2016 Stakeholder Survey

Report to the Metrics & Scoring Committee,
May 2016

Introduction

The Oregon Health Authority fielded this survey to inform the Metrics & Scoring Committee's development of the CCO incentive program structure, as well as measure selection for 2017 and beyond.

The intent was to collect feedback from a variety of stakeholders, including coordinated care organizations (CCOs), providers, community partners, state programs, and other advocates with an interest in the CCO incentive measures. The survey asked for feedback in three areas:

- Potential ideas for the incentive program structure under the new Medicaid waiver
- Proposed new (transformational) measures for the Committee's consideration
- The current (2016) incentive measures.

The survey was open from April 12, 2016 through May 15, 2016. During this period, OHA received 130 responses from across the state.

This report provides an overview of the survey respondents, results for each survey question, and all new measures proposed for the Committee's consideration.

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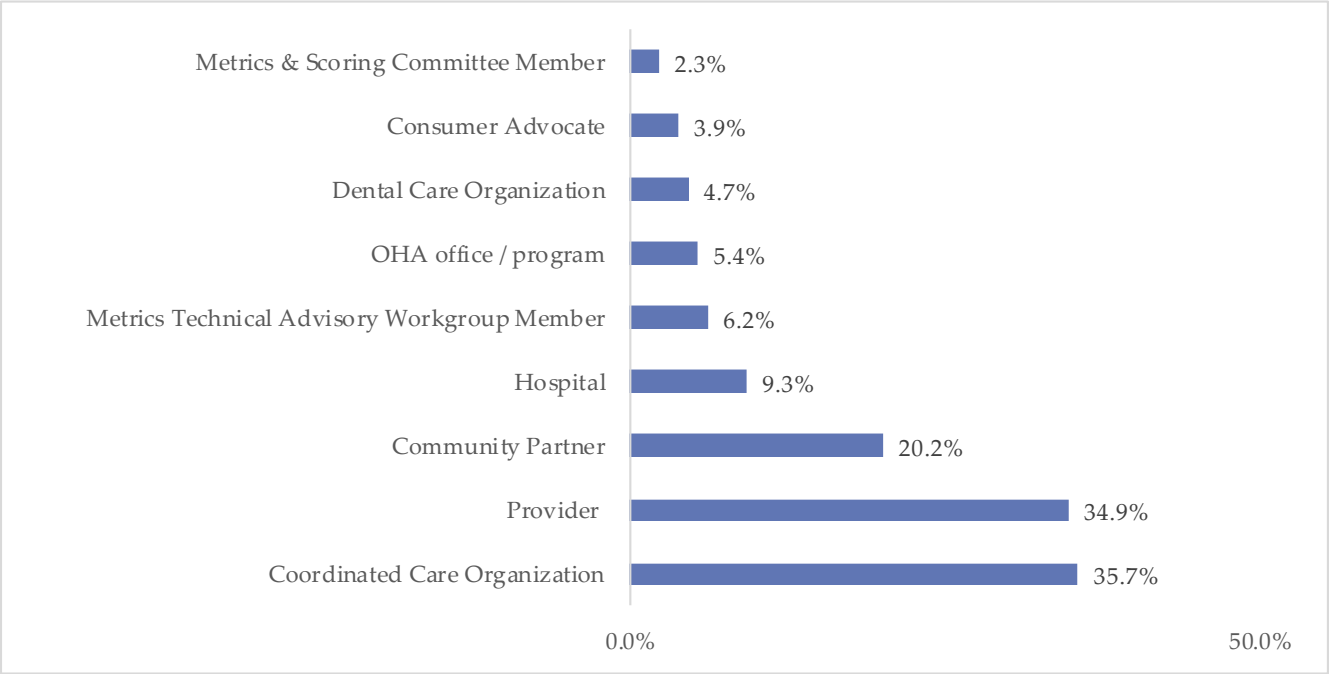
Survey Respondents

OHA received ~130 responses to the survey, including responses from at least 13 of the 16 CCOs. The survey asked respondents to identify which stakeholder group they identified with (respondents could select multiple options).



Of the responding providers, more than half indicated they were primary care, family medicine, or pediatric providers. Compared to the 2014 survey, more 2016 respondents were providers (~35% compared to 29%) and many of the comments shared reflect the "on the ground" provider perspective.

Other respondents included local health departments, practice facilitators, professional organizations, and pharmaceutical representatives.

Program Structure: Measure Selection

In this section, respondents were asked to provide feedback to the Metrics & Scoring Committee on the measure selection process, and how the measure set reflects the services and populations CCOs serve.

The main themes from the responses to these questions have been summarized below by respondent category. Responses in this section have been grouped by CCO and by provider. Full responses to questions in this section are included in Appendix A.

Do you have any feedback for the Committee on balancing measurement fatigue concerns with the responsibility for the measure set to reflect the services and populations that CCOs serve?

Coordinated care organization responses:

- Select measures that are aligned across multiple programs, payers, and other CCO contractual obligations (e.g., PCPCH standards, Transformation Plans, etc…).
- Adopt only national measures with standardized specifications and benchmarks. Modified or customized measures create more burden for providers and can require significant workflow change without reimbursement.
- Simpler measures with economies of scale across payers and programs are desired (e.g., claims-based HEDIS measures).
- Consider combining metrics to reduce burden on providers and resources.
- Consider metrics with time frames longer than 1 year to demonstrate improvement.
- Allow CCOs to select measures that are relevant to their population and provide flexibility for emerging issues (e.g., coordination with criminal justice).
- Providers should be more involved in selecting the metrics.
- Select fewer metrics overall, in exchange for focusing on alignment and/or greater efforts to support education and care transformation. Fewer metrics will allow CCOs to focus on greater improvement in specific areas and reduce provider fatigue.
- Concern that new measures will continue to be added without retiring measures.
- If retiring measures, need to ensure that new measures serve similar populations, to reflect all populations the CCO serves.
- Stop creating new measures without rigorous testing and evidence behind them.

Provider responses:

- Measures should be meaningful and actionable by providers, if they are to be held accountable.
- Too many measures across too many areas of focus will lead to burnout, as providers have to spread their attention.
- Primary care has a disproportionate share of the measures, consider transformational efforts for specialists and hospitals.
- Stop adding new measures; providers need to time to implement workflows and make improvements on the existing measures.
- Measures should be national, standardized measures, and aligned with other measurement efforts.
- Measures, especially new measures and EHR-based measures, need more lead time for implementation and report development.
- Measures need to be more clearly linked to improved patient outcomes and/or mortality.

Do you have any specific recommendations for new or revised measure selection and/or retirement criteria that the Committee could use in guiding their discussion?

Measure selection criteria:

- Select measures that are meaningful to patients and providers.
- Select measures that are actionable at the CCO and practice level.
- Metrics must have actionable data. PCPCH enrollment, CAHPS-based measures, and the dental sealant measure are not actionable for CCOs.
- Do not exceed 18 incentive measures. Do not retire or introduce more than one measure in a given year, unless there is good reason.
- Require that the statewide performance improvement project (PIP) be one of the incentive measures.
- Measures should align with national specifications (e.g., HEDIS, Meaningful Use).
- Measures need to focus on access, prevention, chronic condition management, and care coordination.

- New measures in consideration should be balanced with existing measures – they should not focus on one service, area, or population to the exclusion of others.

- Better address measures with small denominators / smaller CCOs, for example creating a buffer of plus / minus 10 members for each benchmark / improvement target so CCOs are incentivized to invest disproportionate resources per member. Alternately, adopt measures that impact larger percentage of the population in a CCO (as opposed to measures that address children in DHS custody or people who have been hospitalized for mental illness).

Measure retirement criteria:

- Need to retire measures when CCOs are either unable to impact, or have achieved benchmarks.

- If a measure is not meeting the original intent of the measure, or is no longer appropriate, despite overall performance, the Committee should consider retiring it.

- Balance practices' ability to change outcomes with the need to move measures – if a practice is not achieving on any of their 5 measures, they shouldn't have any new measures added.

- Do not retire a measure until we have reached a high quality benchmark (e.g., 90th percentile) for at least two years.

- Revise measures so they encompass follow-up and referral processes that follow the existing screening measures. This will lead to more transformational outcomes.

Given the current (2016) measure set, are any populations or services not reflected or over-represented?

Under Represented Populations

- Aging members, and members with chronic diseases.
- Adult males ages 19-44
- Children ages 3-5
- Children ages 4-11
- Populations experiencing health or health care disparities
- Children in foster care system
- DHS-involved families
- Criminal justice involved members
- Members with severe and persistent mental illness
- Members with mental health diagnoses
- Members with substance abuse
- Members experiencing homelessness
- Members with cognitive/intellectual disabilities
- Members with special health care needs, particularly children

Under Represented Services

- Dental services, particularly for children, prenatal, and geriatric populations.
- Provider capacity / workforce
- Low acuity and preventive mental health services
- Mental health services for children
- Integration and care coordination across services
- Complex care management
- Substance use treatment
- Pediatrics (as a specialty)
- Outcomes
- Specialists
- Hospitals
- Social determinants of health (e.g., hunger, homelessness)
- Medication adherence

Over Represented Populations

- Children
- Adolescents ages 12-21

Over Represented Services

- Prevention
- Primary care

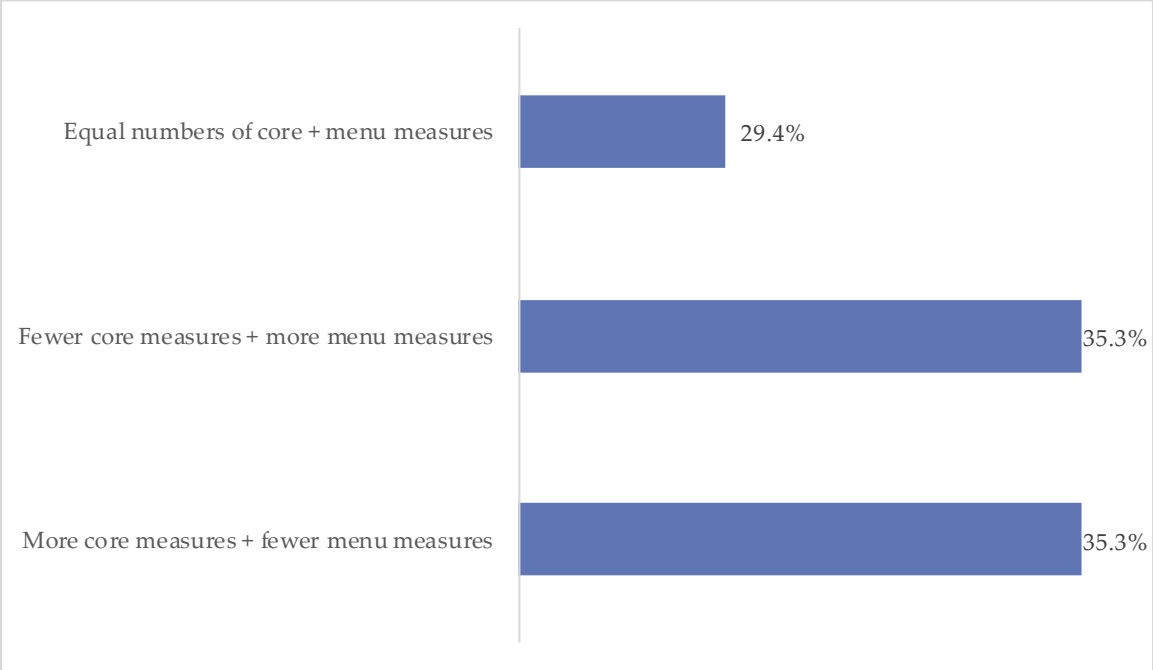
Appropriate Emphasis

- Early childhood / pediatric primary care
- Prenatal care
- Chronic disease management in primary care

Program Structure: Core & Menu Measure Sets

This section of the survey asked several questions about the proposed core and menu measure sets, which the Committee is considering for future years of the program.

If the Committee moves to a core / menu measure set – which model is most appealing?



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What criteria would you want the Committee to consider when deciding which measures are core versus menu?

Responses have been summarized here. Full text of the responses are provided in Appendix B.

Core Measures

- Core measures are better if they are process measures, standard work that is likely to improve outcomes (e.g., SBIRT, cancer screening, well visits, etc…) and measures that address public health concerns – outcome measures around state priorities for targeted improvement.
- Those measures that reach the most vulnerable, at-risk populations.
- Those measures that have the greatest impact on population-level preventive health outcomes, versus process measures.
- Areas where progress needs to be made across the state / across all CCOs. Areas with lowest CCO performance. Measures trending in the wrong direction.
- Include measures where the majority of CCOs already do well.
- Could be either the most transformational measures, or those that align with federal expectations.
- Have actionable data.
- Have larger denominators so they are more representative of the CCO's entire population.
- Address population health and preventive care in ways that support CCO / provider collaboration.

- Have discrete values (not subjective). Data should be easy to capture and report.
- Outcomes focused, result in the greatest cost savings (e.g., prevention and early intervention).
- Have high clinical value. Align with USPSTF category A and B recommendations.
- Do not benefit any practices based on size or location. Should be measures that are important for enhancing standardized patient care and are relevant to all practices.
- Include patient experience of care metrics.
- Reflect basic health indicators of most or all populations.
- Align with IOM Vital Signs report; those that most support improvement towards Triple Aim.
- High priority areas for the state.
- Address areas where health disparities exist.
- Align with national measures.
- Balance of data sources – not all core measures should be claims-based.
- Can be monitored during the measurement year and adjustments made if needed.
- Those measure where providers can help create improvement and be effective.

