

# 2016 Measure Selection To-Date

Oregon Metrics & Scoring Committee

This document summarizes the 2016 CCO incentive measure decision making and requests for additional information from the Metrics & Scoring Committee's June 19, 2015 meeting.

Current 2015 Incentive Measures	2016 Incentive Measure?	Discussion
Adolescent well care visits	Yes	Consider adolescent SBIRT as a 2016 challenge pool measure – will drive SBIRT and adolescent well care visits.
Alcohol and other substance misuse (SBIRT)	Yes	
Ambulatory care: emergency department utilization	Yes	Potential measure for future refinement (e.g., focus on specific conditions driving ED utilization) or replace with avoidable ED utilization.
Assessments for children in DHS custody	Yes	
CAHPS: Access to care	Yes	
CAHPS: Satisfaction with care	Yes	
Colorectal cancer screening	Pending	Provide summary of CCO feedback on the chart review process from TAG.
Clinical quality measures: <ul style="list-style-type: none"> <li>Controlling high blood pressure</li> <li>Depression screening &amp; follow-up</li> <li>Diabetes: HbA1c poor control</li> </ul>	Yes	
Dental sealants	Yes	
Developmental screening	Yes	Revisit measure after Child & Family Wellbeing Measures Workgroup wraps up: how can we move from screening to services provided, community access, etc.
Effective contraceptive use	Yes	
EHR adoption	Pending	Review current CCO data; is there value in adopting a modification to the measure (e.g., EHR adoption by stage)? How can we continue to raise the bar rather than dropping the measure?
Follow-up after hospitalization for mental illness	Yes	
PCPCH enrollment	Pending	Review current CCO data; when do we know we have topped out on this?
Prenatal care	Yes	

