
Metrics & Scoring Committee

May 15, 2015

The logo for the Oregon Health Authority is centered at the bottom of the slide. It features the word "Oregon" in a smaller, orange, sans-serif font above the word "Health" in a large, blue, serif font. Below "Health" is the word "Authority" in a smaller, orange, sans-serif font. The entire logo is set against a light blue, curved background that spans the width of the slide.

Oregon
Health
Authority



Consent agenda

Legislative update

SB 440

SB 832

HB 2027



Final 2014 metrics

OHA released CY 2014 data and final 2014 quality pool size to CCOs on April 30th.

CCOs have until May 31st to submit any questions or validation requests.

OHA will finalize data and calculating final quality pool distribution in June.

Final 2014 report to be published June 24th.

Public testimony





Patient-Centered Primary Care Home Program Update

Nicole Merrithew, MPH
PCPCH Program Director

PATIENT  **CENTERED**
PRIMARY CARE HOME PROGRAM

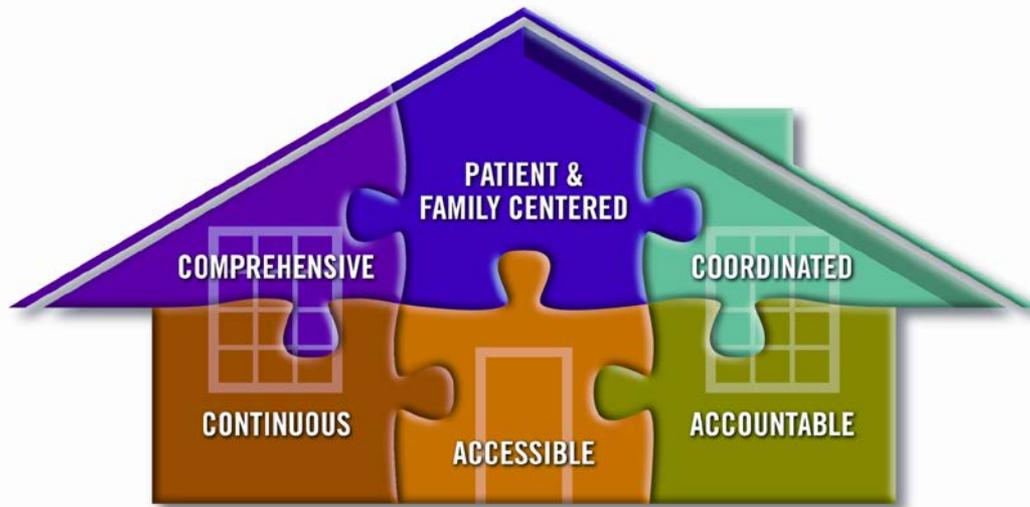
Oregon
Health
Authority

Patient-Centered Primary Care Home Program

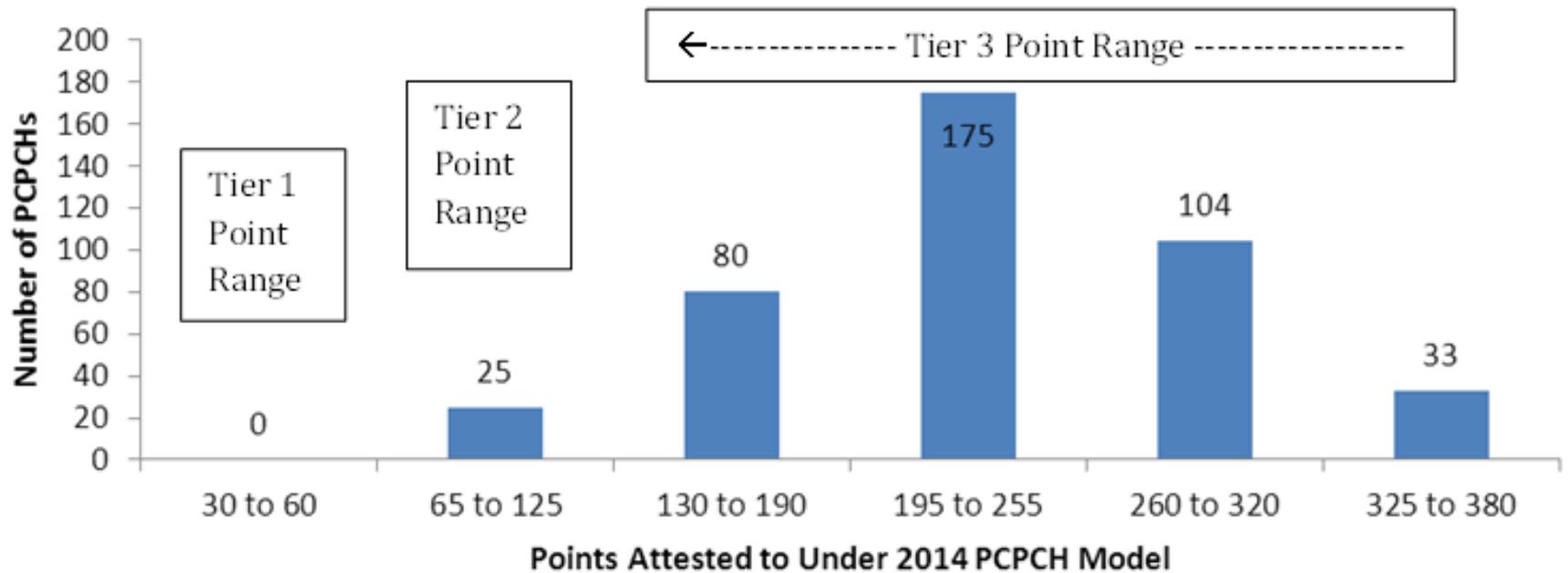
- HB 2009 established the PCPCH Program:
 - ***Create access to patient-centered, high quality care and reduce costs by supporting practice transformation***
- Key PCPCH program functions:
 - PCPCH recognition and verification
 - Refinement and evaluation of the PCPCH standards
 - Technical assistance development
 - Communication and provider engagement
- Goals:
 - All OHA covered lives receive care through a PCPCH
 - 75% of all Oregonians have access to a PCPCH by 2015
 - Align primary care transformation efforts by spreading the model to payers outside the OHA

Oregon's Primary Care Home Model

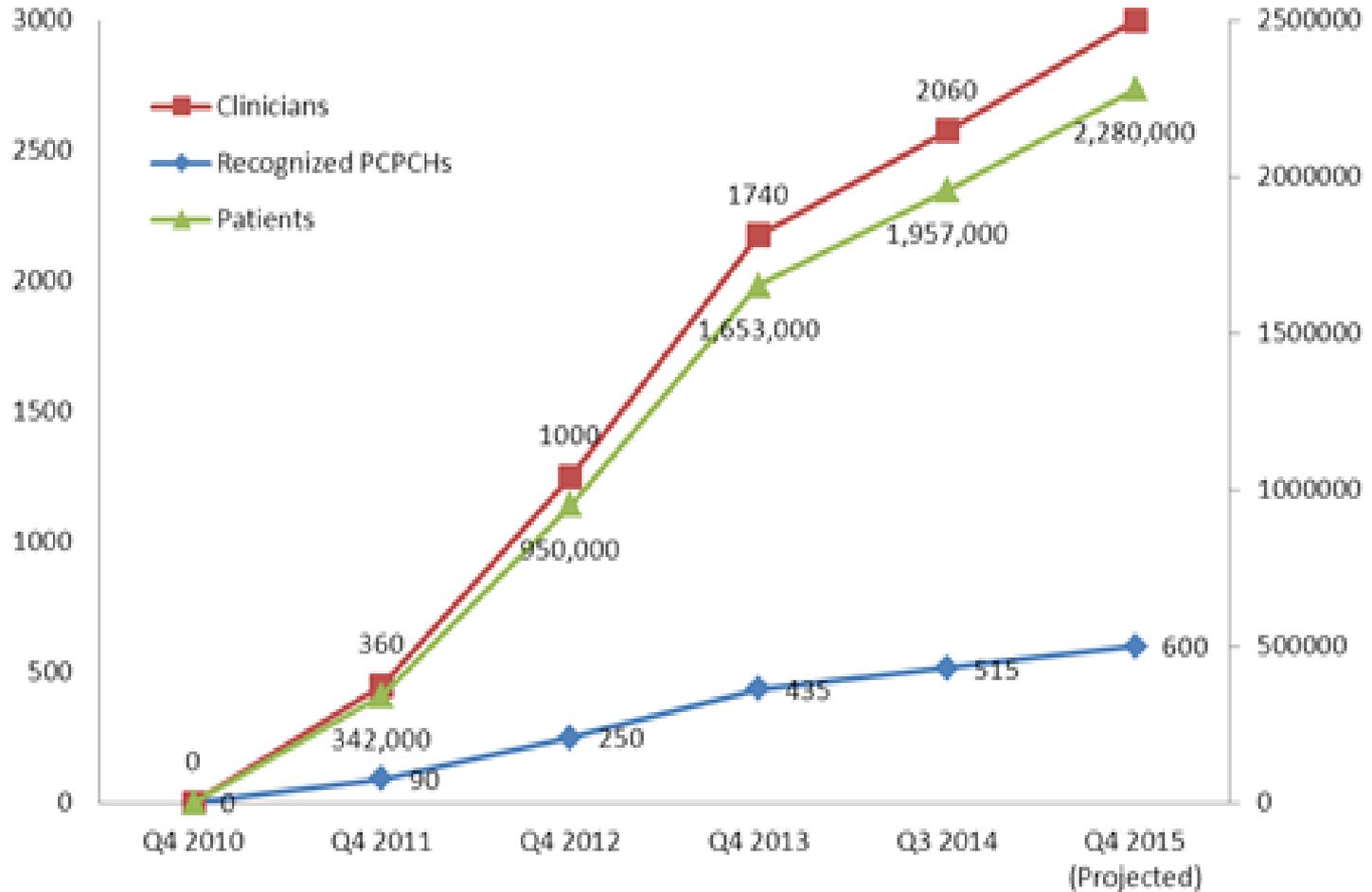
- The PCPCH model is defined by six core attributes, each with specific standards and measures.
- There are 10 “must pass” measures all clinics must meet.
- Clinics can achieve three different Tiers of recognition depending on the criteria they meet.