Menu Measures

- Menu measures are better if they are local priorities of focus for improving outcomes, and specialized areas of focus (e.g., OB, pediatrics, geriatrics).
- Process measures and those that affect specific population sub-groups.
- Measures where there is a lot of variation among CCOs.
- Menu measures cannot be ones where CCOs are already performing well.
- Ideally linked to performance improvement projects (PIPs).
- More appropriate for smaller populations (e.g., children in foster care, pregnant women).
- Moderate clinical value, but challenging to improve on.
- Measures that have historically been hard to improve on (e.g., SBIRT, effective contraceptive use).
- Those measures where the CCO or larger organization drives improvement (rather than provider).

Do you have other feedback for the Committee on the core / menu measure set idea?

Responses have been summarized here. Full text of the responses are provided in Appendix B.

- Menu measures should be required to be selected prior to the measurement year.

- Timelines for measure selection, specifications, and benchmark setting are often close to or during the measurement year. The workload of selecting and contracting for menu set measures will be complicated.

- Regardless of core or menu measure, the targets should be developed based on the CCO's prior individual performance rather than a single statewide target.

- Consider categories for the menu selection, as well as "other" option that may not be represented already.

- Menu measures should be weighted less strongly than core measures to account for CCOs selecting menu measures that might be more easily achieved.
- Denominators should only include patients that providers have seen, not all that have been assigned.
- Consider how many menu measures can be for measures that will have small populations within a CCO.
- How will the Committee determine appropriate benchmarks for regional measures without having local knowledge of the area and the unique local challenges?
- Practices see patients served by multiple CCOs; allowing CCOs flexibility in choosing measures may mean more work at the clinic level, as clinics would have to report differently for different CCOs.
- When changing the structure, be careful not to create additional fatigue. May be mitigated by keeping measures as similar as possible during transition to new structure.

Transformational Measures

This section of the survey asked about measuring successful health system transformation, and included space for respondents to propose new incentive measures for the Committee's consideration.

What would tell you that health system transformation in Oregon was successful? What are the two or three top things you would want to monitor to demonstrate this success? This might be conceptual, rather than specific incentive measures.

Given the depth of content across these responses, they have been replicated here in full. Responses have been edited slightly for clarity and to protect respondents' privacy. Select measures in responses highlighted in sidebar

- Health system transformation will have succeeded when we have a healthier population in our state. Health will be achieved equitably across class, racial, ethnic groups and other status. Oregon's total health care spending will be controlled.

  Health care plays a "necessary but not sufficient" role in achieving this goal because many of the contributors to improvement will involve changing communities and people's lives in other ways. Living in poverty, struggling to meet basic needs, living in settings with violence, and social isolation may contribute far more to a population's health than the quality of health care services they receive.

  Health care needs to participate in these solutions, especially when it comes to decreasing the rise in health care costs. Beyond that, health care systems can only make limited contributions to improve health across a broad population. Health care can try to stabilize disease and disability, but the actions to prevent them in the first place lie outside our sphere of influence. Progress to this goal can be assessed through process measures that assess drivers of larger scale health improvement. The Institute of Medicine, the Prevention Institute, and the Robert Wood Johnson Foundation have recently proposed measures that provide frameworks that we could use for assessing our progress.

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- Self-reported health status
- Stable housing / employment
- Quality-adjusted years of life gained
- Decreasing early / avoidable death rate

• • •

- Kindergarten readiness
- Incarceration rate
- Rates of complications from chronic disease
- Utilization of high- and low- value health services
- Communities' social and physical environments.

- Every person in Oregon would have access to timely, quality healthcare. The health system would be seamless (with regard to communication, EHR access, referrals, and pharmacy issues).

  The vast majority of taxpayer monies would go to funding services and providers of these services (an appropriate cap would be placed on profits for CCOs and their investors; CCOs would be mandated to pay for services in a way that ensured access to those services, etc…).

- A successful health system should include seamless coordination between healthcare services for individuals. A truly coordinated system would eliminate avoidable health spending on unnecessary or duplicative services and improve the care individual patients receive.

  To that end, proper medication adherence is vital to any successful health program for keeping patients healthier and avoiding costly hospital visits. Medication adherence occurs when a patient takes their medications as prescribed, which includes taking it according to the specific dosage, time, and frequency prescribed. A breakdown in any one of these elements has the potential to result in unanticipated side effects and complications. Despite this, studies show that:

  - Half of all patients do not take their medications as prescribed;
  - Twenty percent of all new prescriptions go unfilled; and
  - Adherence is lowest among patients with chronic illnesses.

  Therefore, in order for the OHA to successfully transform its health system, we believe that coordinating the prescription/pharmacy and medical benefits would enable an effective and dynamic medication management system. This system could go a long way in reducing the negative outcomes that arise due to non-adherence and positively impact beneficiaries in improving health outcomes and lowering avoidable health costs.

- Transformation is slow, and this is a big sprawling question. There are many potential indicators of success, including just a few (see sidebar). Measures like adolescent well care, SBIRT, or effective contraceptive use may be transformational in what they are trying to accomplish, but they are claims-based and don't actually get at the quality of the care that is received, only that the care occurred or was coded for on a claim.

  Developmental screenings is the only measure that gets near ACES, so it may be considered transformational. CAHPS measures are transformational in that they are trying to tackle important issues of access and satisfaction, but the measurement is problematic with such a small sample size. DHS Custody works with the most vulnerable population, but is hard to be considered transformational when the denominator is so low.

- Appropriate utilization. More focus on preventative care and social determinants of health; this won't show immediate impact and is difficult to measure but is truly transformative.

- Higher preventive costs
- Lower ED or surgical costs
- Earlier diagnosis of cancer
- Lower mortality rate
- Lower ACE scores
- Lower pregnancy rate

- All-cause mortality
- Tobacco cessation
- Obesity
- Diabetes prevention & management
- Cancer screening

- Emergency Dept utilization
- Inpatient / outpatient utilization
- Appropriate utilization
- Primary care appointments

- Improve inter-operability across various health systems.

- Demonstrating progress toward the Triple Aim. Improved health outcomes and life expectancy. Improved member experience and access to health care. Improved value of health care spending.

- Reduced cost in a population based on per member per month improved health as reflected by measures (e.g., HbA1c control, hypertension control, SBIRT, and colorectal cancer screening).

- It would be hearing that FQHCs are "at the table" when it comes to the work of their CCO, and that they are receiving timely, actionable data from their CCOs to improve the incentive quality metrics. This from my understanding is a hit-and-miss and largely depends on the CCO.

  Secondly, we would hear about true, financial partnerships between the CCOs and clinics. Right now, it is "optional" (e.g. depends on their contracts, the CCO itself, etc…) for the CCOs to pass any of the incentive dollars on to clinics, who are comprised of providers doing the work. Playing a role in improving metrics but not receiving financial compensation can cause friction as a system as $$ is needed to support this work at all levels.

- Improved quality of life for members. More provider interaction with members. More member social engagement in healthy settings. Greater empowerment of member population over health and sense of well-being. More sense of trust and care between patients, providers, and institutions. Increased access to affordable care Increased ability to have fundamental needs met. Increased individual attention by primary provider More meaningful and thoughtful CCO outreach to members

  Reduced cost of care. Far less ER use. More access to immediate care that is connected to primary care. Far greater mental health follow-up that is coordinated, accountable, and long-term. Improved access to cost reducing processes and facilities (strategic). More volunteerism to engage in healthy lifestyle between population members.

- The consistent inclusion of safety net providers and others that serve vulnerable populations that churn in and out of these programs. These providers need timely, actionable data from their CCOs to improve on incentive metrics and other goals of transformation. And we must recognize alignment of metrics and integration of payment to support integration of medical, dental, and behavioral health. We would see that this transformation was moving forward if we saw a significant reduction in health disparities and a decrease in friction that enrollees experience as they receive care and move across silos of care, from primary to specialty care, from medical to dental, and as they enroll and renew their enrollment to Medicaid.

- Consistent demonstrable participation by over 90 percent of large and small (fewer than 5 provider) clinics. True bending of the cost curve (not artificially created by simply enlarging the denominator). Patients feeling like their quality of care has improved.

- True 'system' transformation requires a shared medical record and bi-lateral electronic interfaces. Time and money is wasted because providers cannot get the records in real time (don't even know a patient is at the ED or being admitted) or the image ordered by the PCP isn't returned electronically. We currently rely on faxing which on multiple occasions has failed.

  If you're referring to the triple aim then the following are the top three items that can affect change: reducing tobacco prevalence, controlling high blood pressure, and avoiding and or controlling diabetes (HbA1c <9%).

- Reduced healthcare costs, improved outcomes and better communication between various health systems (i.e., specialists, ED and primary care providers).

- Care would be proactively managed, coordinated and integrated.

- There is a balance between prevention and treating conditions or acute conditions. Reduction in disparities paired with overall population-level improvement. The goal is to promote health, not decrease impact of a chronic condition.

- To tell if health system transformation in Oregon was successful, I would generally say that relationships and care coordination between different providers and specialists would be more streamlined, and that there is less communication breakdown and lag time between them for best patient care. Juggling multiple directions from multiple providers is a huge burden for families to navigate through and take on, especially when they are in the middle of a health crisis.

  If this process of collaboration, integration, and partnership could work much more smoothly and folks would be able to better communicate with each other (via: EMRs, referral tracking, and follow-up processes), that would be a huge success.

- Better access to care, especially mental health services in rural areas.
- Ensure more children are developmentally on track, healthy, and ready for kindergarten.
- Decrease in patient mortality rates.
- Reduce inappropriate utilization / increase appropriate utilization.
- Improved health of the community.
- Reduced health disparities
- Improved / seamless communication across health systems
- Health and educational outcomes for children.

- First, that measures existed to indicate that care is coordinated and integrated across systems. Second, that measures of patient experience were collected, used, and reflected high scores in experience and satisfaction. Lastly, that metrics for kids include health <u>and</u> education and that outcomes for both are achieved.

- Objective reduction in the percentage of births to the Medicaid population/total births as a surrogate for reducing unwanted pregnancy. Absolute reductions in CVA and CAD (as reflected in mortality and morbidity/admissions) in the Medicaid age group 40-64. Ninety-five percent or higher immunization rates amongst all children in Oregon.

- One indicator that would tell us that health system transformation was successful in Oregon is the decrease in health care costs and increase of patients receiving health care. When the CCOs meet or exceed their targets it shows growth in patient care and increased understanding by the providers. To monitor this success we would want to look at patient health care and overall health. Are they using the emergency room less and accessing their PCPs more? Do the patients take advantage of the services and education being provided by the CCOs and PCPs? Have preventative screenings and visits resulted in early detection of more serious issues? Is awareness of preventive health helping make patients healthier? Are CCOs and the state seeing a drop in spending, particularly costs associated with expensive procedures and ED visits, or preventive routine health care visits.

- Decreased Statewide BMI Decrease number of patients diagnosed with pre-diabetes or Type II Diabetes and/or decrease number of insulin prescribed for Type II (the prescription method might be the easiest to measure)

- Member access to information when a problem arises with enrollment. It takes hours on the phone and then the call is often dropped. If someone does answer the phone they often cannot answer the question saying they do not have access to the information.

- I think there are two populations that need to be addressed: those who don't come in - either because they are basically healthy but have urgent/emergent needs and those who come in but might not have all their needs addressed. Is everyone getting at least some care?

  For patients who are assigned to primary health care facilities - how many of those were seen at the clinic? How many were seen at urgent/emergent care? It is going to take time and perhaps outreach to get people establishing care and checking in, but if we can't get them in, then we can't manage their conditions. Are the people seeking care getting complete care? At the person level, of all chronic conditions, how many of those are completely or partially under control? I don't honestly know how to best address this since it would be a mix of procedures and results.

- A change in the health of the population or subpopulation. The change would reflect either improved quality, health or satisfaction.

- That we maintain the number of Medicaid lives that we see enrolled across the state post-ACA. My fear is that re-enrollment is going to diminish the number of Medicaid lives we see enrolled in the state. We should be able to take all of the quality metrics that we're measuring and compare them at a national level. When we make this comparison we should see Oregon right at the top. We should also be able to demonstrate that cost of care had gone down because of more preventative care being done and fewer ER visits for this population.

- The overall cost per patient has been reduced. By overall, I'm referring to all services...pharmacy, primary care, etc. Ideally, we'd like to see patients seeing a primary care provider vs the emergency room or hospital for care.

  Transformation is a success if more people not only have healthcare insurance but are utilizing it/seeing a primary care provider. There are thousands of patients that have insurance but aren't yet utilizing it.

- If health care transformation is successful, I think we will see patient's being considered "more compliant". If we are being given the ability to address social determinants of health, we can address the foundational issues that affect patient's health that are not medical in nature. This includes addressing housing, food insecurity, etc… and seeing that patients are able to better manage their diabetes and COPD because their core needs are being met.

  I think if transformation is successful, we will also see the retention of primary care providers as well. The churning of patients through the hamster wheel of medicine is not retaining providers. If we can truly help our patients and move away from productivity based medicine, providers can do what they went to school for and care for their patients well without being penalized in the current system.

- Measurement strategy ultimately needs to have outcome measures tied to all aspects of the Triple Aim. Costs and patient experiences are currently underrepresented in the measurement set.

- Level of measurement fatigue as time goes on. Staff engagement, both at leadership and front-line levels. Level to which we are achieving national benchmarks rather than just benchmarks set for the state.

- Fewer people on OHP and less reapplications/returning beneficiaries to OHP. How does OR rank in health outcomes among the US States.

