047)

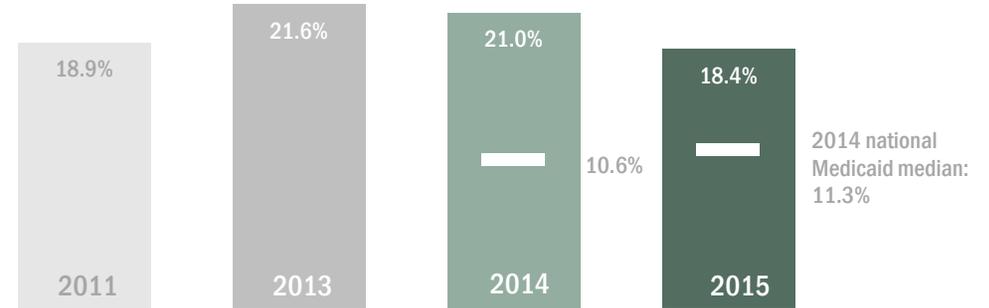
Statewide change since 2014: **-12%**

Number of CCOs that improved: **3**

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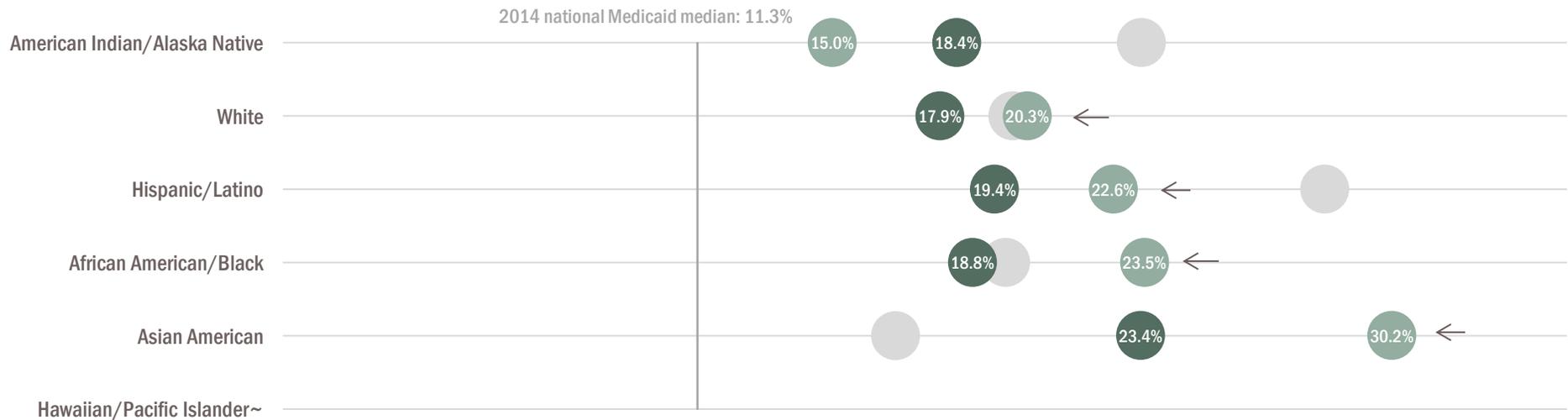
Engagement of alcohol or other drug treatment, statewide.

Data source: Administrative (billing) claims



Engagement of alcohol or other drug treatment in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 10.5% of respondents / Each race category excludes Hispanic/Latino
~ Data suppressed (n<30)





INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (ENGAGEMENT PHASE)

Engagement of alcohol or other drug treatment in 2014 & 2015, by CCO.

Grey dots represent 2013

2014 national Medicaid median: 11.3%



LOW BIRTH WEIGHT

Low birth weight

Percentage of live births that weighed less than 2,500 grams (5.5 pounds). A lower score is better.

2015 data (n=16,189)

Statewide change since 2014: **+5%** (lower is better)

Number of CCOs that improved: **7**

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Low birth weight, statewide.

Data source: Administrative (billing) claims



Low birth weight in 2014 & September 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for % of respondents / Each race category excludes Hispanic/Latino

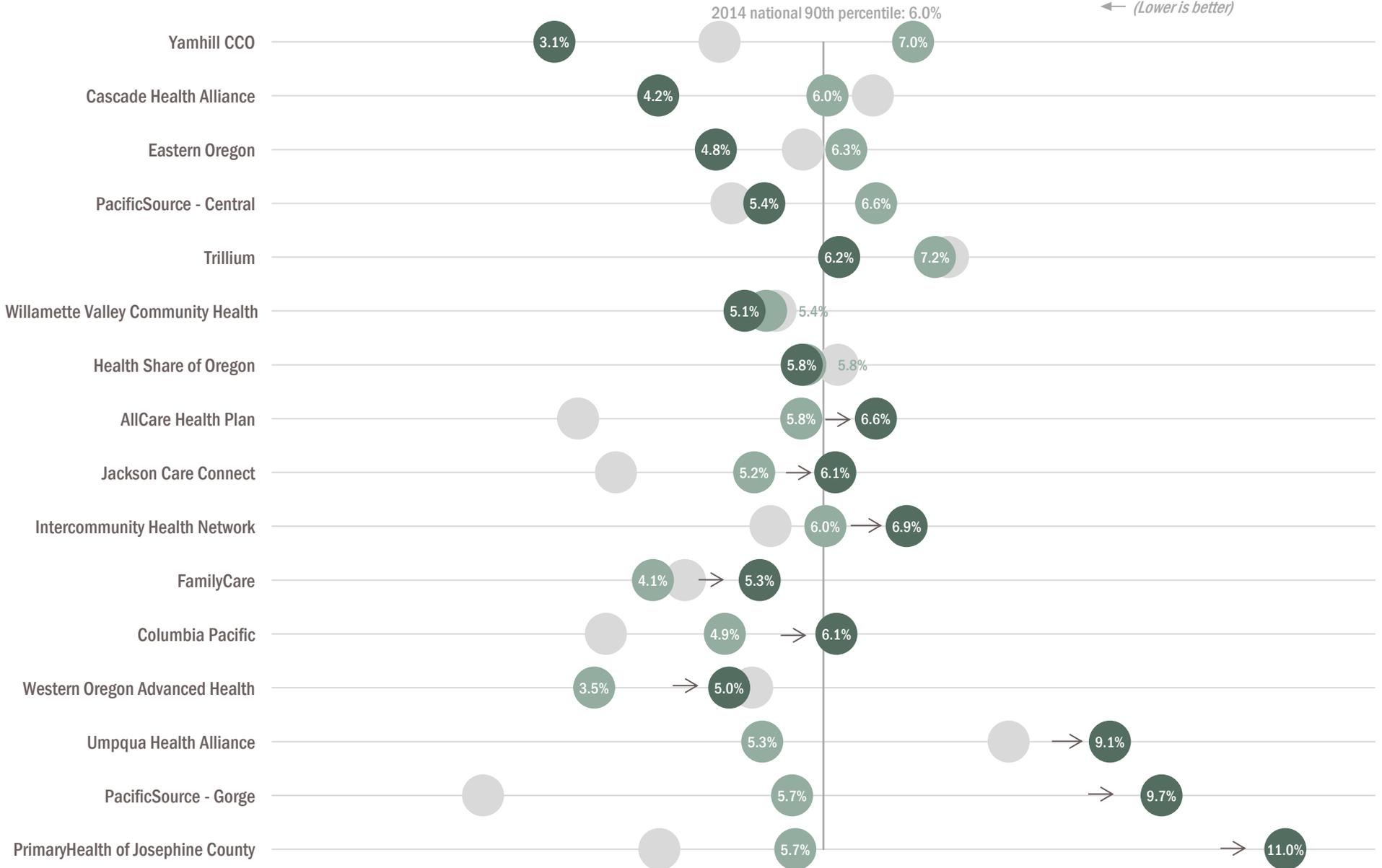




LOW BIRTH WEIGHT

Low birth weight in 2014 & 2015, by CCO.

Grey dots represent 2013.





MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (ADVISED TO QUIT)

Medical assistance with smoking and tobacco use cessation: doctor advised to quit (CAHPS survey)

Percentage of adult tobacco users advised to quit by their doctor.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care.

2015 data

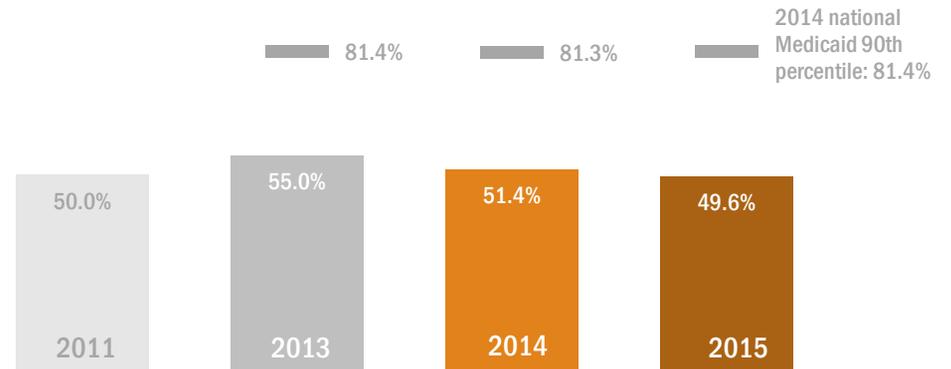
Statewide change since 2014: **-4%**

Number of CCOs that improved: **6**

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Percentage of tobacco users who were advised by their doctor to quit, statewide.

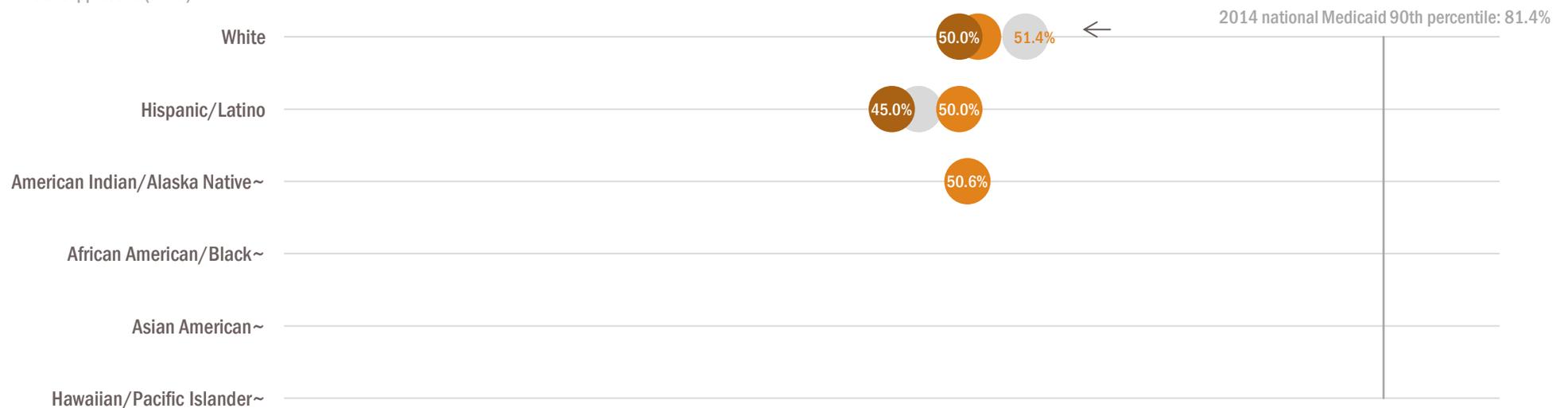
Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Percentage of tobacco users who were advised by their doctor to quit in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Ethnicity data missing for 7.2% of respondents / Each race category excludes Hispanic/Latino

~ Data suppressed (n<30)



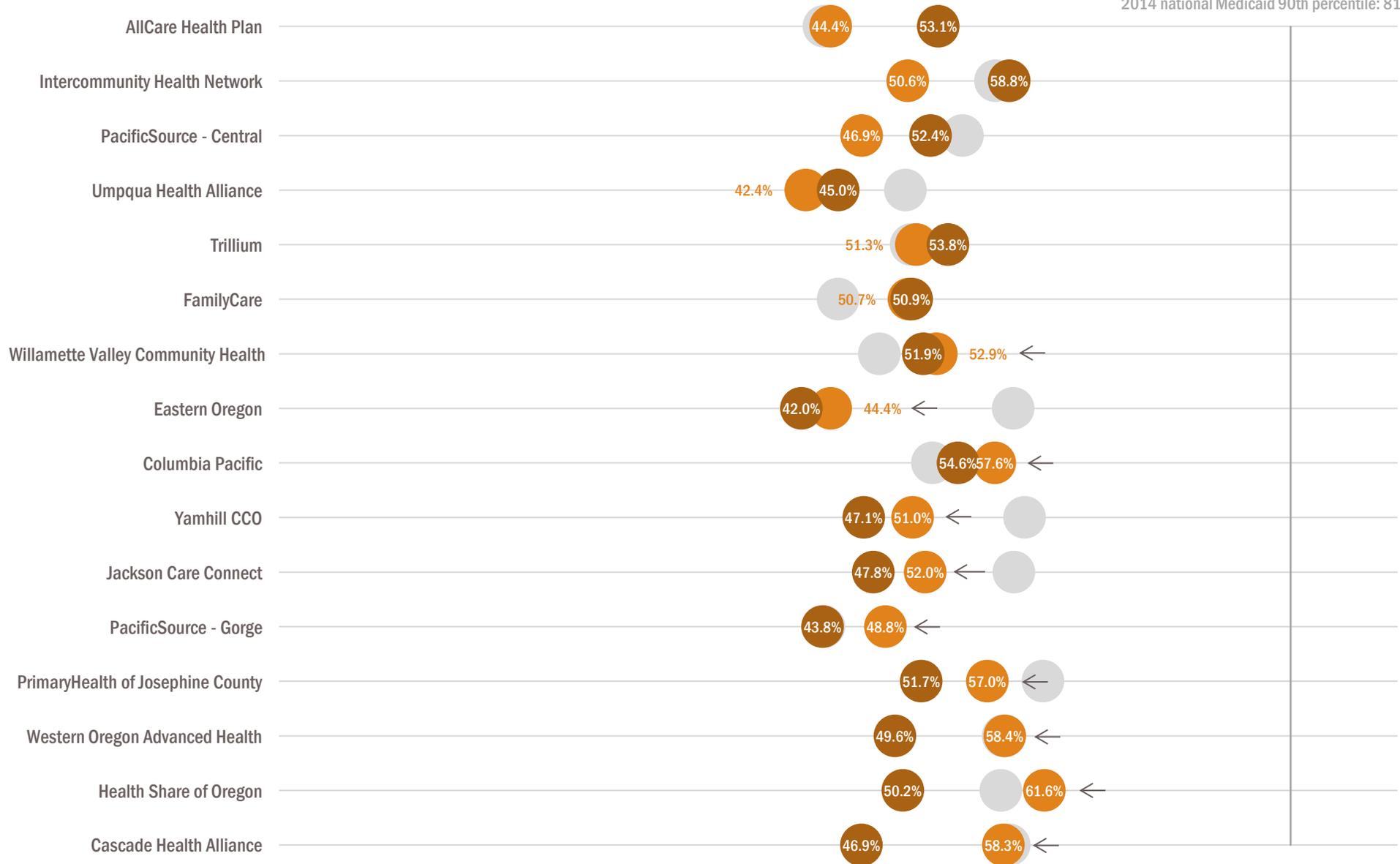


MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (ADVISED TO QUIT)

Percentage of tobacco users who were advised by their doctor to quit in 2014 & 2015, by CCO.

Grey dots represent 2013

2014 national Medicaid 90th percentile: 81.4%



MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (ADVISED MEDICATION TO QUIT)

Medical assistance with smoking and tobacco use cessation: doctor recommended medication to quit (CAHPS survey)

Percentage of adult tobacco users whose doctor discussed or recommended medication to quit smoking.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care.

2015 data

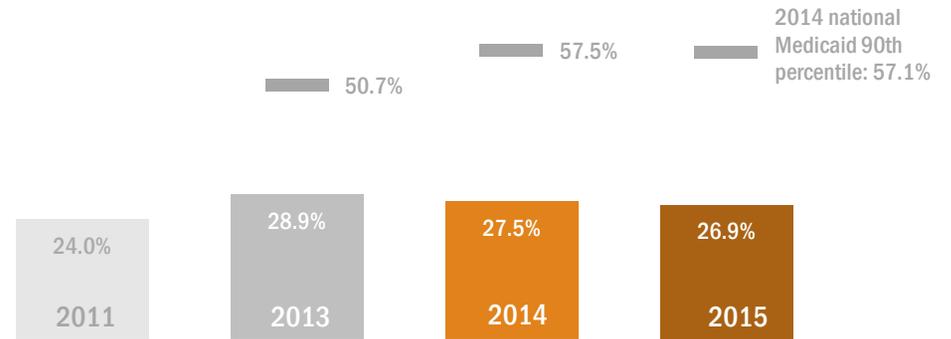
Statewide change since 2014: **-2%**

Number of CCOs that improved: **9**

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Percentage of tobacco users who said their doctor recommended medication to quit smoking, statewide.

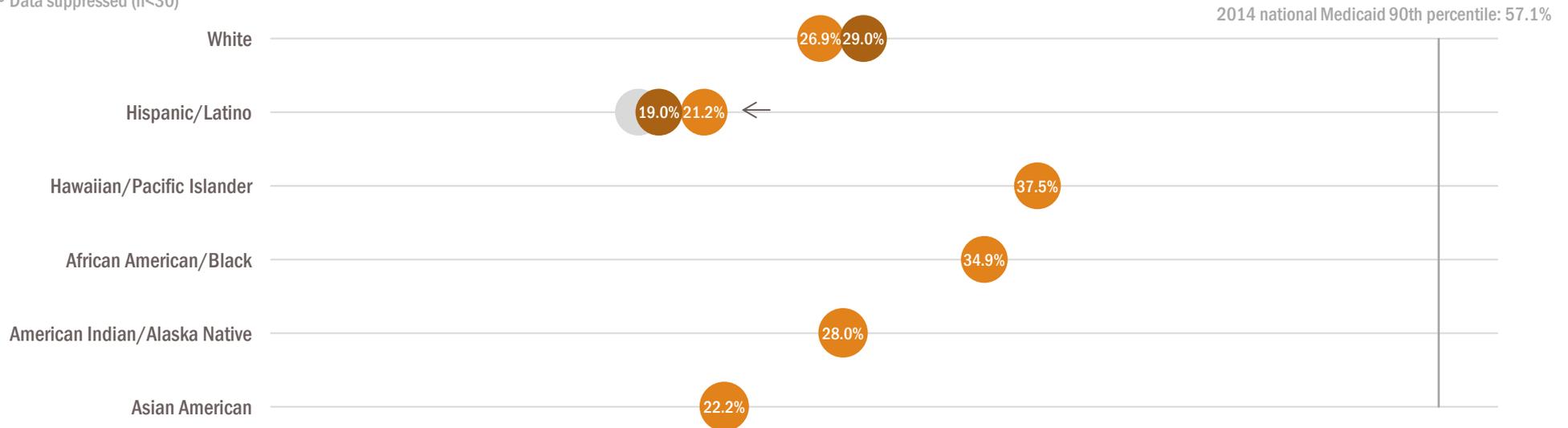
Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Percentage of tobacco users who said their doctor recommended medication to quit smoking in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Ethnicity data missing for 7.2% of respondents / Each race category excludes Hispanic/Latino

~ Data suppressed (n<30)

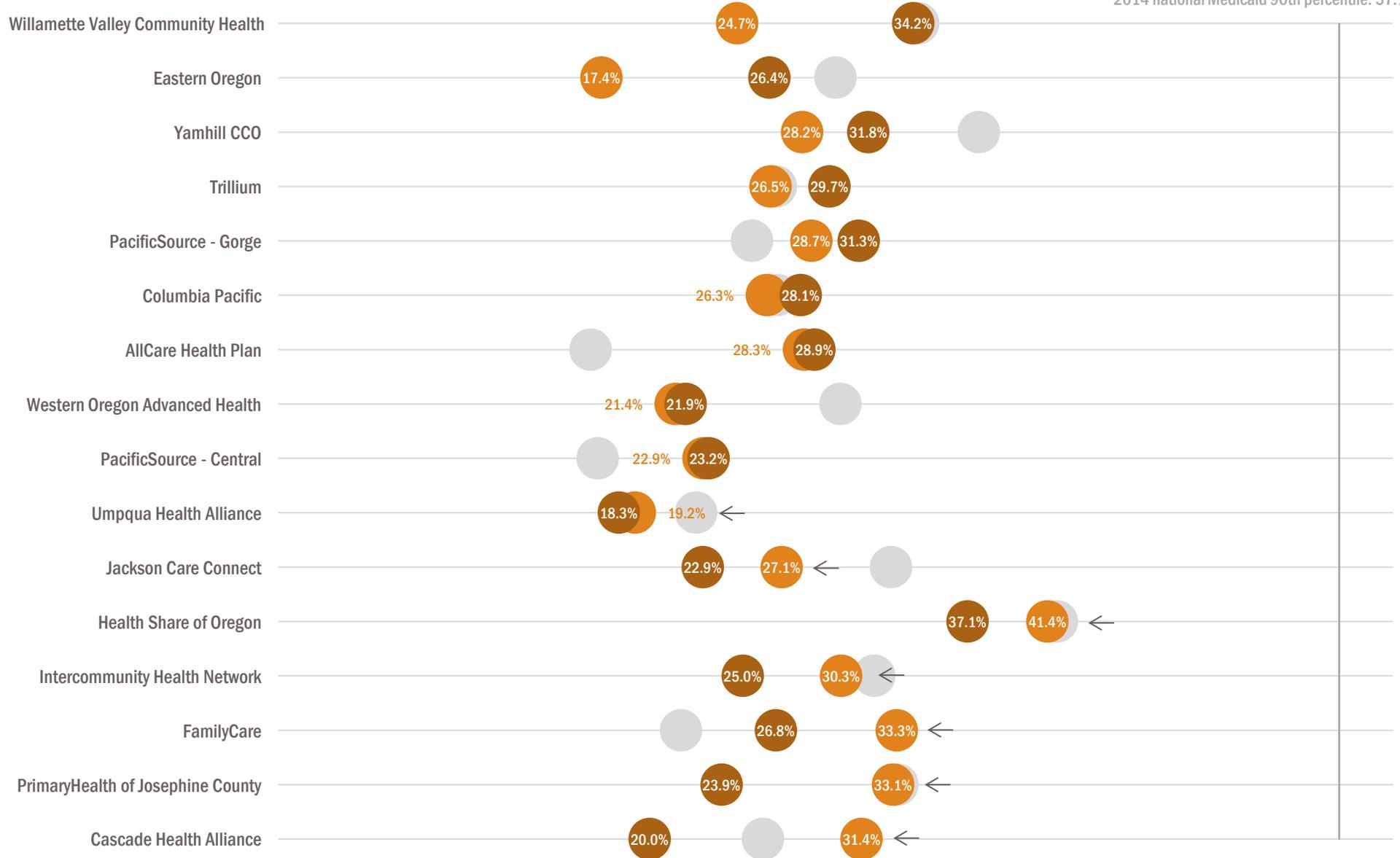


 **MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (ADVISED MEDICATION TO QUIT)**

Percentage of tobacco users who said their doctor recommended medication to quit smoking in 2014 & 2015, by CCO.