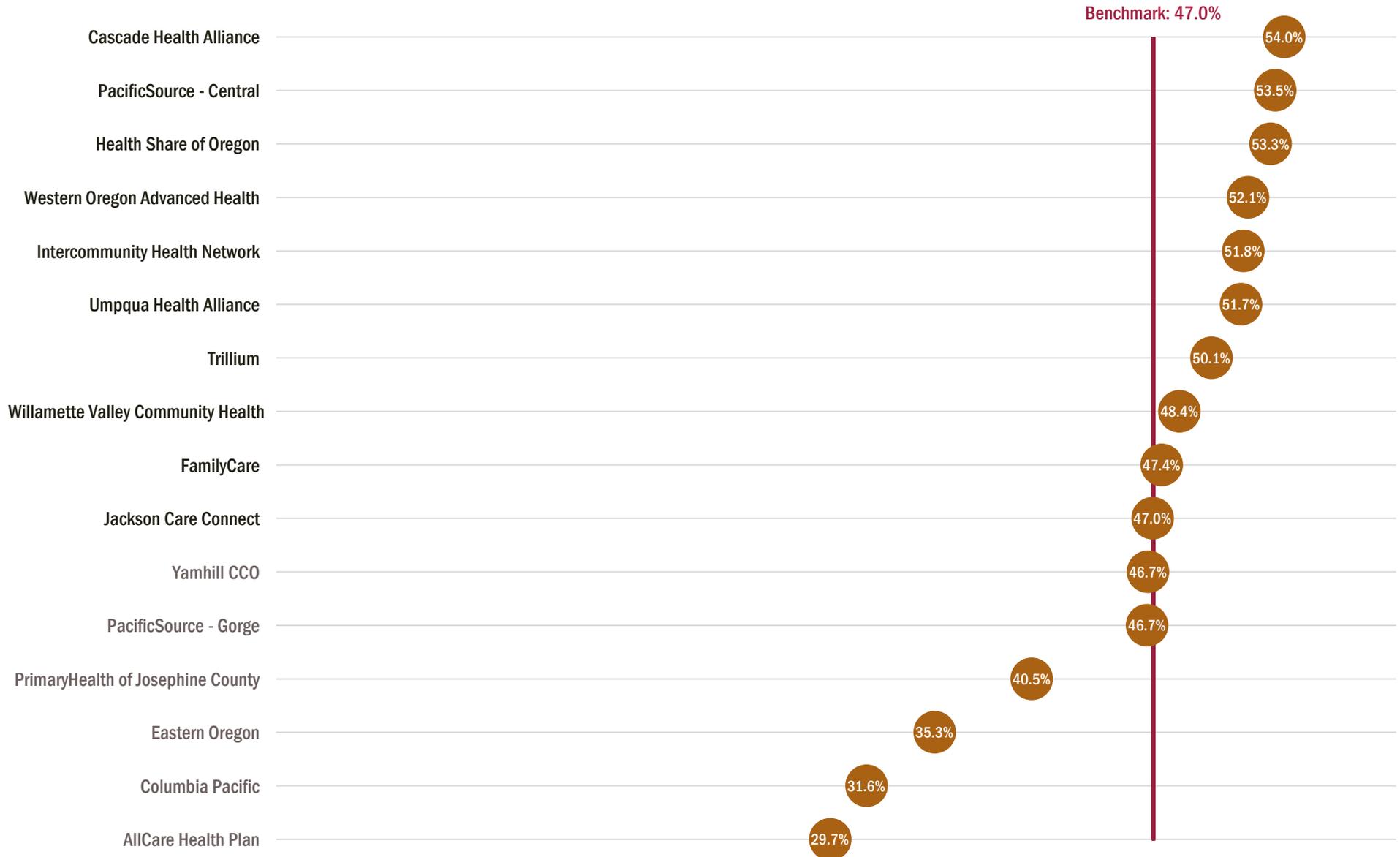


# COLORECTAL CANCER SCREENING

Ten of 16 CCOs met the benchmark for colorectal cancer screening in 2014.

**Bolded** names met benchmark. This measure does not have an improvement target for 2014.

2014 data are not comparable to earlier years due to changed methodology.



