Oregon Metrics and Scoring Committee

AGENDA

January 31, 2014
1:00 – 3:00 p.m.

Phone Meeting
Conference Line: Dial: 1-888-808-6929; Committee Code: 275474; Public Listen Only Code: 915042

For those who would like to attend in person:
421 SW Oak Street, Suite 850, Abraham Room
Portland, OR 97204

#	Time	Item	Presenter	Action Item
1	1:00 – 1:10 pm	Welcome • Consent Agenda	Bob Dannenhoffer	x
2	1:10 – 1:30 pm	Committee Bylaws	Lori Coyner	
3	1:30 – 1:45 pm	Updates • Dental Quality Metrics Workgroup • 2014 measure specifications • Guidance documents	Lori Coyner	
4	1:45 – 2:15 pm	Adopt remaining 2014 benchmarks • Colorectal cancer screening • Depression screening* • Diabetes: HbA1c poor control* *CCOs must meet benchmarks to qualify for challenge pool in 2014	Lori Coyner Michael Bailit	X
5	2:15 – 2:45 pm	Measurement Framework – continued discussion	All	
6	2:45 – 3:00 pm	Public testimony	Bob Dannenhoffer	
		Adjourn	Bob Dannenhoffer	

Next Meeting:
February 21, 2014
1:00 – 4:00 p.m.

- Adopt Committee bylaws
- Adopt dental measures for CY 2015

DRAFT

Oregon Metrics & Scoring Committee
Minutes
December 13, 2013
1:00 – 4:00 PM

ITEM
Welcome Committee members present: Maggie Bennington-Davis, Robert Dannenhoffer, Phil Greenhill, Bob Joondeph, David Labby, Jeff Luck. Not attending: Gloria Coronado, Jeanine Rodriguez. OHA Staff: Lori Coyner, Sarah Bartelmann, Ari Ettinger. Consultants: Michael Bailit, Bailit Health Purchasing.
Consent Agenda The Committee approved the November 25, 2013 meeting minutes. The Committee also agreed to schedule additional phone meetings in 2014 as needed, beginning with a meeting in January.
Updates Lori Coyner provided an update on the quality pool methodology webinar OHA hosted Thursday, December 12, 2013. • Webinar slides are available online here: www.oregon.gov/oha/CCOData/Quality%20Pool%20Webinar%20(Dec%202013).pdf • The updated quality pool methodology is available online here: www.oregon.gov/oha/CCOData/ReferenceInstructions.pdf OHA will schedule a repeat of this webinar in January for Committee members, Innovator Agents, and any CCOs who were unable to attend on the 12th. Committee members shared thoughts on CCO Summit held December 5, 2013. A video of the panel interview with CCO CEOs discussing reflections on their first year and moving forward is available online here: http://transformationcenter.org/cco-summit/
2014 Benchmarks and Improvement Targets Lori Coyner provided a summary of the Committee's November 25th decisions to adopt existing measures and specifications for a majority of measures and noted changes for 2014 for the remaining measures. The Committee adopted the following benchmarks and improvement targets for 2014:

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Oregon Metrics & Scoring Committee
Minutes
December 13, 2013
1:00 – 4:00 PM