- Provider and patient satisfaction measures
- Team-based care
- Improved outcomes in primary care homes
- Fewer medications
- Lower opioid use
- Opioid MED <90
- Fluoride varnish at well child visits
- Dental visits by age 2
- Streamlined referrals to care
- Integrated mental health in primary care
- Improved transitions of care
- Fewer medication errors
- Fewer readmissions
- Lower costs
- Better management of chronic conditions
- Reducing impact of social determinants of health

- Decline in chronic disease over time. High patient satisfaction. Decline in costs to consumers and government.

- Seeing performance rates improve up to and exceeding the targets or benchmarks. Seeing preventative measures rates improve. Seeing that providers are being rewarded financially for their improvements. Seeing that Oregon is able to continue operating within the global budget. Seeing

that clinics have implemented screenings and workflows that were not previously in place. For example, a clinic may have not had a workflow for screening for clinical depression and follow up in prior years but now they do.

- From a million mile high perspective, children would be experiencing fewer preventable ACEs and this would be reflected in lower rates of depression, substance use disorders, obesity and chronic health conditions, etc. In addition, our populace would be better educated by attending school prepared and able to learn, with increased rates of high school graduation and higher education would be promoted and accessed by a high percentage of the population. Poverty would be lower with increased employment rates and rates of crime and incarceration would decrease.

- Improvements in access reflect success of health system transformation for the greater population, unlike those measures that only capture those already in the system (e.g., those measures that use claims data).

- Evidence of true care coordination and integration across delivery systems. Metrics that represent members with chronic disease. Proactive outreach to at-risk members beyond screenings in the office. Many of the members who need care the most are not coming into an office.

- PCPCH enrollment - opportunity to realign with new PCPCH standards to re-energize the program and reward those practices that have implemented transformational changes at their practice.

  Primary Care spend - There is evidence that the more that is spent on preventive primary care, the more potential impact on overall total cost of care. As payers shift to recognize the important role of primary care, this spend to maintain the investment made in the medical home by providers is critical. We need to ensure patients have access to primary care providers, which could improve if the investment/payment to primary care was proportionate to the effort required to care for this population.

  Integrated behavioral health is one of the most transformational elements of medical home, but also has many barriers to effectively integrate with primary care. Attention on the number of practices truly integrated could show efforts by the state to invest in this transformational service and help continue to focus attention on breaking down the barriers.

  A measure of after-hours care by primary care (and specialists) could help demonstrate the ability to reduce costly emergency visits. However, after-hours care requires investment by the medical home. Incentives and/or payment should align with the desire to encourage medical homes to offer increased after hours care.

Please select the three measures below that you believe could be most transformative, or could be modifications that you will describe below.

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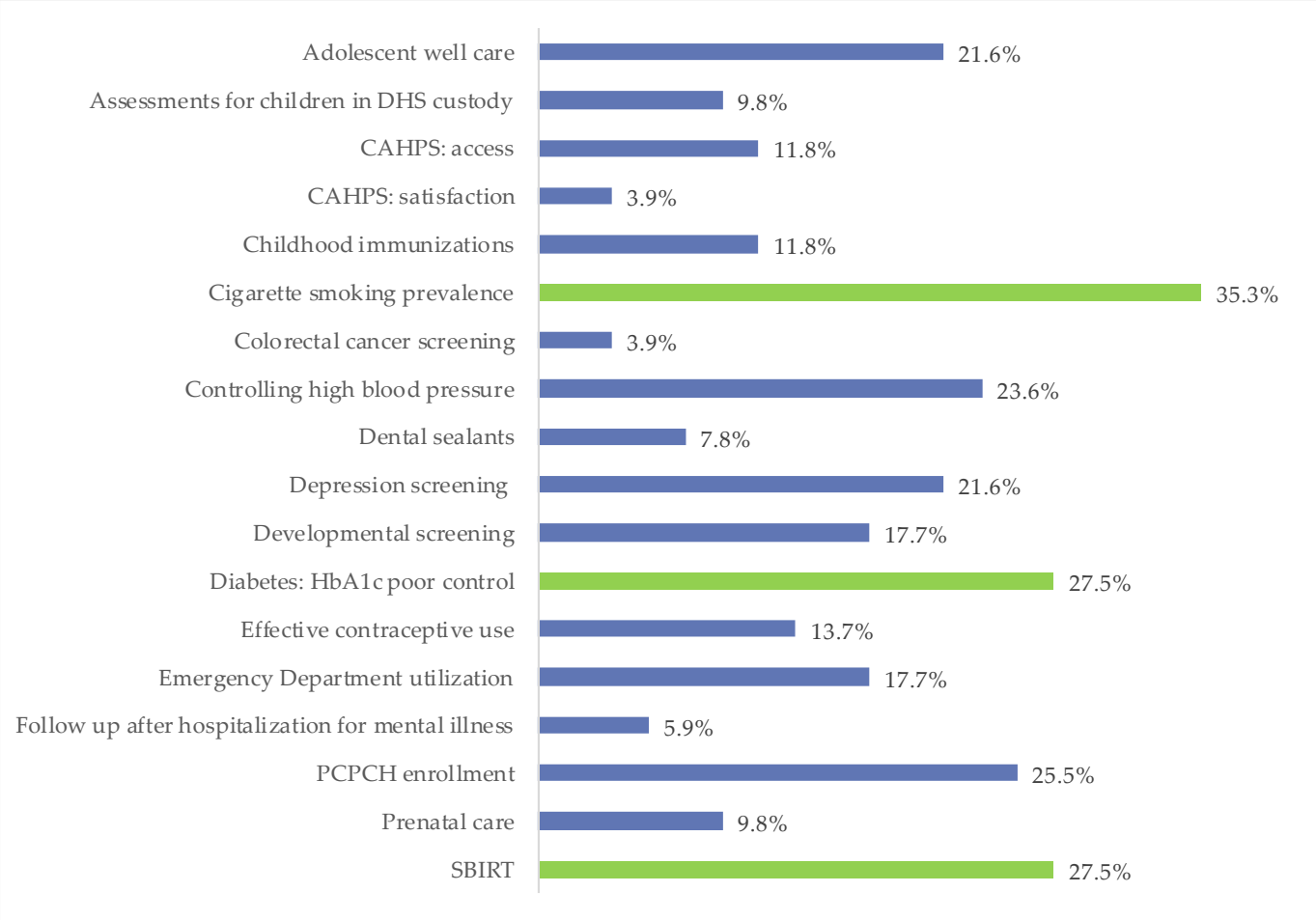

Full text of the 30 comments describing why, or how, these measures could be the most transformational are provided in Appendix C.

Proposed Measures

In this section of the survey, respondents could propose new measures for the Committee's consideration. Proposed measures are provided in the following pages. Measure descriptions and additional details available from specifications and other documentation have been provided in italics where possible.

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Kindergarten readiness measure 23

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Targeted services for children ages 3-5 and their families 24

Timely updating of member phone and address by OHA 25

Weight screening and follow up for children, adolescents, and adults 25

Well Child Visits in the first 15 months of life (NQF 1392) 25

Well Child Visits in the Third, Fourth, Fifth, and Six Years of Life (NQF 1516) 25

Yearly oral health screening in primary care (First Tooth) 26

Adult BMI Assessment (NQF 1690)

Measure description: The percentage of adults 18-74 who had an outpatient visit and whose BMI was documented in the past two years. Note there is also NQF 0421: BMI screening and follow-up.

Rationale: BMI provides the most useful population-level measure of overweight and obesity. Careful monitoring of BMI will help health care providers identify adults who are at risk and provide focused advice and services to help them reach and maintain a healthier weight.

Data source: the measure has an administrative (claims) and medical record review option.

Additional CAHPS measures

Measure description: Propose for consideration additional CAHPS-Health Plan survey measures, including:

- Getting Care Quickly
- Shared Decision Making
- Access to Specialized Services (stratified by patient-reported, or front-end data collected to allow for understanding by behavioral health).
- Coordination of Care (for children only)

Rationale: *None provided*.

Data source: CAHPS survey.

Annual monitoring for patients on persistent medications (NQF 0021)

Measure description: the percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. The measure includes four rates, and a combined total rate:

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).
- Annual monitoring for members on digoxin.
- Annual monitoring for members on diuretics.
- Annual monitoring for members on anticonvulsants.
- Total combined.

Rationale: Drugs don't work in patients who don't take them. With more than half of all Americans not taking their medications as prescribed, billions of dollars in additional, unnecessary health costs are added to our economy every year. Improving medication adherence in Oregon should be a priority and this measure is a step in the right direction for monitoring patients with chronic medications and preventing avoidable adverse events.

Data source: Medicaid claims.

Antiplatelet therapy for patients with cardiovascular disease (NQF 0067)

Measure description: Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12 month period who were prescribed aspirin or clopidogrel. PQRS measure specifications at: https://www.pqrspro.com/cmsmeasures/2015/coronary_artery_disease_cad_antiplatelet_therapy/

Rationale: It is proven that this type of medical intervention reduces mortality.

Data source: Medicaid claims.

Care coordination for children with medical complexity

Measure description: *The Family Experiences with Coordination of Care includes 20 quality indicators, including, but not limited to:*

- *Caregivers who report that their child has a designated care coordinator should report that they know how to access their care coordinator*
- *Caregivers who report having a designated care coordinator and who require community services should also report that their care coordinator helped their child obtain needed community services in the last year*
- *Caregivers who report having a care coordinator should also report that their care coordinator has contacted them (via face-to-face contract, telephone, email, or written correspondence) or attempted to contact them at least once in the last 3 months*
- *Caregivers who report their child was referred to see a specialist in the last 12 months and who report having a care coordinator for their child should also report that the care coordinator contacted them to confirm they were able to get an appointment with the specialist.*

http://www.seattlechildrens.org/research/child-health-behavior-and-development/mangione-smith-lab/measurement-tools/ and http://www.seattlechildrens.org/pdf/FECC-detailed-measure-specs.pdf.

Rationale: Care coordination and complex care management are integral to consider. *Increasing numbers of children in the United States are living with medical complexity. Although these children comprise only 13 percent of the pediatric population, they account for a disproportionality high (26-49 percent) of hospital days and 70 percent of overall health expenditures. Given the cost and complexity of caring for these children, optimizing the quality of their care is likely to yield significant health and economic benefits. Comprehensive, well-coordinated care in a medical home improves patient and family experiences of care and patient outcomes. Improving care coordination for children with medical complexity is likely to improve many aspects of care received by these children and their families.*

Data source: Survey. These items could be added as supplemental items to the CAHPS Health Plan survey and a supplemental sample *of children with medical complexity* used.

Childhood obesity

Measure description: *None provided.*

Rationale: It leads to so many problems later in life.

Data source: Electronic Health Records

Complete demographic information for Medicaid members

Numerator: members whose enrollment files go to the CCO with race, ethnicity, and language data present.

Denominator: all CCO members.

Rationale: CCO's ability to detect disparities is compromised by receiving incomplete data from OHA.

Data source: Enrollment files.

Continuous Medicaid enrollment for eligible members

Numerator: members continuously enrolled for the calendar year.

Denominator: members continuously enrolled for the calendar year, plus members enrolled in January and December who have gaps of enrollment less than 90 days during the calendar year.

Rationale: in order for CCOs to function well, OHA needs to improve its process for redetermination to avoid administratively-driven gaps in coverage for members who remained eligible through the year.

Data source: Enrollment files.

Food insecurity screening and follow up

Measure description: percent of CCO members screened for food insecurity, and of those who screened positive, the percent referred to resources, or receiving follow-up services. See specifications developed by the Metrics Technical Advisory Workgroup.

Rationale: 71 percent of Medicaid members are food insecure; 70 percent of health care costs are driven by diet-related diseases; and 66 percent of eligible people are not using some of the free food and nutrition resources available to them.

Data source: Electronic Health Records. Food insecurity screening is being added to all Epic EHRs by January 2017.

Dental access measure – prenatal and children

Measure description: *None provided. Potential dental access measures for children or that could be stratified by pregnant women include:*

- *Percentage of all enrolled children under age 21 who received at least one dental service within the measurement year.*
- *Percentage of children receiving at least one preventive dental service by or under the supervision of a dentist within the measurement year.*

- *Percentage of pregnant women receiving at least one preventive dental service by or under the supervision of a dentist within the measurement year.*

Rationale: Reduce oral health issue as well as reduced future incidence of chronic disease. Aligns with Health People 2020.

Data source: Medicaid claims.

Fluoride varnish

Measure description: *There are several fluoride measure options:*

- *The percentage of children ages 1-6, assessed with moderate to high risk of developing dental caries, who received at least one topical fluoride treatment.*
- *The percentage of children ages 1-5 with receipt of fluoride varnish in any setting (dental, primary care, schools) at least annually.*
- *The percentage of children ages 12-72 months defined as being at higher-risk of dental disease who receive 1 or more fluoride varnish applications.*
- *Topical fluoride intensity: percentage of all enrolled children who received at least one dental service, who are at elevated risk, who received 1, 2, 3, >4 topical fluoride applications within the measurement year. (DQA)*
- *Percentage of enrolled adults who received at least one dental service at elevated risk, who received 1, 2, 3, >4 topical fluoride applications within the measurement year.*
- *Percentage of children age 0-20 who received a fluoride varnish application during the measurement period (eCQM)*

Specifications include:
http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/7_DQA_Topical_Fluoride_Intensity_for_children_at_elevated_caries_risk%282%29.ashx and
https://ecqi.healthit.gov/system/files/ecqm/2014/EP/measures/CMS74v5_2.html

Rationale: *Dental caries is the most common chronic disease in children in the United States. In 2009-2010, 14 percent of children aged 3-5 years had untreated dental caries. … Evidence-based Clinical Recommendations suggest that topical fluoride should be applied at least every 3 to 6 months in children at elevated risk for caries.* Varnish is highly effective at reducing dental decay, inexpensive and easy.

Data source: *Medicaid claims*.

