

ATTENDING

AllCare Alan Burgess Natalie Case Greg Hilstad	FamilyCare Emileigh Canales Iris Grill Kevin McLean	PrimaryHealth Sharon Merfeld	Acumentra Sara Halvik Quality Corp Cindi McElhaney
Cascade Amanda Blodgett Angela Leach Liz Simpson	GOBHI	Trillium DR Garrett	Guests Stephanie Renfro (OHSU) Sarah Dryfoos (OPCA)
CareOregon Amit Shah Jaclyn Testani Rosemary Zanke	Health Share Graham Bouldin	Umpqua Debbie Standridge Rose Rice	OHA Susan Arbor Sarah Bartelmann Summer Boslaugh Lisa Bui Sheila Clausen Sara Kleinschmit Milena Malone Scott Montegna Crystal Nielson
Columbia Pacific	IHN Staci Alver Ellen Altman Megan Underwood	WOAH	
Dental organizations Sharity Ludwig (Advantage)	Jackson	WVCH Greg Fraser	
Eastern Oregon Hanten Day Jordan Rawlings	PacificSource Tyler Nass (Mosaic) Beth Quinlan Laura Walker Coco Yackley	Yamhill	

UPDATES

DASHBOARDS

The July dashboard was re-released on August 14th, containing the same rolling 12 months previously released, but updated to include the effective contraceptive use baseline, improvement target, and rolling 12 months; the dental sealant improvement target; and the DHS custody baseline and improvement target.

The August dashboard was released on August 25th and contained an updated rolling 12 months (April 2014 – March 2015).

ICD-10 CROSSWALK

OHA has published a preliminary ICD-9 / 10 crosswalk online, identifying potential ICD-10 codes for inclusion in the 2015 and 2016 incentive measures. The preliminary crosswalk is based on crosswalks from HEDIS and OHA and is not the final determination of which ICD-10 codes will be used in the measure specifications.

METRICS & SCORING COMMITTEE

The next Committee meeting will be held Friday, September 18th from 9:00 am – noon. The Committee will focus on selecting the 2016 benchmarks and determining the 2016 challenge pool measures. Agenda and materials will be posted online at: www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx

ONC “TOWN HALL”

Kevin Larsen from the Office of the National Coordination for Health Information Technology (ONC) is coming to Oregon to talk about quality measurement; stakeholders are invited to participate in a town hall session on Wednesday, September 9th from 8:30 – 10:30 am. The meeting will be held in Portland with a webinar option for remote participation. Please email Crystal (Crystal.Nielson@state.or.us) by September 2nd if you plan to attend in person.

OHA will record the town hall meeting and plan on reporting out at a future TAG meeting.

SBIRT E-SPECIFICATIONS

Crystal Nielson presented on the SBIRT measure concept for Electronic Health Record (EHR) - based reporting and requested TAG feedback on the operationalization and implementation of the concept. The measure concept is built upon the current claims-based specifications, but enables a new reporting mechanism and requires that documentation is collected as structured/reportable data within the EHR (i.e., not manual review of text fields in charts).

Crystal reviewed the intent and history behind developing an EHR-based SBIRT measure and walked through the numerator and denominator concepts. Discussion included:

Denominator

- Denominator concept does not reflect any changes to the current claims-based specifications
- Why emergency department visits are not being counted as an outpatient service, as we know SBIRT screenings are occurring in the ED?
 - The CCO SBIRT measure is intended to be primary care / outpatient focused, while the Hospital SBIRT measure is intended to be emergency department focused. OHA will provide additional clarification on this in the CCO SBIRT specifications for 2016.
- What logic are CCOs using to determine eligibility for the three current Clinical Quality Measures? Have any CCOs tested options to determine how it affected the denominator? Which should be used for the SBIRT measure? Options include: (1) Active Medicaid coverage as of the last date of the reporting period; (2) Active Medicaid coverage on the date of the qualifying encounter; or (3) other.
 - Assumption that active coverage on the date of the qualifying encounter is easier for report writers to identify.
 - If a member is assigned to a CCO at the end of the measurement year, would have active coverage as of the last date of the reporting period but may or may not have had a qualifying

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encounter before the end of the year. Would this artificially inflate the denominator, with no opportunity to provide numerator-qualifying services?