Measure	2013 Benchmark	2014 Benchmark	2014 Improvement Target
Adolescent well care visits	53.2% *2011 National Medicaid 75th percentile (admin data only)*	57.6% *2013 National Medicaid 75th percentile (admin data only)*	Minnesota method[1] with 3 percentage point floor.
Alcohol and drug misuse (SBIRT)	13% *Committee consensus.*	13% unless CCOs demonstrate higher performance in 2013. Review in Q1 2014.	Minnesota method with 3 percentage point floor.
Ambulatory care: emergency dept. utilization	44.4/1,000 member months *2011 National Medicaid 90th percentile*	44.6/1,000 member months *2013 National Medicaid 90th percentile*	Minnesota method
CAHPS: Access to Care	87% *Average of the 2012 National Medicaid 75th percentiles for adult and child rates.*	88% *Average of the 2013 National Medicaid 75th percentiles for adult and child rates.*	Minnesota method with 2 percentage point floor.
CAHPS: Satisfaction with Care	84% *Average of the 2012 National Medicaid 75th percentiles for adult and child rates.*	89% *Average of the 2013 National Medicaid 75th percentiles for adult and child rates.*	Minnesota method with 2 percentage point floor.
Colorectal cancer screening	n/a – improvement target only	TBD by Committee in January 2014	n/a – benchmark only.
Developmental screening	50% *Committee consensus.*	50% *Committee consensus.*	Minnesota method.
Early elective delivery	5% or below *Committee consensus.*	5% or below *Committee consensus*	Minnesota method with 1 percentage point floor.

[1] Additional information about the Improvement Target methodology is available online at: http://www.oregon.gov/oha/CCOData/Improvement%20Targets%20--%20Revised%20September%202013.pdf

Electronic Health Record Adoption	49.2% *Federal benchmark for EHR adoption by 2014.*	72% *Committee consensus, based on highest performing CCO in July 2013.*	Minnesota method with 3 percentage point floor.
Follow up after hospitalization for mental illness	68% *2012 National Medicaid 90th percentile*	68.8% *2013 National Medicaid 90th percentile.*	Minnesota method with 3 percentage point floor.
Follow up for children prescribed ADHD medication (initiation rate)	51% *2012 National Medicaid 90th percentile*	51% *2013 National Medicaid 90th percentile*	Minnesota method.
Mental and physical health assessments for children in DHS custody	90% *Committee consensus.*	90% *Committee consensus.*	Minnesota method with 3 percentage point floor.
Patient Centered Primary Care Home (PCPCH) enrollment	Goal: 100% of members enrolled in Tier 3 PCPCH	Goal: 100% of members enrolled in Tier 3 PCPCH	n/a
Timeliness of prenatal care	69.4% *2012 National Medicaid 75th percentile, admin data only.*	90% *2013 National Medicaid 75th percentile*	Minnesota method.

The three clinical measures (depression screening, diabetes control, and hypertension control) will remain "pay for reporting" in 2014. CCOs will be required to submit an updated technology plan and expanded proof of concept data to "meet" these three measures. OHA will provide updated guidance in 2014. However, to qualify for the challenge pool on depression screening and diabetes control, the CCO will need to meet a benchmark. The Committee will establish benchmarks for these two measures in their next meeting.

Dental Metrics Workgroup Recommendation

Dr. Patrice Korjenek and Dr. Eli Schwarz presented the Dental Quality Metrics Workgroup recommendation of outcome and quality measures and benchmarks. They reviewed workgroup membership, charge, domains and criteria used.

Recommended CCO incentive measures include:

- Sealants on permanent molars for children age 6-9 and 10-14.
- Members age 2-21 receiving any dental service.

Recommended measures for performance monitoring include:

- Patient experience with access to dental care (two questions from the CAHPS dental survey).
- Topical fluoride intensity.
- Comprehensive exam rate.

The Committee discussed the lack of standardized measures for dental outcomes. The Committee was particularly interested in measures such as "improved oral health", "school absenteeism due to dental pain", "retaining teeth as long as possible" or "not having new cavities from one visit to the next."

The Committee also addressed whether dental measures should be pediatric or adult (or both), and whether dental metrics should be determined based on dental as a line of CCO business, or based on how oral health affects members' lives and health outcomes.

The Committee was very interested in whether or not the recommended dental metrics aligned with other metrics, with priority populations, and with the quality improvement focus areas for CCOs. The Committee highlighted the importance of measures that would "force" cooperation between dental and medical, to further integration and drive performance improvement.