Follow-up for children identified at risk on developmental screening tool

Measure description: The percentage of children age 3 – 48 months who received a well-child visit in the last 12 months, who were determined to be at high or moderate risk for developmental, behavioral, or social delays (based on the Parents Evaluation of Developmental Status items in the Promoting Healthy Development Survey), who received some level of follow-up health care.

Follow-up items include testing of child's learning development and behavior, referral to another

doctor or speech/language testing, and/or whether a doctor or other health provider noted a concern that should be watched carefully.

See NQMC specifications http://www.qualitymeasures.ahrq.gov/content.aspx?id=27469. *Note the NQMC specifications could be adapted to apply the follow-up component to children who were identified at risk through the developmental screening measure, rather than the Promoting Healthy Development Survey.*

Rationale: early identification of children at risk for developmental, behavioral and social delays is an integral component to high quality well-child care. The early identification of developmental problems should lead to further developmental and medical evaluation, diagnosis, and treatment, including early developmental intervention. When developmental surveillance or screening identifies a child as being at high risk of a developmental disorder, diagnostic developmental evaluation should be pursued.

Adapting the current developmental screening measure to incorporate follow-up would allow for refinement of the current measure and data collection to allow for differentiation of developmental and autism screening. It would also focus on the core outcome of screening, which is to ensure children identified at risk receive follow-up services. And it is aligned with Early Learning Hub goals and state-level transformation for young children.

Data source: Patient survey. *Adapting the measure to Oregon's existing developmental screening measure would require an EHR-based measure.*

Kindergarten readiness measure

Measure description: Pending development.

Rationale: While the measure needs further development, this is an extremely important issue for children and to support general population health. Proponents of this measure would like to support conversations and proposals that have already begun around consideration and development of a metric related to kindergarten readiness. This could be a third wave metric that follows after the developmental screening measure.

Data source: no data source currently exists.

Medication Therapy Management: Completion rate for Comprehensive Medication Review

Measure description: the percentage of prescription drug plan members age 18 years and older who met eligibility criteria for medication therapy management 9MTM) services and who received a comprehensive medication review (CMR) during the eligibility period. Pharmacy Quality Alliance measure. https://www.qualitymeasures.ahrq.gov/content.aspx?id=47513

Rationale: *Medication therapy management is a distinct service that optimizes therapeutic outcomes for individual patients. In recognition of their importance, MTM services are mandated by CMS to include a comprehensive medication review.*

Data source: Medicaid claims.

Medication reconciliation post-discharge (NQF 0554)

Measure description: the percentage of discharges between January 1 and Dec 1 of the measurement year for members age 66 or older, for whom medications were reconciled on or within 30 days of discharge.

Rationale: Implementing routine medication reconciliation post-discharge from an inpatient facility is an important step in ensuring continuity of care. Medication errors are present in approximately 50 percent of patients after hospital discharge and are more common among patients with lower numeracy or health literacy. Medication errors lead to improper adherence and other more costly and avoidable health outcomes.

Data source: Medicaid claims.
Ed. The NQF 0554 measure has an administrative (claims) and medical record review option.

Obesity prevalence

Measure description: the percentage of the Medicaid population who are obese.

Rationale: Obesity is clearly a key determinant of many future negative health outcomes including cardiovascular disease, cancer, and stroke.

Data source: Electronic Health Records. Potentially drivers' licenses.

Opioid Use MED>90

Measure description: *Percent of chronic opioid users with prescriptions for >90 morphine equivalent doses (MED). Measure could potentially be based on the CCO PIP measure development work.*

Rationale: It is a national public health crisis that can be solved.

Data source: Medicaid claims.

Targeted services for children ages 3-5 and their families

Measure description: *None provided.*

Rationale: Community analysis identifies a significant gap in services for this age group.

Data source: *None provided.*

Timely updating of member phone and address by OHA

Measure description: Percentage of all Medicaid members for whom updated information was submitted who had updated data entered within 5 business days.

Rationale: delays in receiving and entering address and phone changes impairs CCOs' ability to contact members and connect them with care.

Data source: Enrollment files.

Weight screening and follow up for children, adolescents, and adults

This measure could be the HEDIS / CMS CHIPRA core measure: Weight assessment and counseling for nutrition and physical activity in children and adolescents. NQF 0024.

Measure description: Percentage of children and adolescents ages 2-17 who had an outpatient visit with a primary care provider or OB/GYN during the measurement year, who have their Body Mass Index (BMI) percentile on record in administrative data or medical record review during the measurement year, and who received counseling for nutrition and counseling for physical activity during the measurement year. Specifications at: http://www.ncqa.org/portals/0/Weight%20Assessment%20and%20Counseling.pdf

Data source: This measure can be calculated from either administrative (claims) data or medical record review.

Well Child Visits in the first 15 months of life (NQF 1392)

Measure description: the percentage of members who turned 15 months old during the measurement year and who had at least 5 well-child visits. Specifications at: http://www.ncqa.org/portals/0/Well-Child%20Visits%20in%20the%20First%2015%20Months%20of%20Life.pdf

Rationale: As pediatricians, we believe that the well-visits at every stage are some of the most transformation measures. Pediatricians follow Bright Futures, which includes age-appropriate immunizations, screenings, interventions, etc… If the pediatrician (or other provider) can get the child in to the office for a visit, the rest will follow.

Data source: Medicaid claims.

Well Child Visits in the Third, Fourth, Fifth, and Six Years of Life (NQF 1516)

Measure description: the percentage of members 3-6 years of age who received one or more well-child visits with a primary care provider during the measurement year. Specifications at: http://www.ncqa.org/portals/0/Well-Child%20Visits%20in%20the%20Third%20Fourth%20Fifth.pdf

Rationale: As pediatricians, we believe that the well-visits at every stage are some of the most transformation measures. Pediatricians follow Bright Futures, which includes age-appropriate immunizations, screenings, interventions, etc… If the pediatrician (or other provider) can get the child in to the office for a visit, the rest will follow.

Data source: Medicaid claims.

Yearly oral health screening in primary care (First Tooth)

Measure: Percent of children ages 1-6 who received an annual screening.

Rationale: An opportunity to impact oral health in primary care. Increase early referrals for dental care, and avoid higher dental costs due to delayed care.

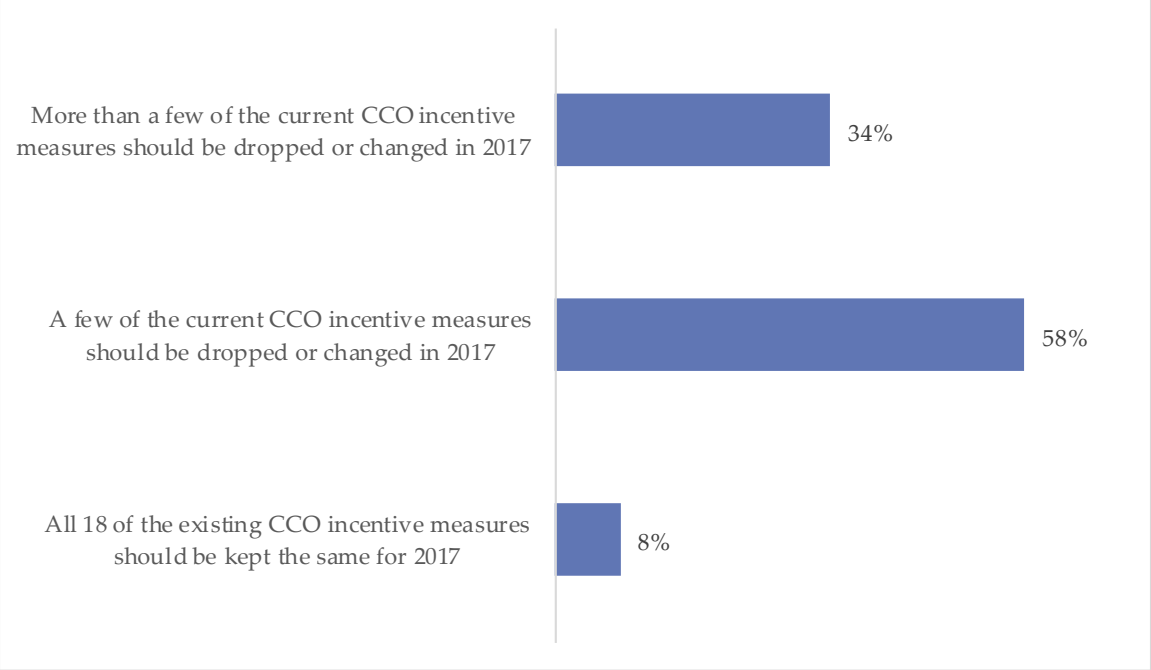
Data source: Medicaid claims.

Feedback on the Current (2016) CCO Incentive Measures

In this section of the survey, respondents were asked to provide their thoughts on the current set of CCO incentive measures to help inform measure selection for 2017 and beyond.

Responses have been summarized and may have been edited slightly for clarity and to protect respondents' privacy. Full text responses are available in Appendix D.

Please describe the statement that most closely describes your preference for 2017.



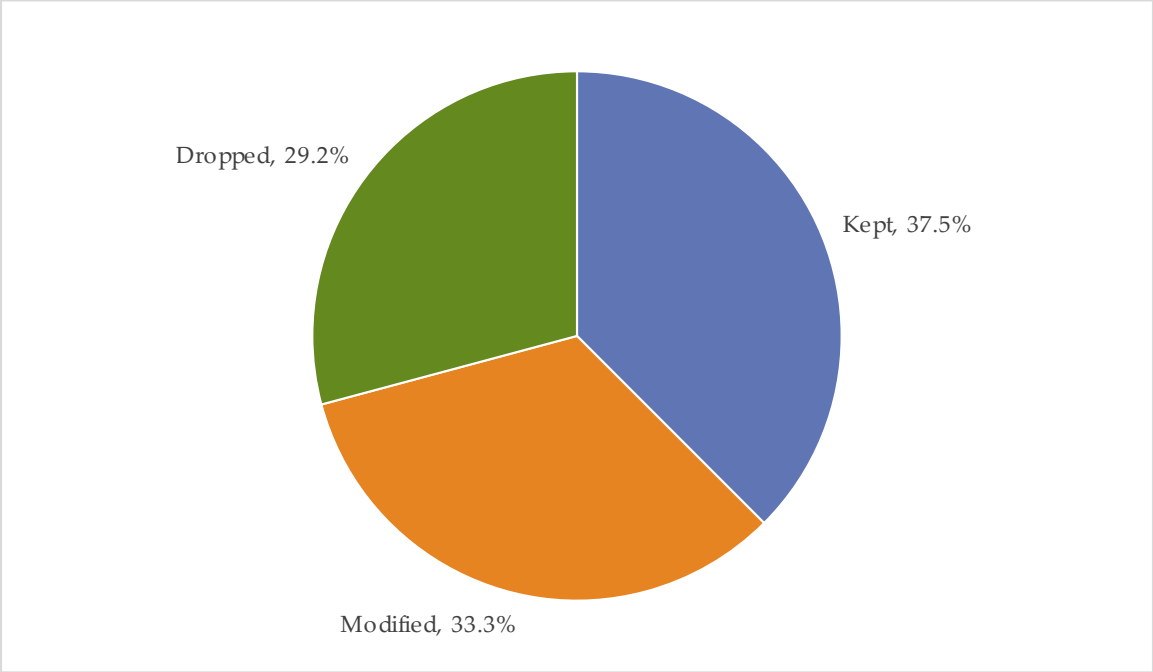
N=50.

The survey then asked about each of the current CCO measures and whether they should be kept, modified, or dropped. These responses and open-ended responses are provided for each measure below. Responses have been edited slightly for clarity and to protect respondents' privacy. Duplicate, or very similar responses have been consolidated. There were some overarching comments that applied to multiple measures, including:

- The measure should reflect a rolling 12-months, not the measurement year. It is cumbersome for clinics to track current status throughout the year if the activity was performed in later months of the previous measurement year and is not indicated to repeat the activity in less than 12 months.
- Measures based on enrollment are difficult for providers, as many of the patients "enrolled" with the clinic have never been seen there, are receiving care elsewhere, or have moved. The only way clinics can identify these patients is by conducting labor intensive chart review on the many patients identified in gap reporting. There needs to be a better / more user-friendly platform to identify patients.