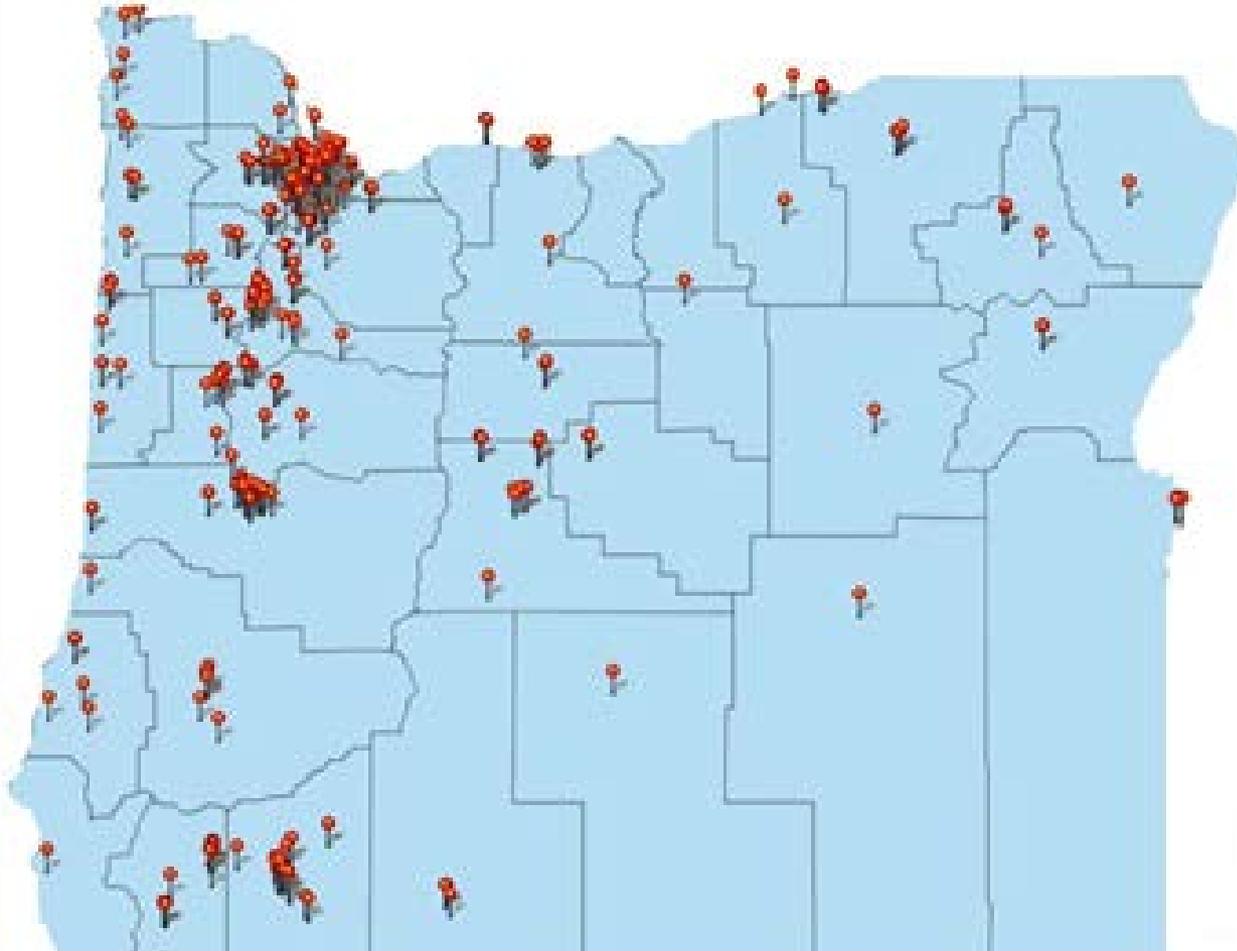
Distribution of Points by PCPCHs under 2014 Model



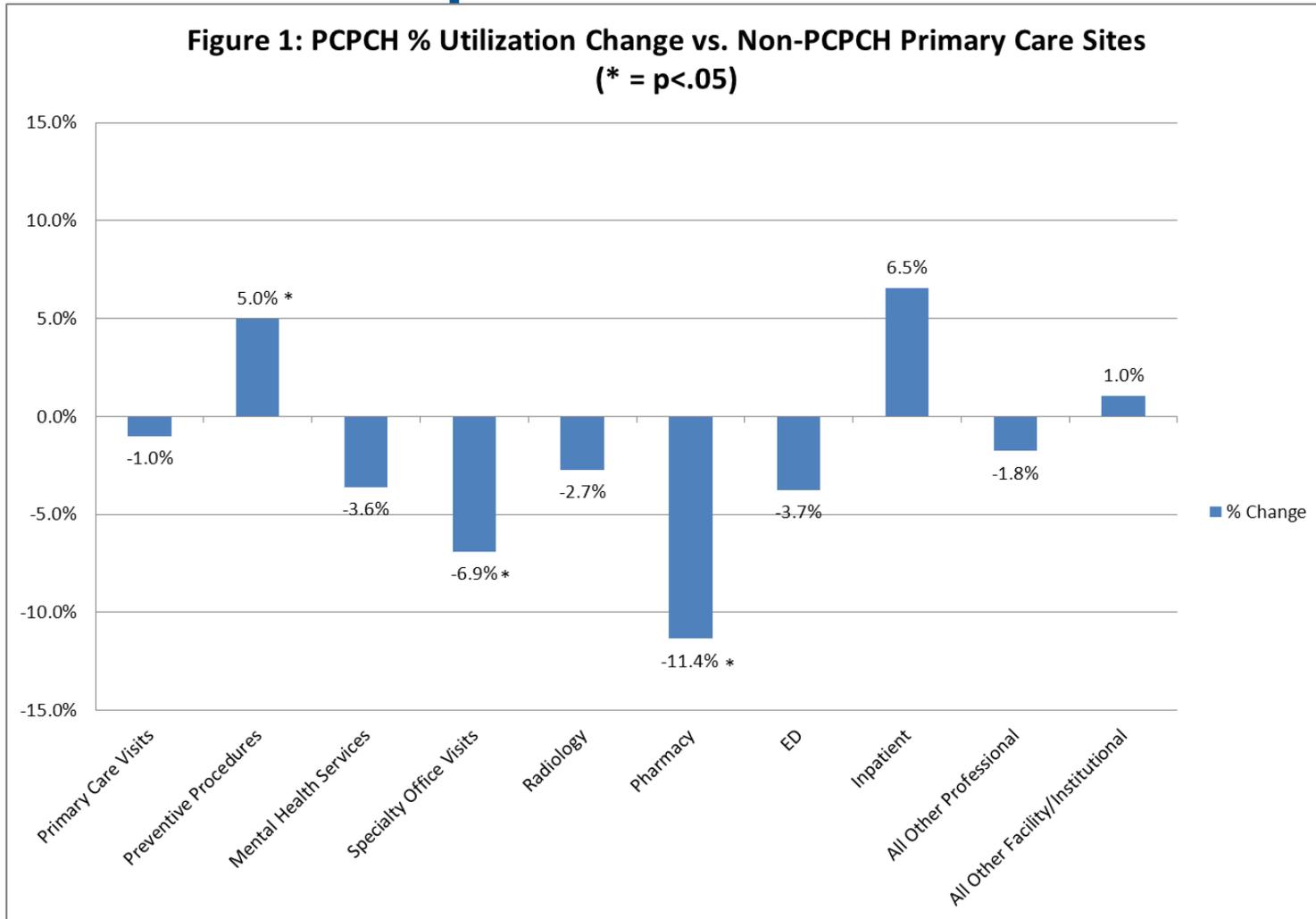
Practices, Clinicians and Patients - PCPCH Program 2010-2015



Where are PCPCHs?