The Committee did not make a decision about the recommended dental metrics in their December meeting, and have requested additional information for consideration at their next meeting, including:

- Exact methodology and specifications (including codes) for each of the recommended measures;
- Baseline data at the Dental Care Organization level for the recommended measures;
- Opportunities for dental metrics to align with current CCO measures, populations of interest, and other quality improvement efforts.

Measurement Framework

David Labby introduced the concept of a measurement framework that would help the Committee determine which domains, outcomes, and populations are represented in selected measures, and where there are gaps. This framework would help guide the Committee's future metric decisions: "given where we are trying to go as a state, what are we trying to measure, and will these measures tell us if we are getting there."

In January, the Committee will review the seven quality improvement focus areas and the criteria used to select the initial 17 CCO incentive measures, and continue developing a framework. Staff will provide the Committee with a brief overview of the various groups working on measure alignment.

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Public Testimony

No public testimony was provided.

Next Meeting

January 31, 2014 from 1:00 – 3:00 pm – by phone.

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Metrics & Scoring Committee

January 31, 2014

Oregon Health Authority

Consent Agenda

Committee Bylaws

OHA proposes the Metrics & Scoring Committee adopt bylaws for 2014 and beyond.

Draft bylaws are provided for Committee review and feedback.

The Committee will adopt bylaws at the February 21st meeting.

Oregon Health Authority

Updates

Oregon Health Authority

Dental Quality Metrics Workgroup

The Workgroup met in mid-January and will meet again in early February to continue to discuss the recommended dental metrics and alignment with the existing CCO incentive metrics.

The Workgroup will present again at the February 21st Metrics & Scoring Committee meeting.

2014 Measure Specifications

OHA has updated the specification sheets posted online for the 2014 CCO Incentive Measures.

These updated specification sheets incorporate:

- HEDIS 2012 --> HEDIS 2013.
- Hybrid specifications for colorectal cancer and prenatal care.
- New benchmarks.

2014 specification sheets are online at www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

Oregon Health Authority

Guidance Documents

OHA has provided new guidance documents for CCOs, including:

- Colorectal cancer screening (by 1/31)
- Revised prenatal care guidance (by 1/31)
- Technology Plan review criteria
- Proof of Concept data submission formats (by 1/31)

Documents are online at
www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

Oregon Health Authority

2014 Benchmarks

Oregon Health Authority

Summary

- In December, the Committee adopted benchmarks and improvement targets for the majority of the CCO incentive measures.
- The Committee still needs to determine a benchmark for colorectal cancer screening.
- The Committee also needs to determine a benchmark for the challenge pool for diabetes and depression.

Colorectal Cancer Screening

HEDIS does not use the Colorectal Cancer Screening measure for the Medicaid population and a national comparison benchmark is not readily available for the quality pool.

Three potential approaches to creating a Medicaid benchmark for the Colorectal Cancer Screening measure are presented for your consideration.

Challenge: no hybrid baseline for 2011 or 2013

As aspirational benchmark could be set, using an adjusted 75th percentile from option 1 or 2 (below).

- Con: no ability to set an improvement target between baseline and benchmark. To meet the measure, CCOs would have to meet the benchmark.

Alternately, a "floor" benchmark could be set, using an adjusted 25th or 50th percentile from option 1 or 2.

- Con: would be setting the benchmark without a sense of CCO performance; may set the benchmark too low or too high.

Colorectal Cancer Screening – Option 1

Create an adjustment factor based on the average difference between Medicaid and commercial rates for other cancer screening measures: breast cancer screening and cervical cancer screening.

Limitations:

- The populations are not the same.
- Colorectal cancer screening has a longer look back period.
- Average difference between Medicaid and commercial varies greatly by measure.