Grey dots represent 2013

2014 national Medicaid 90th percentile: 57.1%



MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (ADVISED STRATEGIES TO QUIT)

Medical assistance with smoking and tobacco use cessation: doctor recommended strategies to quit (CAHPS survey)

Percentage of adult tobacco users whose doctor discussed or recommended strategies to quit smoking.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care.

2015 data

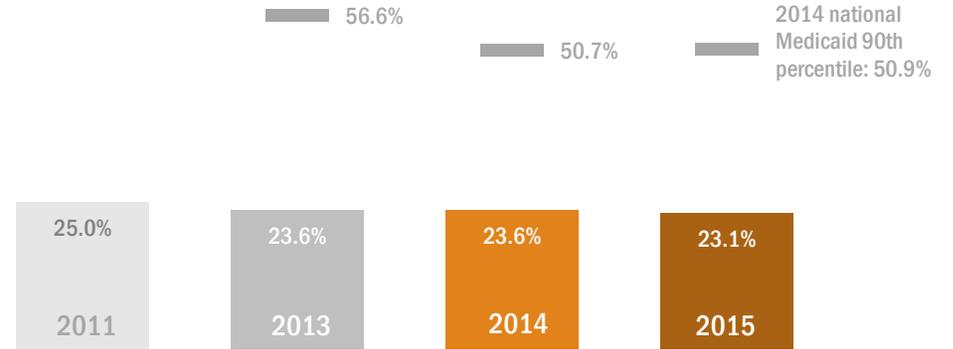
Statewide change since 2014: **-2%**

Number of CCOs that improved: **7**

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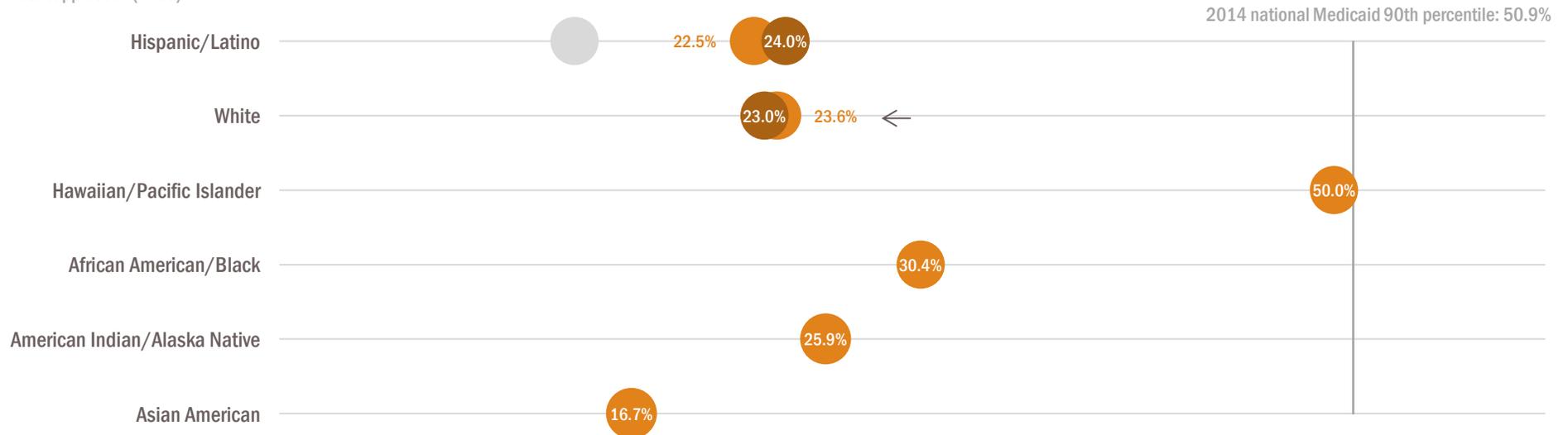
Percentage of members who said their doctor advised alternate methods to quit smoking, statewide.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Percentage of members who said their doctor advised alternate methods to quit smoking in 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Ethnicity data missing for 7.2% of respondents / Each race category excludes Hispanic/Latino
 ~Data suppressed (n<30)

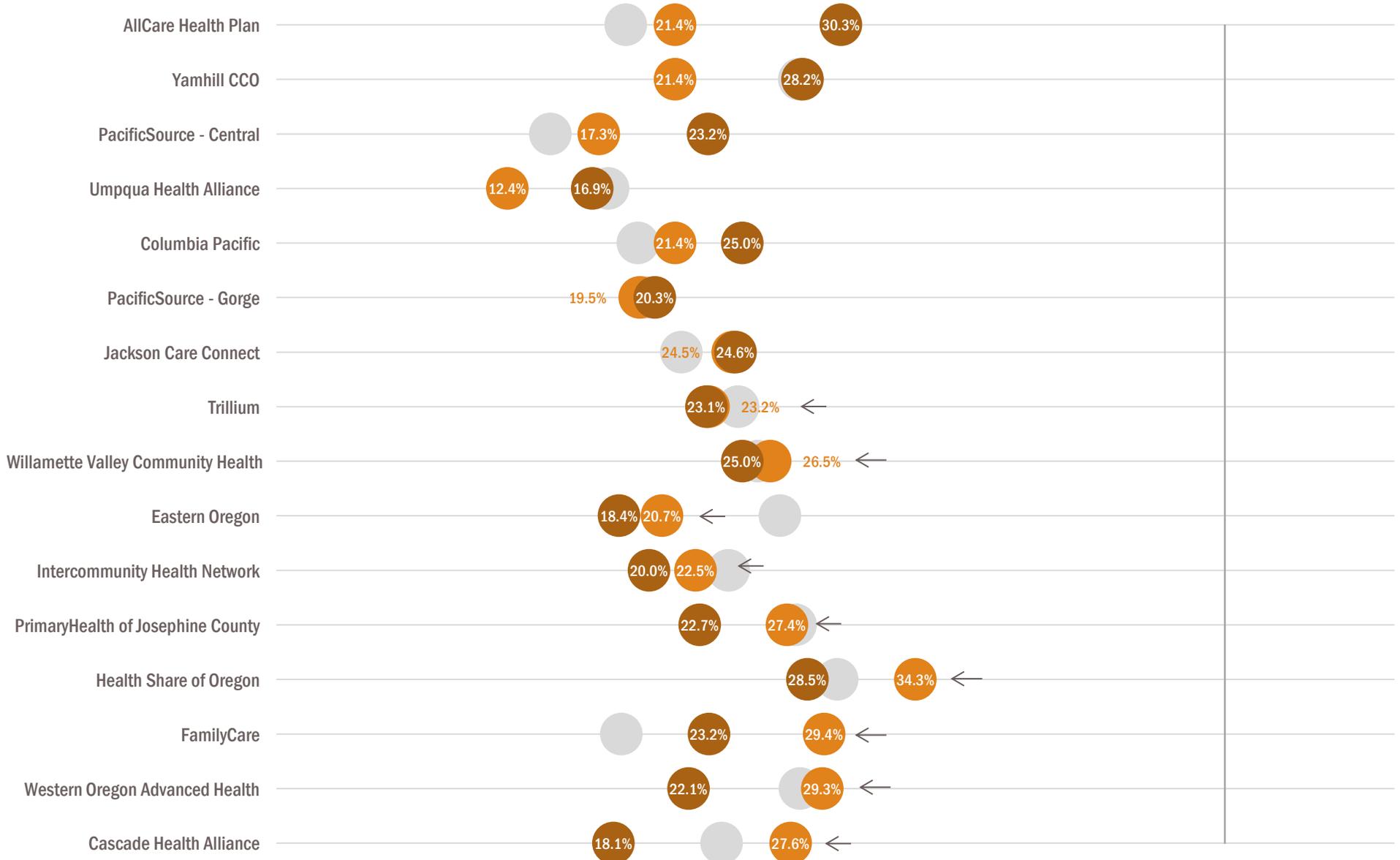


MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (ADVISED STRATEGIES TO QUIT)

Percentage of members who said their doctor advised alternate methods to quit smoking in 2014 & 2015, by CCO.

Grey dots represent 2013

2014 national Medicaid 90th percentile: 50.9%





MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Health assessments for children in DHS custody

Percentage of children ages 4+ who received a mental, physical, and dental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care). Physical and dental health assessments are required for children under age 4, but not mental health assessments.

2015 data (n=1,830)

Statewide change since 2014: **+109%**

Number of CCOs that improved: **all 16**

Number of CCOs achieving benchmark or improvement target: **15**

See pages [158](#) and [164](#) for results stratified by members with disability and mental health diagnoses.

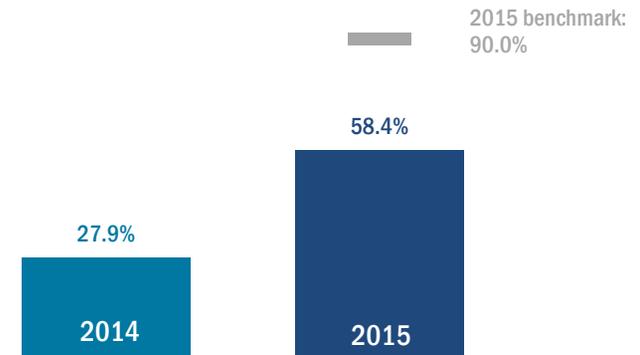
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Statewide, health assessments for children in DHS custody more than doubled between **2014** and **2015**, but remain well below the benchmark.

Data source: Administrative (billing) claims + ORKids

Benchmark source: Metrics and Scoring Committee consensus

2014 results have been recalculated according to updated measure specifications and differ from previously published reports

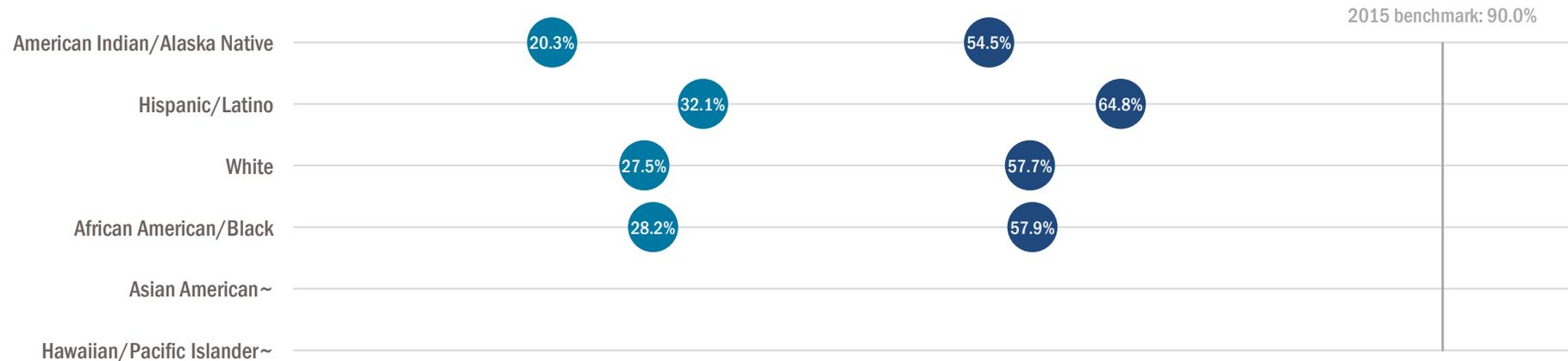


Percentage of children in DHS custody who received health assessments in 2014 & 2015, by race and ethnicity.

Race and ethnicity data missing for 10.2% of respondents / Each race category excludes Hispanic/Latino

2014 results have been recalculated according to updated measure specifications and differ from previously published reports

~ Data suppressed (n<30)



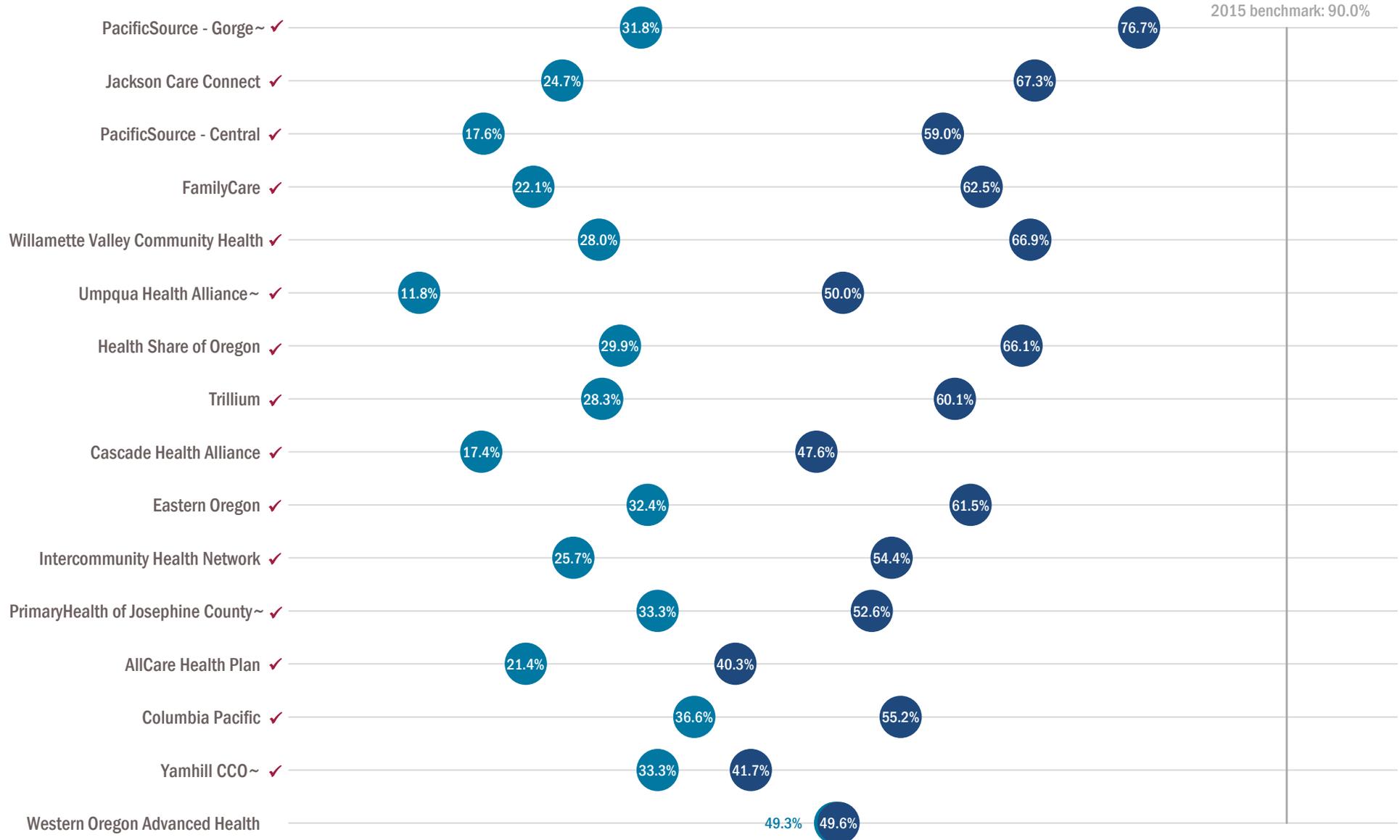


MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Fifteen CCOs achieved improvement target on health assessments for children in DHS custody between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target / 2014 results have been recalculated according to updated measure specifications and differ from previously published reports

~ Note small denominator (n<30)



OBESITY PREVALENCE AMONG ADULTS

Obesity prevalence

Percentage of adult Medicaid members (ages 18 and older) who are obese, defined as body mass index greater than 30.

2014 data

Statewide change since 2014: **-17%** (lower is better)

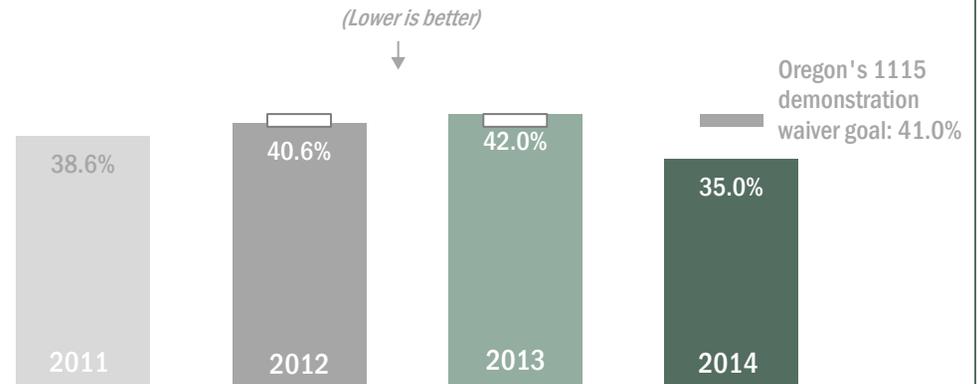
The lower rate of obesity prevalence among Medicaid members may be due to the inclusion of new members enrolled after the ACA expansion, who may be healthier overall.

This measure is not available by race and ethnicity or by CCO; however 2014 results by CCO can be found in the Medicaid-BRFSS (MBRFSS) report available online at www.oregon.gov/oha/analytics/Pages/MBRFSS.aspx.

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Obesity prevalence, statewide.

Data source: Oregon Behavioral Risk Factor Surveillance System (BRFSS) survey





PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Patient-centered primary care home enrollment

Percentage of CCO members who were enrolled in a recognized patient-centered primary care home (PCPCH).

2015 data (n=906,584)

Statewide change since 2014: **+8%**

Number of CCOs that improved: **12**

Number of CCOs achieving benchmark: **all 16**

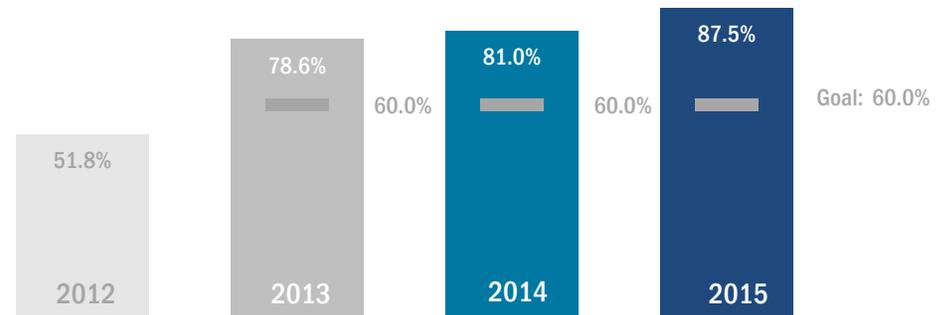
Enrollment in patient-centered primary care homes increased by 69 percent since 2012. This improvement is impressive considering that CCO enrollment has increased more than 70 percent due to Medicaid expansion (see graph at lower right).

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Results for this measure are not available by race and ethnicity.

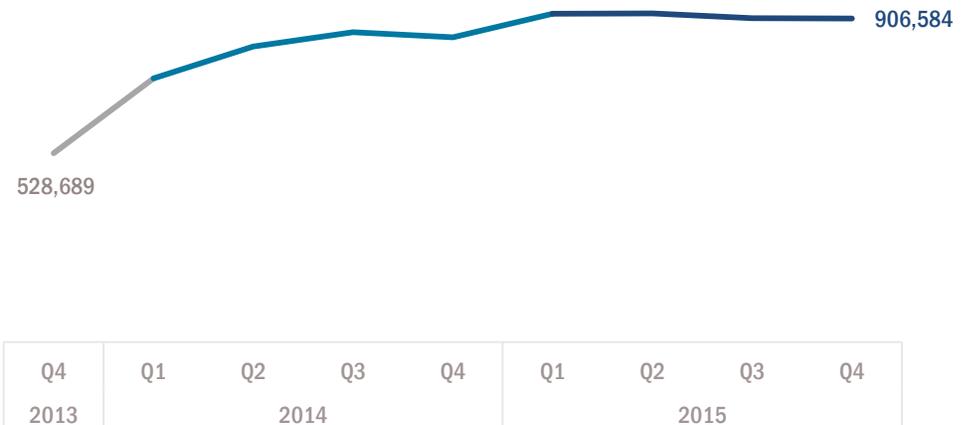
Statewide, patient-centered primary care home continues to increase.

Data source: CCO quarterly reporting



Total CCO enrollment increased 72 percent between 2013 and 2015.

87.9% of Medicaid members were enrolled in a CCO in December 2015.

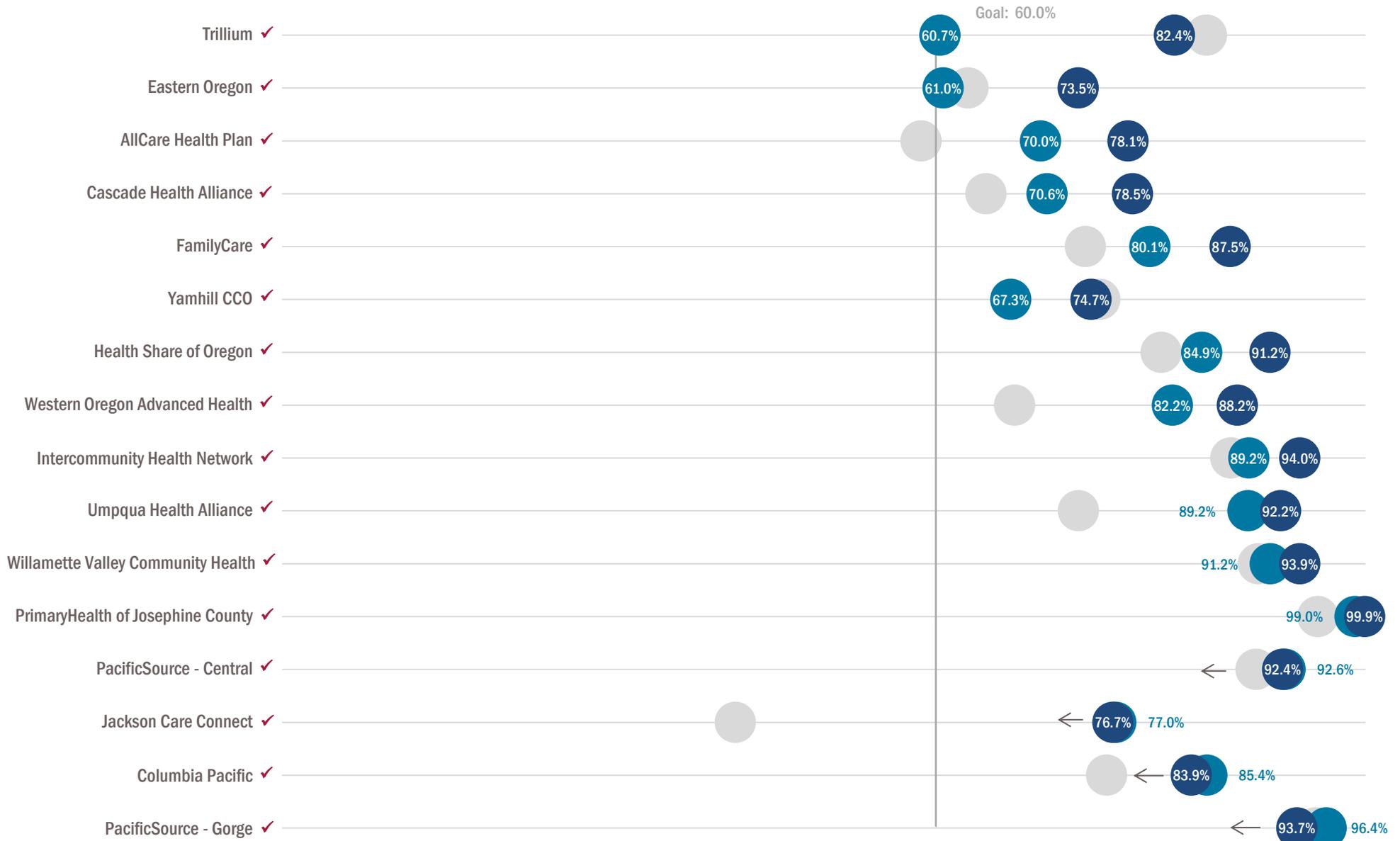




PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Overall, CCOs continued to increase patient-centered primary care home enrollment between 2014 & 2015.