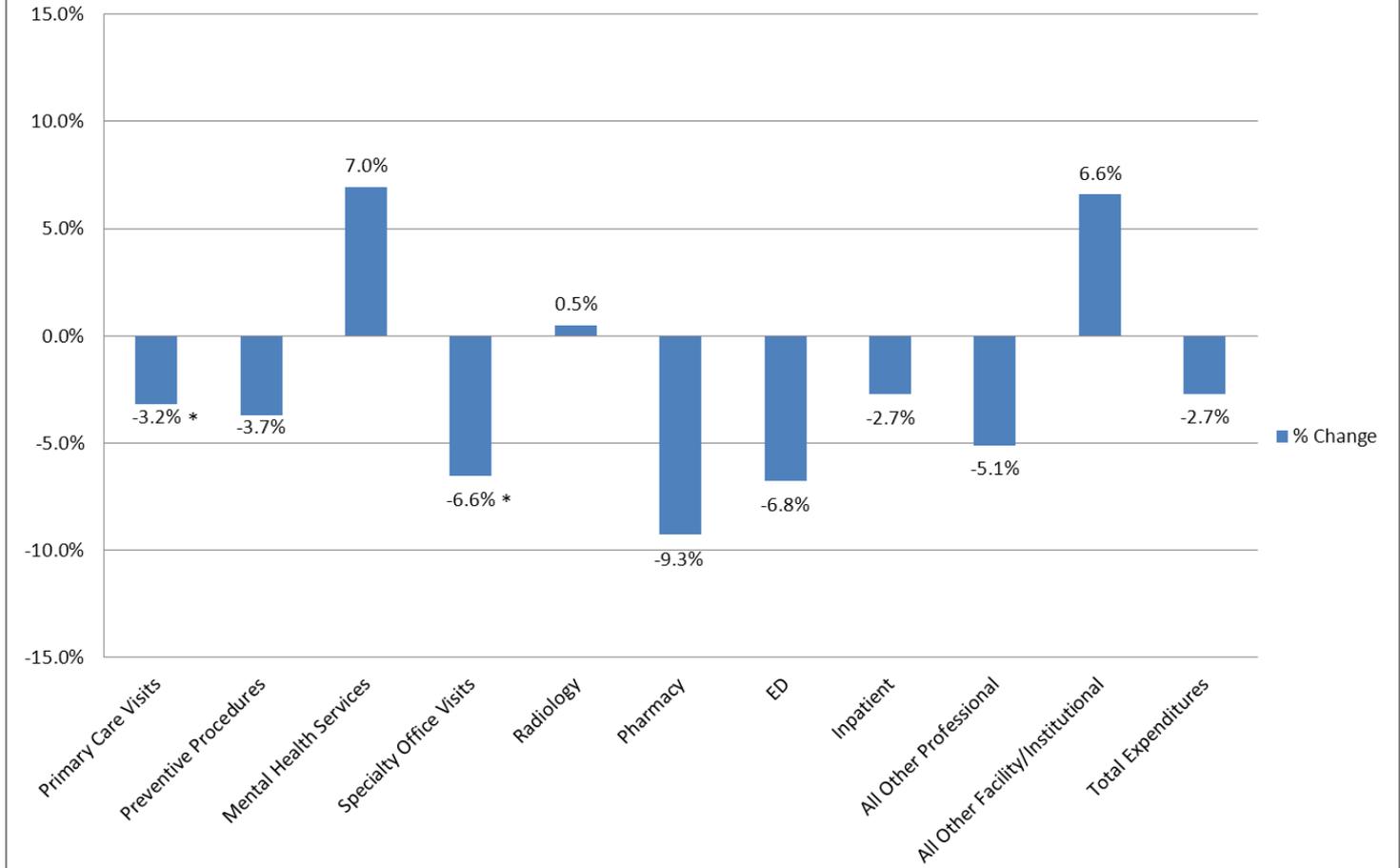


Impact on Utilization



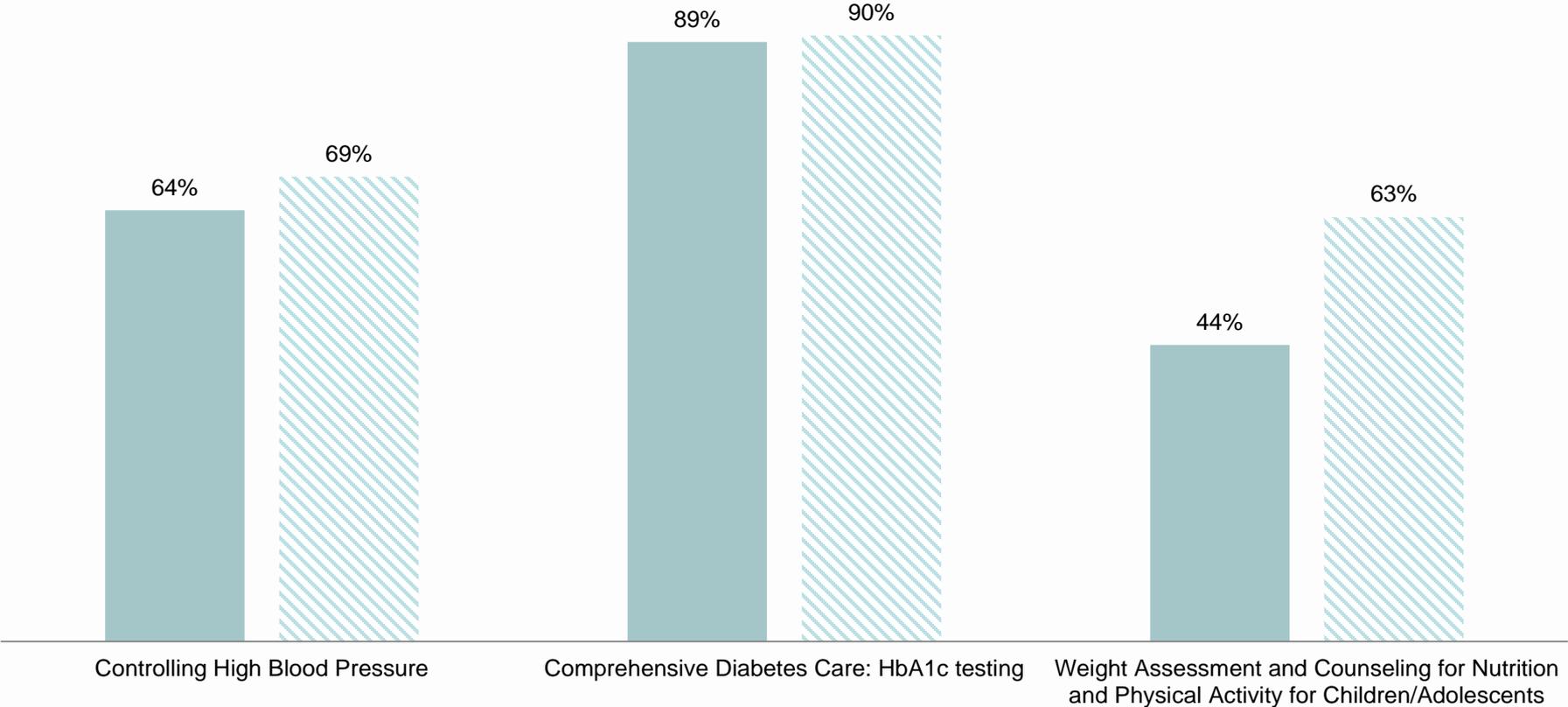
Impact on Expenditures

Figure 2: PCPCH % Expenditure Change vs. Non-PCPCH Primary Care Sites
(* = p<.05)



Clinical Quality Measures

■ HEDIS 2014 National 50thpercentile (Commercial) ▨ PCPCH



| Measure | Mean PCPCH Clinic Score (n) | Mean Non-PCPCH Clinic Score (n) | Percent Difference | p-value |
|--|-----------------------------|---------------------------------|--------------------|---------|
| Chlamydia Screening | 42.9% (175) | 38.7% (130) | +10.9 | 0.011 |
| Diabetes Eye Exam | 62.4% (210) | 59.9% (199) | +4.2 | 0.030 |
| Diabetes Kidney Disease Monitoring | 80.4% (210) | 76.5 (199) | +5.1 | <0.001 |
| Appropriate Use of Antibiotics for Children with Sore Throats | 83.4% (58) | 75.0% (47) | +11.2 | 0.030 |
| Well Child Visits in the 3 rd , 4 th , 5 th and 6 th Years of Life | 63.3% (148) | 55.3% (152) | +14.5% | <0.001 |

Oregon Health Care Quality Corporation. (2013). *Information for a Healthy Oregon: Statewide Report on Health Care Quality.*