Colorectal Cancer Screening – Option 1

Two calculation options:

Approach	Adjustment Factor (% points)	2013 HEDIS commercial rate	Potential Benchmark
Average across all percentiles	12.059	75th percentile: 66.5% 50th percentile: 59.4% 25th percentile: 54.0%	75th: 54.4% 50th: 47.4% 25th: 41.9%
Average difference at a percentile	75th percentile: 9.825 50th percentile: 12.345 25th percentile: 15.875	75th percentile: 66.5% 50th percentile: 59.4% 25th percentile: 54.0%	75th: 56.6% 50th: 47.1% 25th: 38.1%

Oregon Health Authority

Colorectal Cancer Screening – Option 2

Create an adjustment factor based on the average difference between Medicaid and commercial rates for 34 measures with populations similar to the colorectal cancer screening measure.

Limitations

- Measures vary widely by clinical purpose: not limited to cancer screening or even prevention-focused measures.
- Colorectal cancer screening has a longer look back period.
- Average difference between Medicaid and commercial varies greatly by measure .

Colorectal Cancer Screening – Option 2

Two calculation options:

Approach	Adjustment Factor (% points)	2013 HEDIS commercial rate	Potential Benchmark
Average across all percentiles	6.376	75th percentile: 66.5% 50th percentile: 59.4% 25th percentile: 54.0%	75th: 60.1% 50th: 53.1% 25th: 47.6%
Average difference at a percentile	75th percentile: 5.566 50th percentile: 6.373 25th percentile: 6.440	75th percentile: 66.5% 50th percentile: 59.4% 25th percentile: 54.0%	75th: 60.9% 50th: 53.1% 25th: 47.5%

Oregon Health Authority

Colorectal Cancer Screening – Option 3

Set a benchmark using CDC-published national data on rates of adults aged 50-75 who received colorectal cancer screenings by family income level (2010).

Limitations:

- CDC data collected via survey, not claims or charts.
- 2010 data outdated.
- CDC data do not match exactly with Medicaid eligibility and may overstate the benchmark.

Colorectal Cancer Screening – Option 3

Family Income Level	Potential Benchmark
100%-199% FPL	47.5%

Oregon Health Authority

Diabetes: HbA1c Poor Control

Recommendation: Use national Medicaid 2013 percentiles

Note: lower is better for this measure.

National	Percentiles			
	25th	50th	75th	90th
	51%	43%	34%	28%

Oregon Health Authority

Depression Screening and Follow Up Plan

- Update from other states
- Other options?
- Recommendation: wait to set benchmark until proof of concept data are available to provide some context (June Committee meeting).

Measurement Framework Discussion

Oregon Health Authority

Public Testimony

Oregon Health Authority

Next Meeting

February 21, 2014

1:00 – 4:00 pm

Wilsonville Training Center

Oregon Health Authority

Oregon Metrics & Scoring Committee
Draft By-Laws

ARTICLE I
The Committee and its Members

- The Metrics & Scoring Committee ("Committee") is established by Oregon's 2012 Senate Bill 1580, Section 21. The Committee's function is to identify objective outcome and quality measures and benchmarks for health services provided by coordinated care organizations, consistent with the Committee's Charter, and as further determined by the Oregon Health Authority.

- The Members of the Committee will be appointed by, and serve at the pleasure of, the Director of the Oregon Health Authority. Committee members will be appointed by the Director for an initial 2-year term. Committee members may be re-appointed at the discretion of the Director for 1-year terms, for a total of 4 years on the Committee.

- Members of the Committee are not entitled to compensation for services but shall be reimbursed for actual and necessary travel expenses incurred by them by their attendance at committee meetings, in the manner and amount provided in ORS 292.495.

ARTICLE II
Committee Officers and Duties

- The Committee shall select a Chair from among its members. The Chair will serve for 12-months from the date of their election.

- Duties of the Chair are:
  - Preside at all meetings of the Committee.
  - Coordinate meeting agendas after consultation with Committee staff.
  - Review all draft Committee meeting minutes prior to the meeting at which they are to be approved.
  - Be advised of all presentations or appearances before legislative committees that relate to the work of the Committee.
  - The Chair may designate other Committee Members to perform duties related to Committee business such as, but not limited to, attending other agency or public meetings, meetings of the Board, training programs, and approval and review of documents that require action of the Chair.