✓ indicates CCO met requirement for quality pool payment (at least 60% enrollment) / Grey dots represent 2013



PQI 01: DIABETES SHORT-TERM COMPLICATION ADMISSION RATE

Diabetes short-term complications admission rate

Rate of adult members (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease. Rates are reported per 100,000 member years. A lower score is better.

PQI stands for Prevention Quality Indicators, which is a set of indicators developed by the Agency for Healthcare Research and Quality (AHRQ) to track avoidable hospitalizations.

2015 data (n=4,939,038 member months)

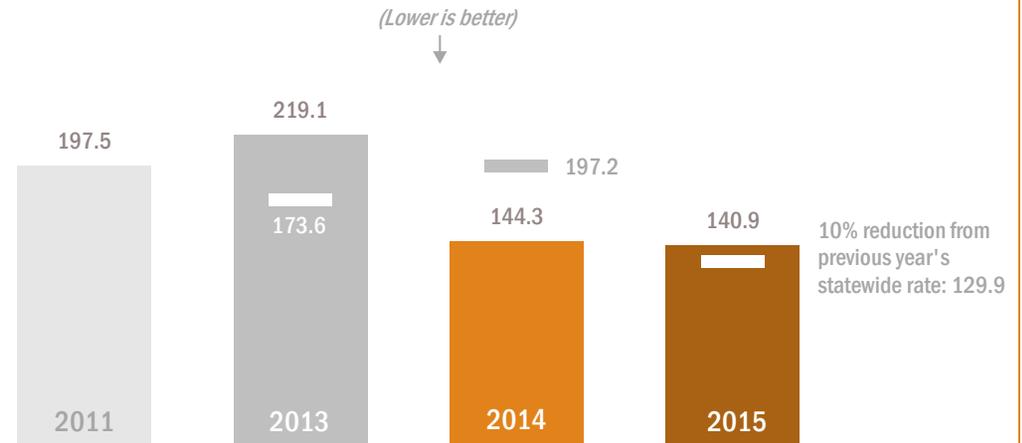
Statewide change since 2014: **-2%** (lower is better)

Number of CCOs that improved: **6**

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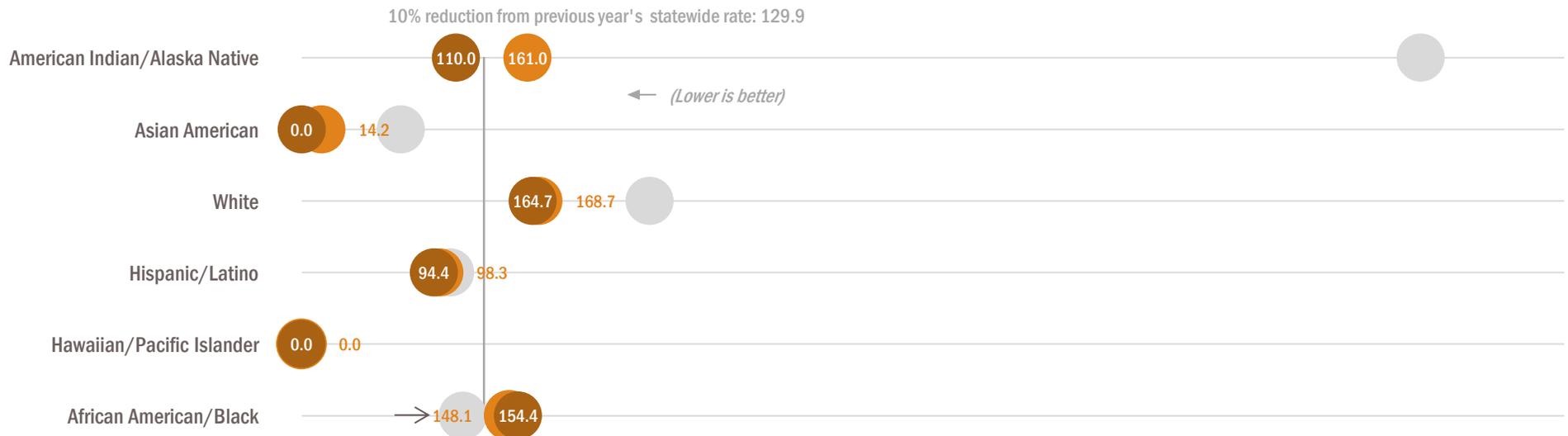
Admissions for diabetes short-term complications, statewide.

Data source: Administrative (billing) claims



Admissions for diabetes short-term complications between 2014 & 2015, by race and ethnicity.

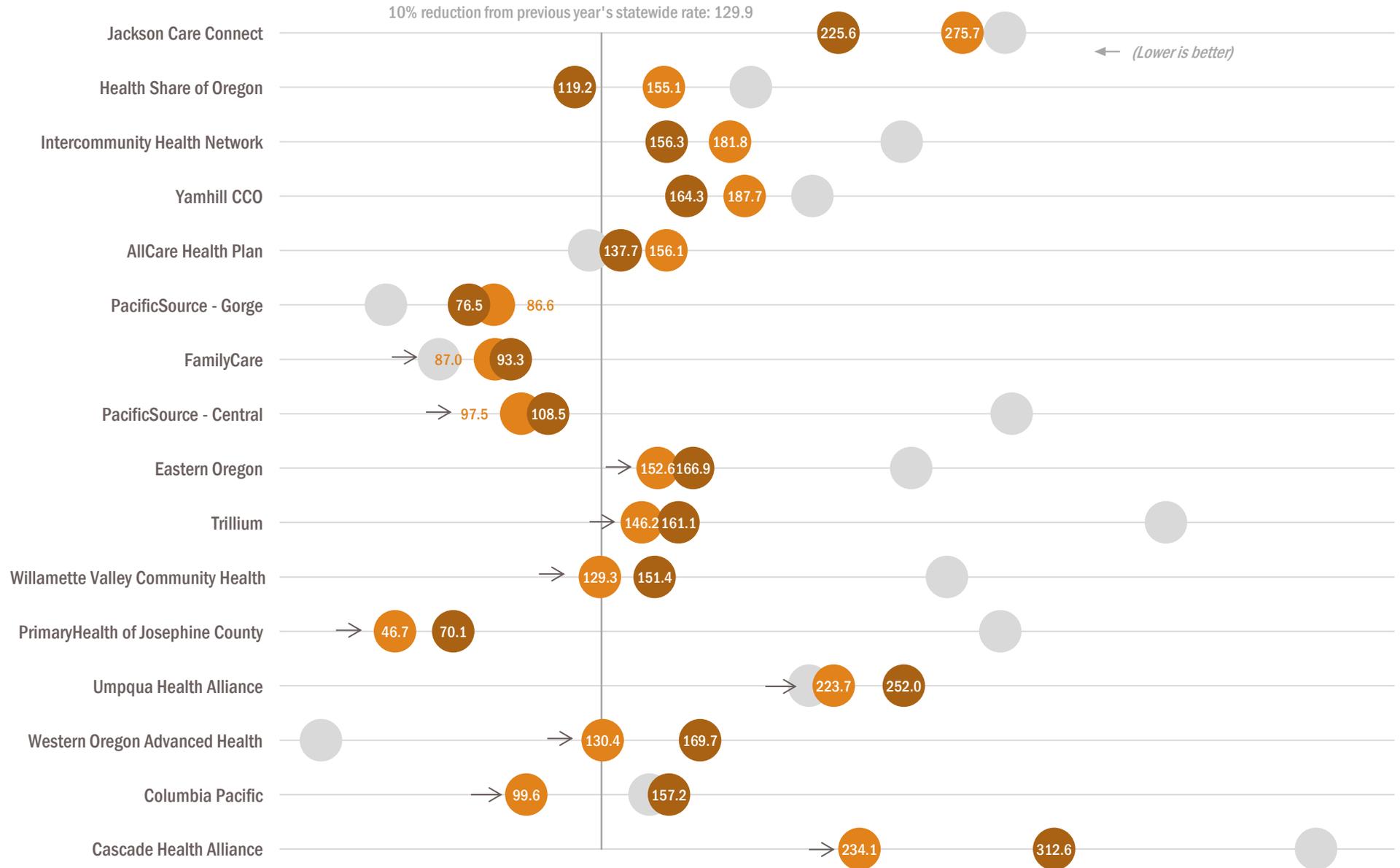
Grey dots represent 2013 / Race and ethnicity data missing for 18.1% of respondents / Each race category excludes Hispanic/Latino



PQI 01: DIABETES SHORT-TERM COMPLICATION ADMISSION RATE

Admissions for diabetes short-term complications between 2014 & 2015, by CCO.

Grey dots represent 2013





PQI 05: CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE

COPD or asthma in older adults admission rate

Rate of adult members (ages 40 and older) who had a hospital stay because of chronic obstructive pulmonary disease (COPD) or asthma. Rates are reported per 100,000 member years. A lower score is better

PQI stands for Prevention Quality Indicators, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

2015 data (n=2,301,359 member months)

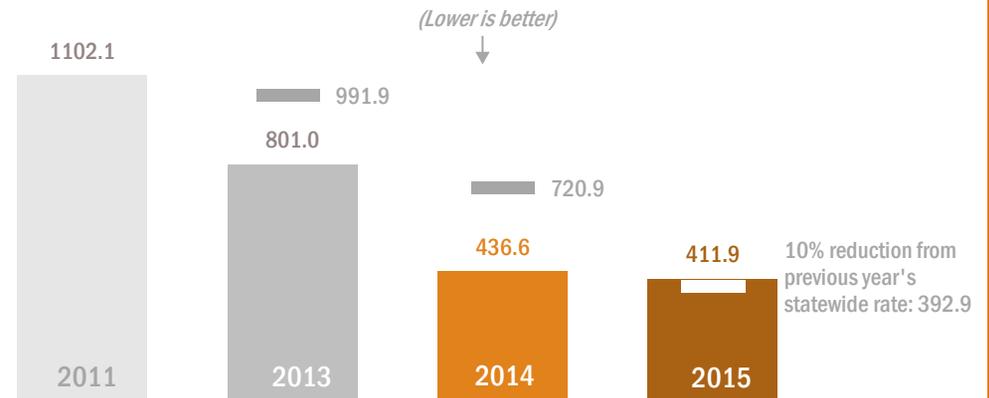
Statewide change since 2014: **-6%** (lower is better)

Number of CCOs that improved: **7**

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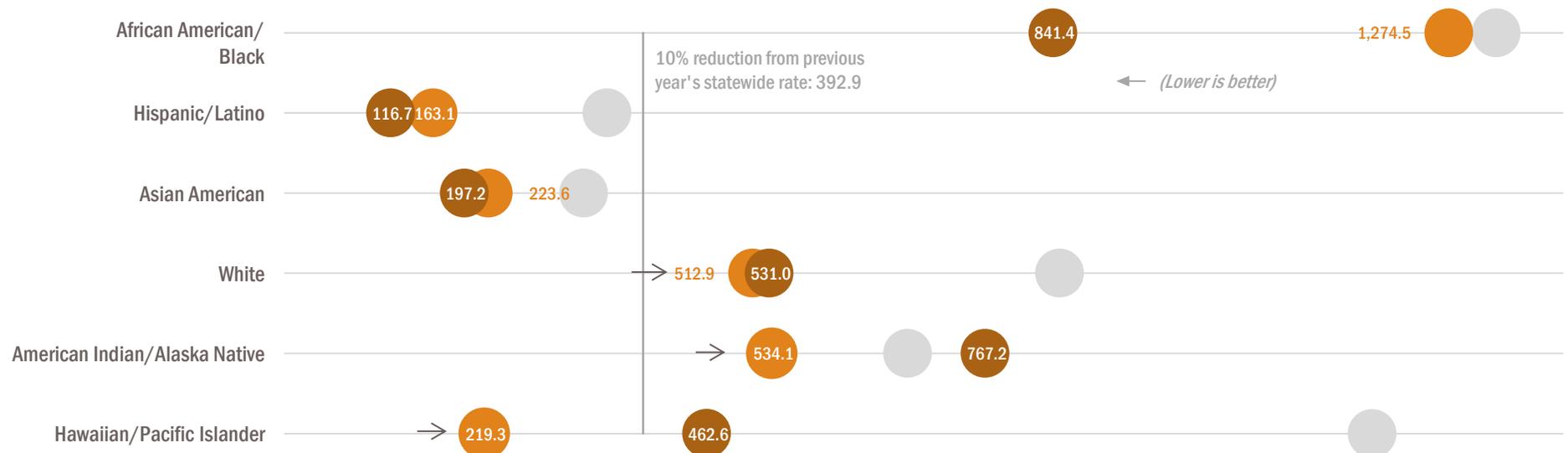
Admissions for COPD or asthma in older adults, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years



Admissions for COPD or asthma between 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 16.2% of respondents / Each race category excludes Hispanic/Latino





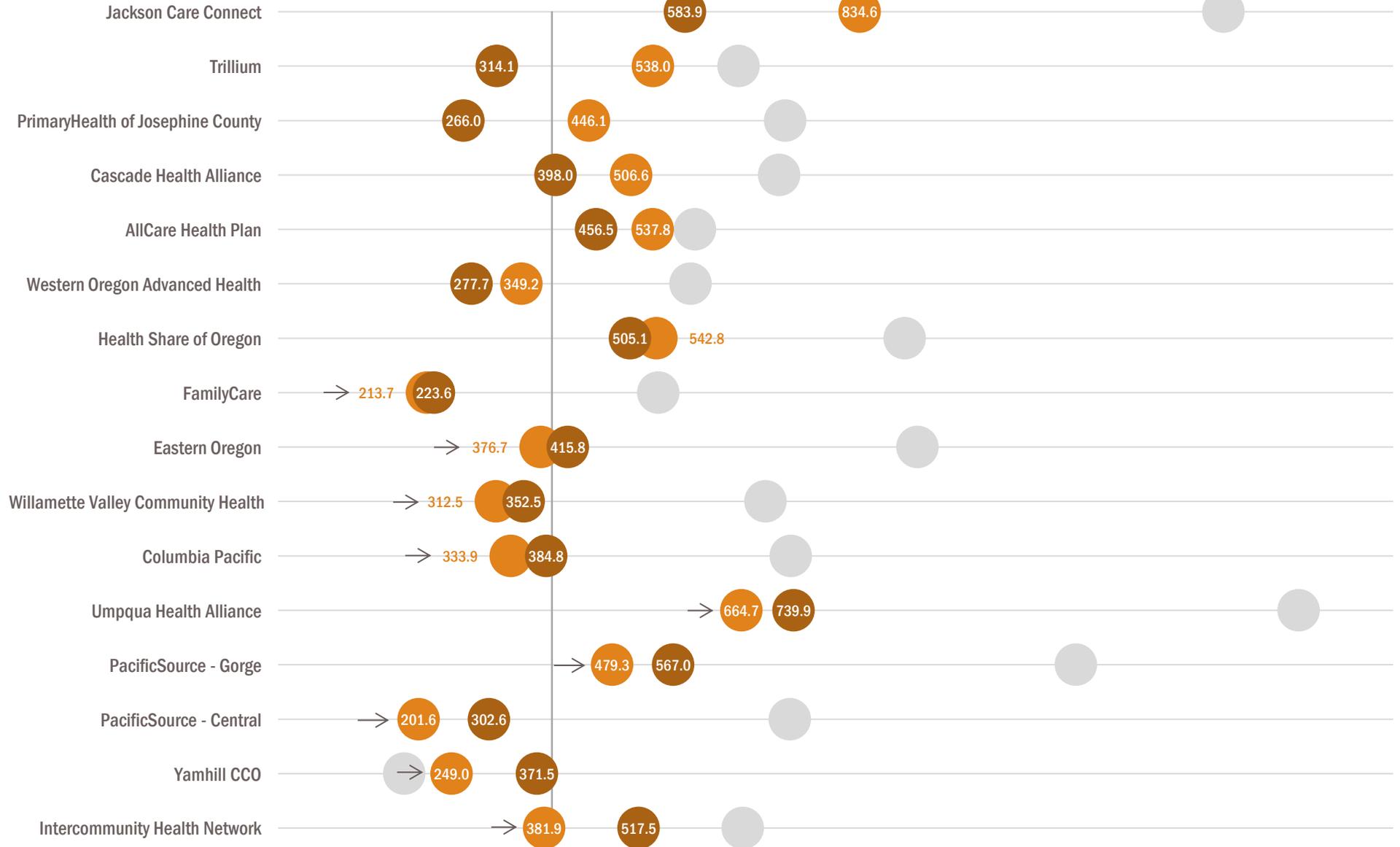
PQI 05: CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE

Admissions for COPD or asthma between 2014 & 2015, by CCO.

Grey dots represent 2013

10% reduction from previous year's statewide rate: 392.9

← (Lower is better)





PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

Congestive heart failure admission rate

Rate of adult members (ages 18 and older) who had a hospital stay because of congestive heart failure. Rates are reported per 100,000 member years. A lower score is better.

PQI stands for Prevention Quality Indicators, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

2015 data (n=4,939,038 member months)

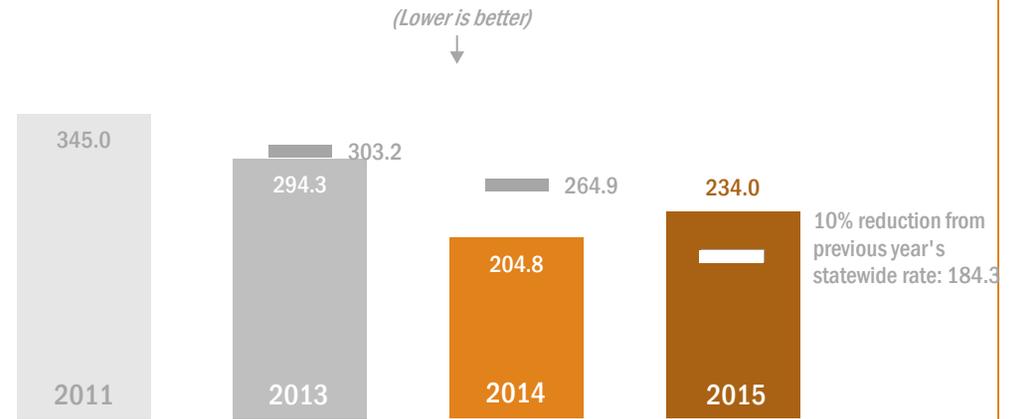
Statewide change since 2014: **+14%** (lower is better)

Number of CCOs that improved: **5**

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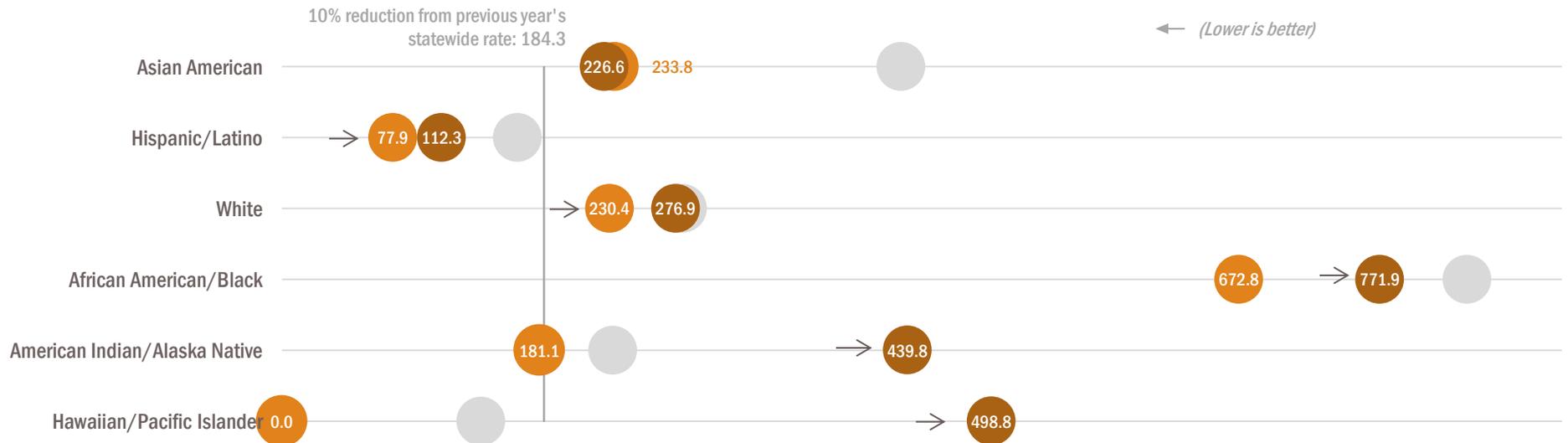
Admissions for congestive heart failure, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years



Admissions for congestive heart failure between 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 16.2% of respondents / Each race category excludes Hispanic/Latino