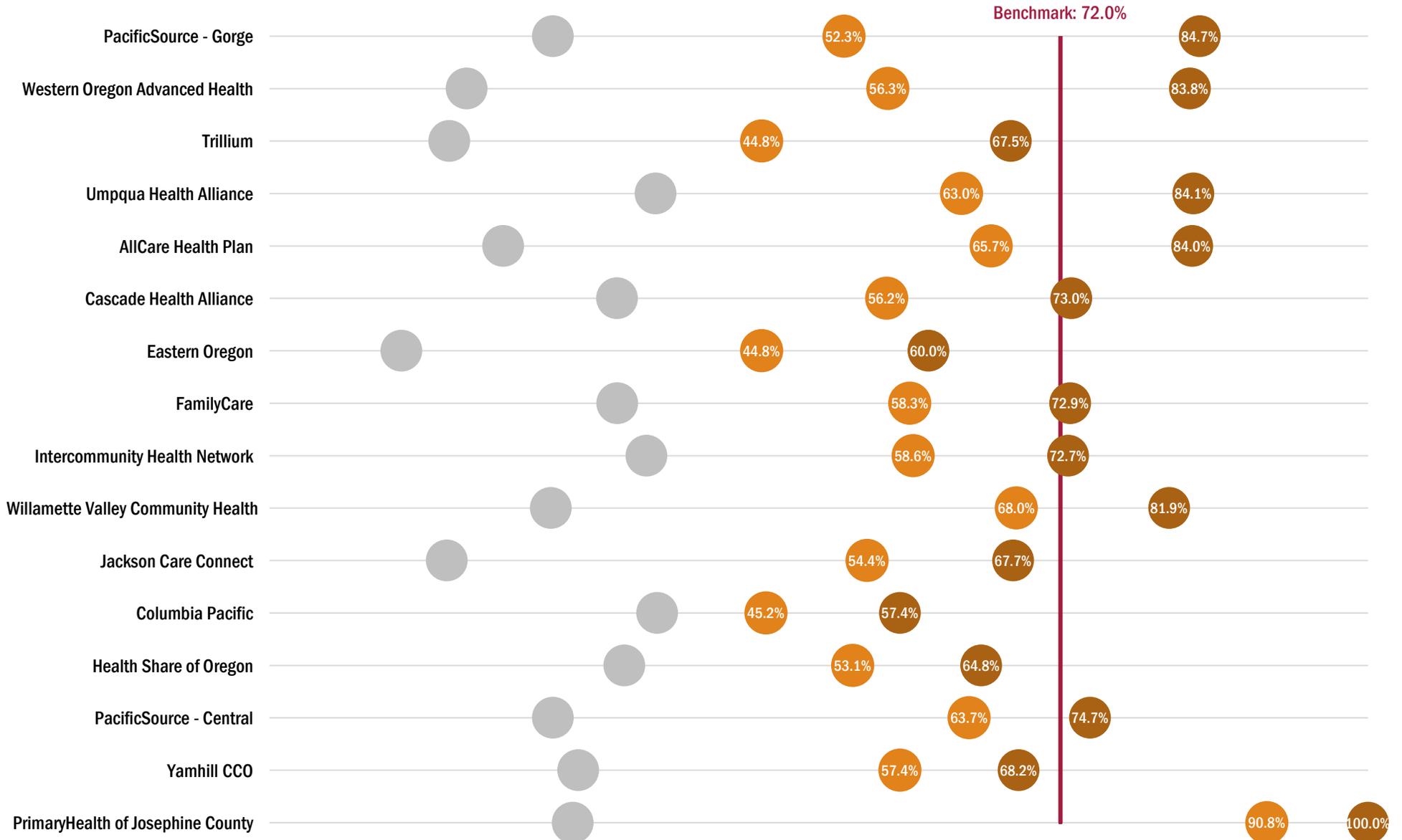


# ELECTRONIC HEALTH RECORD ADOPTION

All 16 CCOs increased electronic health record adoption between 2013 and 2014, and 10 achieved the benchmark.

All CCOs met benchmark or improvement target.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