Provider Perceptions

Improving outcomes

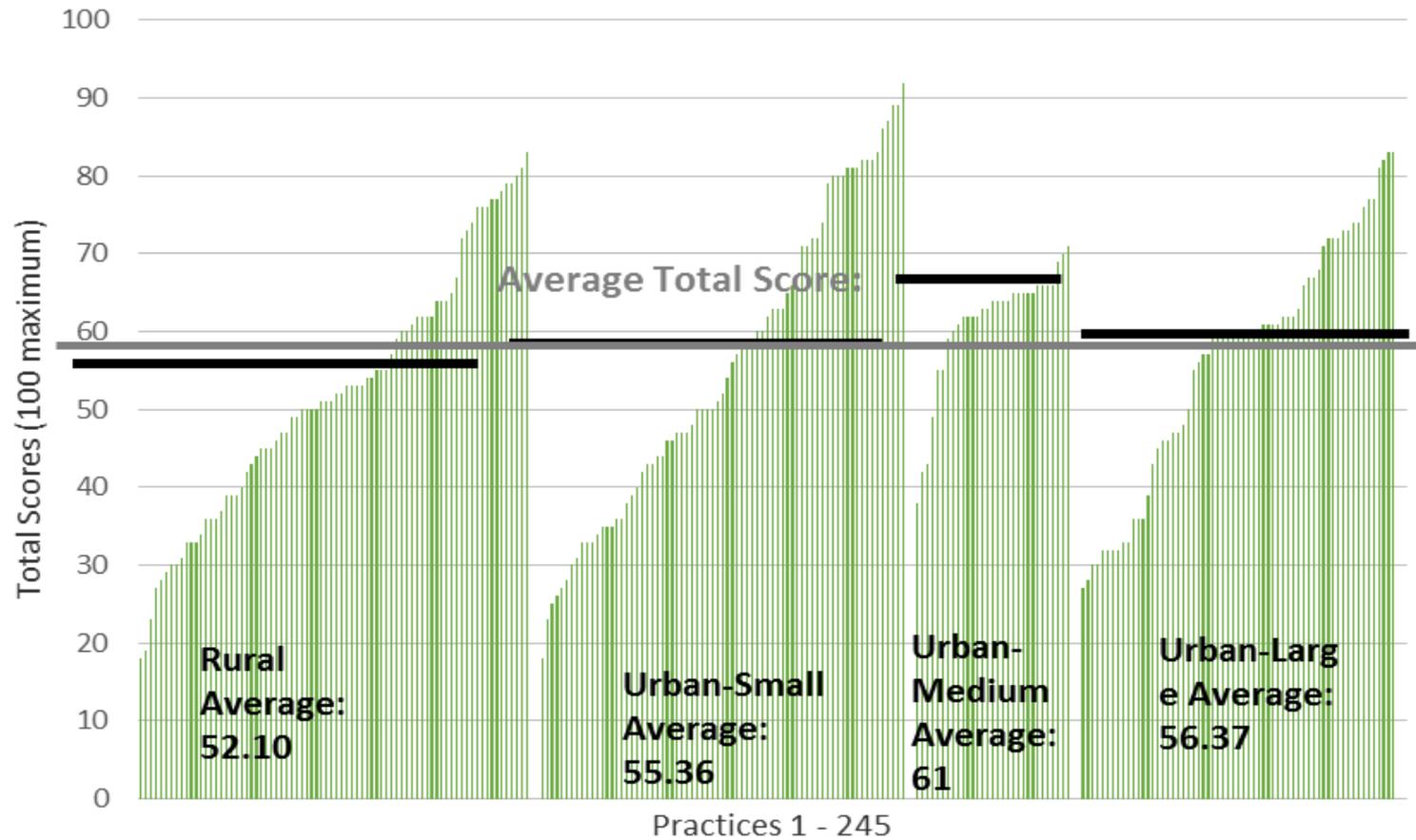
- 85% feel the model is helping their practice increase the quality of care

Improving access and experience of care

- 75% feel the model is helping their practice increase access to services
- 85% of those surveyed believe the PCPCH model is helping them improve the individual experience of care
- 82% report the model is helping them improve population health management

PCPCH Total Attribute Scores

Total Scores, Urban/Rural Categorization (N=245)



Recent Key Activities

- Focus on technical assistance
 - Patient-Centered Primary Care Institute
 - Site visits: clinical champion/practice coach team approach
- 3 STAR designation
- Payment Reform
 - 2013 Multi-payer agreement
 - SB 231

What's Next for PCPCH Program

- Continued focus on technical assistance
- PCPCH Standards Advisory Committee
 - Convening in 2015 to review the model
 - Focus on behavioral health & primary care integration
- Program Evaluation
 - Case study of 30 exemplary PCPCHs
- 2014 Annual Report



Thank you!

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Adolescent Well Visit Measure:

Understanding Barriers to Performance Improvement

Dana Hargunani, MD, MPH
Child Health Director



Overview

- Importance of Adolescent Well-Visits
- Current Oregon performance data
- Potential barriers to performance improvement
- Next steps
- Questions

Importance of Adolescent Well Care

- Adolescence is a critical period for preventing high risk behaviors
 - Adolescents are more likely to engage in activities that risk their overall health, including the use and abuse of alcohol, and other substances, unprotected sex, poor eating and exercise habits, and physically-endangering behaviors (CMS)
- Adolescence is also a time when many chronic physical, mental health and substance use conditions first emerge (CMS)
- The leading causes of illness and death among adolescents and young adults are largely preventable. (Healthy People 2020)

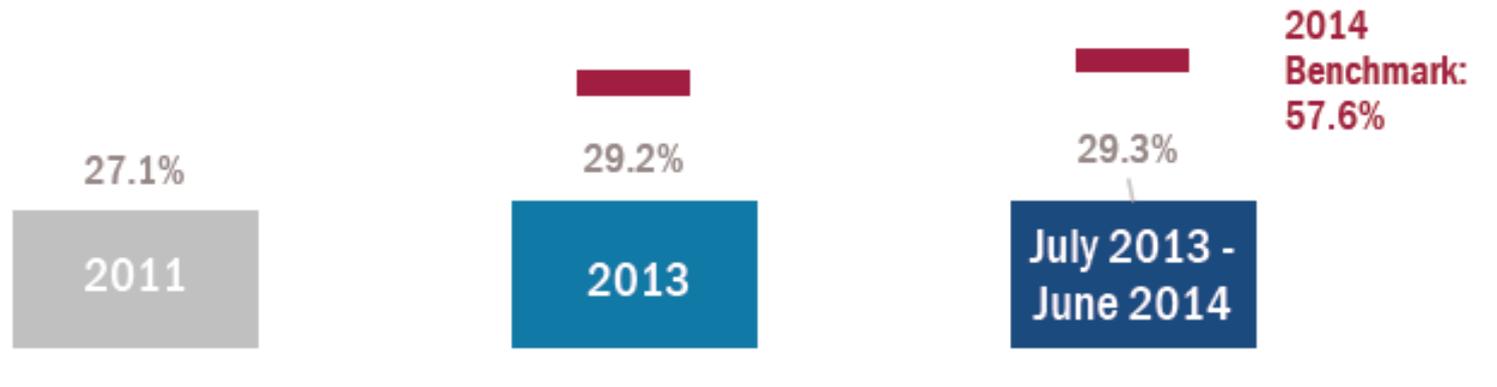
Oregon Data

- Deaths among 10-24 year olds in 2013 (CDC WISQARS data, 2013):
 - 36% Unintentional injury
 - 29% Suicide
 - 5% Homicide
- Health behaviors among 11th graders (OR Health Teens Survey, 2013):
 - 27% were depressed in the last year
 - 15% seriously considered suicide; 5% attempted suicide
 - 45% have ever had sex; of those, 36% didn't use condom with last intercourse
 - 31% drank alcohol in the past month
 - 21% used marijuana in the past month
 - 9.8% smoked tobacco in the past month