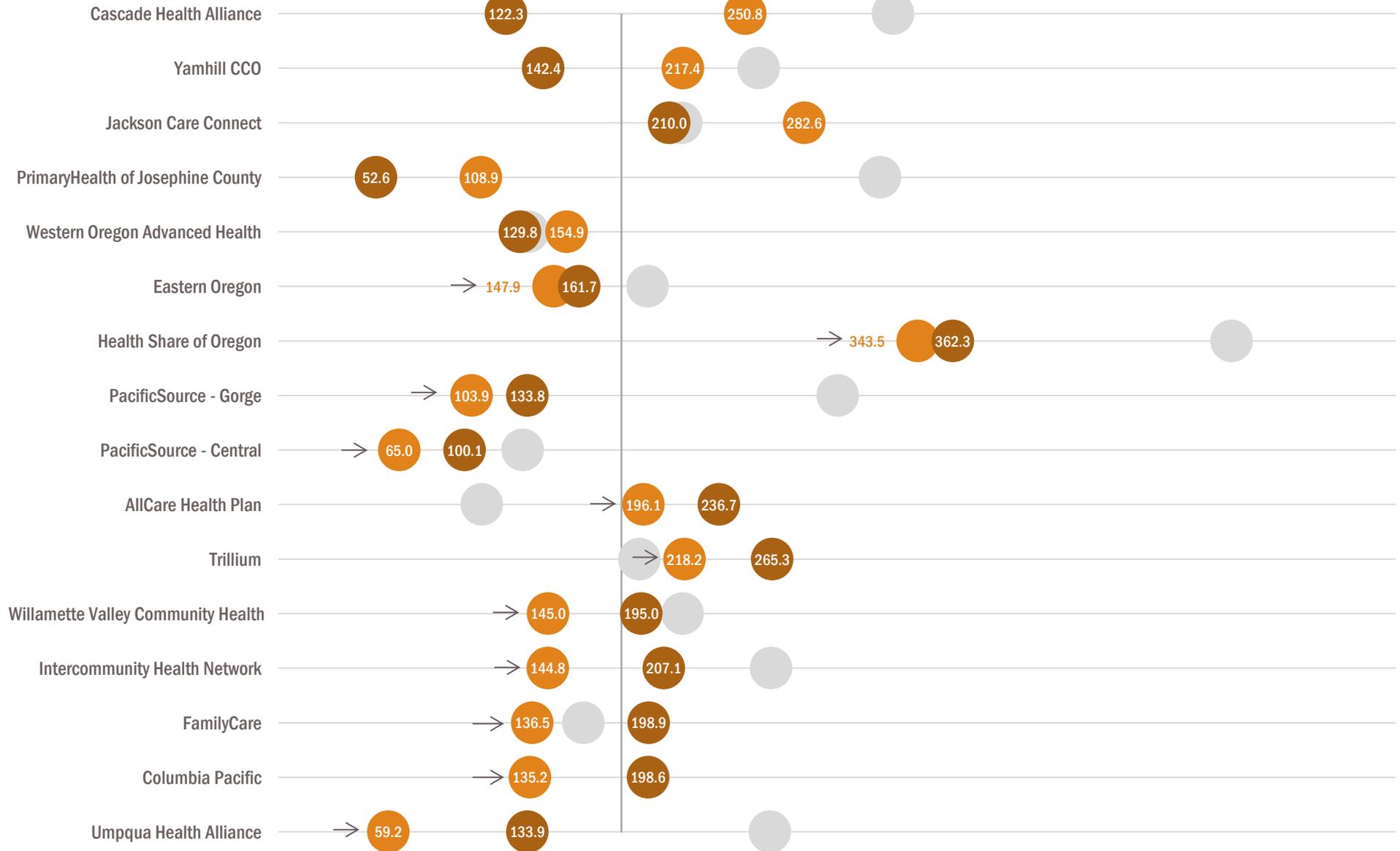
PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

Admissions for congestive heart failure between 2014 & 2015, by CCO.

Grey dots represent 2013

10% reduction from previous year's statewide rate: 184.3

← (Lower is better)





PQI 15: ASTHMA IN YOUNGER ADULTS ADMISSION RATE

Asthma in younger adults admission rate

Rate of adult members (ages 18-39) who had a hospital stay because of asthma. Rates are reported per 100,000 member years. A lower score is better.

PQI stands for Prevenon Quality Indicators, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

2015 data (n=2,675,088 member months)

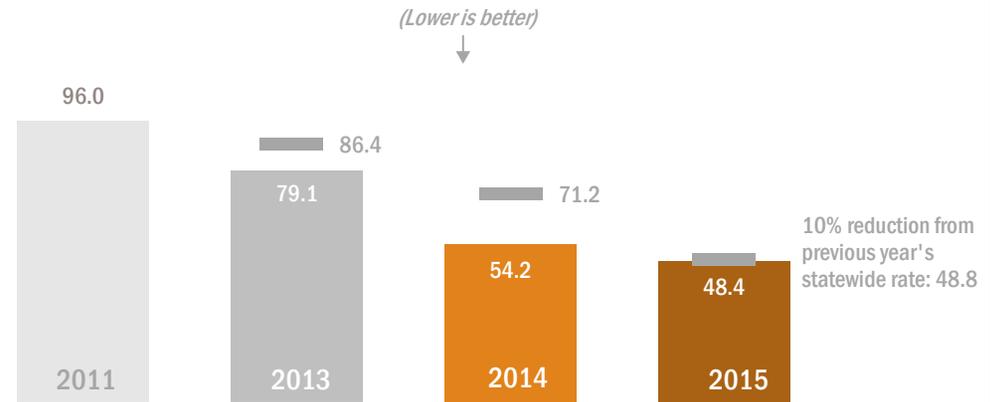
Statewide change since 2014: **-11%** (lower is better)

Number of CCOs that improved: **9**

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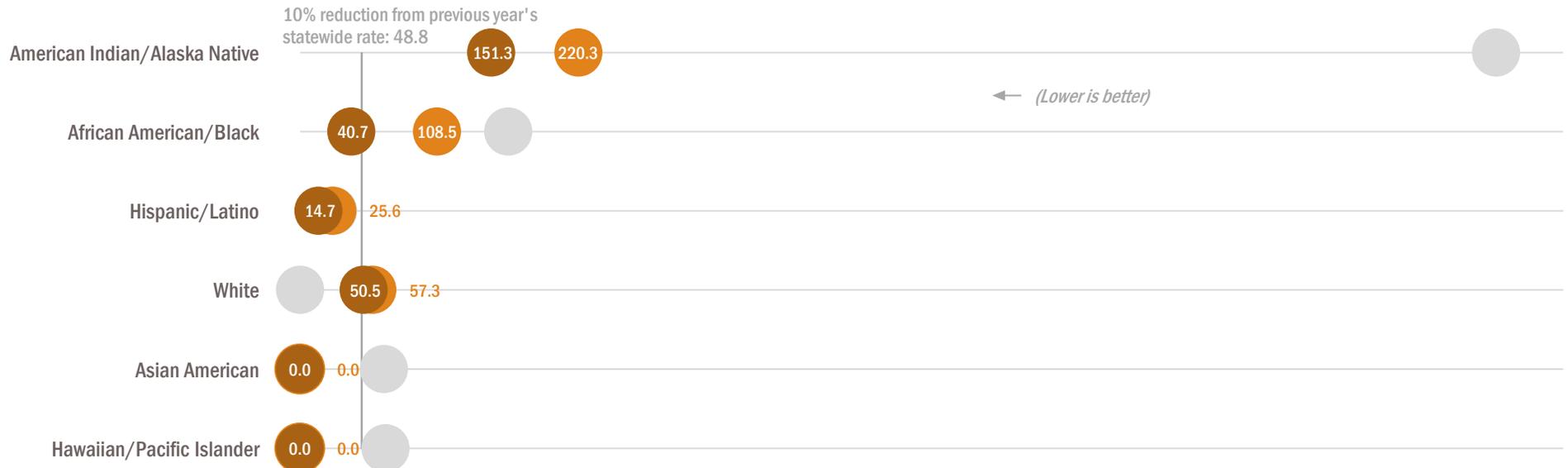
Admissions for asthma in younger adults, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years



Admissions for adult asthma between 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 17.6% of respondents / Each race category excludes Hispanic/Latino





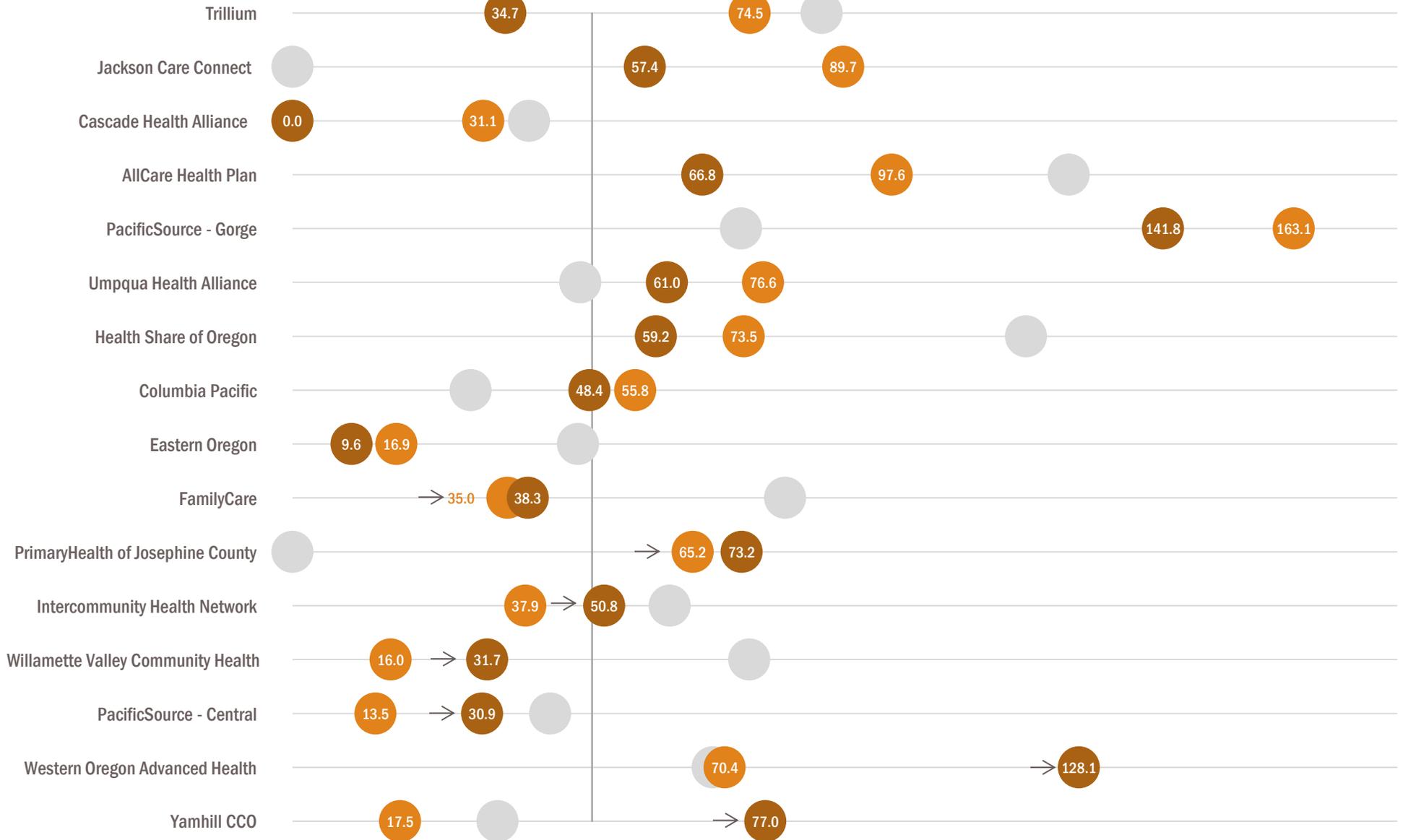
PQI 15: ASTHMA IN YOUNGER ADULTS ADMISSION RATE

Admissions for asthma in younger adults between 2014 & 2015, by CCO.

Grey dots represent 2013

10% reduction from previous year's statewide rate: 48.8

← (Lower is better)



PQI 90: PREVENTION QUALITY OVERALL COMPOSITE

PQI 90: Prevention quality overall composite

Composite rate of adult members who were admitted to a hospital for any of the following preventable conditions:

- Diabetes with short-term complications (PQI 1, [see page 131](#))
- Diabetes with long-term complications
- Uncontrolled diabetes without complications
- Diabetes with lower-extremity amputation
- COPD (PQI 5, [see page 133](#))
- Heart failure (PQI 8, [see page 135](#))
- Hypertension
- Asthma (PQI 15, [see page 137](#))
- Angina
- Dehydration
- Bacterial pneumonia
- Urinary tract infection

Rates are reported per 100,000 member months and a lower score is better. PQI stands for Prevention Quality Indicator, which is a set of indicators developed by the Agency for Healthcare Research and Quality (AHRQ) to track avoidable hospital admissions.

2015 data (n=4,978,699 member months)

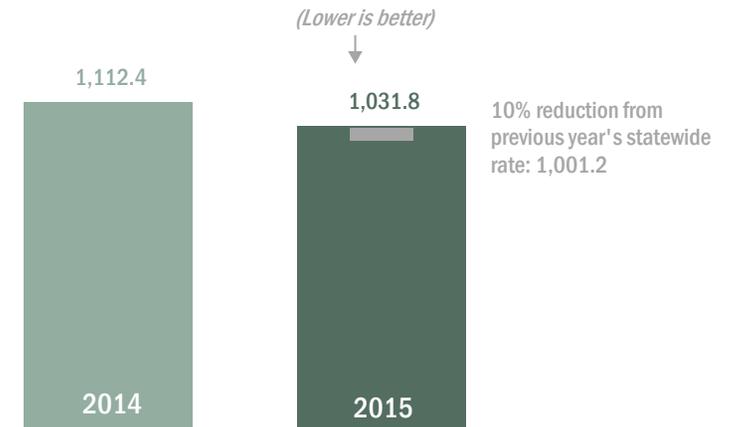
Statewide change since 2014: **-7%** (lower is better)

Number of CCOs that improved: **10**

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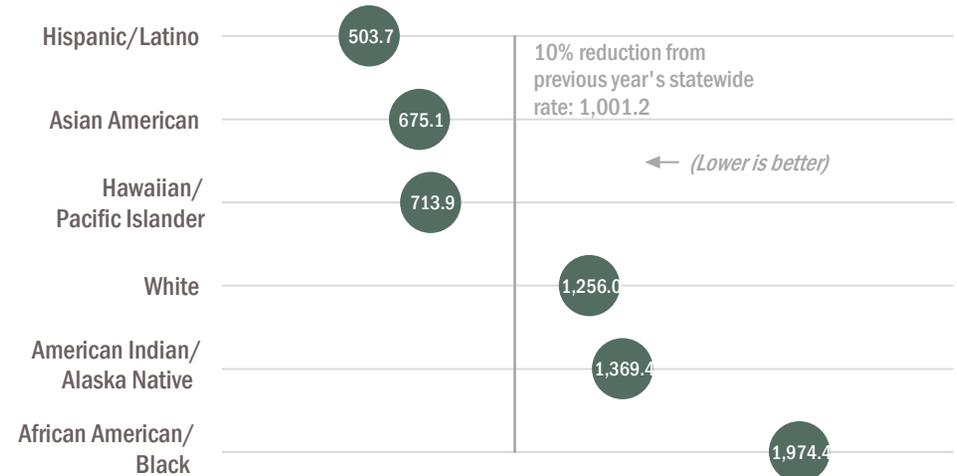
Overall rate of hospitalizations for preventable conditions, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member months



Overall rate of hospitalizations for preventable conditions in 2015, by race and ethnicity.

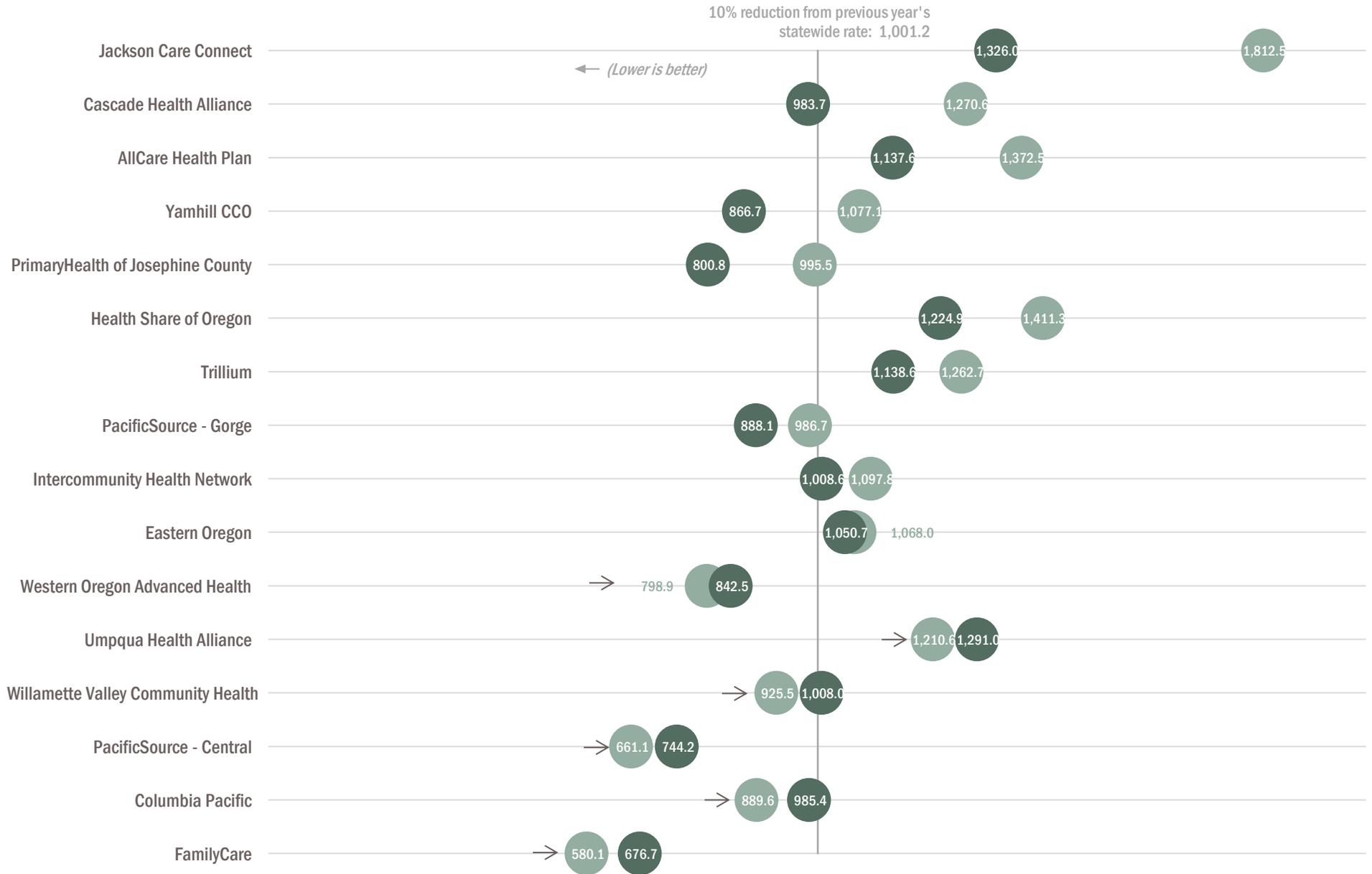
2014 results by race and ethnicity are not available for this measure
Race and ethnicity data missing for 7.1% of respondents / Each race category excludes Hispanic/Latino





PQI 90: PREVENTION QUALITY OVERALL COMPOSITE

Overall rate of hospitalizations for preventable conditions in 2014 & 2015, by CCO.





PQI 91: PREVENTION QUALITY ACUTE COMPOSITE

PQI 91: Prevention quality acute composite

Composite rate of adult members who were admitted to a hospital for any of the following acute conditions:

- Dehydration
- Bacterial pneumonia
- Urinary tract infection

Rates are reported per 100,000 member months and a lower score is better. PQI stands for Prevention Quality Indicator, which is a set of indicators developed by the Agency for Healthcare Research and Quality (AHRQ) to track avoidable hospital admissions.

2015 data (n=4,978,699 member months)

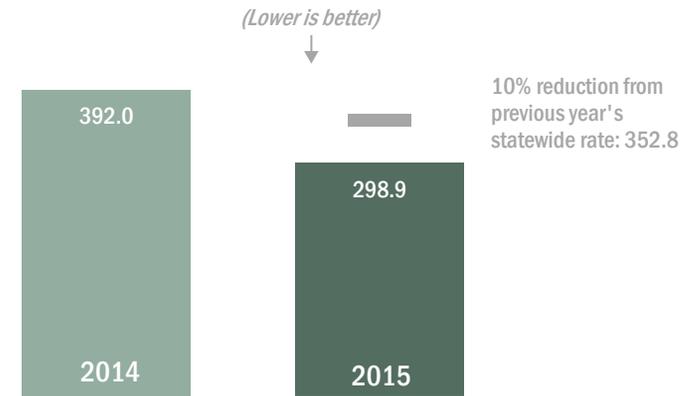
Statewide change since 2014: **-24%** (lower is better)

Number of CCOs that improved: **14**

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Admissions for acute conditions, statewide.

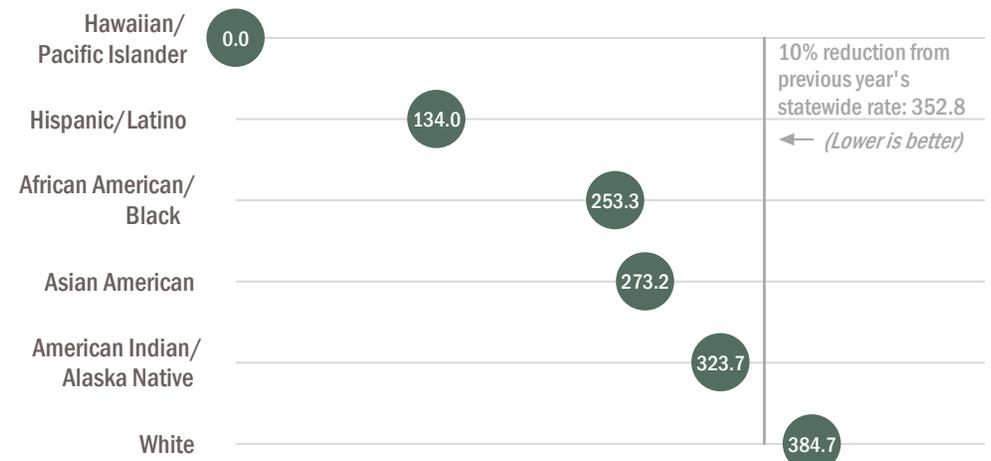
Data source: Administrative (billing) claims



Admissions for acute conditions in 2014 & 2015, by race and ethnicity.