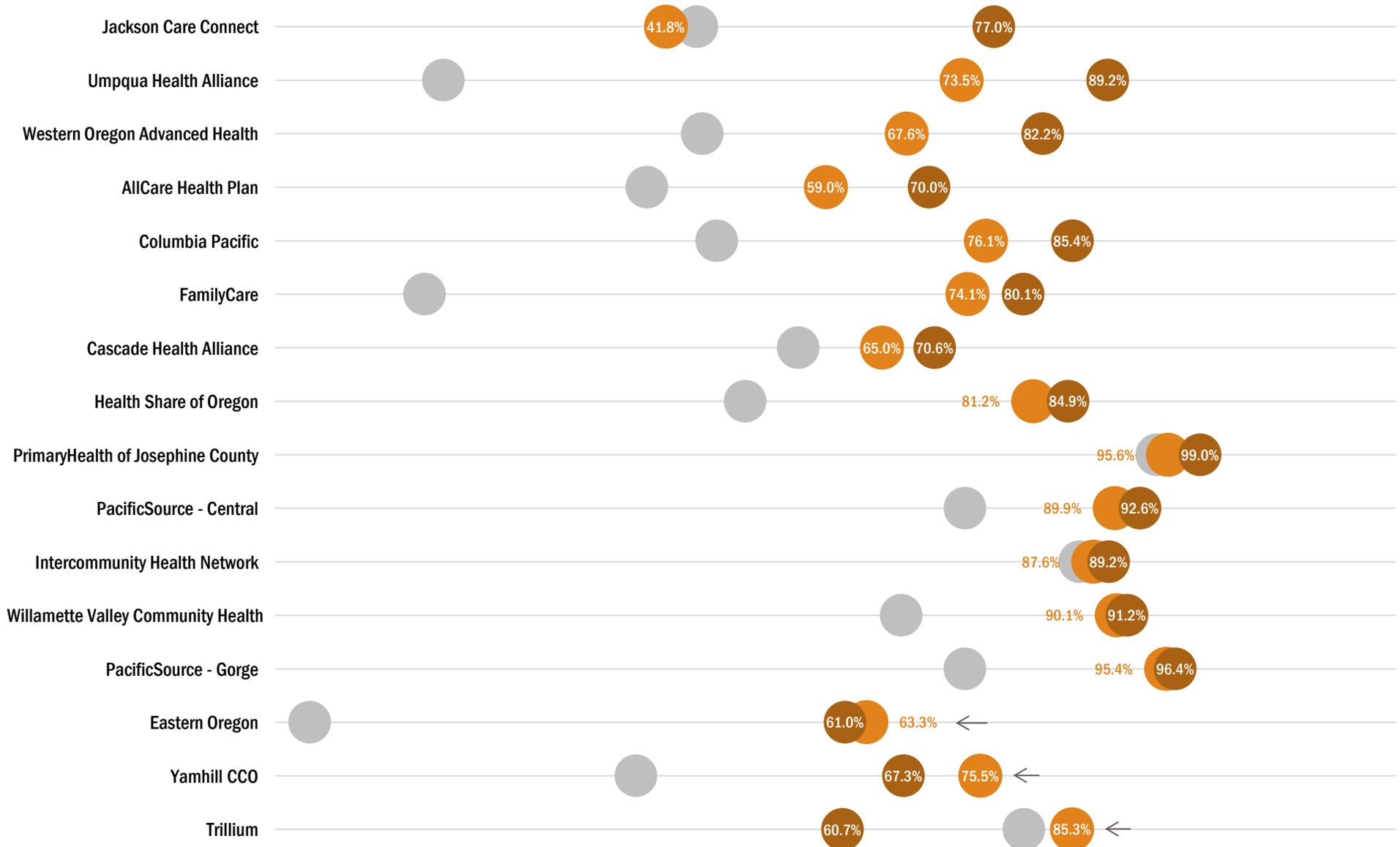


# PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Overall, PCPCH enrollment continued to increase between 2013 and 2014.

All CCOs met requirement for quality pool payment (at least 60% enrollment).

Gray dots represent 2012 baselines, which are pre-CCO and based upon a predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.