- The Committee shall select a Vice-Chair from among its members. The Vice-Chair will serve for 12-months from the date of their election.

- Duties of the Vice Chair are:
  - Perform all of the Chair's duties in his/her absence or inability to perform;

- Perform any other duties assigned by the chair.

ARTICLE III
Committee Meetings

- The Committee shall meet at least quarterly and more frequently at the call of the Chair in consultation with the Committee Members and staff.

- The Committee shall conduct all business meetings in public and in conformity with Oregon Public Meetings Laws.

- The preliminary agenda will be available from the Committee staff and posted on the Committee website [*http://www.oregon.gov/oha/Pages/metrix.aspx*] at least two working days prior to the meeting.

- A majority of Committee Members shall constitute a quorum for the transaction of business.

- As a general rule, the Committee will conduct its business through discussion and consensus. In cases where consensus cannot be achieved, a vote may be used. Use of a vote and its results will be recorded in the meeting minutes. Official action by the Committee requires the approval of a majority of a quorum of Members.

- When voting on motions, resolutions, or other matters, a voice or electronic vote may be used. At the discretion of the Chair, or upon the request of a Committee Member, a roll call vote may be conducted. Proxy votes are not permitted.

- If a Committee Member is unable to attend a meeting in person, the Member may participate by conference telephone or internet conferencing provided that the absent Committee Member can be identified when speaking, all participants can hear each other and members of the public attending the meeting can hear any Member of the Committee who speaks during the meeting. A Committee Member participating by such electronic means shall be considered in constituting a quorum.

- Committee Members shall inform the Chair, Vice-Chair, or Committee staff with as much notice as possible if unable to attend a scheduled Committee meeting. Committee staff preparing the minutes shall record the attendance of Committee Members at the meeting for the minutes.

- The Committee will conduct its business through discussion, consensus building and informal meeting procedures. The Chair may, from time to time, establish procedural processes to assure the orderly, timely and fair conduct of business.

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- The by-laws in this section apply to the full Committee and any subcommittees or designated workgroups.

ARTICLE IV

Amendments to the By-Laws and Rules of Construction

- These By-laws may be amended upon the affirmative vote of five (5) Members of the Committee.

DRAFT

bailit health PURCHASING

56 Pickering Street Needham, MA 02492 T: (781)453-1166 F: (781)453-1167 www.bailit-health.com

TO: Oregon Health Authority
FROM: Michael Bailit and Kate Bazinsky
DATE: January 22, 2014
RE: Colorectal Cancer Screening Measure Adjustment Factor Options-Revised

This memo serves as a revision to that previously sent on January 10, 2014. It incorporates HEDIS 25th and 50th national percentile values into Options 1 and 2.

Introduction

Oregon Health Authority (OHA) included the HEDIS Colorectal Cancer Screening measure in its CCO incentive measure year for CY 2013. However, HEDIS does not define the Colorectal Cancer Screening measure for use with the Medicaid population. As a result, OHA did not have a HEDIS national comparison benchmark readily available for the quality incentive pool. For CY 2013 OHA only defined a 3% improvement target for the CCOs.

For CY2014 OHA is again considering using the commercially-insured population benchmark that NCQA publishes annually to calculate a performance target for Colorectal Cancer Screening and requested that Bailit provide options for constructing such a target.

Options for Constructing a Performance Target for Colorectal Cancer Screening

We have identified three potential approaches to creating a Medicaid benchmark for the Colorectal Cancer Screening measure.

1. Create an adjustment factor to apply to commercially-insured population data that is based on the average difference between Medicaid and commercial rates for cancer screening measures.
2. Create an adjustment factor to apply to commercial data that is based on the average difference between Medicaid and commercial rates for a subset of measures focused on patient populations similar to that targeted by the Colorectal Cancer Screening measure.
3. Set a benchmark using data from the Centers for Disease Control and Prevention.