Adolescent Well Care Visits

n=24

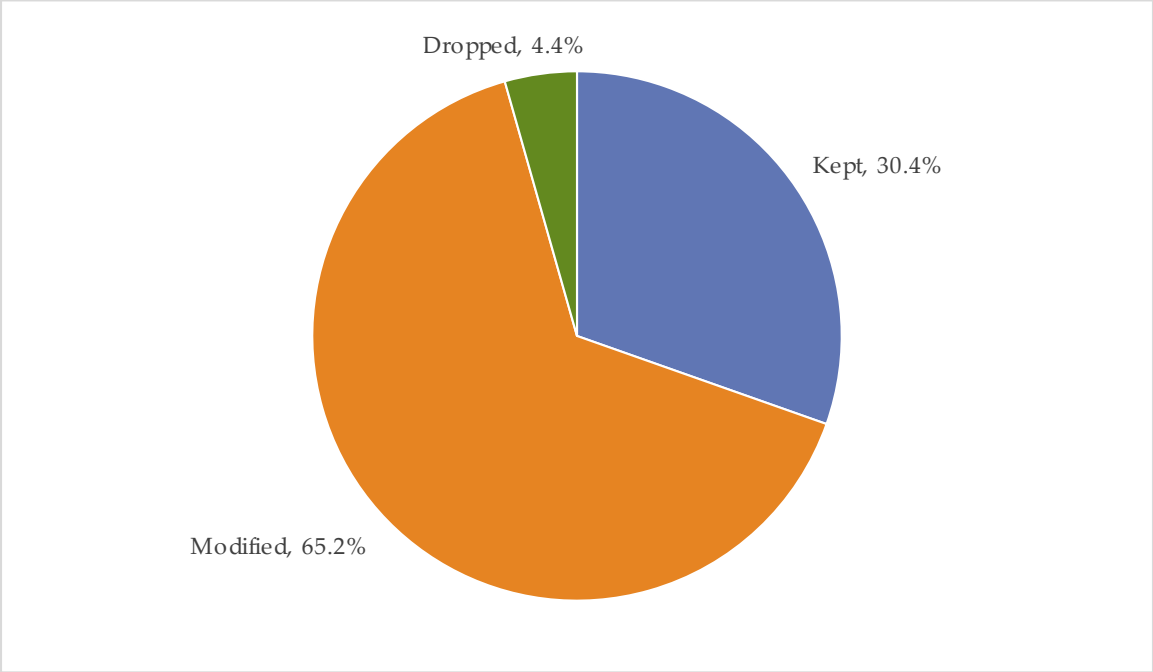


Comments:

- This is an important measure, but we need to ensure alignment with the commercial payers as well. Are annual well visits going to continue to be best practice?
- Consider changing the upper age limit to 18 / dropping ages 19-21 from the measure.
- Does not affect mortality, patient outcomes, or a large segment of the population.
- In the current adolescent well-care visit measure, sports physicals are included. This should be changed to explicitly exclude sports physicals, because they do not meet the intent of the measure.
- Stratify and report measure by the claims provided. There are some [codes] that are directly tied to Bright Futures and some that are not. Incentives should only apply with the Bright Futures indicated well-visits occur (e.g., v20.2 / Z00.129).
- Well care visits do not affect mortality. This measure does not affect a large segment of the population. It has been extremely difficult to reach the unrealistic goal for this measure, given that this age range tends to not purpose medical services unless they absolutely need it. Most of the patients in the age range are fairly healthy and will not seek annual well-care visits, nor will they be easily influenced to do so.

Alcohol or other substance misuse (SBIRT)

n=23

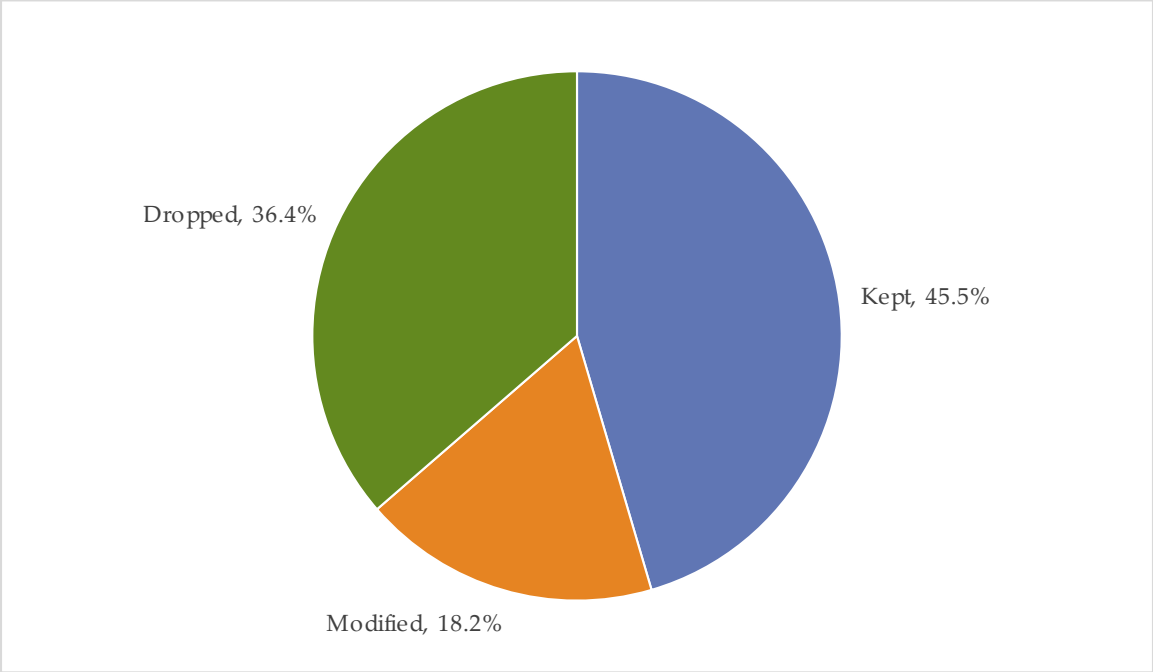


Comments:

- For adolescents, this can be a challenging measure based on the billing codes. For adolescents, pediatricians administer the CRAFFT, which is considered a full screen. Regardless of results, a brief intervention follows. If negative, the provider provides positive reinforcement… very important in the development of the adolescent. If positive, a brief intervention and appropriate referral follows. Ensuring that the claims-based measure can properly capture this intervention without a diagnosis is critical. In addition, ensuring that commercial plans are following the billing requirements (and paying) for this service is also critical.
- Change to report brief screen, or stop requiring brief screen if only full screenings are included in the measure. The current measure results in telling providers "Please screen for breast cancer with mammograms, but we will only give you 'credit' for mammograms that find cancer." CCOs and providers have no control over what percentage of the population will screen positive.
- For adolescents, consolidate SBIRT and depression screening measures.
- Include brief screenings with negative responses in the measure. [The measure has resulted in] paying clinics to skip the brief screen, which leads to over screening and over payment. Only pay for the screen that needs to be done, which in most cases, is the brief screening.
- Note coding changes in ICD10 result in a less specific measure that may cause challenges in differentiating between alcohol and depression screenings.
- Keep measure as is, since there really isn't a better alternative right now and there is progress being made in multiple clinics to make this a standard part of their work flow.

Ambulatory Care: Emergency Department Utilization

n=22

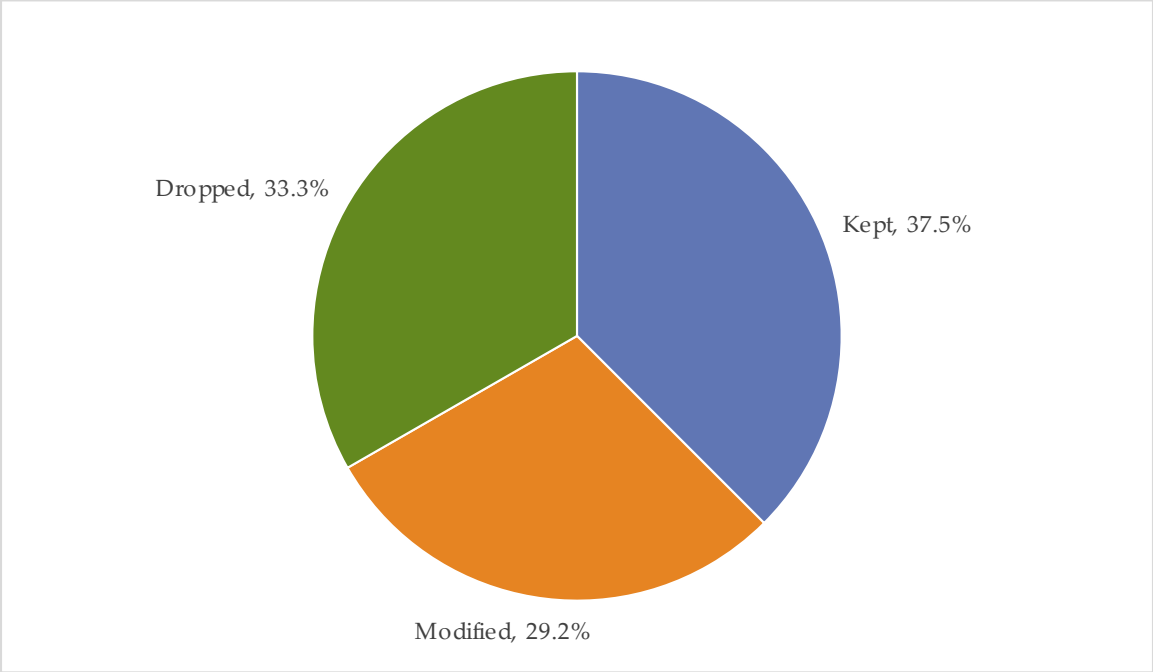


Comments:

- The current strategy for accurate measurement is not effective at this time, due to the lack of communication processes in place between hospitals and primary care clinics.
- This is a system metric, not a clinic-level metric. You could solve the problem immediately with incentives to patients directly to not use the ED unnecessarily. As long as the ED is free care, providers have little influence.
- Consider whether we really know what good ED utilization looks like in a community – the benchmark seems somewhat arbitrary.

CAHPS: Access to Care

n=24

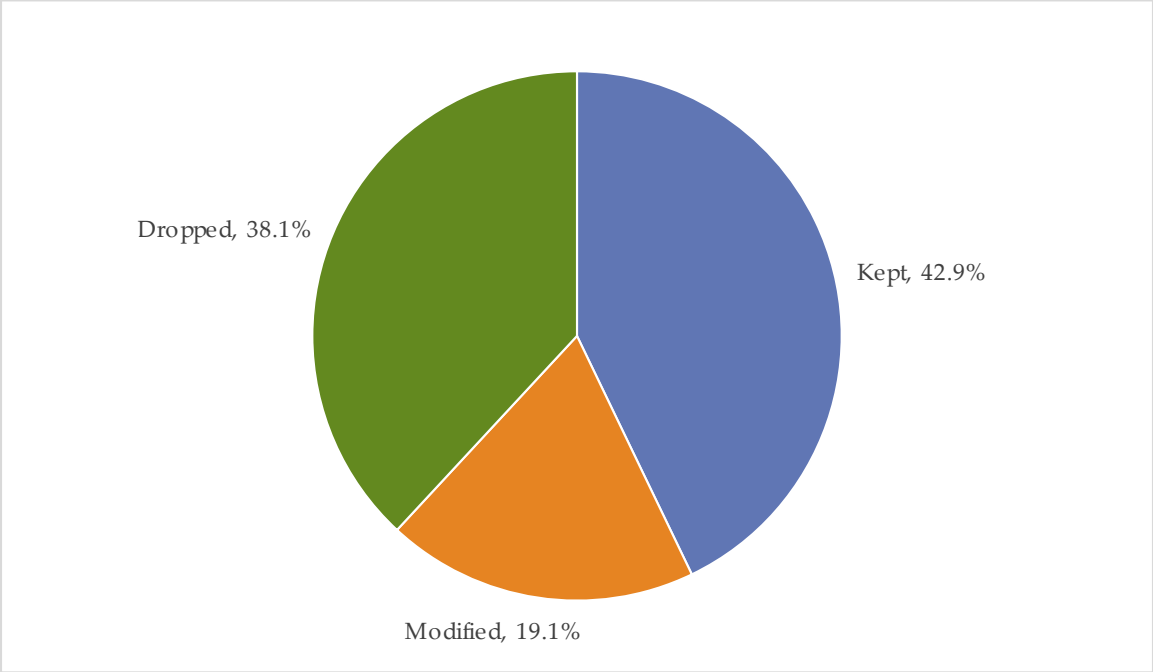


Comments:

- Small sample sizes impair the accuracy of the measurement process / increase the sample size.
- We need measures with actionable data.
- Top Box scoring methodology is ineffective for representing patient experience / unrealistic to reach.
- Stratification by populations, and by health status, would be valuable. In past work, examination by use or need of mental and behavioral health services was significantly different.
- Consider better ways to evaluate access: third next available appointment?
- No changes to the measure specifications, but would prefer to see the CAHPS surveys conducted throughout the year, rather than all at once in February for the prior year. Regular feedback to the CCOs on their performance during the actual measurement year would give CCOs and providers a better chance of determining the effects of their improvement efforts. It would also be nice to have member level data so we could look for trends among providers and clinics for more targeted improvement efforts.
- Poorly written, too long, and the scoring methodology is ineffective (for a clinic to get credit, we have to be scored a 5/5) to represent patient access.