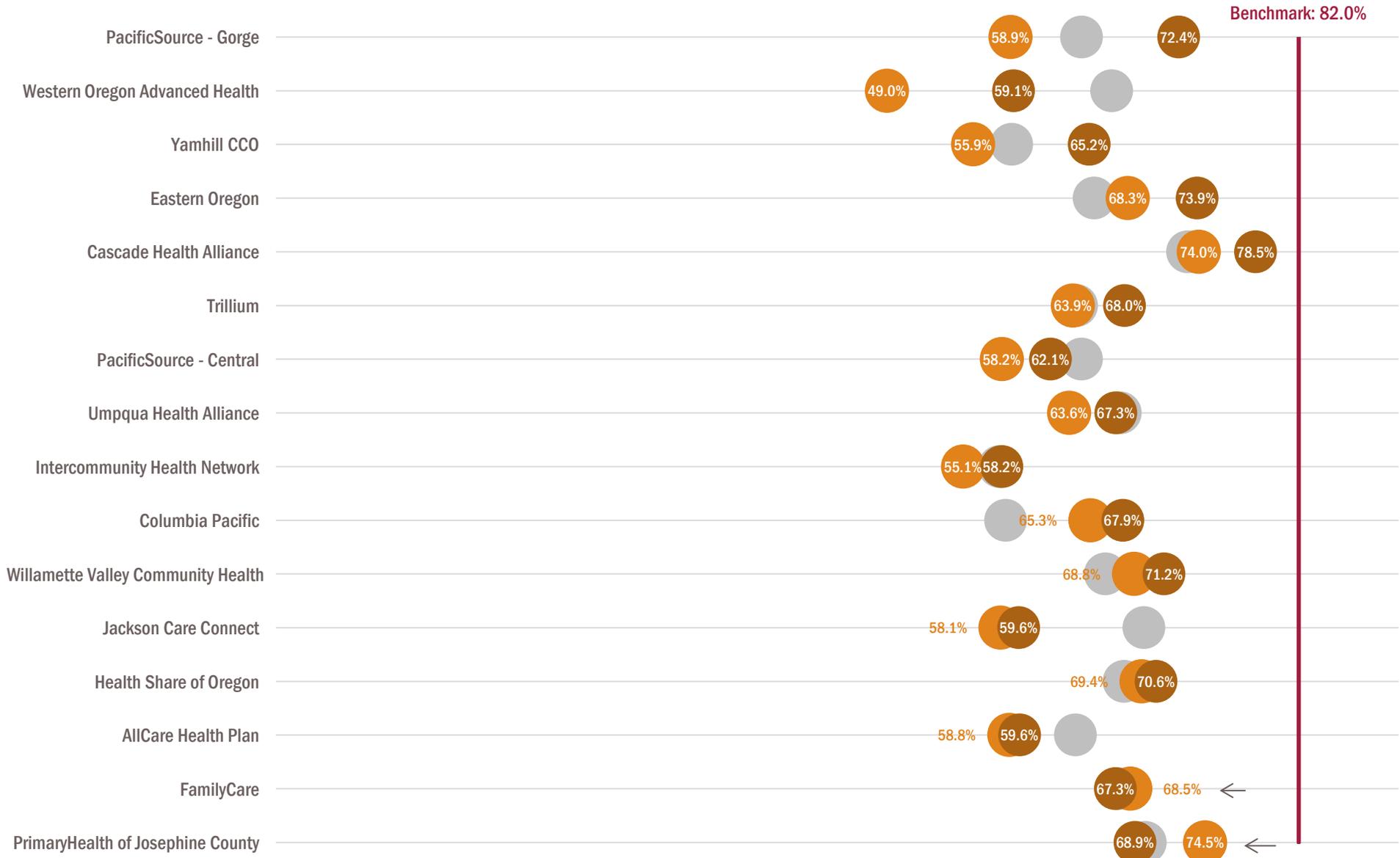




# CHILDHOOD IMMUNIZATION STATUS

Fourteen of 16 CCOs improved childhood immunizations between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



# PQI 92 COMPOSITE

PQI 92 CCO performance between 2013 & 2014.



## Tobacco Use Prevalence (Bundled Measure)

### Measure Basic Information

**Name and date of specifications used:** OHA developed these specifications based on the Meaningful Use standards required for electronic health records in 2014, as well as the clinical practice guidelines for treating tobacco use and dependence and the ACA-recommended tobacco cessation benefits.

**URL of Specifications:**

- Meaningful Use standards for recording tobacco use status:  
[http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/9\\_Record\\_Smoking\\_Status.pdf](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/9_Record_Smoking_Status.pdf)
- Treating Tobacco Use and Dependence, 2008 Update:  
[http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/treating\\_tobacco\\_use08.pdf](http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/treating_tobacco_use08.pdf)
- Departments of Health and Human Services, Labor and Treasury FAQ regarding implementation of various provisions of the Affordable Care Act, May 2, 2014:  
<http://www.dol.gov/ebsa/faqs/faq-aca19.html>

**Measure Type:**

HEDIS  PQI  Survey  Other  Specify: OHA-developed, bundled measure / Meaningful Use.

**Measure Utility:**

CCO Incentive  Core Performance  CMS Adult Set  CHIPRA Set  State Performance   
Other  Specify:

**Data Source:** Electronic Health Records, **cessation benefit survey TBD**

**Measurement Period:** 2016

Note OHA will publish a preferred measurement period for Year Four data submission for all clinical quality measures, include tobacco prevalence.