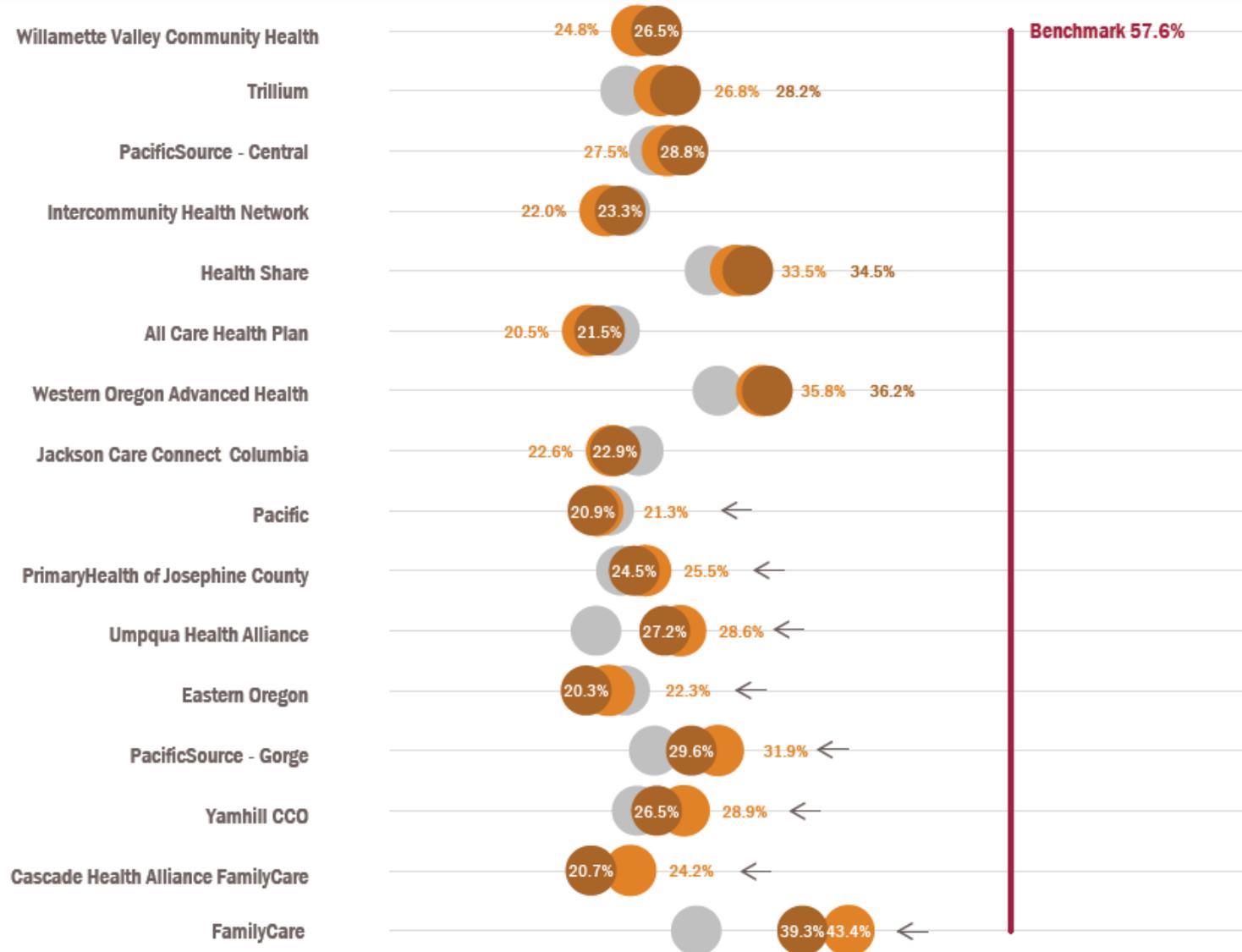
Comprehensive Adolescent Well Visits

- Ensuring adolescents have access to a primary care physician who provides an annual, comprehensive well-care visit can:
 - ✓ Foster early screening, counseling, and intervention;
 - ✓ Reinforce health promotion messages for both adolescents and their parents;
 - ✓ Identify adolescents with chronic conditions who are at-risk for health problems or have initiated health-risk behaviors
 - ✓ Provide the opportunity to monitor growth and development, support psychological and emotional well-being, and encourage healthy lifestyles; and
 - ✓ Build confidence in adolescents to effectively and appropriately utilize the health care system

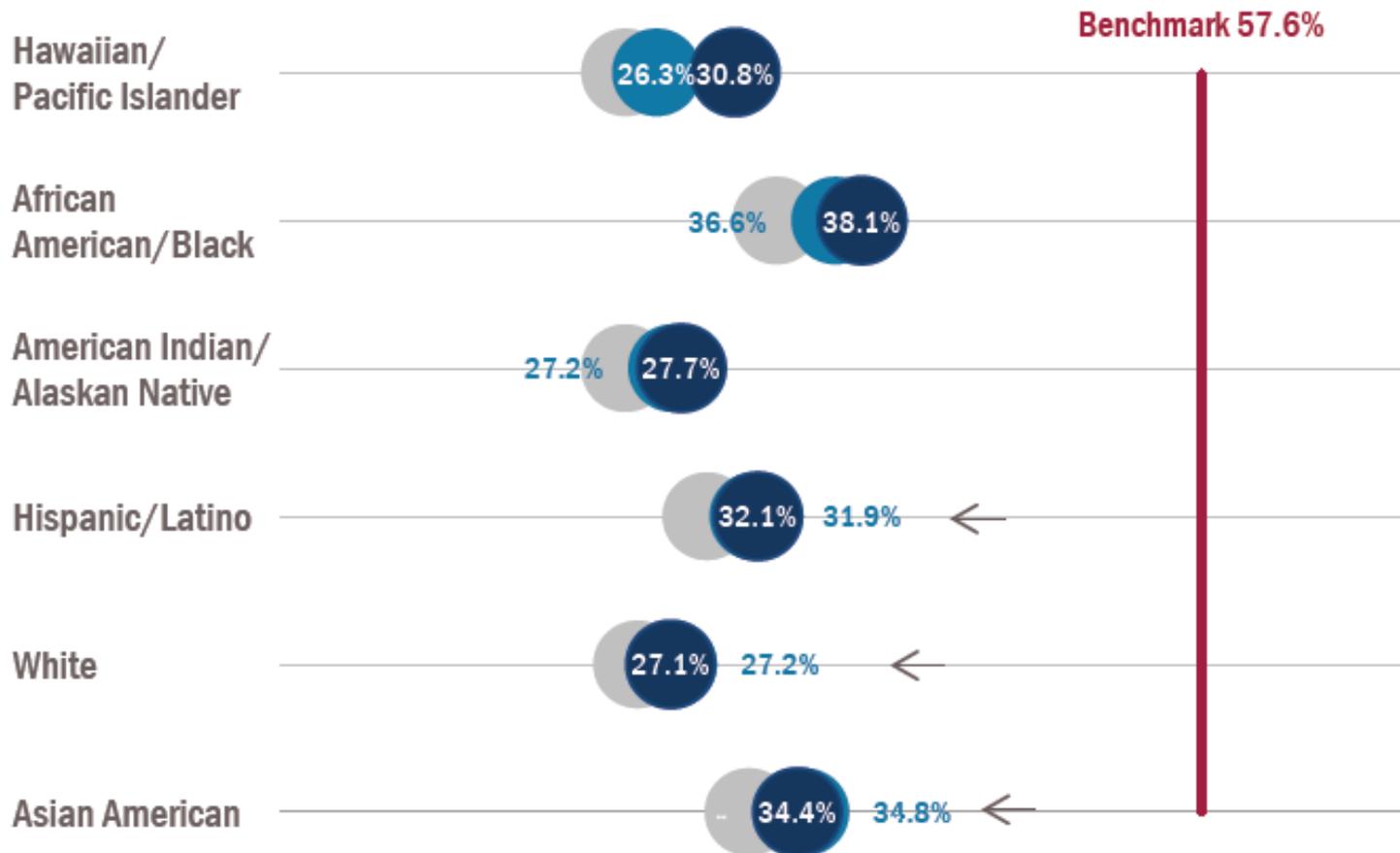
Adolescent Well Visits: State Performance



Adolescent Well Visits: CCO Performance



Adolescent Well Visits: by Race and Ethnicity



Adolescent Well Visit Measure:

Potential barriers to performance improvement

- **Culture shift:** Adolescents, families, providers and/or payors may not recognize the importance of the Adolescent Well Visit for addressing health promotion in addition to emerging conditions that arise in this age group.
- **Inadequate optimization of comprehensive well-care:** Missed opportunities may occur when adolescents access primary care. Providers may perform (and bill for) acute care visits or Sports Physical exams when patients would benefit from comprehensive well care.

Adolescent Well Visit Measure:

Potential barriers to performance improvement

- **Missed opportunity for “package deal”:** Payors and providers may not recognize the opportunity to improve performance on other measures during the well-visit (e.g. SBIRT, depression screening, chlamydia screening, contraceptive management)
- **Clinic workflow:** clinic/provider may not be prepared for workflow associated with Adolescent Well Visits [including extra time needed for provider to see adolescent with and without parent(s) for confidentiality purposes]

Adolescent Well Visit Measure:

Potential barriers to performance improvement

- **Co-payment concerns:** Providers may be hesitant to switch an appointment to a well visit due to risk of triggering a co-payment (which may be unwelcome by adolescents/families).
Providers/clinics may be unaware of regulation changes under the ACA pertaining to cost sharing, and/or some payors may still require co-payments causing a “spillover” effect to overall clinic policy.
- **Low Reimbursement:** Reimbursement/incentives for Well Adolescent Visits may be too low in relationship to the time spent and thus creates a disincentive for focusing on improvements in this measure.

Adolescent Well Visit Measure:

Potential barriers to performance improvement

- **Change in recommendations for clinical care:** Recommended care for the adolescent population has changed in the last 5-10 years. These changes may create barriers, for example:
 - PAP smears are no longer recommended for most women before the age of 21; providers may be less likely to perform annual adolescent well visit without the “need” for getting PAP smears completed.
 - Providers may be unaware of current recommendations for adolescent immunizations, transition planning, STI screening and contraception management that may help promote need for adolescent well visits.

Adolescent Well Visit Measure:

Potential barriers to performance improvement

- **School-based Health Clinics (SBHCs):** Many Oregon adolescents access care at school-based health clinics. Claims for Adolescent Well Visits occurring in the SBHC setting may not be captured in the CCO incentive measure calculations for various reasons (contracts, PCP designation, FQHC wrap/billing, and beyond)
- **Access barriers related to confidentiality:** Adolescents may not seek care by their primary care provider due to concerns that confidentiality may not be maintained especially for sensitive services.

Adolescent Well Visit Measure:

Potential barriers to performance improvement

- **Health plan limits on Adolescent Well-visits:** Health plans may have limits on frequency of Adolescent Well Visits (e.g. once a calendar year or no less than once every 12 months), which don't match the utilization pattern of adolescents. Given the pre-existing barriers to accessing care for this population, additional limits on these visits may create an unnecessary, additional barrier.
- **Panel management:** practices may not have sufficient experience, tools or skills for panel management focused on their adolescent population

Adolescent Well Visit Measure:

Potential barriers to performance improvement

- **Cultural competency and age appropriateness:** Adolescents may not access care if their previous experience has not been positive (e.g. care is not culturally relevant and/or “teen friendly”)
- **Competing priorities:** CCOs and providers have to focus their time and energy in many areas; the low rates and challenges re: Adolescent Well Visits may be a deterrent to focusing on this measure in a time of competing priorities.

Next Steps

Exploring impact of confidentiality concerns

- OHA administered a survey for health providers to assess their clinic policy and practices related to confidentiality; over 200 responses were received.
 - Early findings:
 - 38% reported avoiding coding or billing for services due to patient concerns about confidentiality;
 - 31% have redirected care to another setting;
 - over half (51%) stated they need additional education/training on providing confidential services.
 - Next steps include dissemination of survey findings and gathering policy information from CCOs.