CAHPS: Satisfaction with Care

n=21

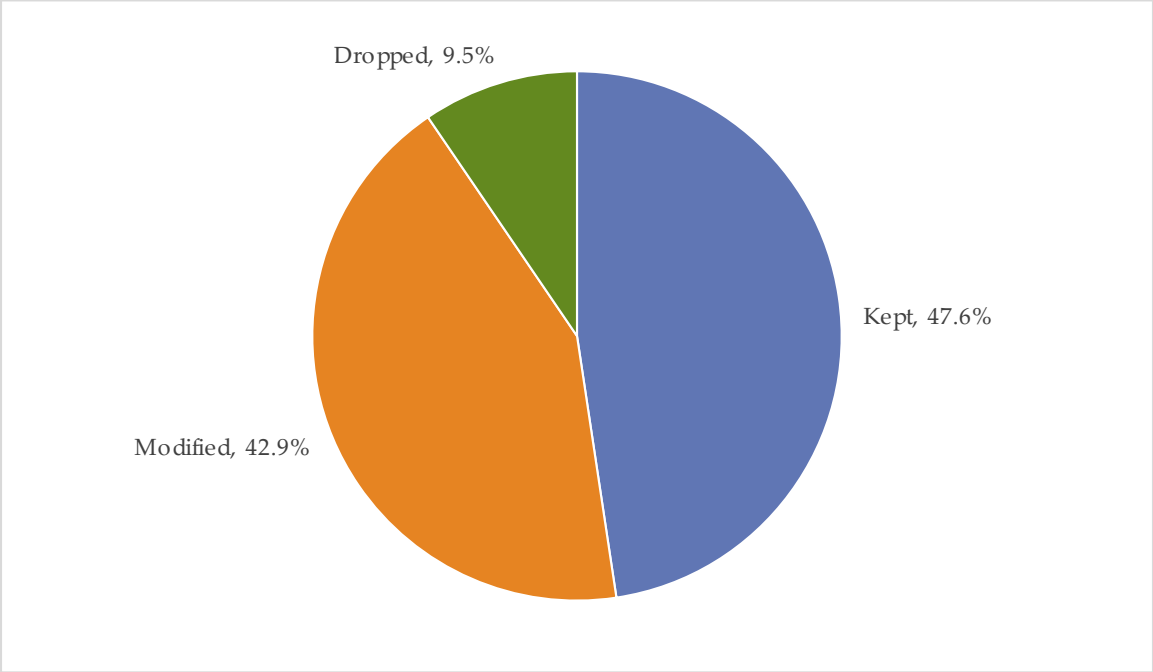


Comments:

- Small sample sizes impair the accuracy of the measurement process / increase the sample size.
- Members have a hard time differentiating between CCO services and OHA services. Until OHA is achieving better levels of customer service, this measure should be removed from the measure set.
- CAHPS data are not actionable.
- Top Box scoring methodology is ineffective for representing patient experience.
- The measure should be about satisfaction with care a patient receives, not satisfaction with the health plan itself.
- No changes to the measure specifications, but would prefer to see the CAHPS surveys conducted throughout the year, rather than all at once in February for the prior year. Regular feedback to the CCOs on their performance during the actual measurement year would give CCOs and providers a better chance of determining the effects of their improvement efforts. It would also be nice to have member level data so we could look for trends among providers and clinics for more targeted improvement efforts.
- Change measure to be satisfaction with providers rather than satisfaction with health plan. Provider satisfaction is much more important since they are providing direct care to members.
- Poorly written, too long, and the scoring methodology is ineffective (for a clinic to get credit, we have to be scored a 5/5) to represent patient access.

Childhood Immunization Status

n=21

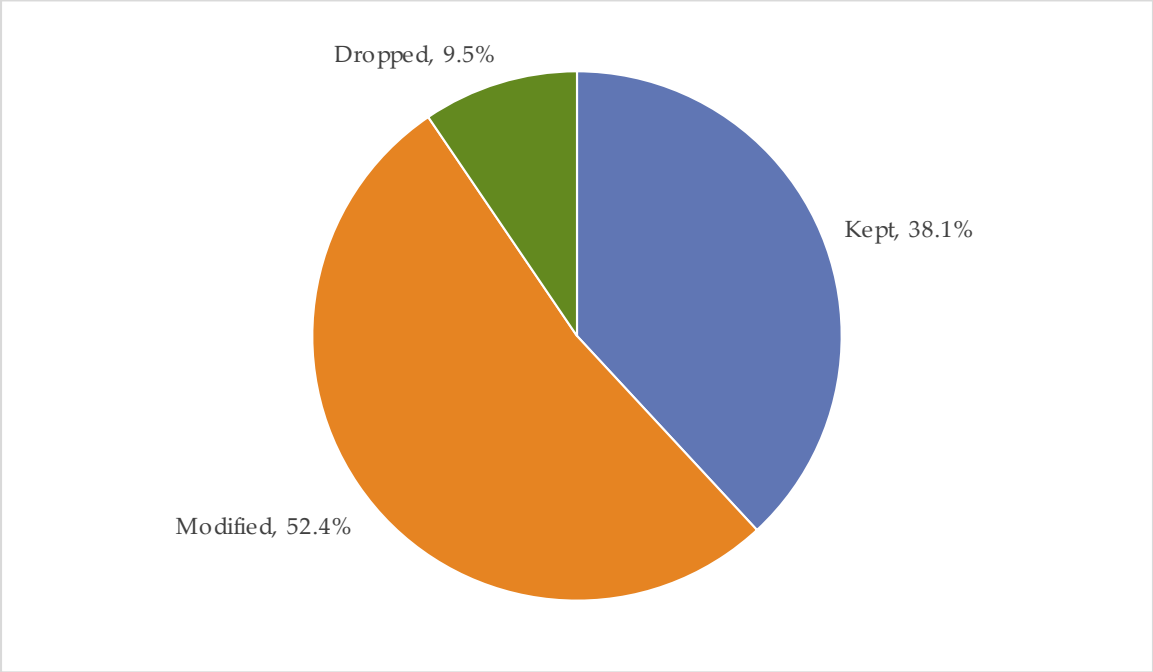


Comments:

- It is very important that the benchmark for this measure is carefully selected. If it is too high, it might encourage providers to not accept those families who are vaccine-refusers, which may be centered around one particular clinic or region. Perhaps this can be a public health measure versus primary care measure.
- The margin for improvement is very small. Clinics are already working hard on this in areas with low immunization rates and cannot influence meaningful change.
- Patients on catch-up schedules should be counted in the numerator.
- Exclude rotavirus because of 16 weeks of life cut off.
- CCOs need regular and timely access to ALERT IIS data in order to help drive improvements with providers.

Cigarette Smoking Prevalence

n=21

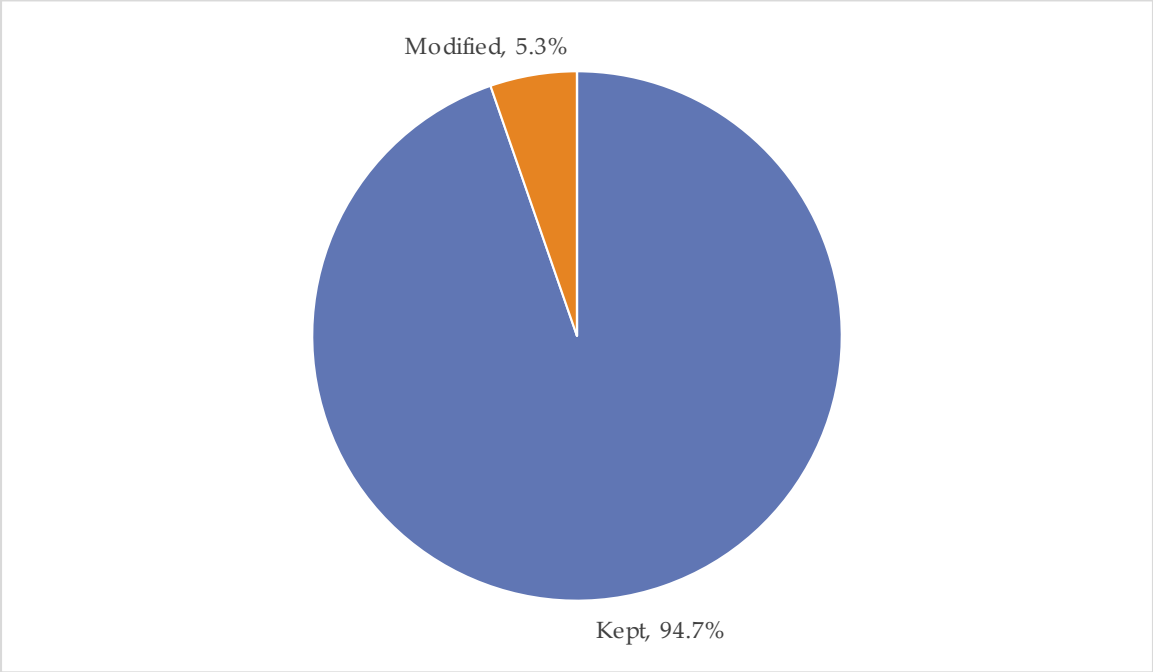


Comments:

- This is important to measure but it is also of growing importance to track e-cigarette and marijuana use in adolescents. However, data within EHRs are not always available.
- This may be a better public health than primary care measure.
- Bundling requirements should be simplified to make it clear what is required for each measurement year.
- Change to all tobacco use, rather than cigarette smoking prevalence.
- Documenting prevalence is important but it doesn't ensure that the provider realized that the patient smokes (may not have looked in the EHR where prevalence was recorded). The measure should be modified to include some documentation of cessation counseling.
- Include the total number of patients for whom a smoking cessation medication was prescribed. The denominator should be patients who reported smoking during the measurement year and exclude patients who declined intervention.
- Agree in concept with the metric, but have significant concerns with data quality and reporting.

Colorectal cancer screening

n=19

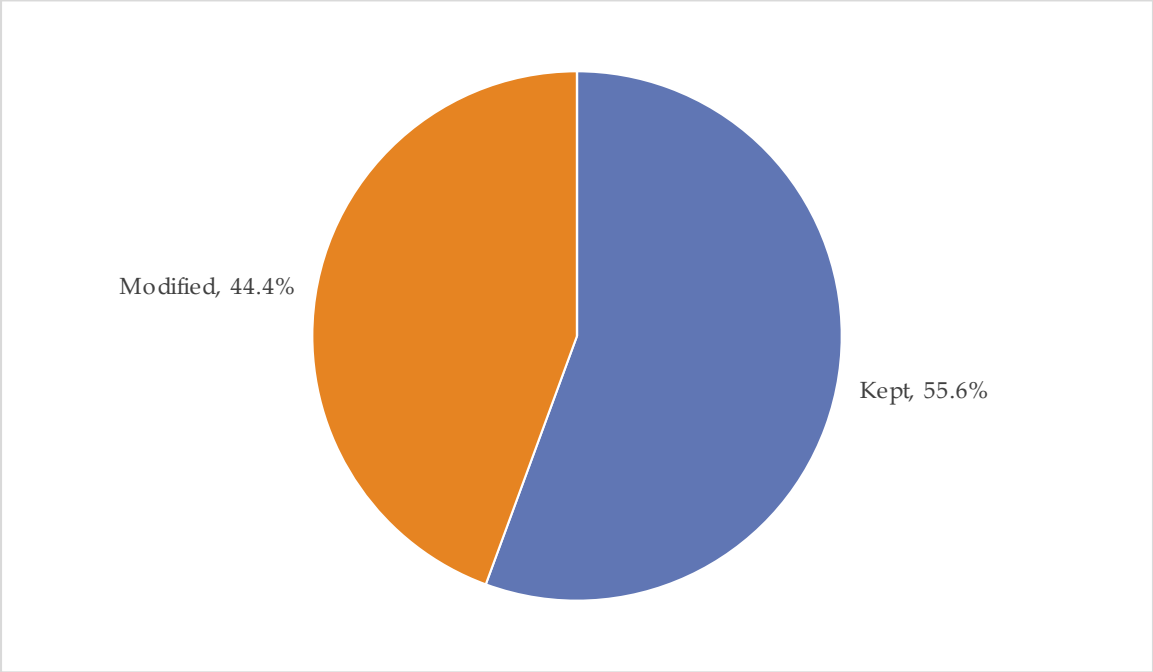


Comments:

- This measure is not applicable for pediatrics.

Controlling High Blood Pressure

n=18

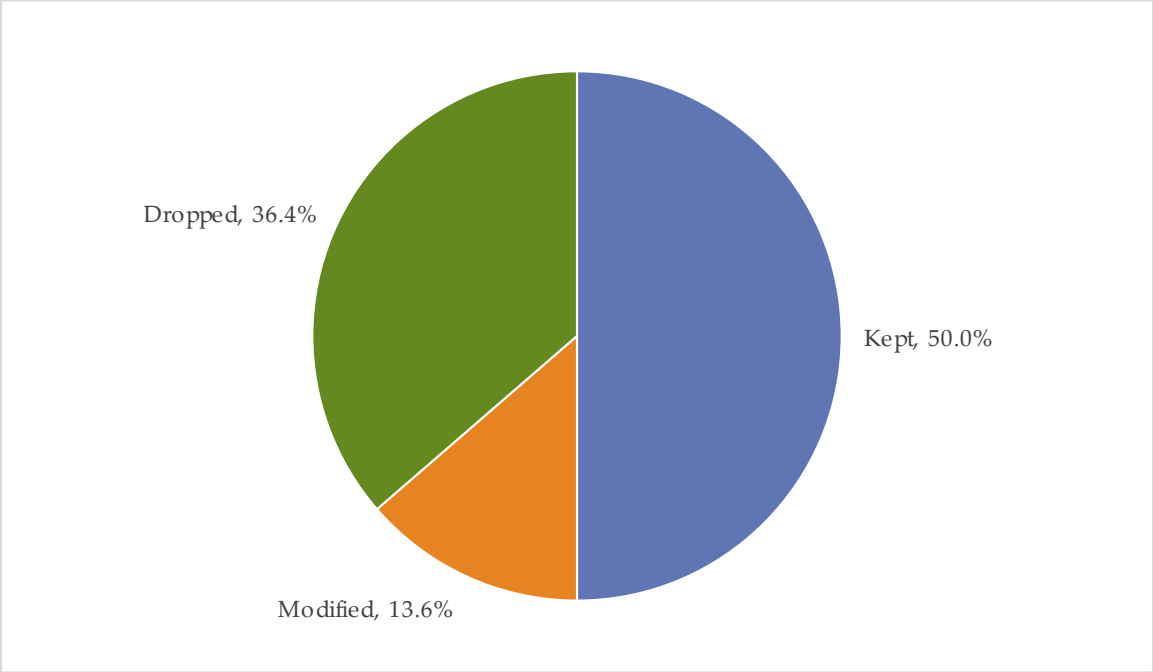


Comments:

- This measure is not applicable for pediatrics.
- Modify the measure to reflect preventing hypertension. This measure and the EHR-based measure submission process is a barrier to understanding full population impacts.
- Consider using different measure treatment thresholds to follow best practice guidelines instead of one-size fits all target. For example, having the blood pressure control goal of 150/90 for ages 60 and above, and 140/90 for all others.