We note that all of three of the identified approaches have limitations that OHA will have to acknowledge if it chooses to set a benchmark using one of the aforementioned methodologies.

Option 1: Create an adjustment factor to apply to the commercially-insured population data that is based on the average difference between Medicaid and commercial rates for cancer screening measures. There are currently two other HEDIS cancer screening measures that are used in both the commercial and Medicaid populations: Breast Cancer Screening and Cervical Cancer Screening. Two approaches may be used to calculate the

adjustment factor: it may be calculated by taking the average of the average differences across all of the percentiles or by considering only the average difference at the 75th percentile, the 50th percentile and the 25th percentile. The adjustment factors are provided in Table 1 below.

Table 1: Adjustment factors calculated using Option 1

Approach	Adjustment Factor (% points)	2013 HEDIS rate	Potential Benchmark
Average across all percentiles (75th percentile)	12.059	75th: 66.46%	54.401%
Average across all percentiles (50th percentile)	12.059	50th: 59.44%	47.381%
Average across all percentiles (25th percentile)	12.059	25th: 53.97%	41.911%
Average difference at the 75th percentile	9.825	75th: 66.46%	56.635%
Average difference at the 50th percentile	12.345	50th: 59.44%	47.095%
Average difference at the 25th percentile	15.875	25th: 53.97%	38.095%

Limitations of Option 1:

1. The populations are not the same. The populations included in these screening measures are limited to women who fall within wider age ranges.
2. Colorectal Cancer Screening has a much longer "look back" period than do either Breast or Cervical Cancer Screening.
3. The average difference between Medicaid and commercial varies greatly by measure. There is a much larger discrepancy (more than twice as large at some percentiles) between the commercial and Medicaid population rates for Breast Cancer measure than for the Cervical Cancer measure. Bailit would feel more confident using this adjustment factor if the rates were similar across both measures.

Option 2: Create an adjustment factor to apply to the commercial data that is based on the average difference between Medicaid and Commercial rates for a subset of measures with populations similar to the Colorectal Cancer Screening measure. Bailit created a subset of HEDIS measures based on the following criteria:

1. The measure must be reported for both the Medicaid and commercial populations.
2. The age range for the measure must overlap with the age range for the Colorectal Screening measure (e.g., no Childhood Immunizations and Chlamydia Screening).
3. The measure must be clinically-focused (e.g., no utilization or patient experience measures).
4. The measure must be collected through either administrative or hybrid method (e.g., no survey-based measures).

Applying these criteria to all of the HEDIS measures reported in 2013, Bailit identified 34 measures for inclusion and calculated the average difference between the Medicaid and commercial populations using two different approaches: taking the average of the average differences across all of the percentiles and by taking the average difference at the 75th percentile, the 50th percentile and the 25th percentile. The adjustment factors a across the three benchmarks vary far less than those considered for Option 1. The adjustment factors are provided in Table 2 below.

Table 2: Adjustment factors calculated using Option 2

Approach	Adjustment Factor (% points)	2013 HEDIS rate	Potential Benchmark
Average across all percentiles (75th percentile)	6.376	66.46%	60.084%
Average across all percentiles (50th percentile)	6.376	59.44%	53.064%
Average across all percentiles (25th percentile)	6.376	53.97%	47.594%
Average difference at the 75th percentile	5.566	66.46%	60.894%
Average difference at the 50th percentile	6.373	59.44%	53.067%
Average difference at the 25th percentile	6.440	53.97%	47.530%

Limitations of Option 2:

1. The measures included in the subset vary widely by clinical purpose. They are not just limited to cancer screening measures or even prevention-focused measures.
2. Colorectal Cancer Screening has a much longer "look back" period than do any of the other measures.
3. The average difference between Medicaid and commercial varies greatly by measure. While on the whole, the commercial rates are still generally higher than the Medicaid rates, on specific measures (e.g., Annual Monitoring for Patients on Persistent Medications) Medicaid plans outperform health plans serving the commercial population. This suppresses the average difference and reduces Bailit's confidence in the adjustment factor.