- May need to consider a minimum enrollment criteria to address this denominator inflation (e.g., must be on the plan at least 15 days in the measurement year).
- Earlier rationale for not including continuous enrollment criteria for any Clinical Quality Measures was because of difficulty in tracking enrollment at the practice level; practice EHR may only know enrollment as of the date of the encounter; would require some kind of enrollment or eligibility data feed from plans to practice.
- Regardless of which eligibility criteria for the denominator is selected, the specifications need to be very clear.
- In some EHRs, the insurance status is attached to the specific encounter; could only run the denominator with the first option.

Numerators

- Measure concept proposes four discrete counts for the different components of the SBIRT process, designed as a cascading measure based on the results of the preceding component. OHA will share the logic flow with the TAG.
- Is there flexibility in the measure logic / cascade to capture those clinics that are skipping the brief screening and administering full screenings to everyone (given acuity of population, etc)?
 - Some providers express frustration that the brief screening isn't captured in the current claims-based measure; the measure does not reflect all the preventive work happening up front and this may have led some to skip the brief screening step. Some communities argue that the full screening reflects better care.
 - Need to be able to report based on any accommodations that providers / EHRs have already made to work around the limitations of the claims-based measure. Practices want to get credit for the work they are doing to perform the brief screening.
 - Note the Committee's original intent when adopting the SBIRT measure was to look at brief screening as the first step in the process, but when operationalizing the measure, we were limited by availability of codes.
 - It makes sense to build some kind of flexibility to address this into the measure, but we do want to make sure we keep to the fidelity of the SBIRT model. Brief screening is an important aspect of the model.
- Note that the existing benchmark for the claims-based measure may not be appropriate for the EHR-based measure. Additional discussions with the Committee will be needed to determine if we need new benchmarks based on test data from the EHR-based measure option, or multiple benchmarks for the discrete components of the process.
- How, if at all, are brief interventions being documented in EHRs?
 - Some FQHCs have flags for screenings and brief interventions.

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- One example from PacificSource Gorge utilizes a pick-list with 8-10 choices, e.g., discussion with patient, referral to behavioral health consult within clinic, referral to provider outside of clinic.
 - Is a distinction between internal / external referrals important?
 - Not for the purposes of the measure, but likely very useful for alternate payment methodologies, PCPCH recognition, internal quality improvement, etc.
- WVCH EHR has a screen that duplicates the documentation page from the SBIRT Oregon website with a series of checkboxes for the provider to use; checkboxes result in discrete data that can be reported on. Greg will share a screenshot with OHA.
- Referrals must be to provider types that reflect the SBIRT process (as the patient may have been referred to another provider for something unrelated to SBIRT).
 - There is value in not just counting the number of referrals that occurred, but closing the loop to track the number of referrals that were completed. But no feasible, reliable way within the measure / EHR to report whether a patient followed up with their referral.
 - This is redundant with PCPCH Tier 3 certification – which requires a clinic to know this type of information about their patients, but may not be documented within the EHR or within a reportable process.

Timeline

- Q3 2015: More focused conversations to help inform draft specifications, smaller workgroup.
- Q4 2015: Finish draft specifications.
- Q1 – Q2 2016: Two rounds of a reporting pilot, or PDSA. Work with several CCOs / clinics to test the draft specifications and build functionality within an EHR for this reporting. Share and review the test data to determine any modifications to the draft specifications.
- Oct 1 2016: Publish final EHR-based specifications.
- Jan 1 2017: Implementation of EHR-based reporting option for SBIRT measure.

Considerations to work through include: whether or not there will be a pay for performance option based on the 2017 data. Will CCOs have to select either EHR-based reporting or claims-based reporting, or can the data be combined for kind of composite results? Cannot switch the measure over to pay for performance on the EHR-based data until some population threshold has been reached? Will the 2017 data be QRDA (patient level) or aggregate, and what are the implications of this for combining the data with claims?

Next Steps

- Are there groups / individuals interested in a limited “sub workgroup” to assist in completing draft SBIRT specifications?
 - 3-5 meetings over the next 3 months;
 - Provide input on specification details;
 - Participants should have knowledge of SBIRT workflow and how data is currently captured in the EHR.