2014 results by race and ethnicity are not available for this measure

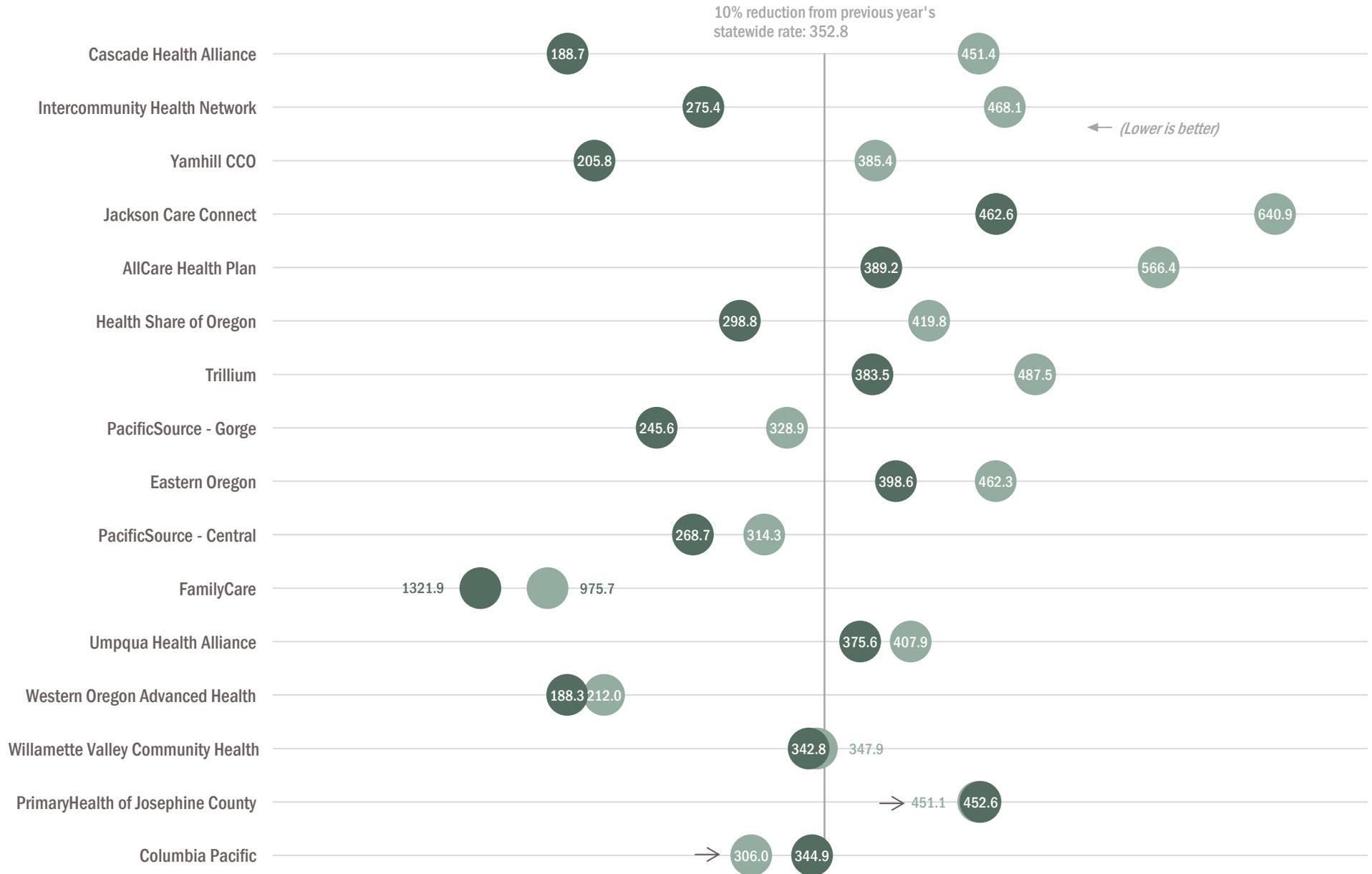
Race and ethnicity data missing for 6.5% of respondents / Each race category excludes Hispanic/Latino





PQI 91: PREVENTION QUALITY ACUTE COMPOSITE

Admissions for acute conditions in 2014 & 2015, by CCO.





PQI 92: PREVENTION QUALITY CHRONIC COMPOSITE

PQI 92: Prevention quality chronic composite

Composite rate of adult members who were admitted to a hospital for any of the following chronic conditions:

- Diabetes with short-term complications (PQI 1, [see page 131](#))
- Diabetes with long-term complications
- Uncontrolled diabetes without complications
- Diabetes with lower-extremity amputation
- COPD (PQI 5, [see page 133](#))
- Heart failure (PQI 8, [see page 135](#))
- Hypertension
- Asthma (PQI 15, [see page 137](#))
- Angina

Rates are reported per 100,000 member months and a lower score is better. PQI stands for Prevention Quality Indicator, which is a set of indicators developed by the Agency for Healthcare Research and Quality (AHRQ) to track avoidable hospital admissions.

2015 data (n=4,978,699 member months)

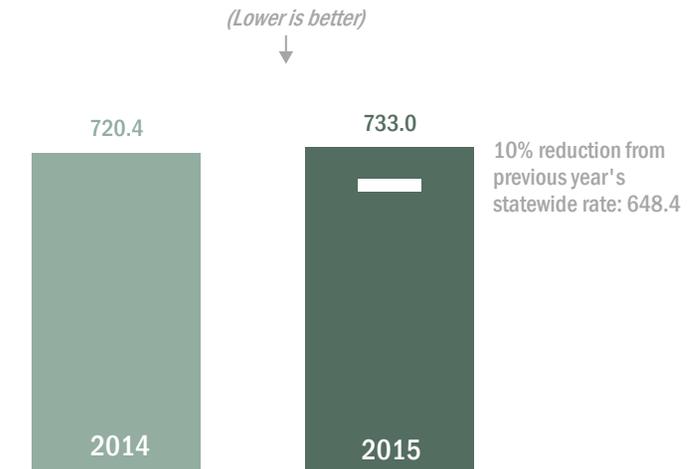
Statewide change since 2014: **+2%** (lower is better)

Number of CCOs that improved: **8**

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Admissions for chronic conditions, statewide.

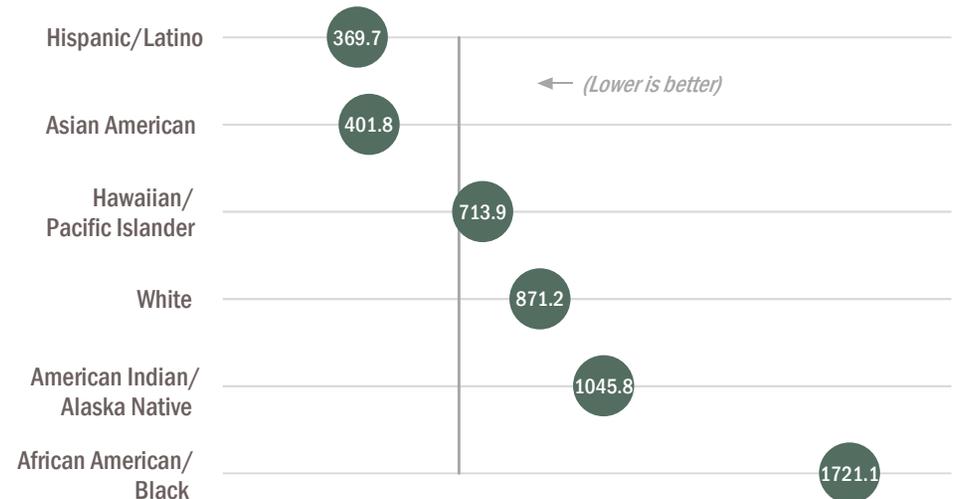
Data source: Administrative (billing) claims



Admissions for chronic conditions in 2014 & 2015, by race and ethnicity.

2014 results by race and ethnicity are not available for this measure

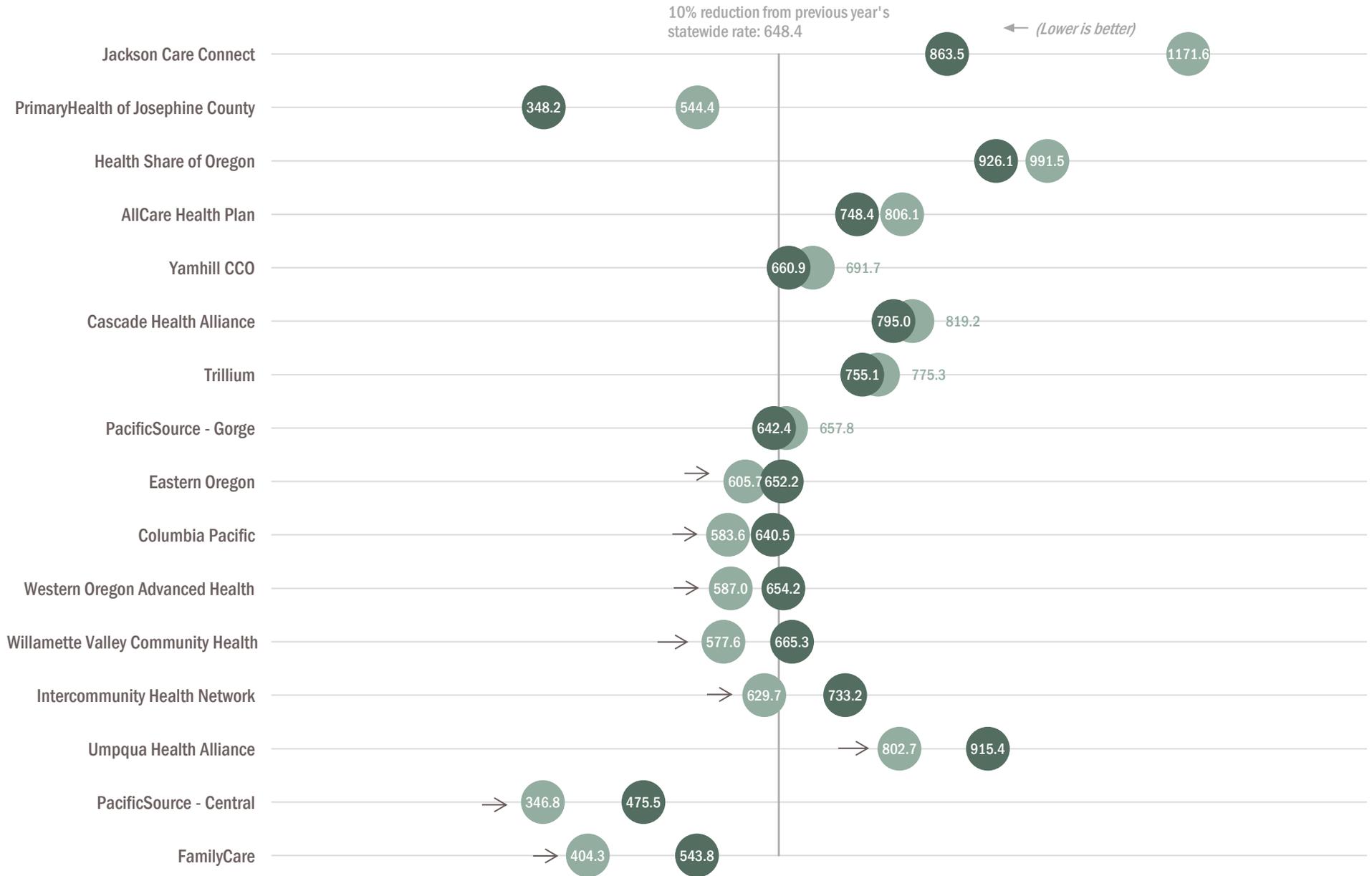
Race and ethnicity data missing for 7.3% of respondents / Each race excludes Hispanic/Latino





PQI 92: PREVENTION QUALITY CHRONIC COMPOSITE

Admissions for chronic conditions in 2014 & 2015, by CCO.





PRENATAL AND POSTPARTUM CARE: TIMELINESS OF PRENATAL CARE

Timeliness of prenatal care

Percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days of enrollment in a CCO.

2015 data (n=5,724)

Statewide change since 2014: **+13%**

Number of CCOs that improved: **all 16**

Number of CCOs achieving benchmark or improvement target: **all 16**

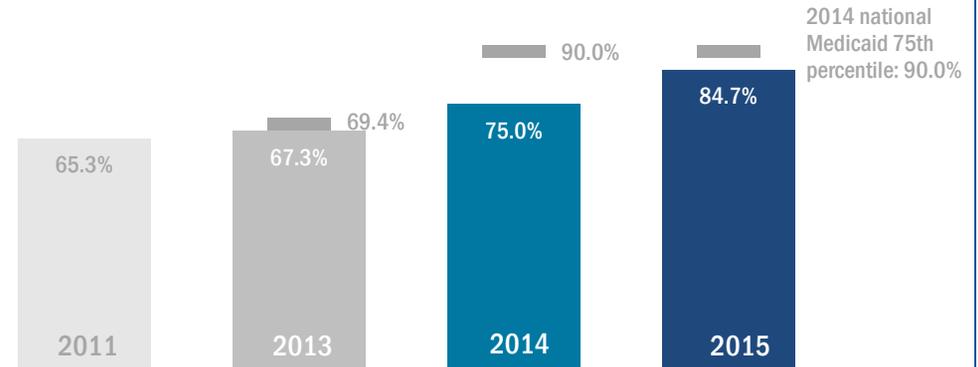
The measure specifications for timeliness of prenatal care were updated beginning in 2014 to use medical record data. Previously, this measure used administrative data only; 2014 and 2015 results are thus not directly comparable to earlier years.

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Results for this measure are not available by race and ethnicity.

Timeliness of prenatal care, statewide.

Data source: Administrative (billing) claims and medical record review
2014 results have been revised and will differ from previously published reports
2014 and 2015 are not directly comparable to earlier years due to changed methodology





PRENATAL AND POSTPARTUM CARE: TIMELINESS OF PRENATAL CARE

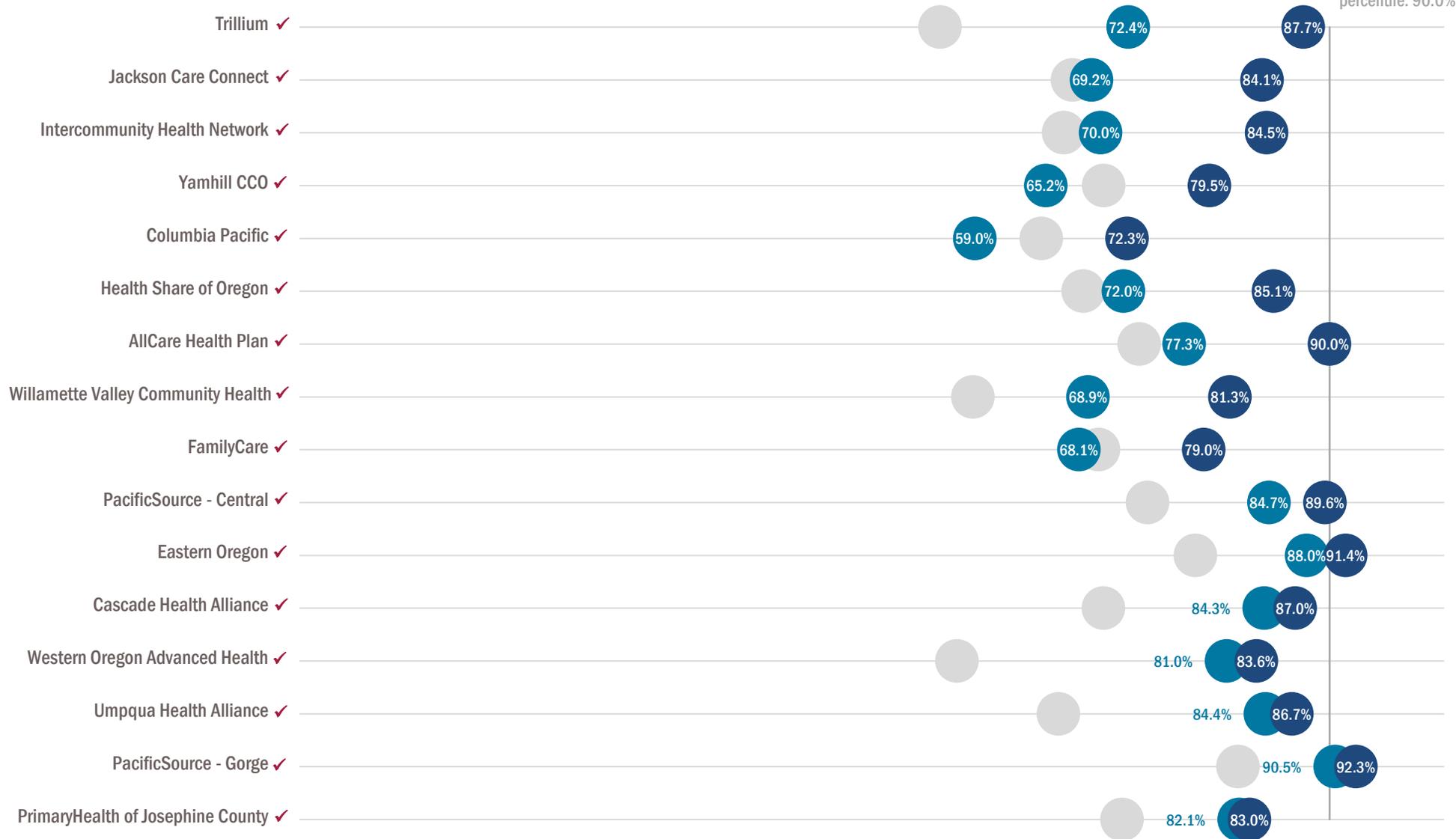
All 16 CCOs achieved benchmark or improvement target for timeliness of prenatal care between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target

2014 results have been revised and will differ from previously published reports

Grey dots represent 2013 and are not directly comparable to 2014 and 2015 due to changed methodology

2014 national Medicaid 75th percentile: 90.0%





PRENATAL AND POSTPARTUM CARE: POSTPARTUM CARE RATE

Postpartum care rate

Percentage of women who had a postpartum care visit on or between 21 and 56 days after delivery.

2015 data (n=5,724)

Statewide change since 2014: **+14%**

Number of CCOs that improved: **9**

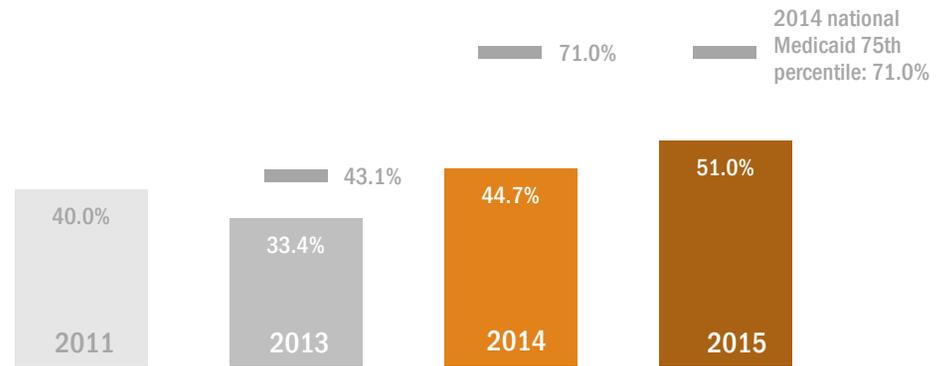
The measure specifications for postpartum care were updated beginning in 2014 to use medical record data. Previously, this measure used administrative data only; 2014 and 2015 results are thus not directly comparable to earlier years.

[Back to table of contents.](#)

Results for this measure are not available by race and ethnicity.

Timeliness of postpartum care, statewide.

Data source: Administrative (billing) claims and medical record review
2014 results have been revised and will differ from previously published reports
2014 and 2015 are not directly comparable to earlier years due to changed methodology





PRENATAL AND POSTPARTUM CARE: POSTPARTUM CARE RATE

Postpartum care rate in 2014 & 2015, by CCO.

2014 results have been revised and will differ from previously published reports

2014 national Medicaid 75th percentile: 71.0%



*CCO did not submit 2014 data

PROVIDER QUESTIONS FROM THE PHYSICIAN WORKFORCE SURVEY

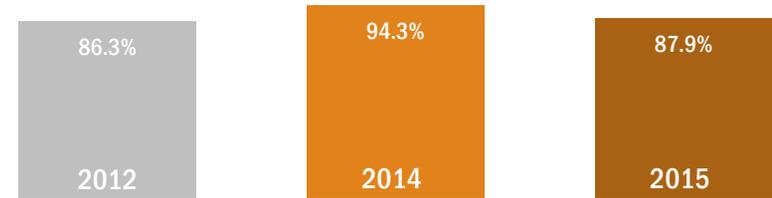
Component 1: Extent to which providers are accepting new Medicaid patients.

Percentage of providers who are accepting new Medicaid / Oregon Health Plan patients.

Statewide change since 2014: **-7%**

Percentage of providers accepting new Medicaid patients, statewide.

Data source: Oregon Physician Workforce Survey



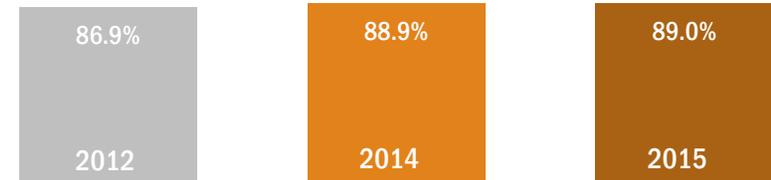
Component 2: Extent to which providers currently see Medicaid patients.

Percentage of providers who currently care for Medicaid / Oregon Health Plan members. This information does not include “don’t know” or missing survey responses.

Statewide change since 2014: **0%**

Percentage of providers seeing Medicaid patients, statewide.

Data source: Oregon Physician Workforce Survey



Component 3: Current payer mix.

Percentage of Medicaid payers at practice.

Statewide change since 2014: **+37%**

Medicaid share of provider payer mix, statewide.