Dental sealants on permanent molars for children

n=22

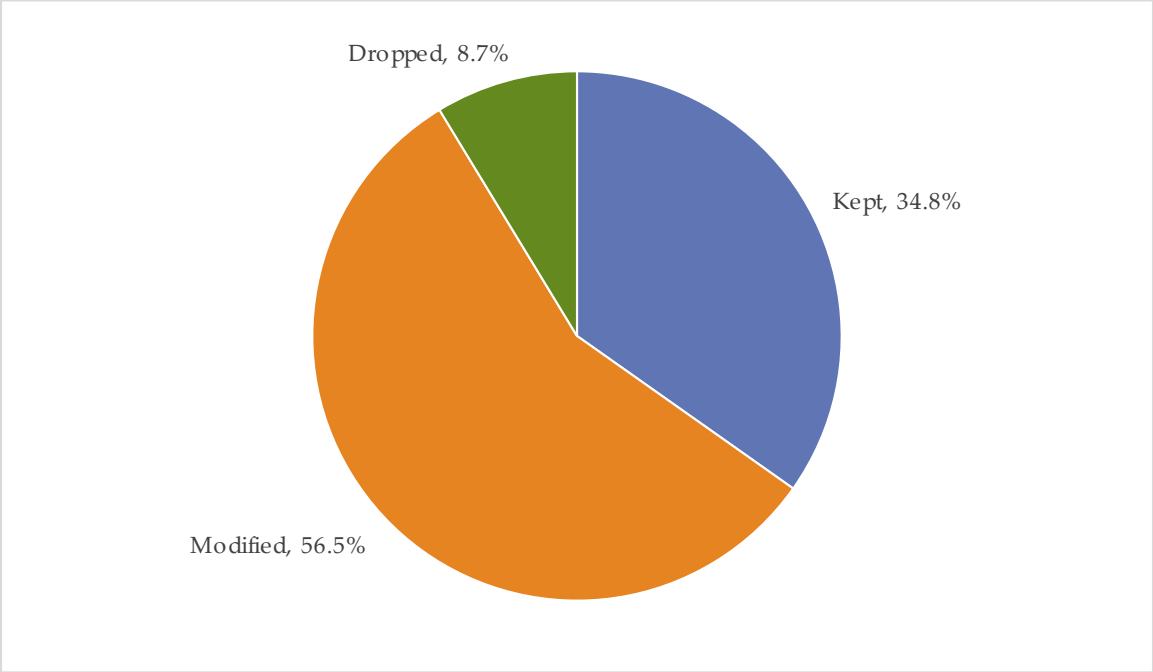


Comments:

- Access to dental services is critical, especially by the age of 3. Perhaps the measure should be geared more towards a visit or access rather than dental sealants.
- Use dental sealants as component of composite measure that assesses completed treatment plans, receipt of preventive services, and member access to care.
- Replace with First Tooth measure (see proposed new measures above).
- Small population and very difficult to track high-risk patients, especially those who seek dental services at different organizations, due to the lack of interoperate processes or communication.
- Chart reviews have indicated that the majority of patients on gap lists provided to the clinic by CCOs have been assigned to a different clinic by the DCO, making it difficult for clinics to influence.
- It is not necessarily indicated that sealants should be applied annually, measure should be modified to include either a roll-over from previous years, or an exclusion for patients who are not clinically indicated to need sealants.

Depression screening and follow-up plan

n=23

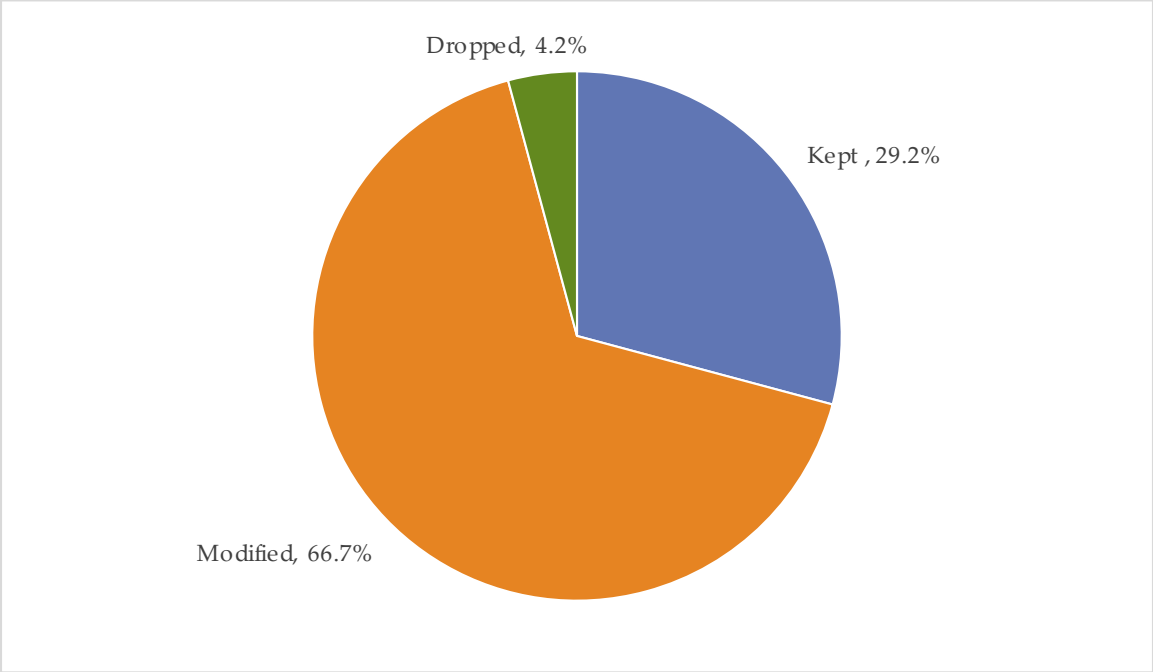


Comments:

- Despite being a Meaningful Use measure, the data fields for appropriate follow-up are very challenging, including administering the PHQ-9 (CPT code is not consistently covered by all payers and the code can be used for other screenings). This is a data transfer field which needs time to ensure data can be effectively be shared between the primary care providers and the CCO.
- More to a measure that assesses specialty mental health access and quality and moves the measurement burden away from primary care.
- Keep as a measure for adults 21 and over. For ages 12-20, consolidate with SBIRT.
- Follow-up should not be limited to provider's same encounter, or to the same day of the encounter.
- This measure is substantially under-reported because of the difficulty of extracting the required data from the EHR systems. The specifications are complex and EHRs are not all equipped to report on all elements in compliance with the specifications. These EHR reporting issues mean that the reported scores do not reflect the actual work being performed by the providers. This measure incentivizes custom report building and data improvements at this point, but has likely increased the rates of depression screening and follow up planning.
- Consider whether PHQ-9 is a valid and robust follow-up step.
- Reporting of specific follow-up steps given very low referral rates given lack of access available.

Developmental screening

n=24

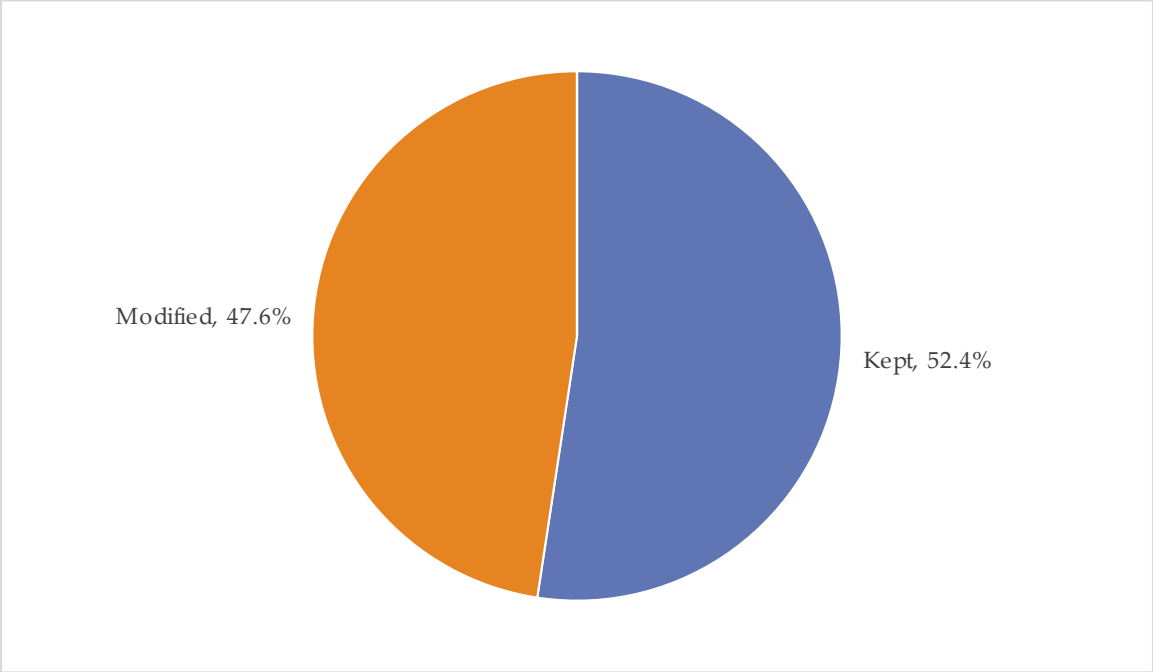


Comments:

- Monitor access to specialists once a child has been identified through screening process.
- Elevate to the next level of care: assess the follow up if an issue was identified through screening.
- Modify to include follow-up referrals and connection to appropriate services.
- Include in a composite measure of preventive care in the first 3 years of life.
- Numerator should include screening tools returned by mail and entered into EHR by care team.
- Numerator should not be limited by provider type.
- Replace with kindergarten readiness measure.
- Raise the benchmark significantly to ensure focus on this topic area that is aligned with other state-level reforms.
- Consideration of methods to enhance understanding of how many claims are for developmental screening versus autism screening. A number of options could be explored.
- Add a hybrid metric collecting information about follow-up for children identified at risk on the developmental screening metric.

Diabetes: HbA1c Poor Control

n=21

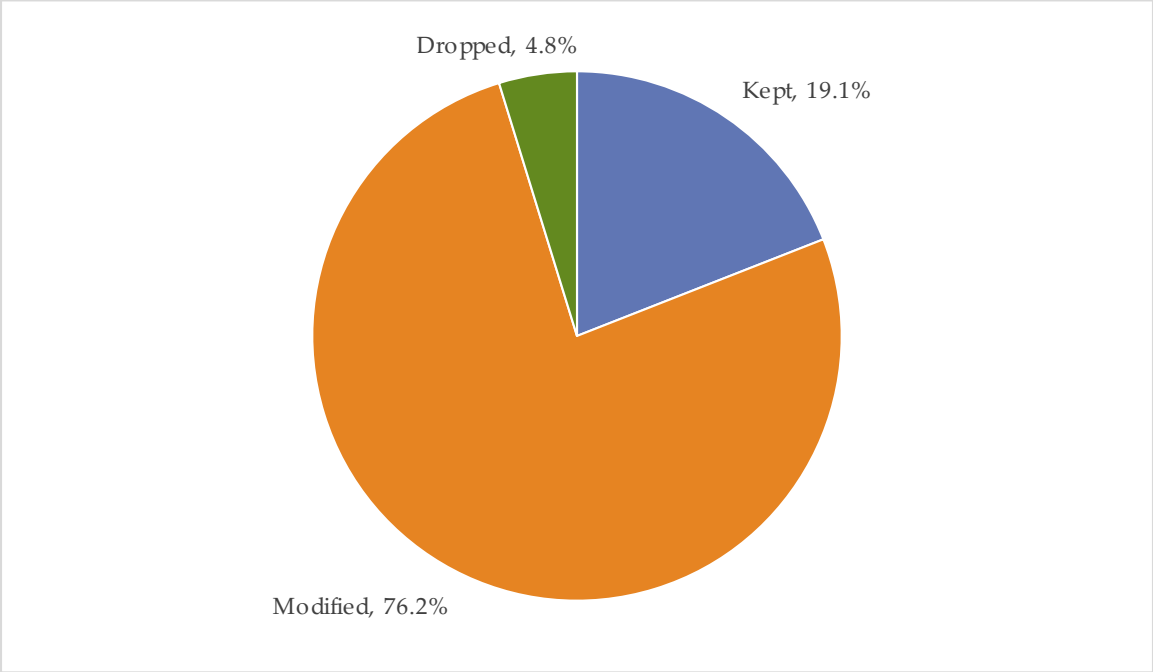


Comments:

- Pediatricians do not always maintain lab results in a discrete field because the patient is managed by the specialist. Therefore it is very difficult to transfer clinical data. This is an extremely small population for pediatrics (and even those 18+ served by pediatrics). Accountability for this measure should be in communication to the primary care provider, not maintaining the data in a reportable field.
- Modify to reflect prevention for members with pre-diabetes.
- Modify measure to align with CMS, where the HbA1c threshold is over 9.0% for all patients, or no HbA1c within the last 12 months. Denominator should exclude patients managed outside of primary care clinics.