Option 3: Set a benchmark using data from the Centers for Disease Control and Prevention (CDC). The CDC published rates of adults aged 50-75 who received colorectal cancer screenings by income family level in 2010.[1] For those individuals at or

[1] Centers for Disease Control and Prevention. QuickStats: Percentage of Adults Aged 50–75 Years Who Received Colorectal Cancer Screening,* by Family Income Level† — National Health Interview Survey, United States, 2010§. Morbidity and Mortality Weekly Report. November 23, 2012 / 61(46); 955. Accessed online on January 8, 2014 at

below 138% of FPL, and therefore eligible for Medicaid in Oregon, the rate of screening is approximately 48%.

Family Income Level	Potential Benchmark
Below federal poverty level (FPL)	38.7%
100%-199% FPL	47.5%
200%-399% FPL	57.4%
400%-599% FPL	63.9%
>=600% FPL	72.9%

Limitations of Option 3:

1. The CDC data is collected through a survey tool whereas the HEDIS data and the rates that will be collected in the context of the CCO incentive program rely on claims data.
2. The CDC data uses 2010 data which is several years old at this point.
3. The CDC data do not match exactly with Medicaid eligibility and therefore my slightly overstate the benchmark.

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www.cdc.gov/mmwr/preview/mmwrhtml/mm6146a10.htm. Also, personal communication with David T. Huang, CDC, National Center for Health Statistics, January 9, 2014.

CCO Incentive Measures by Quality Improvement Focus Areas

January 31, 2014

Note CCO incentive measures are listed in multiple focus areas.

Quality Improvement Focus Areas	CCO Incentive Metrics
Reducing rehospitalizations	• Follow up after hospitalization for mental illness • Ambulatory Care: outpatient and ED utilization
Addressing discrete health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers.	• Controlling high blood pressure • Diabetes: HbA1c poor control
Reducing utilization by "super-utilizers"	• Ambulatory Care: outpatient and ED utilization
Integrating primary care and behavioral health	• Alcohol and drug misuse (SBIRT) • Follow up after hospitalization for mental illness • Screening for clinical depression and follow up plan • Mental and physical health assessments within 60 days for children in DHS custody • Follow up care for children prescribed ADHD medications
Ensuring appropriate care is delivered in appropriate settings	• Ambulatory Care: outpatient and ED utilization
Improving perinatal and maternity care	• Timeliness of prenatal care • Early elective delivery
Improving primary care for all populations	• Colorectal cancer screening • Patient Centered Primary Care Home enrollment • Developmental screening • Adolescent well care visits

Additional Focus Areas	CCO Incentive Metrics
Improving access to timely and effective care	CAHPS Access to care
Addressing patient satisfaction with health plans	CAHPS Satisfaction with care
Meaningful Use	Electronic Health Record adoption

Eight Drivers – CoverOregon Framework

January 21, 2014

1. Addressing discrete health issues (e.g., diabetes, hypertension, asthma) within a specific geographic area by harnessing and coordinating broad set of resources, including community workers

2. Optimizing health care utilization, including:
    a. Promoting use of appropriate procedures and medications
    b. Reducing re-hospitalizations
    c. Intervening with "super utilizers"
    d. Improving care at the end of life

3. Integrating primary and behavioral health

4. Ensuring appropriate care is delivered in appropriate settings

5. Improving perinatal and maternity care

6. Improving health and wellness for all populations, including:
    a. Across the age span
    b. Across demographic groups (equity)
    c. Promoting wellness

7. Providing care that is free of harm

8. Providing patient-centered care