Data source: Oregon Physician Workforce Survey



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SATISFACTION WITH CARE (CAHPS SURVEY)

Satisfaction with care (CAHPS survey)

Percentage of members (adults and children) who received needed information or help and thought they were treated with courtesy and respect by their health plan's customer service staff.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2015 data

Statewide change since 2014: **+1%**

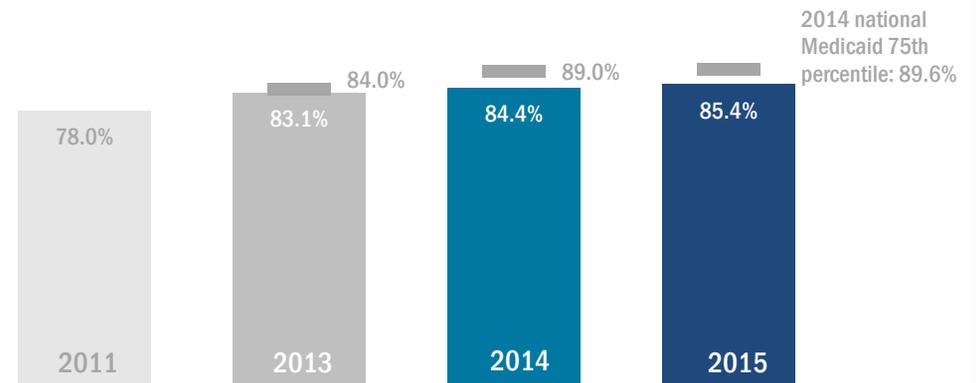
Number of CCOs that improved: **11**

Number of CCOs achieving benchmark or improvement target: **8**

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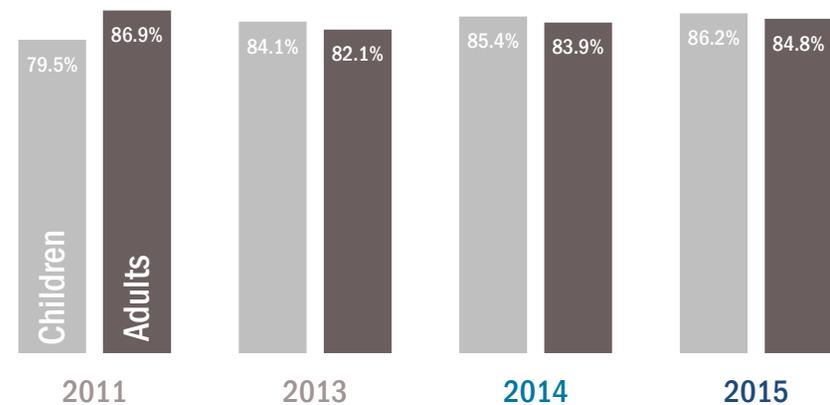
Statwide, satisfaction with care increased slightly in 2015.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Satisfaction with care among children and adults, statewide.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)

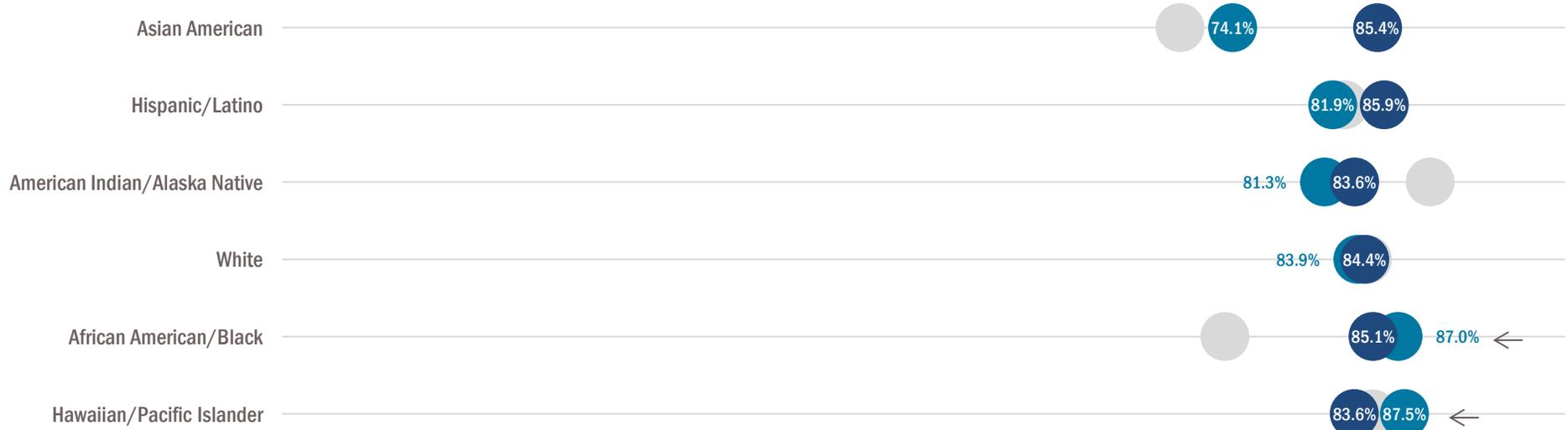




SATISFACTION WITH CARE (CAHPS SURVEY)

Satisfaction with care among ADULTS between 2014 & 2015.

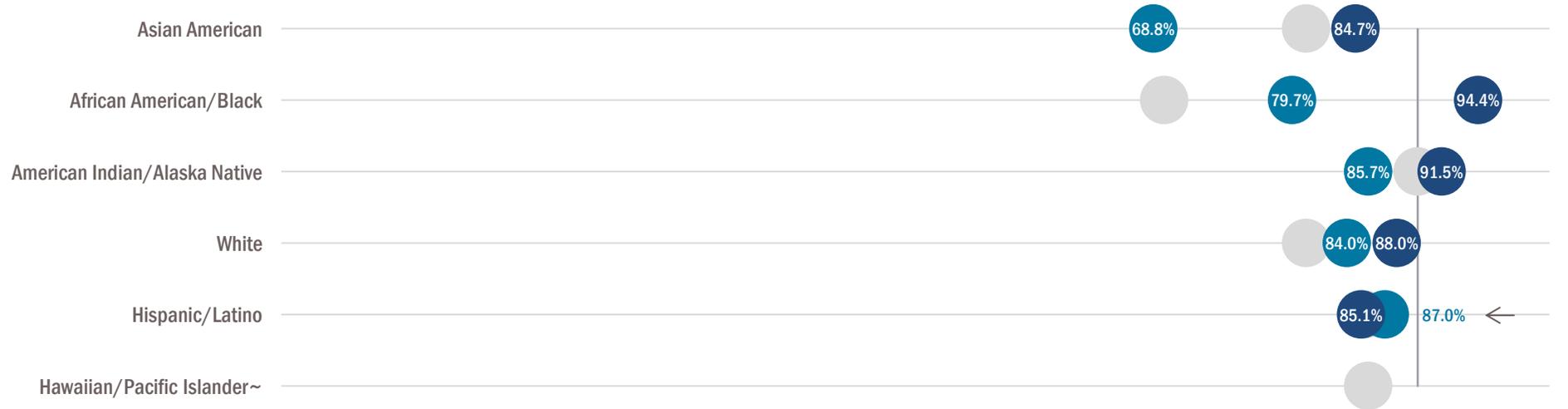
Grey dots represent 2013 / Ethnicity data missing for 7.2% of respondents / Each race category excludes Hispanic/Latino



Satisfaction with care among CHILDREN between 2014 & 2015.

Grey dots represent 2013 / Ethnicity data missing for 8.9% of respondents / Each race category excludes Hispanic/Latino

~ Data suppressed (n<30)





SATISFACTION WITH CARE (CAHPS SURVEY)

Eight CCOs achieved their improvement target for satisfaction with care CCO between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2013

2014 national Medicaid 75th percentile: 89.6%





TOBACCO USE PREVALENCE (CAHPS SURVEY)

Tobacco use prevalence (CAHPS survey)

Percentage of adult Medicaid members (ages 18 and older) who currently smoke cigarettes or use other tobacco products.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care.

2015 data

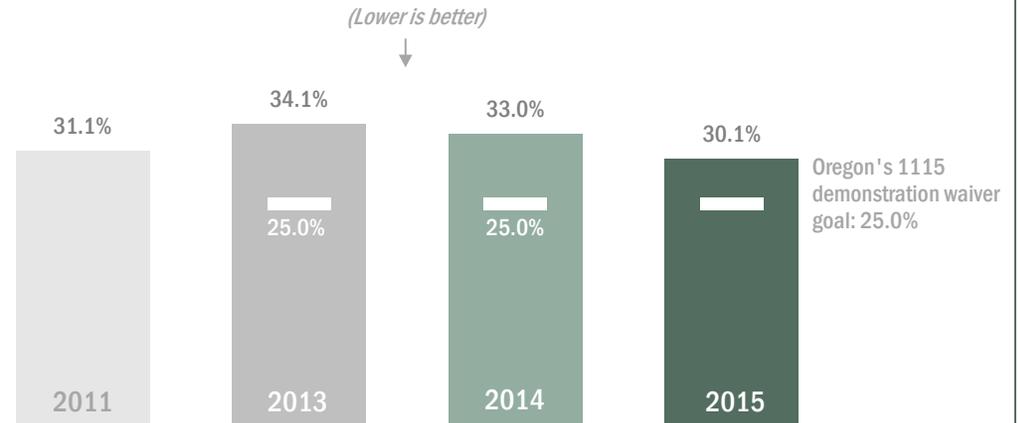
Statewide change since 2014: **-9%** (lower is better)

Number of CCOs that improved: **12**

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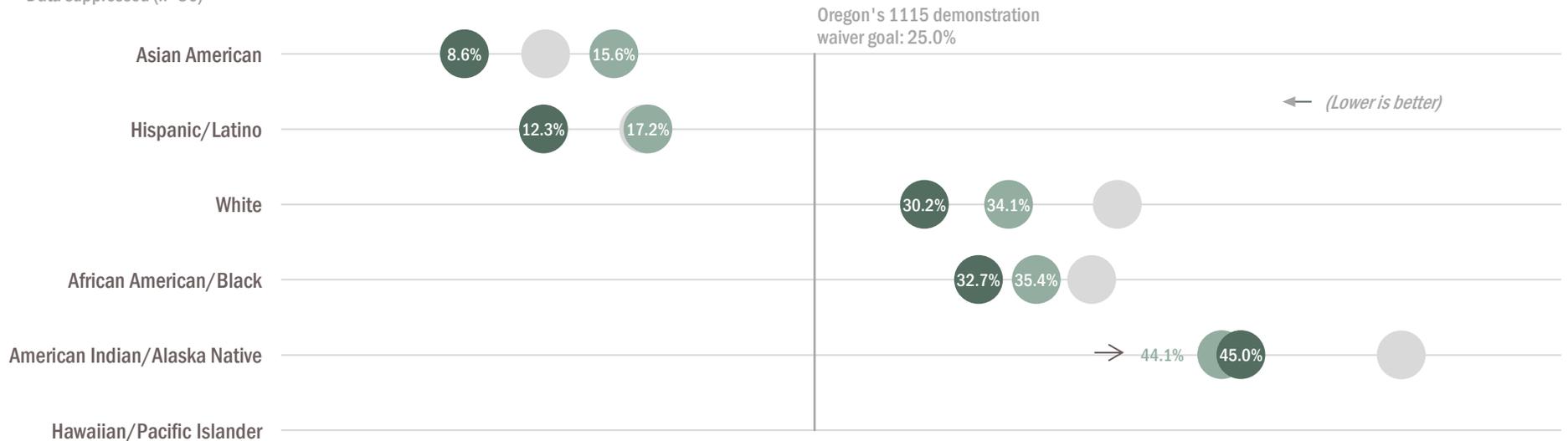
Tobacco use prevalence, statewide.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Tobacco use prevalence between 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Ethnicity data missing for 7.2% of adult and 8.9% child respondents / Each race category excludes Hispanic/Latino
~ Data suppressed (n<30)



TOBACCO USE PREVALENCE (CAHPS SURVEY)

Tobacco use status between 2014 & 2015, by CCO.

Grey dots represent 2013





WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

Well-child visits in the first 15 months of life

Percentage of children who had six visits with their health care provider prior to reaching 15 months of age.

2015 data (n=16,307)

Statewide change since 2014: **+3%**

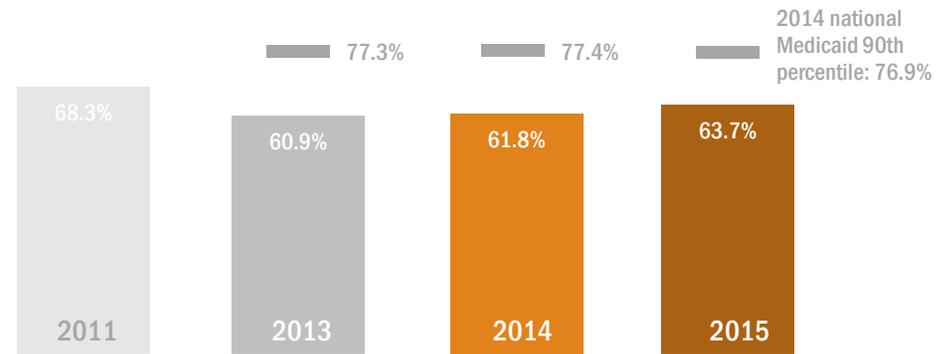
Number of CCOs that improved: **13**

See page [170](#) for results stratified by members with mental health diagnoses.

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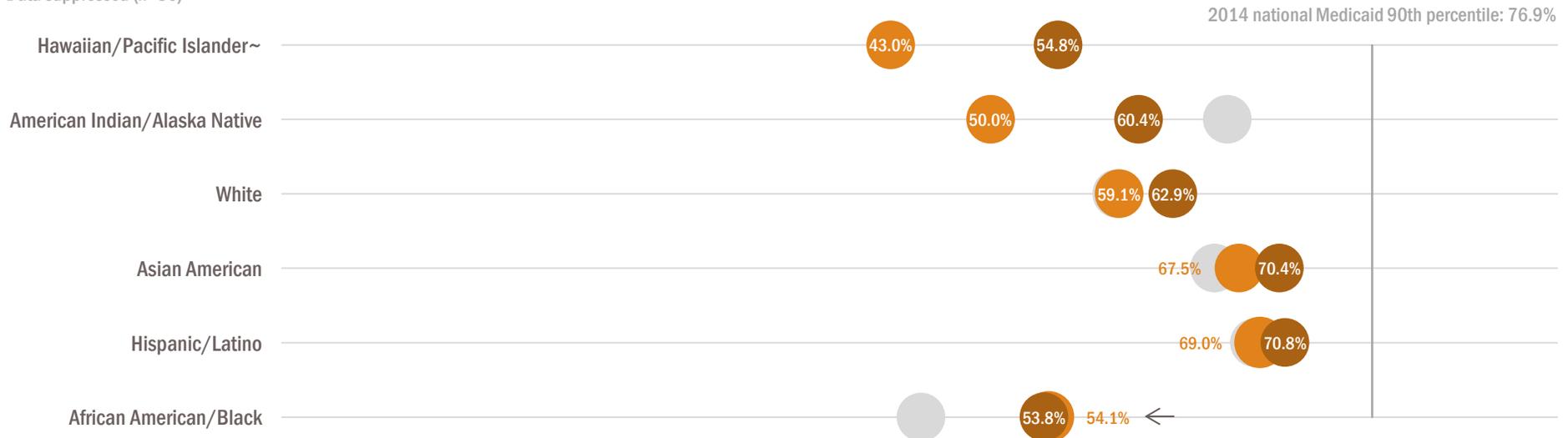
Well-child visits in the first 15 months of life, statewide.

Data source: Administrative (billing) claims



Well-child visits in the first 15 months of life between 2014 & 2015, by race and ethnicity.

Grey dots represent 2013 / Race and ethnicity data missing for 20.9% of respondents / Each race category excludes Hispanic/Latino
~Data suppressed (n<30)





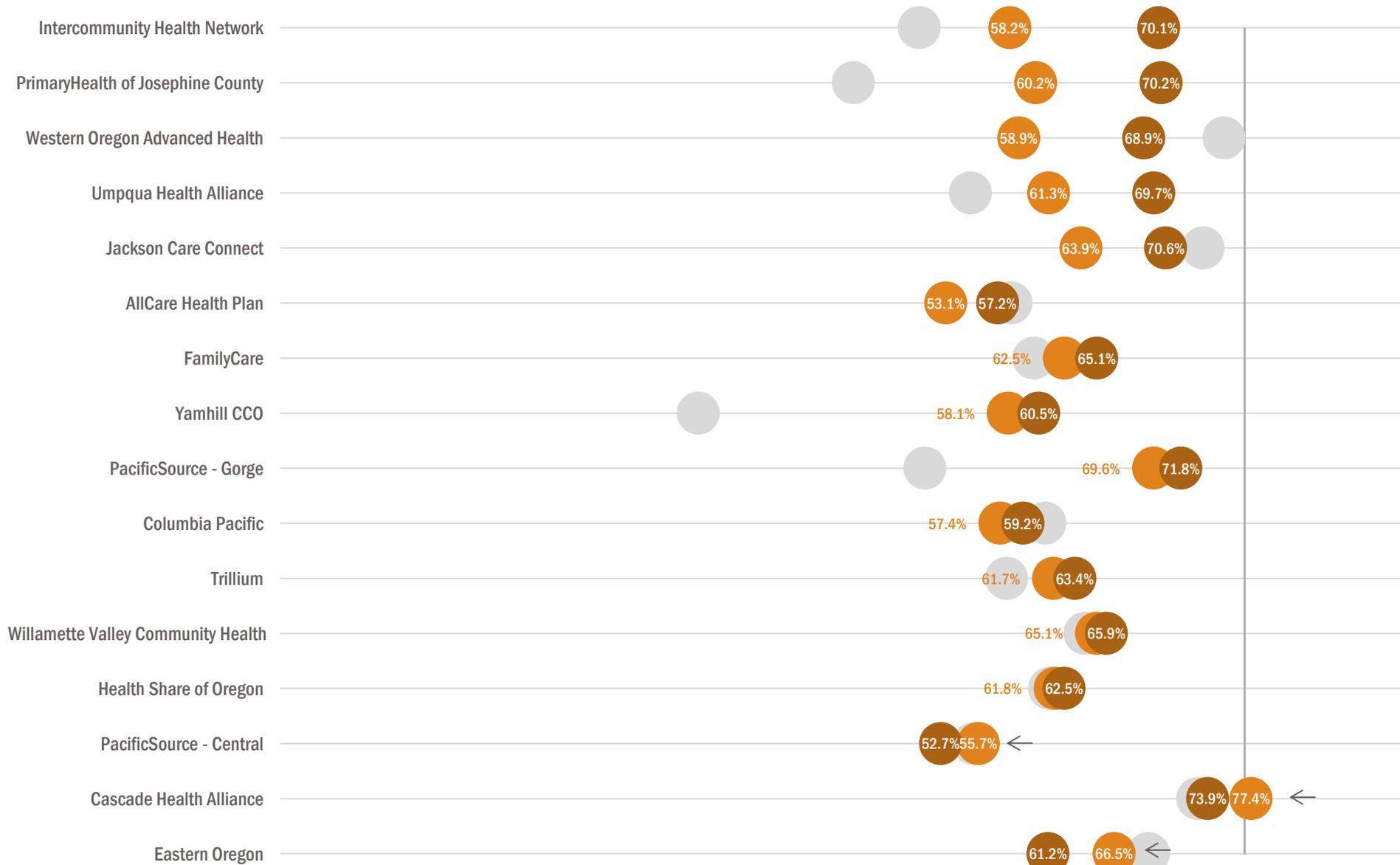
WELL-CHILD VISITS IN THE FIRST 36 MONTHS OF LIFE

Well-child visits in the first 15 months of life between 2014 & 2015, by CCO.

Grey dots represent 2013

2014 results have been updated and differ from previously published results

2014 national Medicaid 90th percentile: 76.9%



ADDITIONAL MEASURE STRATIFICATION: MEASURES BY DISABILITY, MENTAL HEALTH DIAGNOSES, AND SEVERE AND PERSISTENT MENTAL ILLNESS

The Oregon Health Authority is committed to providing data on vulnerable or historically underserved members of our community. This section of the report provides a subset of CCO measures stratified by members with disability, with mental health diagnoses, and with severe and persistent mental illness. These are initial findings and OHA will continue to explore and report on these data in more depth.

MEASURES BY DISABILITY

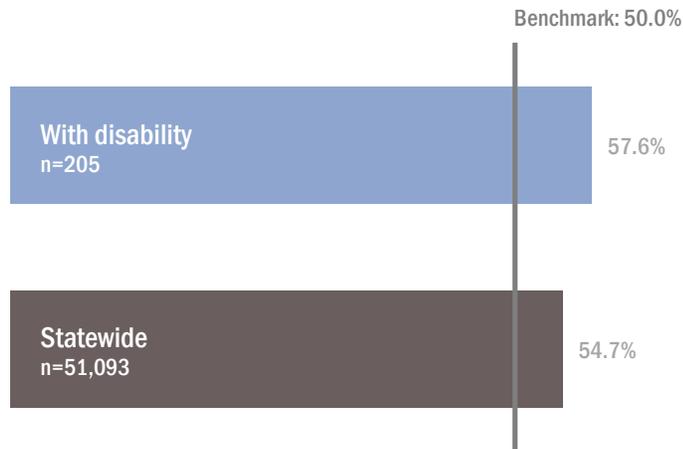
Introduction

This section shows 2015 data for 15 measures, reported for CCO members with disability, compared to statewide.

With disability means people who qualify for Medicaid based on an impairment that has prevented them from performing substantial gainful activity for at least one year, or is expected to prevent them from performing substantial gainful activity for at least one year. This may include physical, mental, emotional, learning, developmental or other disabilities. These individuals may or may not also be qualified for Medicare. Eligibility codes include: 3, 4, B3, and D4.

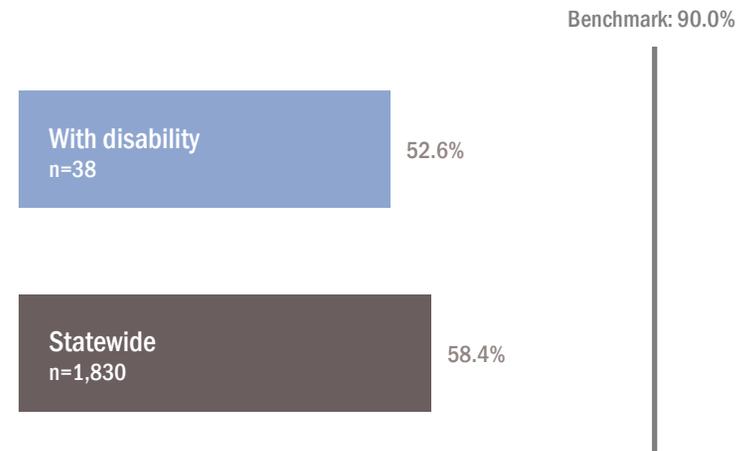
Development screening during the first 36 months of life

Children **with disability** versus statewide



Mental, physical, and dental health assessments for children in DHS custody

Children **with disability** versus statewide



2015 data

Children with disability have higher rates of [developmental screening](#) during the first three years of life, which may reflect a higher engagement with the health system. These children may be more likely to see a provider for reasons related to their disability, which creates more opportunities for them to also receive their developmental screening. It may also be that the developmental screening was what first identified their disability.