Effective Contraceptive Use

n=21

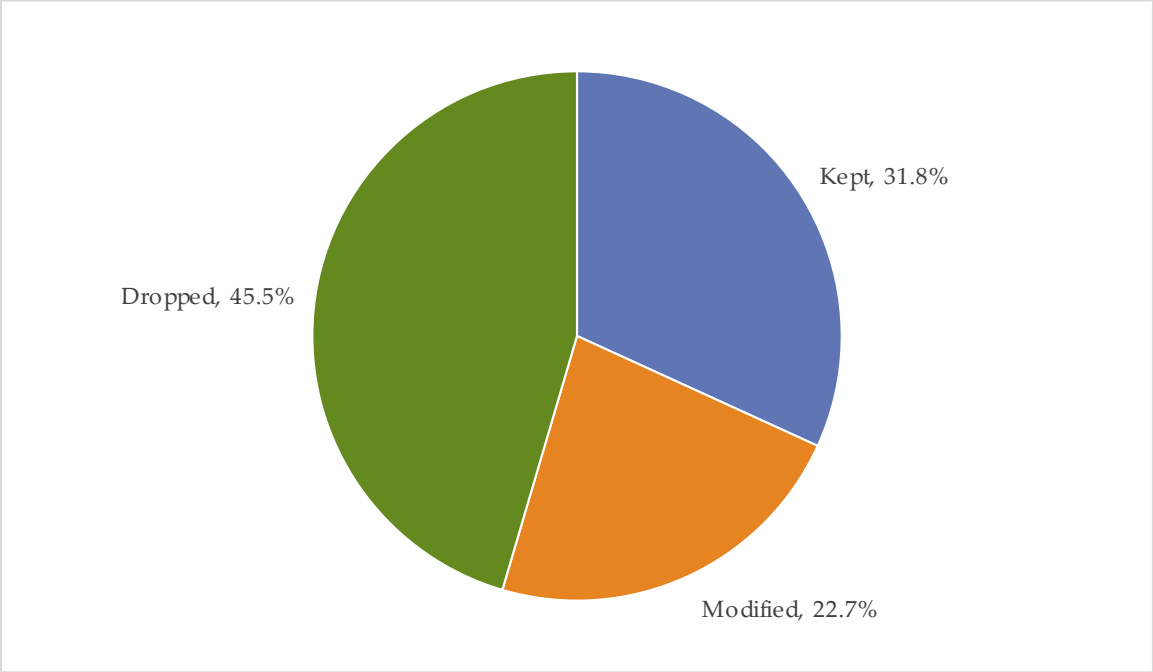


Comments:

- Contraceptive use is not always and effective or appropriate measure for children. A different measure of unintended pregnancies should be monitored. For example, "One Key Question" for both girls and boys could be a good measure of the discussion of the risks of unwanted pregnancies in adolescents.
- Move from claims-based to EHR-based measure; stop using surveillance codes.
- Redefine "women at risk of unintended pregnancy" to exclude same-sex partners, partner sterility, gender orientation, women in menopause, and desire to become pregnant.
- Include teens in the incentivized portion of the measure.
- Need a better measure to address anticipatory guidance regarding pregnancy avoidance.
- Allow Z30.09 (unspecified contraception) to fulfill measure.
- Modify to include a look back in claims data for sterilization codes, similar to the existing hysterectomy exclusion. Don't require providers to document tubal ligation status every year.
- Include oral contraceptives provided by Public Health.
- Measure whether patient is offered contraceptive, rather than whether they use is. This measure dictates patient care by only including women who agree to use birth control. Not using birth control is an appropriate patient choice and should not be penalized.

Follow-up after Hospitalization for Mental Illness

n=22

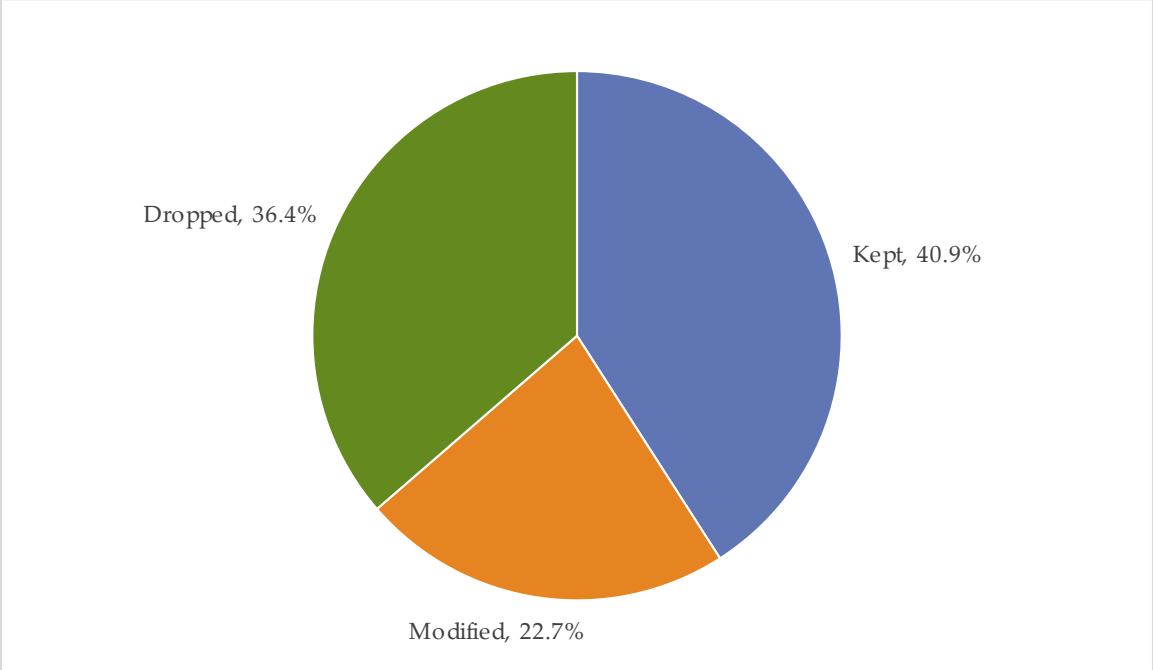


Comments:

- Include as an element of a bundled measure of care for patients with serious mental illness.
- The current measure doesn't address root causes of initial hospitalization, nor does it address the prevention of re-hospitalization.
- Hospitals are already being monitored for this measure.
- Very difficult to track this population.
- Modify to allow a longer timeline for out-of-area discharges.
- Modify to accommodate documented patient refusal.
- Modify to indicate that follow-up is to occur at the mental health facility. Too often patient comes to primary care for follow-up and the primary care clinic is not equipped to serve the patient's need, resulting in adverse patient events, including re-hospitalizations.
- Clinics and CCOs cannot obtain fast and complete data on patients who are hospitalized.
- Measure has reached the point where it should be dropped; processes in place are effective at achieving follow-up. Benchmark is reaching the point of not being possible to meet due to variables that cannot be controlled by those responsible (e.g., out-of-area discharges that cannot make it to an appointment within 7 days, patients who left against medical advice, patient refusals, etc). If not dropped, measure should be modified to allow 30-days for follow-up for out-of-area discharges.
- Although follow-up after hospitalization is important, clinics have no mechanism to know if a patient has been hospitalized. Until there is a mechanism to do so, this measure should be dropped. At a population level, it might be good to measure community law enforcement training in crisis intervention, mental health professional ride-alongs with law enforcement officers, availability of crisis and respite centers, use of mental health courts and diversions, availability and referral to family-to-family classes, and availability and referral to cognitive therapy.

Mental, Physical, and Dental Health Assessments within 60 Days for Children in DHS Custody

n=22

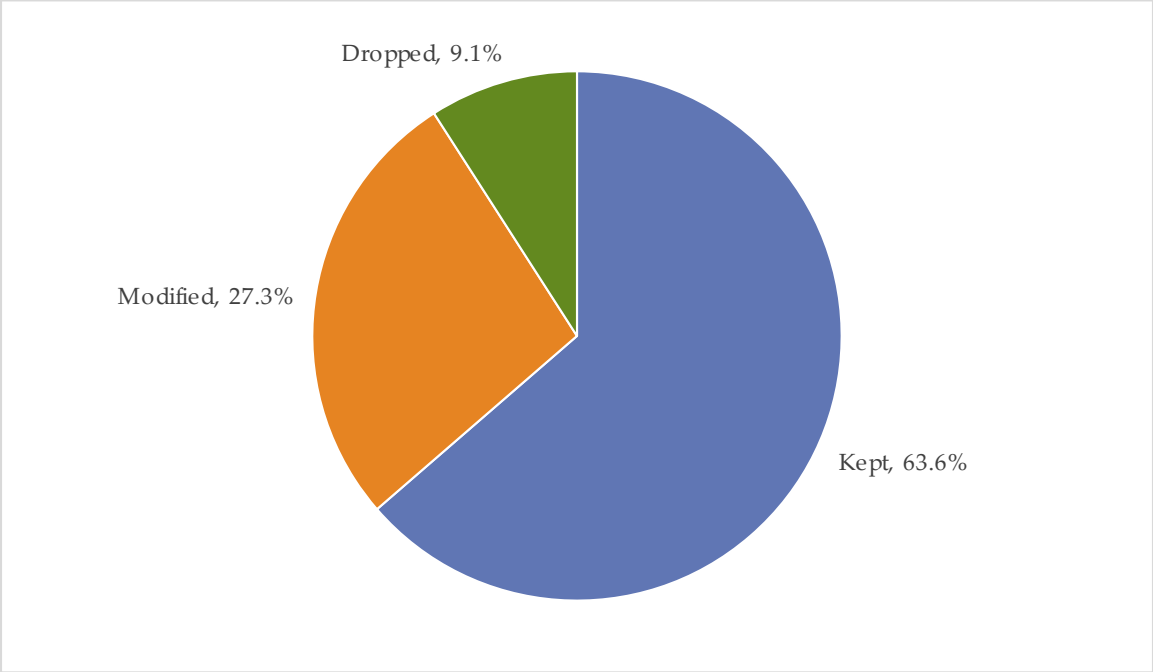


Comments:

- Include as a bundled measure for care for this high-risk population.
- Simplify.
- This is important work, but too narrowly focused / too small of a population at CCO and clinic level
- Increased involvement with DHS needs to be mandatory.
- Modify to include follow-up referrals and connection to appropriate services as part of the measure.

Patient-Centered Primary Care Home Enrollment

n=22

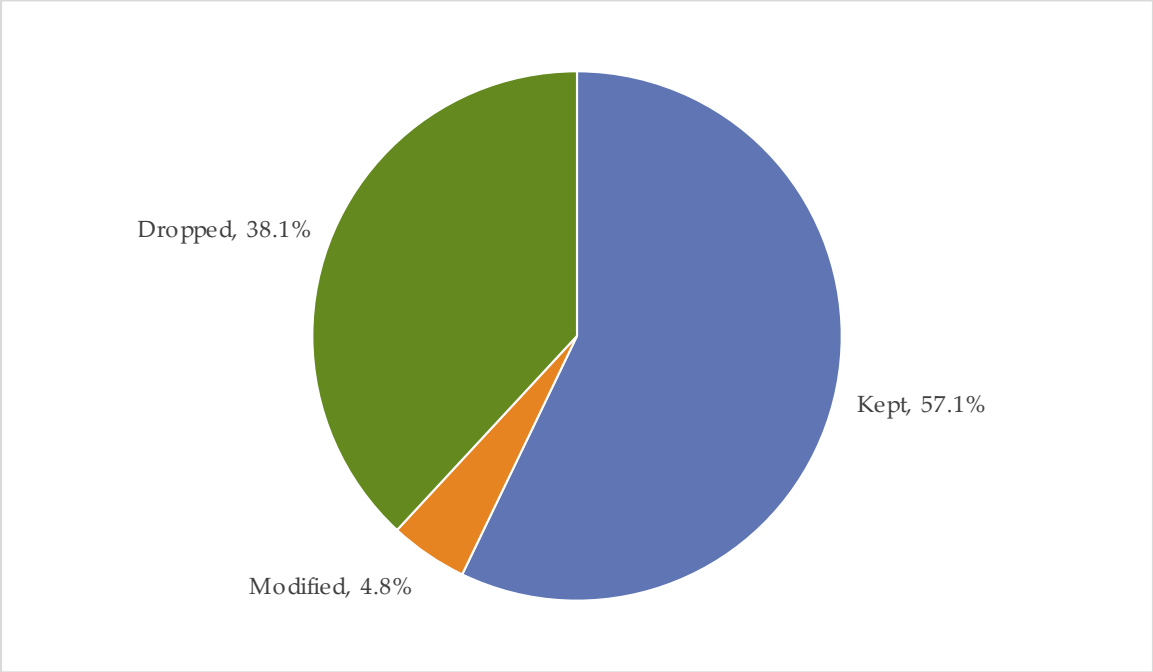


Comments:

- Modify to align with the revised PCPCH standards and tier structure.
- Modify for 2017 to reporting only measure, given significant changes in PCPCH standards / tiers.
- The current metric measures member assignment to recognized PCPCHs which does not directly correspond to an impact on access, utilization, or a member's receipt of the best care. These factors reflecting meaning and quality of health improvement and the measure could be modified as such.
- Will hit a ceiling with providers refusing to adopt EHRs.
- Drop if all CCOs are preforming well and improvement opportunities are minimal.
- Since CCOs are not mandated to pay clinics for achieving any tier medical home status, there is very little incentive currently for clinics to accept the administrative burden of becoming a medical home.
- Different weighting to new PCPCH standards to create a large financial incentive to have more practices at a higher tier. Additional weighting based on reports to items within care coordination and behavioral integration and public reporting of these specific standards.

Timeliness of Prenatal Care

n=21



Comments:

- Timely prenatal care is being compromised by delays in Medicaid enrollment for pregnant women. Until OHA can reliably enroll pregnant women in Medicaid within 48 hours of receiving a completed application, this should be removed from measurement strategy.
- Not all clinics provide prenatal care; not appropriate for tracking at clinic level.
- Small population is difficult to track.
- Allow CCOs to follow the HEDIS specifications and choose either the Estimated Delivery Date, or the Actual Delivery Date to calculate the first trimester. If not using the EDD, preterm deliveries should be excluded from the denominator.