OHA will also provide CCOs with an option to submit EHR-based tobacco prevalence data as part of the Year Three data submission for a trial run.

**2016 Benchmark:** TBD by Metrics & Scoring Committee

*Suggestions from TAG include considering regional benchmarks, based on variations in prevalence across the state (i.e., not reasonable to expect coastal Oregon, with very high prevalence, to meet the same benchmark as metro areas).*

## Measure Details

This bundled measure is intended to address both cessation benefits offered by coordinated care organizations and tobacco prevalence. To meet the bundled measure and earn quality pool dollars, CCOs will have to meet all of the following criteria:

- 1) Meet minimum cessation benefit requirements ('cessation benefit floor'); AND
- 2) Submit EHR-based tobacco prevalence data according to data submission requirements; AND
- 3) Meet tobacco prevalence benchmark or improvement target established by the Metrics & Scoring Committee.

The intent of the measure is to address tobacco prevalence (including cigarette smoking and other tobacco products, such as chew, snuff, and cigars, and excluding e-cigarettes and those using nicotine replacement products such as patches).

Due to variation in how EHRs capture smoking and tobacco use data and to ensure comparability of prevalence across EHRs and CCOs, the data submission component of the measure will be looking for two separate rates: (1) cigarette smoking; and (2) tobacco use. As not all EHRs will be able to report on tobacco use, only the cigarette smoking prevalence will be used for comparison to the benchmark or improvement target.

OHA will report on both cigarette smoking and tobacco use prevalence separately.

### Cessation Benefits Floor

OHA will assess each CCO's cessation benefits annually to determine if CCOs meet the floor. The floor has been established by OHA, based on clinical practice guidelines and the Affordable Care Act.

*Survey modality and timing TBD.*

**DRAFT cessation benefit floor:**

Counseling	FDA approved cessation medications	Increase access to cessation benefit
<input type="checkbox"/> Individual	<input type="checkbox"/> Nicotine gum	<input type="checkbox"/> No prior authorization to access nicotine gum and nicotine patch
<input type="checkbox"/> Group	<input type="checkbox"/> Nicotine patch	<input type="checkbox"/> No copayments, coinsurance, or deductibles
<input type="checkbox"/> Telephone	<input type="checkbox"/> Nicotine lozenge	<input type="checkbox"/> No annual or lifetime dollar limits
	<input type="checkbox"/> Nicotine nasal spray	<input type="checkbox"/> Offer at least two quit attempts per year
	<input type="checkbox"/> Nicotine inhaler	
	<input type="checkbox"/> Bupropion SR	
	<input type="checkbox"/> Varenicline	

*Cessation benefit floor re: cessation medication needs to clarify a minimum quantity of each product that would cover at least two quit attempts per year.*

## EHR-based Prevalence

CCOs must meet data submission criteria for Year Four, to be published no later than October 2016. Year Four data must be submitted no later than April 1, 2017.

CCOs will have the opportunity to submit tobacco prevalence data as a test as part of the Year Three data submission. OHA will publish guidance no later than October 2015.

*Other details on data submission process TBD.*

**Data elements required denominator:** Unique patients 13 years old or older who were seen by the provider during the measurement period. If a patient is seen by the provider more than once during the measurement period, for the purposes of measurement, the patient is only counted once in the denominator.

*Clarification on Medicaid beneficiaries only versus data for the entire patient population in line with the Years Three and Four data submission guidance TBD.*

**Required exclusions for denominator:** None.

**Deviations from cited specifications for denominator:** None.

**Data elements required numerator:** Unique patients 13 years old or older who were seen by the provider during the measurement period, who have their smoking and/or tobacco use status recorded as structured data, who are current smokers and/or tobacco users. Numerator data must be submitted in two separate rates: (1) cigarette smoking only; (2) broader tobacco use.