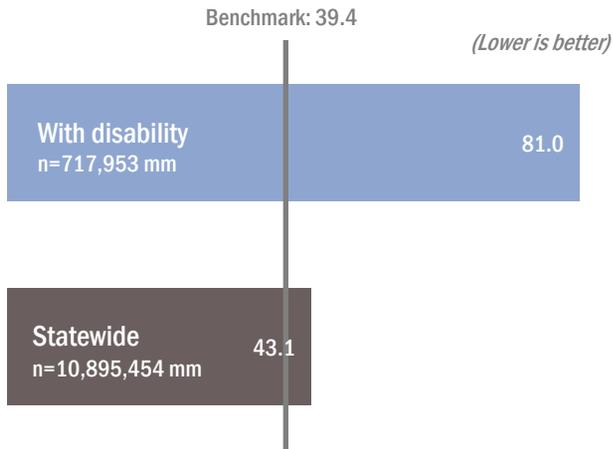
However, children with disability in [DHS custody](#) had lower rates of mental, physical, and dental health assessments upon entering foster care, which may reflect even greater challenges with care coordination for this population.

MEASURES BY DISABILITY

Emergency department utilization

Members **with disability** versus statewide

Rates are reported per 1,000 member months



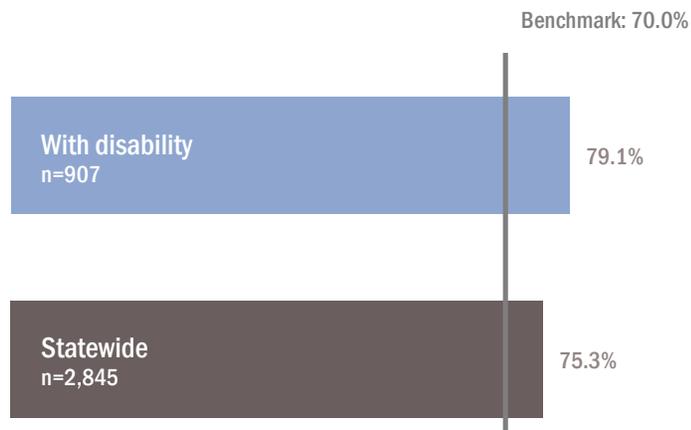
2015 data

Members with disability have higher rates of [emergency department utilization](#), which mirrors national data (lower rates are better).

Members with disability are more likely to receive timely [follow-up \(within 7 days\) after hospitalization for mental illness](#) than statewide. Timely follow-up after hospitalization can reduce the duration of disability and, for certain conditions, the likelihood of re-hospitalization.

Follow-up after hospitalization for mental illness

Members **with disability** versus statewide



MEASURES BY DISABILITY

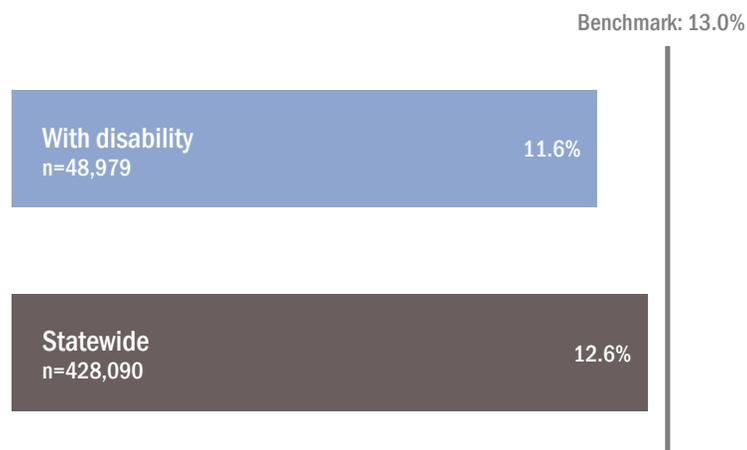
Screening, brief intervention, and referral to treatment (SBIRT) (ages 12-17)

Adolescents **with disability** versus statewide



Screening, brief intervention, and referral to treatment (SBIRT) (ages 18+)

Adults **with disability** versus statewide



Screening, brief intervention, and referral to treatment (SBIRT) - all ages (ages 12+)

Members **with disability** versus statewide



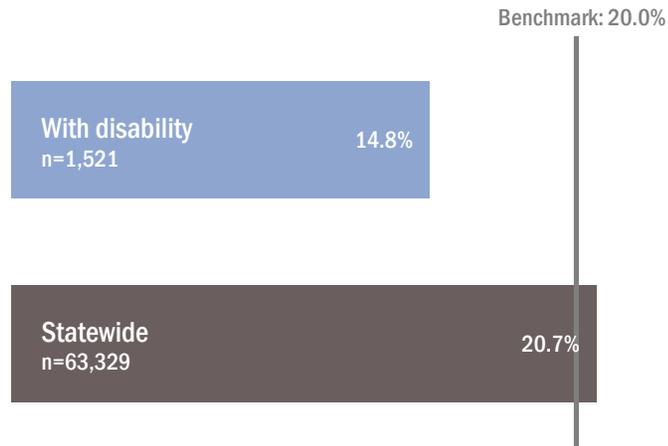
2015 data

[Screening, brief intervention, and referral to treatment \(SBIRT\)](#) for alcohol or substance abuse is lower for Medicaid members across all ages with disability, compared to statewide.

MEASURES BY DISABILITY

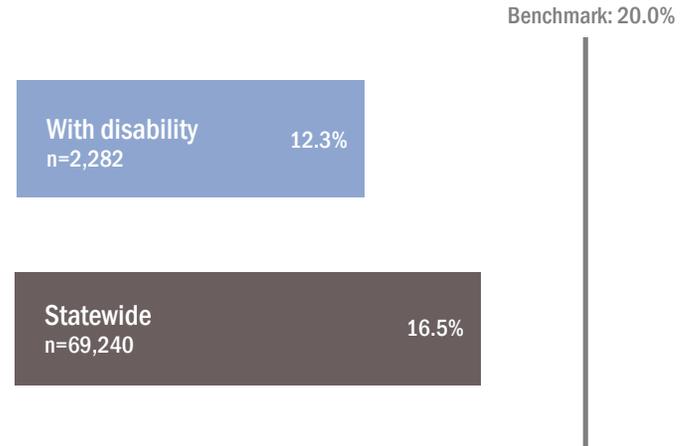
Dental sealants on permanent molars for children (ages 6-9)

Children **with disability** versus statewide



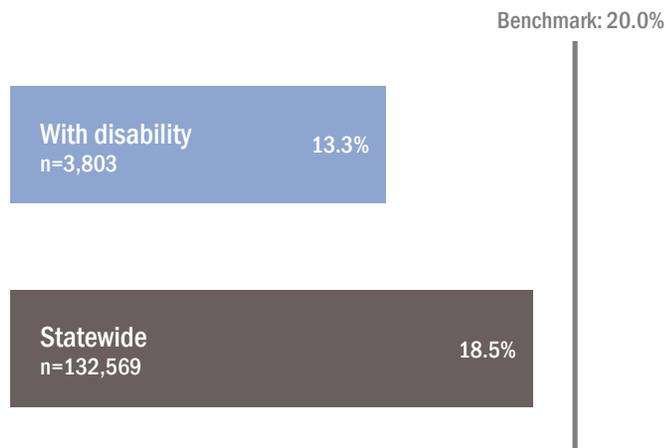
Dental sealants on permanent molars for children (ages 10-14)

Children **with disability** versus statewide



Dental sealants on permanent molars for children - all ages (6-14)

Children **with disability** versus statewide



2015 data

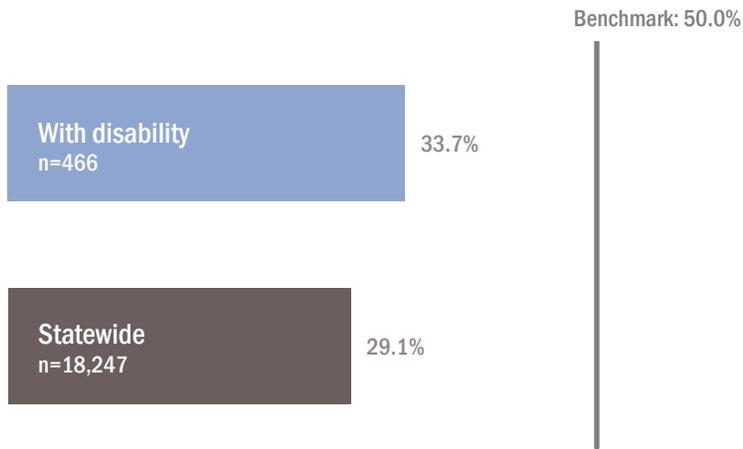
[Dental sealants on permanent molars for children](#) with disability are lower than statewide performance in all age breakouts. National data have found no difference in dental sealants for children with and without disability, indicating a disparity in care for children in Oregon.

As children with disability are more likely to have oral health problems than children without disability, and parents may have difficulty finding dental care for their children with special needs, these results indicate a need to ensure children with disability receive these preventive oral health services.

MEASURES BY DISABILITY

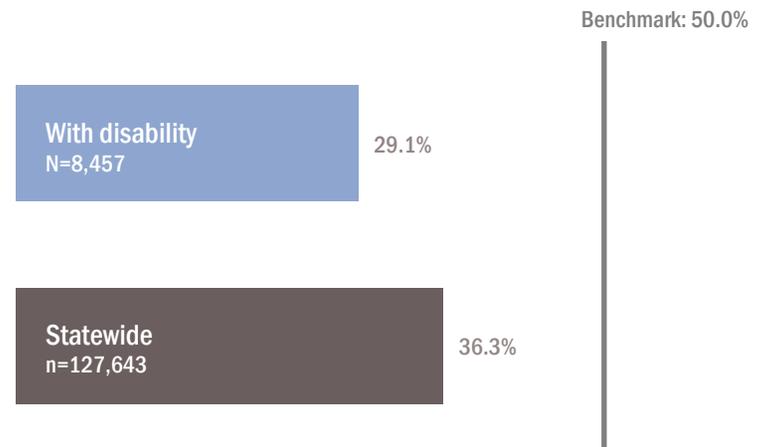
Effective contraceptive use among adolescent women (ages 15-17) at risk of unintended pregnancy

Adolescent women **with disability** versus statewide



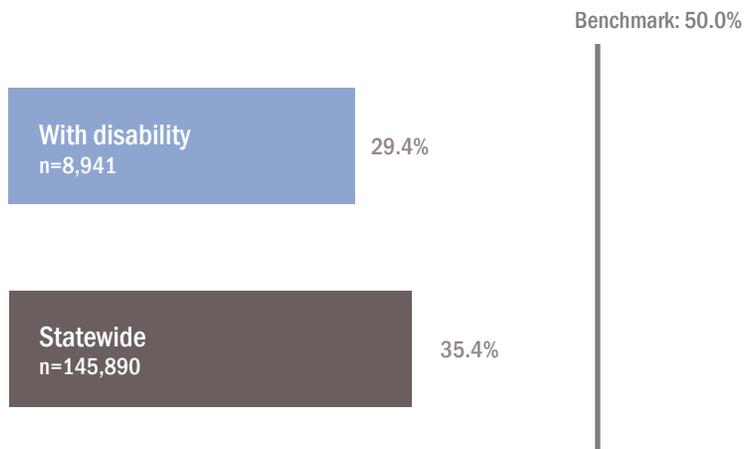
Effective contraceptive use among adult women (ages 18-50) at risk of unintended pregnancy

Adult women with **disability** versus statewide



Effective contraceptive use among all women (ages 15-50)

Women **with disability** versus statewide



2015 data

[Effective contraceptive use among women at risk of unintended pregnancy](#) is lower among adults with disability than the statewide average. However, adolescents ages 15-17 who qualified for Medicaid because of disability are more likely to have evidence of effective contraceptive use than adolescents statewide.

MEASURES BY DISABILITY

Adolescent well-care visits

Adolescents **with disability** versus statewide



Initiation of follow-up for children prescribed ADHD medication

Children **with disability** versus statewide



2015 data

[Initiation of follow-up care for children newly prescribed ADHD medications](#) was similar to the statewide average for individuals with disability.

[Adolescent well-care visits](#) were slightly higher among individuals with disability than statewide, however, less than half of adolescents on Medicaid receive an annual well-care visit, well below the benchmark of 62 percent.

MEASURES BY MENTAL HEALTH DIAGNOSES

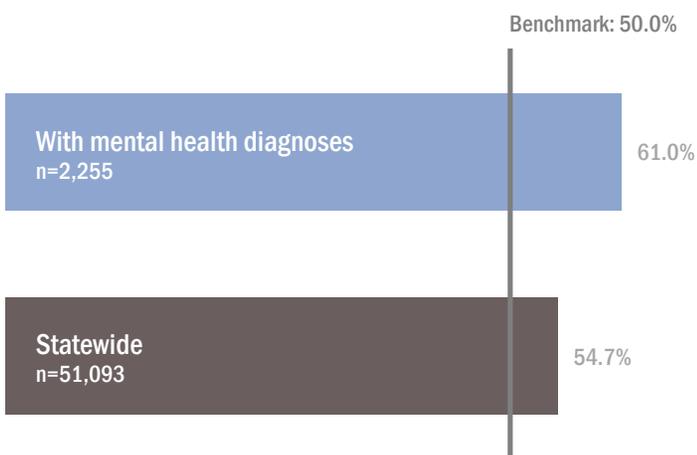
Introduction

2015 data for 18 measures, reported for Medicaid members with mental health diagnoses, compared to Medicaid members statewide.

With mental health diagnoses refers to people who have had two or more services in the past 36 months with any of the qualifying diagnoses for schizophrenia, bipolar, delusional, developmental, anxiety, personality or depressive disorders, as well as other mental health disorders (ICD9 295 – 302.9 and 306.51 – 347). This includes the subset of disorders for the severe and persistent mental illness (SPMI) breakout, on pages 103-104. Mental health diagnoses do not need to be the primary diagnosis for inclusion in these data.

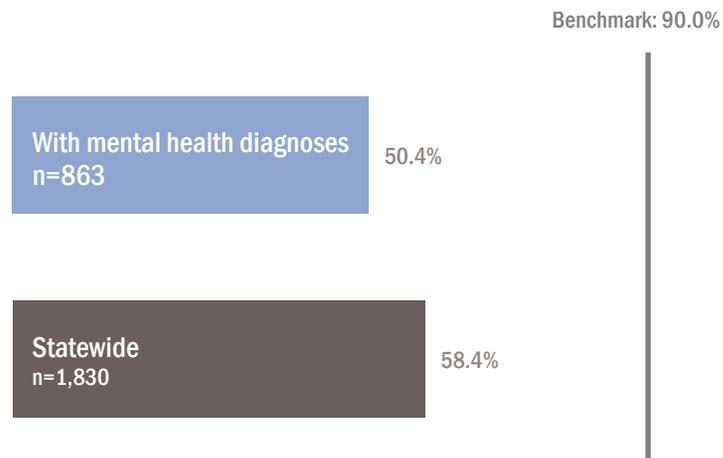
Developmental screening during the first 36 months of life

Children **with mental health diagnoses** versus statewide



Mental, physical, and dental health assessments for children in DHS custody

Children **with mental health diagnoses** versus statewide



2015 data

Children with mental health diagnoses have slightly higher rates of [developmental screening](#) during the first three years of life.

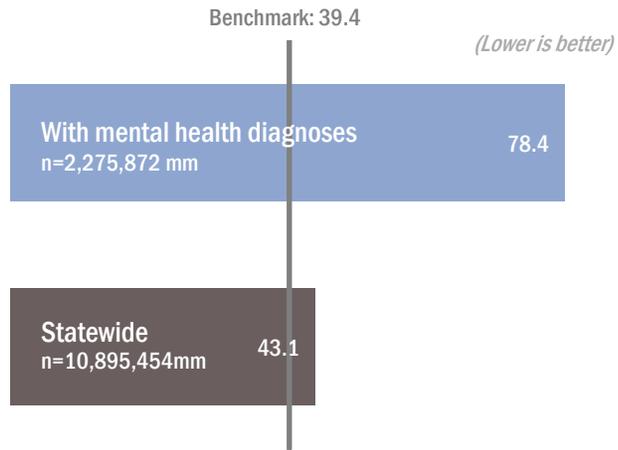
However, children with mental health diagnoses in [DHS custody](#) had lower rates of mental, physical, and dental health assessments upon entering foster care, which may reflect even greater challenges with care coordination, and a particular need for mental health services in this population.

MEASURES BY MENTAL HEALTH DIAGNOSES

Emergency department utilization

Members with mental health diagnoses versus statewide

Rates are reported per 1,000 member months



2015 data

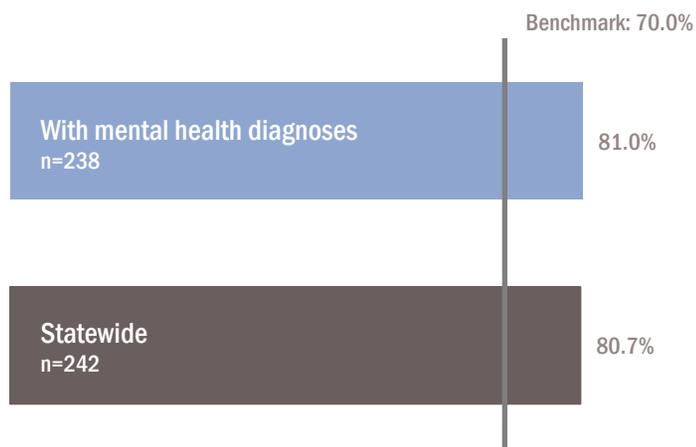
While [emergency department utilization](#) has been declining in Oregon, Medicaid members with mental health diagnoses have much higher rates of emergency department utilization than statewide rates.

National data indicate that individuals with more severe mental health conditions were more likely to have multiple emergency department visits during a year. Oregon will continue to monitor this metric to determine if additional community services made possible by recent investments lead to a decreased utilization of emergency departments for individuals with mental health diagnoses.

MEASURES BY MENTAL HEALTH DIAGNOSES

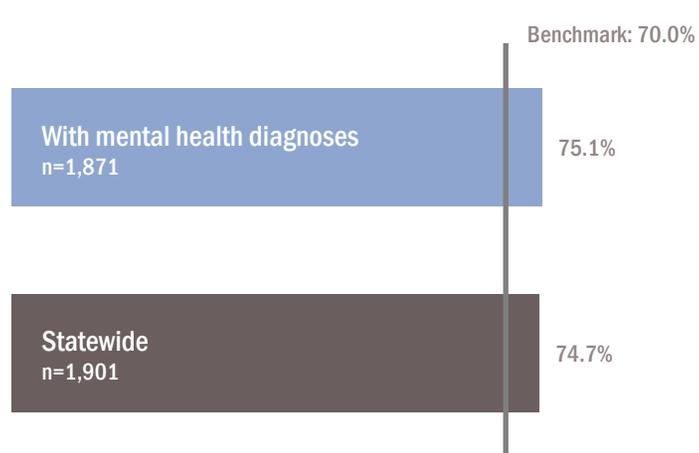
Follow-up after hospitalization for mental illness (ages 6-17)

Children and adolescents with mental health diagnoses versus statewide



Follow-up after hospitalization for mental illness (ages 18+)

Adults with mental health diagnoses versus statewide



2015 data

[Follow-up visits after hospitalization for mental illness](#) are very similar for members with mental health diagnoses, which makes sense, given that the measure looks for mental health related hospitalizations.

Follow-up is higher for children and adolescents (ages 6-17) with mental health diagnoses than for adults.

MEASURES BY MENTAL HEALTH DIAGNOSES

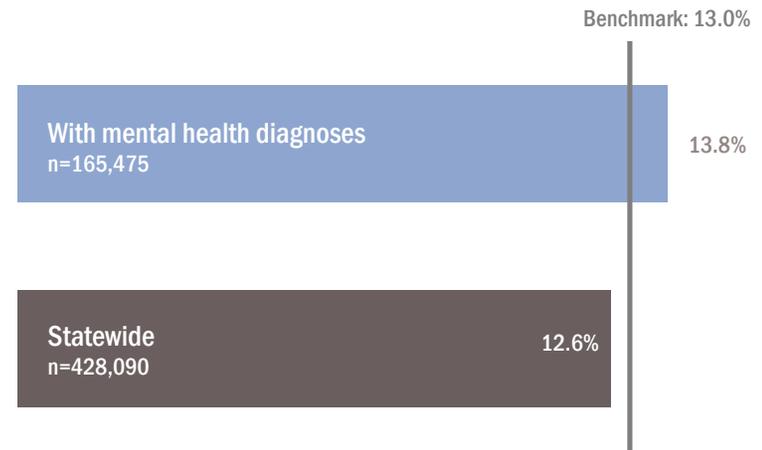
Screening, brief intervention, and referral to treatment (ages 12-17)

Adolescents with mental health diagnoses versus statewide



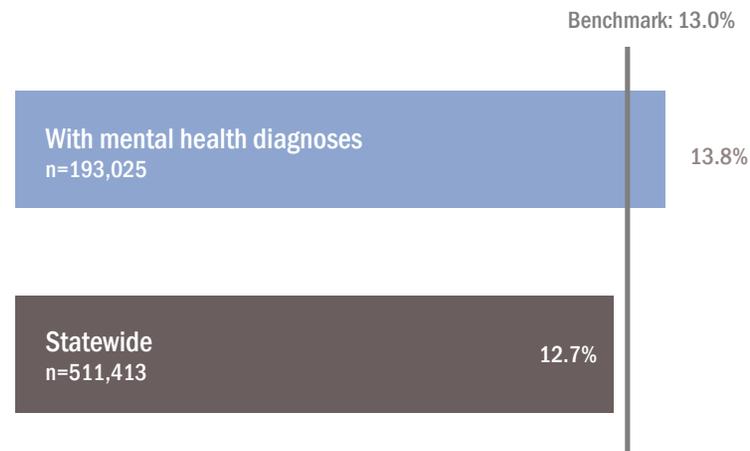
Screening, brief intervention, and referral to treatment (ages 18+)

Adults with mental health diagnoses versus statewide



Screening, brief intervention, and referral to treatment - all ages (12+)

Members with mental health diagnoses versus statewide



2015 data

[Screening, brief intervention, and referral to treatment \(SBIRT\)](#) for alcohol or substance abuse is higher for Medicaid members with mental health diagnoses across all age breakouts, compared to statewide. Since people with mental health conditions may be at increased risk for alcohol or substance abuse disorders, this first look at SBIRT screenings is promising.