Next Steps

- Further explore barriers
- Develop and disseminate a brief regarding barriers and potential solutions at plan and provider levels

Questions?

Dana Hargunani, MD, MPH

Child Health Director

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**Metrics Deeper Dive:
emergency department utilization &
developmental screening**



In March, the Committee asked OHA to help identify some of the “why” CCO performance is what it is, as well as identify best practices across the state.

The Committee prioritized emergency department utilization and developmental screening.

OHA developed and fielded a survey of CCOs to identify interventions and improvement activities across the state.

13 CCOs responded by May 12th.

Key takeaways

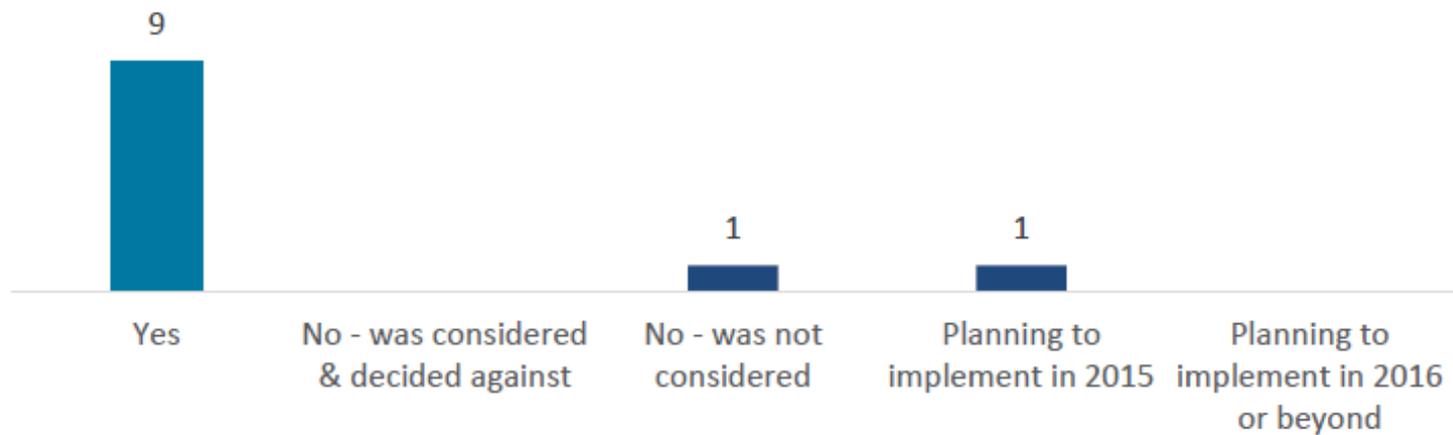
- Each CCO had multiple interventions; no “silver bullet”
- Interventions varied by CCO. The only intervention that all CCOs have implemented is identifying high utilizers for ED utilization.
- Organizations that existed pre-CCO were more likely to have programs prior to 2012, but they also added new interventions once they became CCOs (e.g., APMs).
- CCOs did not roll out interventions wholesale – almost all interventions were tailored, or began with pilot projects before scaling.

Developmental screening

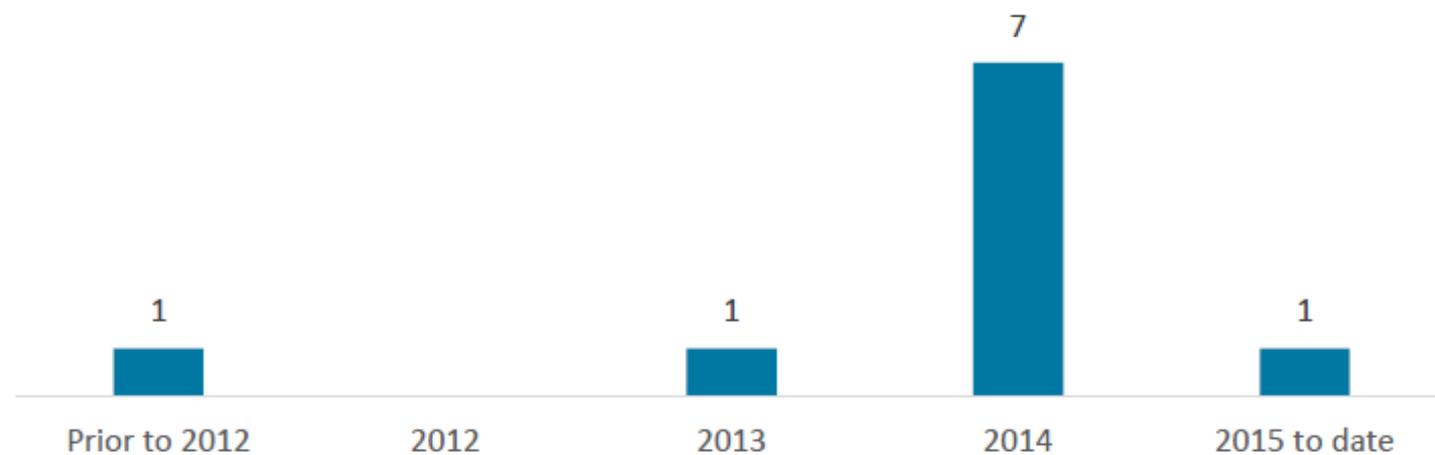
Total number of CCOs implementing each best or promising practice to improve developmental screening (n=13)



Did the CCO implement alternate payment methodologies (APMs)?



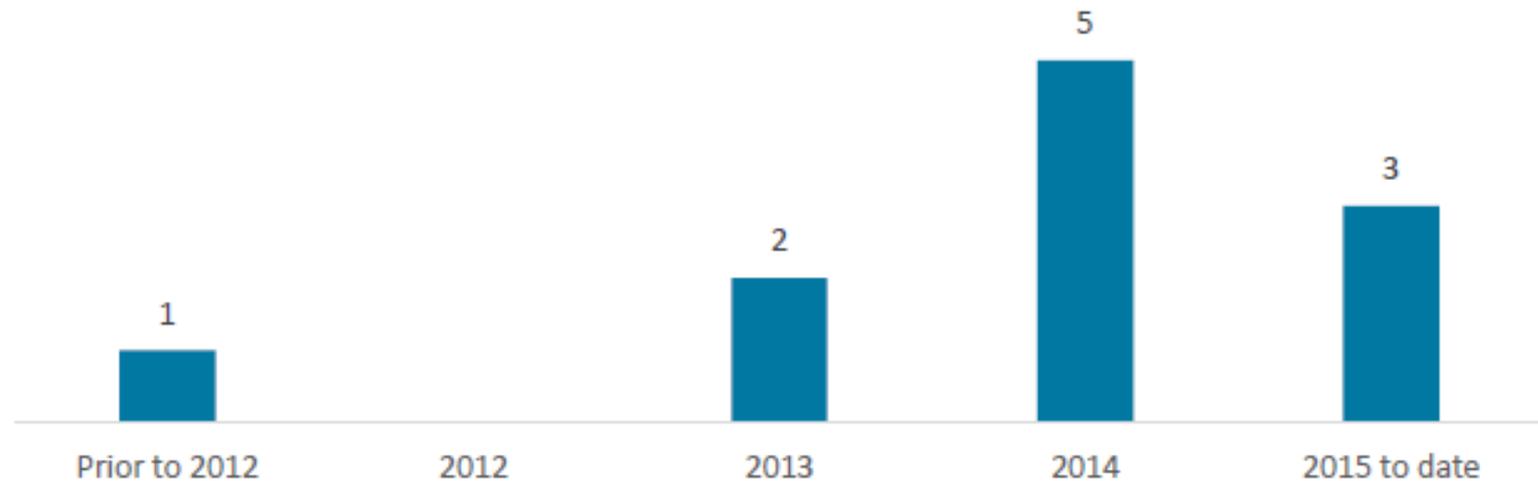
If yes, implementation began:



Did the CCO implement provider education strategies to support developmental screening?

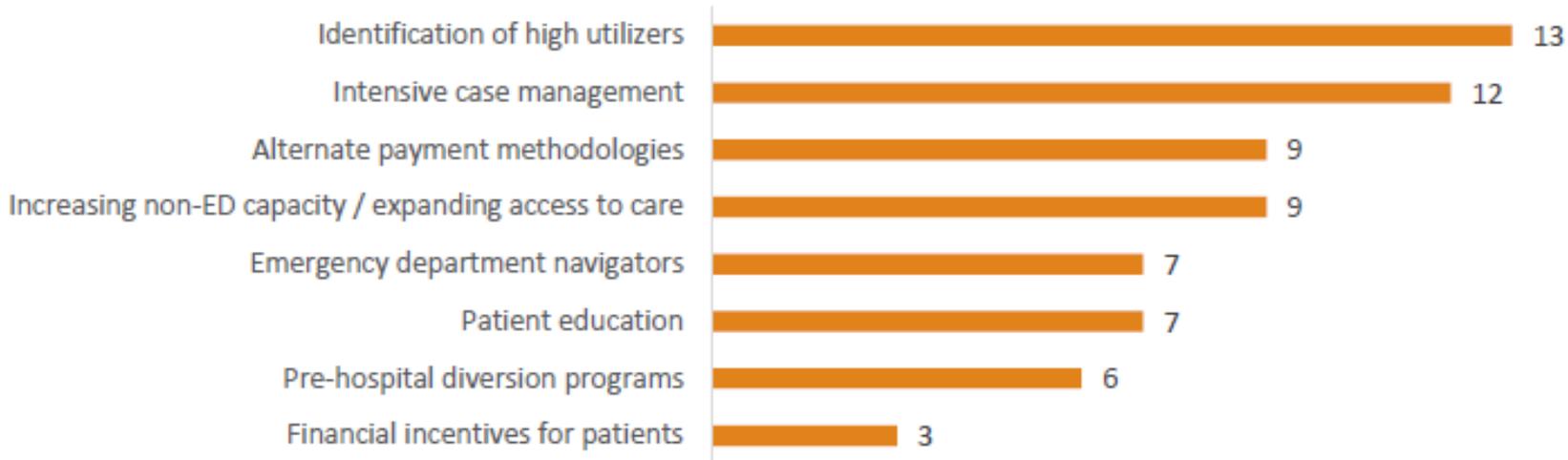


If yes, implementation began:

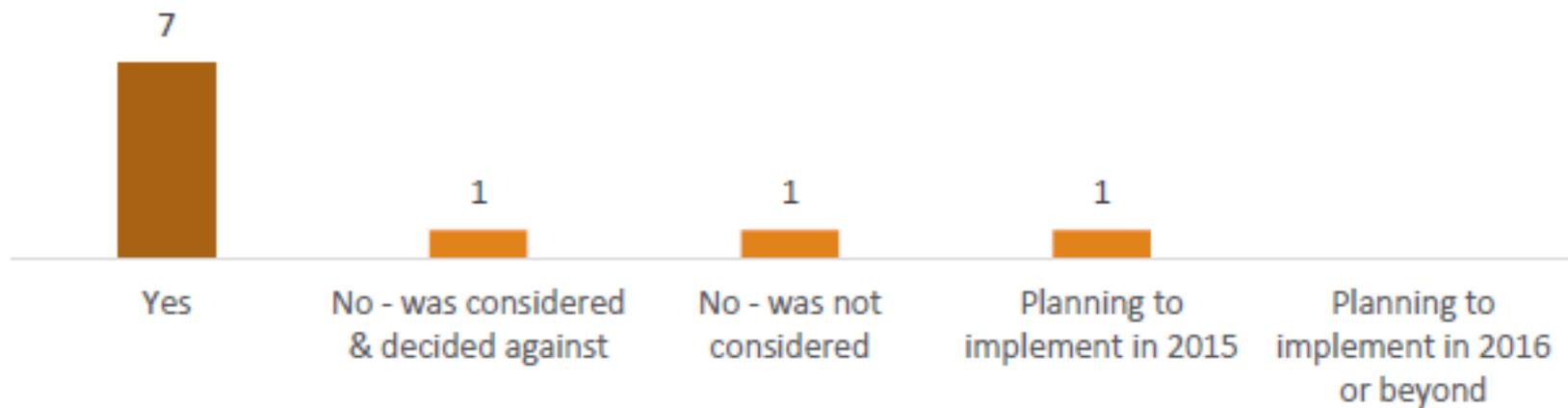


Emergency department utilization

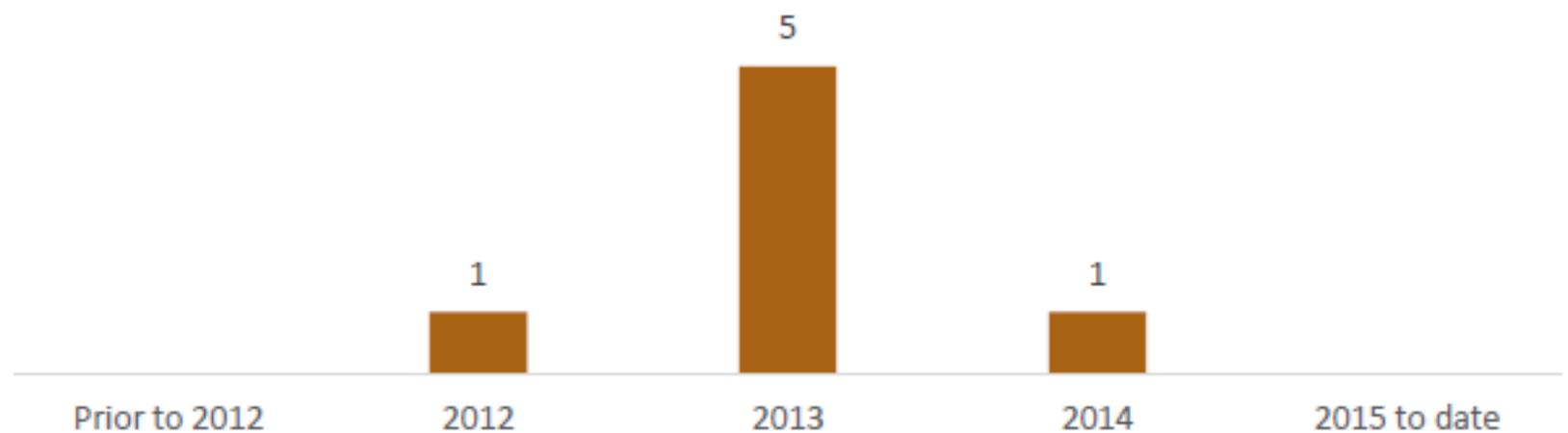
Total number of CCOs implementing each best or promising practice to reduce emergency department utilization



Did the CCO implement emergency department navigators?



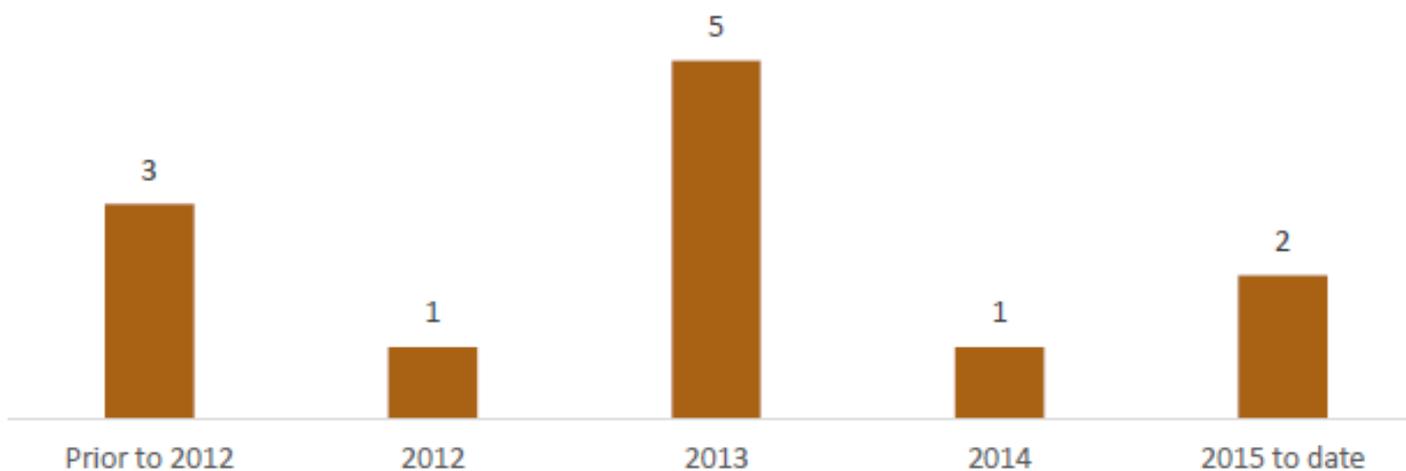
If yes, implementation began:



Did the CCO implement intensive case management?



If yes, implementation began:



Next steps

- Share report with internal OHA staff to support additional transformation activities.
- Work with survey respondents to develop CCO-specific profiles for these two measures.
- Use profiles to support shared learning / best practices across the state.

Break



Measure selection criteria

representative
acceptable opportunity
denominator **increased** goals burdensome
unreasonably **sufficient** improvement consistent greatly
patient mix benchmark
relevant aligned quality present **collect**
evidence-based
influenced measure value feasible
useable program sets other
potential **services** promotes
case size scientifically
transformative population

Measure retirement criteria

In March, the Committee asked for a measure retirement checklist to help guide future measure selection.

OHA proposes the following retirement criteria:

- ✓ No additional opportunity for meaningful improvement.
- ✓ Measure has been / will be retired by measure steward.
- ✓ Supporting clinical guidelines or evidence-base has changed.
- ✓ Measure cannot be measured.
- ✓ Measure no longer adds value.

Measurement framework options



Draft OHPB Framework

OHA is developing a dashboard for the Oregon Health Policy Board to show how well Oregon is doing in achieving the Triple Aim across 8 domains.

The domains are aligned with Key Strategies from the Governor's 10-year Plan.

Subdomains and measures for each will be selected from key health measurement efforts in Oregon.



Fostering Healthy Beginnings
Prenatal Care Initiation



Promoting Healthy Living & Disease Prevention
Flu Shots for Adults Age 50 & Over



Supporting Individuals with Chronic Conditions
PQI-92: Prevention Quality Chronic Composite



Maintaining Choice, Dignity, & Independence at the End of Life
Fall-Related Hospitalizations Among People ≥ 65 Per 100,000



Extending & Maintaining the Coordinated Care Model
Patient Centered Primary Care Home Enrollment



Ensuring Access to Care
Access to Care, Getting Care Quickly Composite



Building Healthy & Safe Communities
% of Adults Age ≥ 25 with a Post-Secondary Degree



Improving Affordability & Sustainability of Coverage
Per Capita Expenditures on Personal Health Care

VITAL SIGNS

CORE METRICS
FOR HEALTH AND HEALTH CARE PROGRESS



INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Thousands of measures are in use today and sheer number and lack of focus limits overall effectiveness in improving performance of the health system.

www.iom.edu/vitalsigns/

Why core metrics?