### Step 1: smoking / tobacco use status recorded as structured data

Ideally, smoking / tobacco use status of the patient is recorded as structured data in the EHR in accordance with the Meaningful Use standard criteria §170.207(h):

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Smoker, current status unknown
- Unknown if ever smoked
- Heavy tobacco smoker
- Light tobacco smoker

However, smoking / tobacco use status could also be recorded as structured data in the EHR in other ways, including, but not limited to:

- Tobacco use status: yes / no / unknown
- Tobacco use status: yes / never / not asked / quit / passive

Tobacco use status noted as free text narrative in a patient's chart is unlikely to be recorded as structured data. The intent of this bundled measure is to utilize the EHR functionality to extract structured data via custom query, rather than manually conducting a chart review of the electronic records to identify tobacco users.

Step 2: those who are current smokers / tobacco users

Of those patients age 13 years and older, who have their smoking / tobacco use status recorded as structured data within the EHR:

- Current every day smoker
- Current some day smoker
- Smoker, current status unknown
- Heavy tobacco smoker
- Light tobacco smoker

Additionally, any combination of “yes” responses based on the individual EHR’s functionality for recording smoking / tobacco use status as structured data also qualifies as a positive numerator event.

*Clarification of the two rates and which categories roll up into which rate.*

**Required exclusions for numerator:** None.

**Deviations from cited specifications for numerator:** None.

**What are the continuous enrollment criteria:** There are no continuous enrollment criteria required for this measure.

Where possible, CCOs should apply the eligibility rule of ‘eligible as of the last date of the reporting period’ to identify beneficiaries. **Clarification on Medicaid beneficiaries only versus data for the entire patient population in line with the Years Three and Four data submission guidance TBD.**

**What are allowable gaps in enrollment:** N/A

**Define Anchor Date (if applicable):** N/A

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# CCO PRIORITIES FOR COMMUNITY HEALTH IMPROVEMENT PLANS

Coordinated care organizations (CCOs) were required to complete community health improvement plans by June 2014. Completed plans included a number of priority areas that can be categorized into five domains. The top priorities in these domains are summarized here.

## CLINICAL

Priorities in this domain include integration of mental health, mental health and substance abuse, access to care, oral health, chronic pain, provider capacity, high utilizers, community health workers and care coordination.

### Top clinical priorities:

- Substance abuse, mental health, mental health integration (14 CCOs)
- Access to care (8 CCOs)
- Oral, dental health (7 CCOs)

## EQUITY

Priorities in this domain include addressing health equity, social determinants of health, socioeconomic disparities, member engagement, health literacy, cultural competency and language access.

### Top equity priorities:

- Health equity, health disparities, social determinants of health (7 CCOs)

## OTHER

Other priority areas referenced in the Community Health Improvement Plans include developing community advisory councils (3 CCOs), community-based participatory research (1 CCO), and fundraising / funding for CHIP priorities (1 CCO).

## PUBLIC HEALTH

Priorities in this domain include a focus on early childhood, healthy beginnings, maternal and perinatal health, chronic disease prevention and management, tobacco and obesity.

### Top public health priorities:

- Early childhood, maternal health, healthy beginnings, perinatal, at-risk youth (12 CCOs)
- Chronic disease prevention and/or management (6 CCOs)
- Tobacco (5 CCOs)
- Obesity, healthy lifestyle (5 CCOs)

## SOCIAL DETERMINANTS

Priorities in this domain include a focus on housing, the built environment, food insecurity, insurance, employment, safety and transportation.

### Top social determinants priorities:

- Housing, healthy living, built environment (7 CCOs)

## FOR MORE INFORMATION

Additional information about the Community Health Improvement Plans is available from the Transformation Center. Please contact:

Anona Gund at [anona.e.gund@state.or.us](mailto:anona.e.gund@state.or.us) or  
Adrienne Mullock at [adrienne.p.mullock@state.or.us](mailto:adrienne.p.mullock@state.or.us).