MEASURES BY MENTAL HEALTH DIAGNOSES

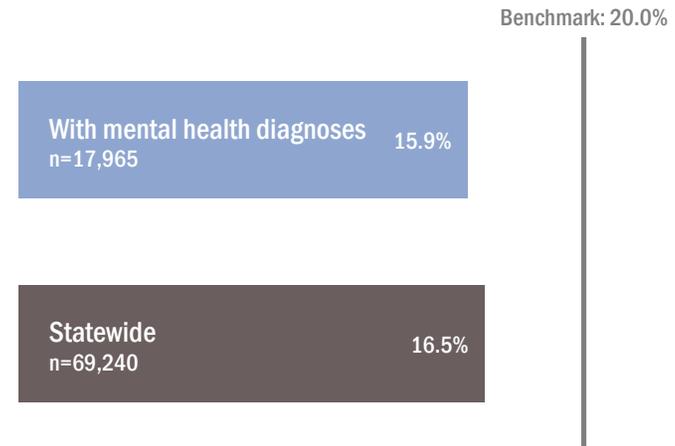
Dental sealants on permanent molars for children (ages 6-9)

Children with mental health diagnoses versus statewide



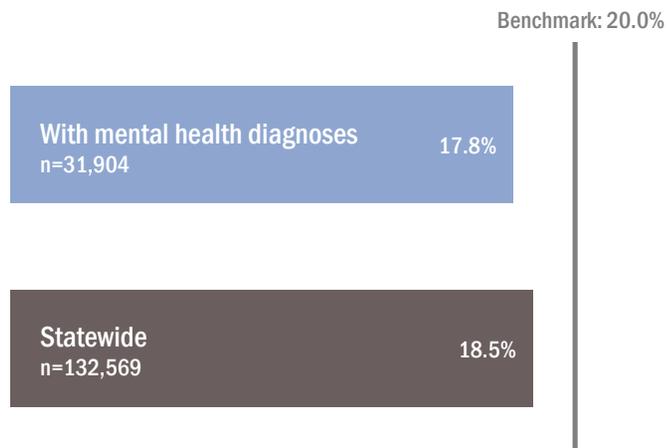
Dental sealants on permanent molars for children - (ages 10-14)

Children with mental health diagnoses versus statewide



Dental sealants on permanent molars for children - all ages (6-14)

Children with mental health diagnoses versus statewide



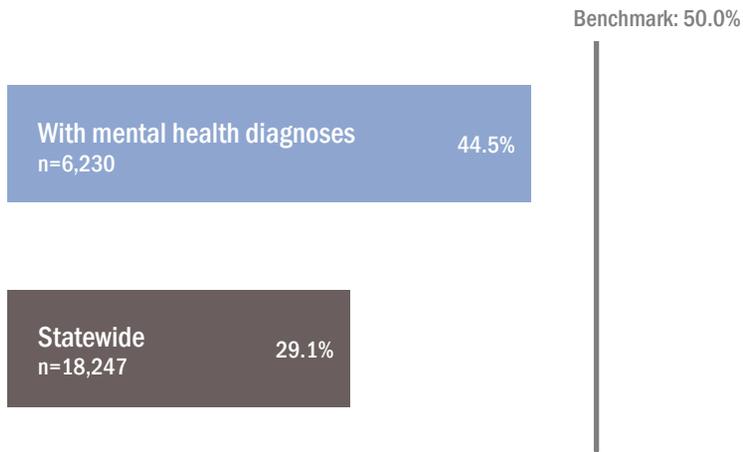
2015 data

[Dental sealants on permanent molars for children](#) with mental health diagnoses are similar to statewide rates for younger children (ages 6-9); however, they are slightly lower for children with mental health diagnoses ages 10-14, who may have unmet oral health needs.

MEASURES BY MENTAL HEALTH DIAGNOSES

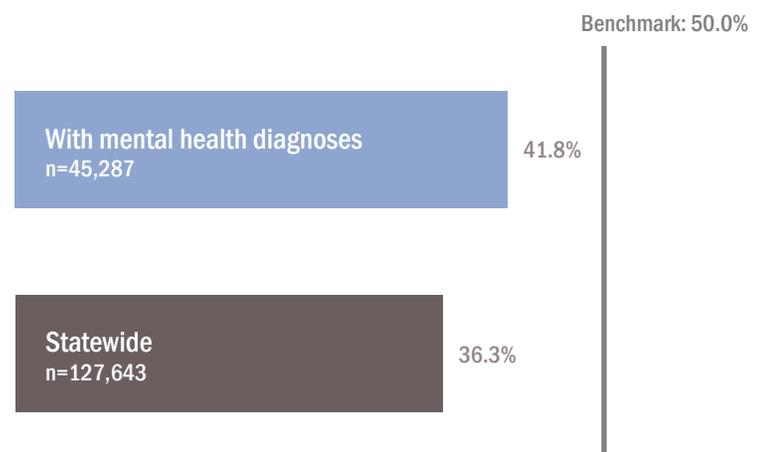
Effective contraceptive use among adolescent women (ages 15-17) at risk of unintended pregnancy

Adolescent women with mental health diagnoses versus statewide



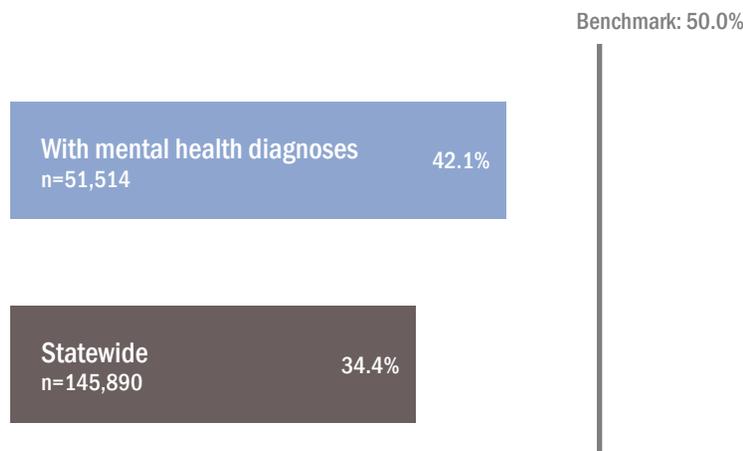
Effective contraceptive use among adult women (ages 18-50) at risk of unintended pregnancy

Adult women with mental health diagnoses versus statewide



Effective contraceptive use among all women (ages 15-50) at risk of unintended pregnancy

Women with mental health diagnoses versus statewide



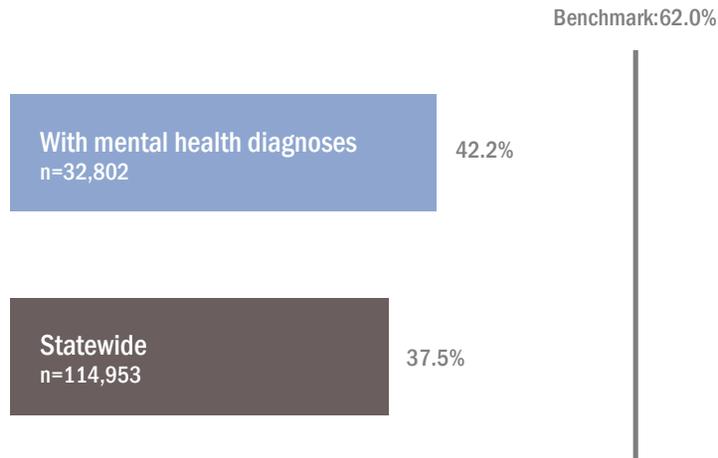
2015 data

Women at risk of unintended pregnancy who have mental health diagnoses are more likely than the statewide average to have evidence of one of the most effective or moderately [effective contraceptive methods](#). The rate is highest among adolescents, with 44.5 percent of young women with mental health diagnoses using effective contraceptives. This may be because members with multiple mental health diagnoses have all of their medications better monitored by their doctor.

MEASURES BY MENTAL HEALTH DIAGNOSES

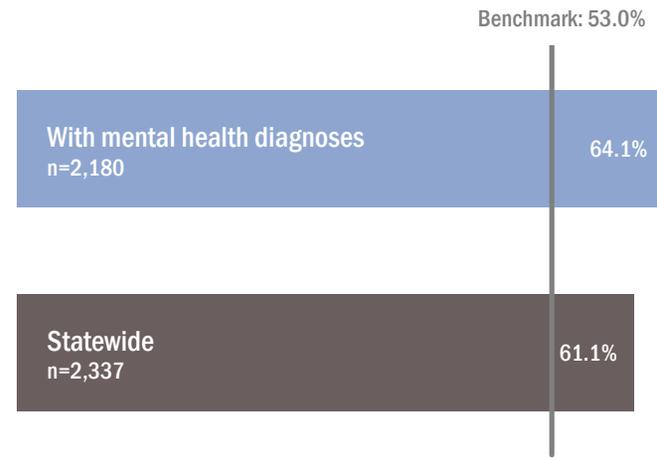
Adolescent well-care visits

Adolescents [with mental health diagnoses](#) versus statewide



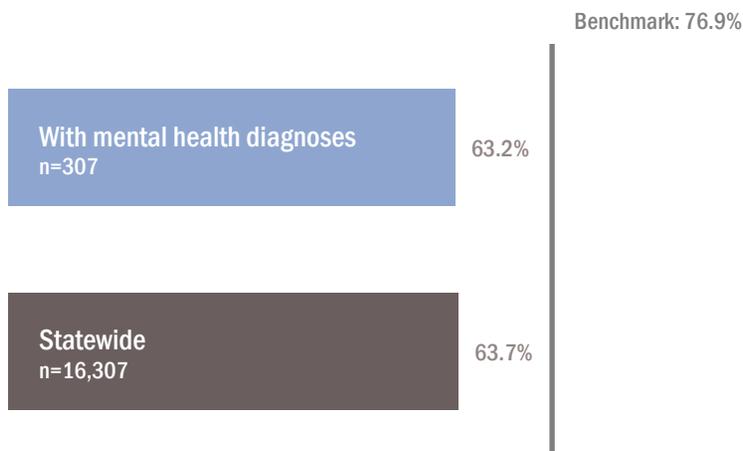
Follow-up after ADHD prescription

Adolescents [with mental health diagnoses](#) versus statewide



Well-child visits during the first 15 months of life

Children [with mental health diagnoses](#) versus statewide



2015 data

[Adolescent well-care visits](#) and initiation of [follow-up care for children newly prescribed ADHD medications](#) were higher for individuals with mental health diagnoses than statewide performance. Because of rapid development occurring during adolescence, many mental health conditions first emerge during this time and the adolescent well-care visit may be when they are first identified. The adolescent well-care visit results are promising, however, fewer than half of adolescents on Medicaid receive an annual well-care visit, well below the benchmark of 62 percent.

The percentage of young children who had six or more [well-visits in the first 15 months of life](#) was similar among children with mental diagnoses compared with the statewide average.

MEASURES BY SEVERE AND PERSISTENT MENTAL ILLNESS

Introduction

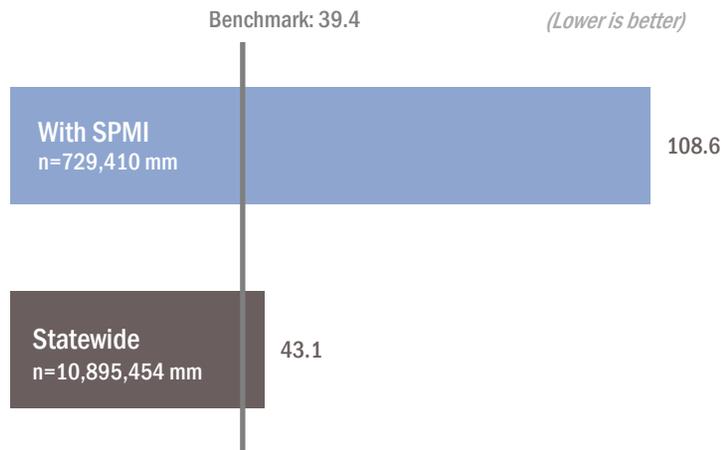
This section shows 2015 mid-year data for four measures, reported for Medicaid members with severe and persistent mental illness, compared to statewide.

Severe and persistent mental illness refers to people 18 years and older who have had two or more services with any of the qualifying diagnosis codes in the past 36 months: 295xx, 297.3, 298.8, 298.9, 300.3, 309.81, 301.22, 301.83, 296xx. This definition is also used for U.S. Department of Justice reporting.*

Emergency department utilization

Members with SPMI versus statewide

Rates are reported per 1,000 member months



2015 data

While emergency department utilization has been declining in Oregon, Medicaid members with severe and persistent mental illness have much higher rates of emergency department utilization than statewide.

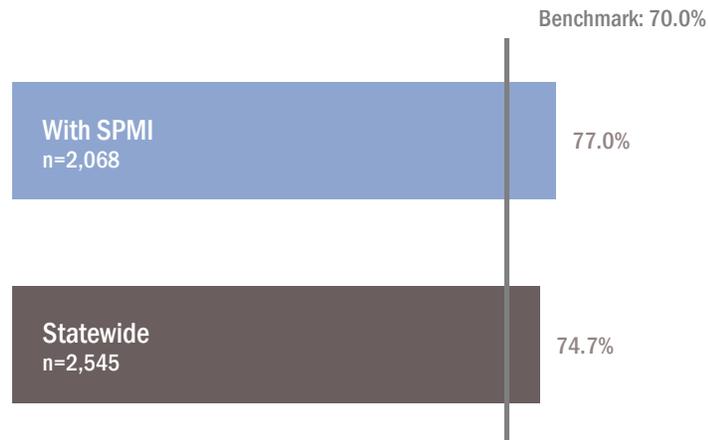
National data indicate that individuals with more severe mental health conditions were more likely to have multiple emergency department visits during a year. Oregon will continue to monitor this metric to determine if additional community services made possible by recent investments lead to a decreased utilization of emergency departments for individuals with severe and persistent mental illness.

*For more information, visit www.oregon.gov/oha/amh/pages/doj.aspx

MEASURES BY SEVERE AND PERSISTENT MENTAL ILLNESS

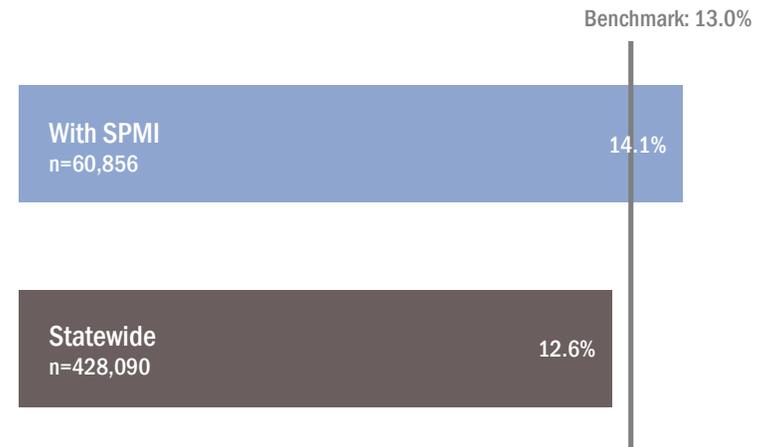
Follow-up after hospitalization for mental illness

Adults with SPMI versus statewide



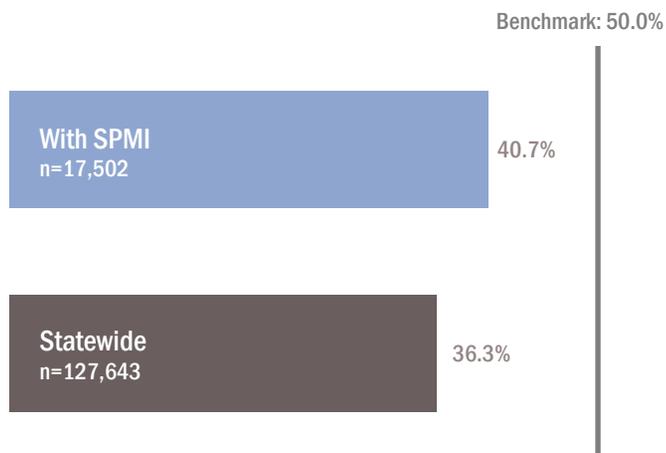
Screening, brief intervention, and referral to treatment (SBIRT) for adults (ages 18+)

Adults with SPMI versus statewide



Effective contraceptive use among adult women (ages 18-50) at risk of unintended pregnancy

Adult women with SPMI versus statewide



2015 data

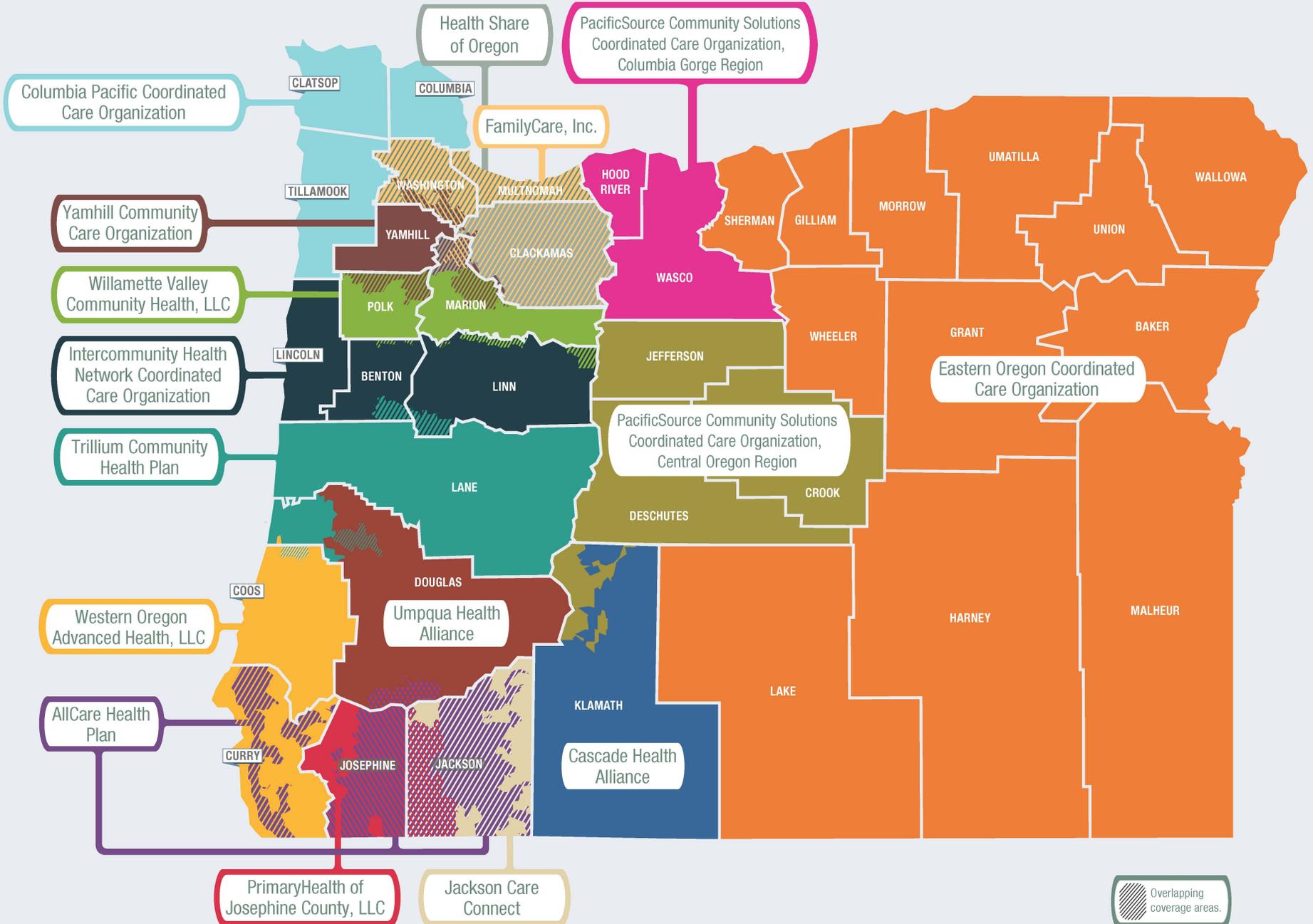
[Screenings and brief intervention for alcohol or other substance abuse \(SBIRT\)](#) are slightly higher for people with severe and persistent mental illness (SPMI) than statewide. Since people with SPMI are at increased risk for alcohol or substance abuse disorders, this first look at SBIRT screenings are promising.

[Follow-up visits after hospitalization for mental illness](#) are also slightly higher for members with severe and persistent mental illness.

Evidence of [effective contraceptive use](#) is higher among adult women with severe and persistent mental illness. This may be a reflection of better medication surveillance and management for members with complex health needs.

Coordinated Care Organization Service Areas

Updated May 2014



OHA CONTACTS AND ONLINE INFORMATION

For questions about this report, contact: Jon C. Collins, PhD
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503-569-0044

For more information about technical specifications for measures, visit: www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

For more information about coordinated care organizations, visit: www.health.oregon.gov

To view this report and previous metrics reports online, visit: www.oregon.gov/oha/metrics

VERSION CONTROL

June 23, 2016 - 2015 Quality Pool Distribution (page 6) was corrected. Previous version incorrectly switched "challenge pool earned" values for PacificSource Central and PacificSource Gorge, thus also affecting total payment and total quality pool earned.

June 29, 2016 - On page 14, Health Share of Oregon's 2014 performance on the *Colorectal cancer screening* measure was corrected to 53.3%. The value was previously misstated as .5.



This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request this publication in another format or language, contact the Oregon Health Authority Director's Office at 503-947-2340 or OHA.DirectorsOffice@state.or.us.

Oregon's Department of Human Services (DHS)
Aging and People with Disabilities (APD) General Assistance Program

What is the General Assistance program?

Oregon's Department of Human Services' new General Assistance (GA) program starts on July 1, 2016. The program is based on a Housing First model, and will be administered by the Aging and People with Disabilities Program's Collaborative Disability Determination Unit (CDDU). The program will serve homeless Presumptive Medicaid (OSIPM) consumers with severe disabilities who are not yet receiving Social Security disability benefits. Direct service will be provided by Disability Benefits Liaison (DBL) staff, who are located in APD and Area Agencies on Aging (AAA) offices throughout the state.

To be eligible for the GA program, consumers must meet all of the following criteria:

- Be adults without minor children living with them;
- Be receiving Presumptive Medicaid-OSIPM medical assistance;
- Meet financial and nonfinancial eligibility criteria for Supplemental Security Income (SSI);
- Apply for SSI;
- Sign an Interim Assistance Reimbursement agreement, allowing the department to recoup assistance paid to the GA consumer once they are awarded SSI benefits; and
- Be homeless as defined by OAR 461-135-0700(1).

Rule numbers: OARs 461-135-0700, 461-135-0701, 461-145-0410, 461-180-0070

Benefits: Benefits will include up to \$545 per month in housing assistance, \$90 in utility assistance per month, and \$60 per month for personal incidentals for individuals, and up to \$818 per month in housing assistance, \$139 in utility assistance per month, and \$93 dollars per month for personal incidentals for couples. GA consumers will also receive free assistance with the Social Security application and appeals process. GA housing, utility, and personal incidental payments can be recouped by the department when GA consumers are awarded Supplemental Security Income (SSI).

How are consumers referred to the GA program?

To make a referral to the General Assistance program, community partners should submit the GA Referral Form by fax (503-373-7902) or email (DBL.Referral@state.or.us).

Program Contacts:

Brian Kirk 503-373-0271 and Marcy Mee 503-373-0775