- Sharpen focus on the actionable issues most broadly important to improving people's health
- Counter the natural tendency to focus on separate pieces at the expense of system performance
- Drive relationships and integration across levels and activities
- Provide key standardized reference points for tailored measurement activities of specialized interest

What are the basic core metric requirements?

- Reliably reflect health, care quality, and cost
- Parsimonious
- Standardized – simply and facilitate comparison
- Multi-level: national, state, local, institutional
- Multi-stakeholder: shared accountability for health
- Publicly led
- Cooperatively stewarded

Core Measure Set with Related Priority Measures



1. Life expectancy

Infant mortality
Maternal mortality
Violence and injury mortality



2. Well-being

Multiple chronic conditions
Depression



3. Overweight and obesity

Activity levels
Healthy eating patterns



4. Addictive behavior

Tobacco use
Drug dependence/illicit use
Alcohol dependence/misuse



5. Unintended pregnancy

Contraceptive use



6. Healthy communities

Childhood poverty rate
Childhood asthma
Air quality index
Drinking water quality index



7. Preventive services

Influenza immunization
Colorectal cancer screening
Breast cancer screening



8. Care access

Usual source of care
Delay of needed care



9. Patient safety

Wrong-site surgery
Pressure ulcers
Medication reconciliation



10. Evidence-based care

Cardiovascular risk reduction
Hypertension control
Diabetes control composite
Heart attack therapy protocol
Stroke therapy protocol
Unnecessary care composite



11. Care match with patient goals

Patient experience
Shared decision making
End-of-life/advanced care planning



12. Personal spending burden

Health care-related bankruptcies



13. Population spending burden

Total cost of care
Health care spending growth



14. Individual engagement

Involvement in health initiatives



15. Community engagement

Availability of healthy food
Walkability
Community health benefit agenda

2016 on-deck measures: status updates



Recap

In March, the Committee asked for an update of all of the previously identified “on-deck” measures for 2016.

| | |
|---|--|
| Any dental service | Food insecurity and hunger |
| Assessment and management of chronic pain | Homelessness screening |
| Childhood immunization status | Kindergarten readiness |
| Childhood obesity prevalence | PQI 92: prevention quality chronic composite |
| Fluoride varnish | Reducing health disparities |

+Tobacco prevalence from previous Committee discussion.

Today

Measure status updates:

- Specifications
- Data source
- Benchmark
- Alignment
- Measure operational by October 2015
- Public testimony for individual measures

OHA recommends holding all measure selection decisions until June 19th.

Kindergarten Readiness



Any Dental Service

Measure Description: % of members (ages 0 -21) receiving any dental services

| | |
|----------------------------|--|
| Specifications? | Yes, based on EPSDT reporting. Can be reported at CCO level, stratified by r/e, etc. |
| Data source? | Administrative data (claims) |
| Benchmark source? | Healthy People 2020 goal |
| Alignment? | Not currently in any measure sets; recommended by dental quality metrics workgroup. |
| Measure ready by Oct 2015? | Yes |

Assessment & Management of Chronic Pain

Measure Description: % of patients (ages 18+) diagnosed with chronic pain w/documentation in the medical record of receiving education regarding their Dx, medications, etc...

| | |
|----------------------------|---|
| Specifications? | Yes, AHRQ and ICSI |
| Data source? | Electronic health record / medical record |
| Benchmark source? | No |
| Alignment? | Not currently in any measure sets. |
| Measure ready by Oct 2015? | No |

Childhood Immunization Status

Measure Description: % of children who received recommended vaccines before their 2nd birthday.

| | |
|----------------------------|---|
| Specifications? | Yes, current OHA measure. |
| Data source? | Administrative data + ALERT immunization registry |
| Benchmark source? | Yes, national Medicaid percentiles |
| Alignment? | OHA's 33 state performance measure; Phase 1 measure from HB 2118; Core CHIP measure |
| Measure ready by Oct 2015? | Yes |

Childhood Obesity Prevalence

Measure Description: % of children (ages TBD) who are obese, using the CDC BMI-for-age guidelines, 95th percentile and above.

| | |
|----------------------------|---|
| Specifications? | No available specifications at CCO level for prevalence; other related measures (e.g., weight assessment & counseling) available instead. |
| Data source? | Not for prevalence |
| Benchmark source? | Oregon statewide target for childhood obesity prevalence in new state health improvement plan |
| Alignment? | Prevalence not currently in any measure sets |
| Measure ready by Oct 2015? | No |

Fluoride Varnish

Measure Description: % of children (ages 1-21) who have received at least one dental service who received at least 2 topical fluoride applications during the measurement year.

| | |
|----------------------------|--|
| Specifications? | Yes, available from the Dental Quality Alliance. |
| Data source? | Administrative data (claims) |
| Benchmark source? | Not yet, national comparative data anticipated in the future. |
| Alignment? | Not currently in any measure sets, recommended by dental workgroup, recently endorsed by NCQA. |
| Measure ready by Oct 2015? | Yes |

Food Insecurity & Hunger

Measure Description: % of patients who screen positive for food insecurity and hunger who received follow up / referral to resources provided by the Oregon Food Bank (or other community programs).

| | |
|----------------------------|--|
| Specifications? | No |
| Data source? | Electronic health record / medical record |
| Benchmark source? | No |
| Alignment? | Not currently in any measure sets, screening questions on food insecurity are used by USDA |
| Measure ready by Oct 2015? | No |

Homelessness Screening

Measure Description: % of patients who screen positive for current or imminent risk of housing instability

| | |
|----------------------------|---|
| Specifications? | No |
| Data source? | Electronic health record / medical record |
| Benchmark source? | No |
| Alignment? | Not currently in any measure sets |
| Measure ready by Oct 2015? | No |

PQI 92: Prevention Quality Chronic Composite

Measure Description: Rate of admissions per 100,000 member years for the following conditions: diabetes (short & long-term complications, uncontrolled, w/lower-extremity amputation), COPD, asthma, hypertension, heart failure, or angina w/o cardiac procedure.

| | |
|----------------------------|---|
| Specifications? | Yes, from AHRQ. |
| Data source? | Administrative data (claims) |
| Benchmark source? | No national data available, OHA uses “10% reduction” from prior year for PQI benchmarks |
| Alignment? | OHA reports on individual PQIs as part of 33 state performance measures; Phase 1 HB 2118 metric |
| Measure ready by Oct 2015? | Yes |

Reducing Health Disparities

Proposed approach (to be developed with TAG)

- Create a “meta-measure” from existing measures (33).
- Use only measures that can be stratified by race/ethnicity, language, zip code, etc and that have large denominators.
- Stratify each measure by CCO and subpopulation, then analyze each for disparities within the CCO (e.g., non overlapping confidence intervals).
- If a CCO was equitable (no disparities among subpopulation for a given measure), CCO earns 100% of incentive. Funds are reduced on a sliding scale, based on % of measures where disparities exist.

Tobacco Prevalence

Committee previously asked the TAG to explore a tobacco prevalence measure based on the Meaningful Use objective for documenting smoking status, and developing a bundled measure (cessation benefit + prevalence).

OHA and the TAG developed a practice-level survey that CCOs fielded across their provider networks to learn more about EHR functionality and how tobacco use status is collected and reported out of EHRs.

Tobacco Prevalence Survey

Respondents were asked about:

- Data collection
- Data reporting from Meaningful Use
- Data reporting from custom query
- Ability to create custom query

Tobacco Prevalence Survey: Takeaway

- Most, if not all, EHRs record smoking or tobacco use status in some way.
- Many EHRs already have some ability to report on prevalence.
- An EHR-based prevalence measure is feasible, if:
 - CCOs and practices are given time to build a custom report if needed; and
 - Measure specifications allow for flexibility in how prevalence is captured.

Bundled Tobacco Measure

Intent of a bundled measure is to address both cessation benefits and tobacco prevalence.

To “meet” the bundled measure, CCOs would have to:

- 1) Meet cessation benefit floor; AND
- 2) Submit EHR-based tobacco prevalence data; AND
- 3) Meet prevalence benchmark or improvement target.

TAG has had initial discussions on the proposed cessation benefit floor and proposed data submission criteria.



NEXT STEPS

2016 Measure Retirement: staff recommendation

Option 1: do not retire any measures for 2016.

- Allow for measure set stability and minimize changes for CCOs and providers.

Option 2: consider retiring EHR Adoption.

- EHR adoption was foundational work to move to EHR-based measurement, which we are continuing to build.
- Will require CMS approval to drop, as this was a CMS-required measure.

| Meeting Date | Goals |
|----------------------------|--|
| June 19 th | 2016 measure selection |
| July 17 th | Review final 2014 performance and quality pool distribution; Finalize 2016 measure selection and begin benchmark setting. |
| September 18 th | Finalize benchmark setting for 2016. |
| November 20 th | Finalize anything outstanding for 2016. |

Wrap Up!

Next meeting: June 19th

9 am – noon

Wilsonville