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- Are there CCOs that would be interested in participating in a reporting pilot in Q1 and Q2 of 2016?
CCOs need at least one practice / clinic willing to participate, although more than one would be ideal.

Please respond to metrics.questions@state.or.us if you are interested in participating in either the workgroup or the pilot.

OHA will bring back updated draft specifications and information on the sub workgroup for future discussion at TAG meetings.

TOBACCO PREVALENCE (BUNDLE)

Sarah Bartelmann reviewed several updated documents related to the tobacco prevalence bundled measure and asked the TAG for feedback.

TAG members requested an online survey to help provide the requested feedback; the survey is now online at: <https://www.surveymonkey.com/r/TAGTobacco>. TAG members are asked to respond by Sept 15th.

TOBACCO CESSATION BENEFITS SURVEY

A draft survey is included in the meeting materials. Questions for TAG include: when should the survey be fielded (before the end of the measurement year, after the measurement year, etc); should the survey be required in 2015 to create a baseline for the measure; and feedback on the optional versus required questions. TAG discussion included:

- Fielding the survey in 2015 is one good way to test whether it gets us the information needed, with an opportunity to revise for 2016 if needed.
- Cessation benefit component of the bundled measure is currently structured as pass / fail. It may be useful for CCOs to run through in 2015 and determine if any changes are needed prior to pass / fail in 2016. May also be interesting for Committee to have a sense of where CCOs stand.
- Having baseline information for 2015 is of interest to OHA, since the last benefits survey was fielded in Q2 2014 and CCOs may have made changes to benefits since then.
- Is the expectation that the cessation benefits (that pass measure criteria) are in place for the entire measurement year, or just as of December 31st of the measurement year? Expectation will inform when to field the survey.

UPDATED SPECIFICATIONS

A revised draft of the measure specifications is included in the meeting materials. The draft has been updated to clarify age requirements, the exclusion of e-cigarettes and marijuana, and separation of cigarette smoking from tobacco use into two distinct numerator rates. A draft table outlining the quantities of each cessation product that would need to be covered to meet the minimum benefit is also included for review.

BENCHMARK / IMPROVEMENT TARGET OPTIONS

Does the TAG want to make a formal recommendation to the Metrics & Scoring Committee about benchmarks / improvement targets for the measure? If not, OHA will convey information about discussions that occurred at TAG related to this topic, but not an official recommendation.

The improvement target only option for 2016 seemed the most reasonable, based on previous TAG discussions, however improvement targets cannot be established for 2016 without some baseline data. Options for baseline data include: requiring CCOs to submit EHR-based prevalence data for 2015; using 2015 prevalence data from CAHPS surveys; or other TBD.

ALTERNATE PROPOSAL

An alternate proposal that the TAG could propose to the Committee would use a weighted methodology for each of the components of the bundled measure and a threshold score, rather than a pass / fail approach based on the minimum cessation benefit. Over time, the weighting would shift away from the cessation benefit and EHR-based reporting of the data (infrastructure) to reducing prevalence. See the table describing the alternate proposal in the meeting materials.

Initial discussion:

- The alternate proposal appears a bit more forgiving and allows more nuance for accountability. While it adds complexity, it does keep the focus on improvement rather than checking boxes.
- Alternate proposal may be a good way to address the benchmark / improvement target issue – spend the first year or two determining the reliability of the data before being held accountable based on that data.
- How often would the minimum cessation benefit floor change? Annually? Never? This needs to be clarified in the specifications.
- How to address members who churn off Medicaid – would be great for the state to ensure that a minimum cessation benefit is available cross-payer.

In 2009, the Oregon Legislature passed SB 734 which required private health insurers to offer a tobacco cessation benefit of at least \$500. The Helping Benefit Oregon Smokers (HBOS) collaborative was convened to establish a standard of care for Oregon so every Oregonian who wants to quit will have the best chance to do so. The HBOS group developed recommendations for the most effective cessation benefit. See more online at: <http://smokefreeoregon.com/resources/policy/helping-benefit-oregon-smokers/>.

HEALTH EQUITY COMPOSITE MEASURE UPDATE

The committee is interested in developing a health equity “meta-measure” for use with the challenge pool. OHA staff from multiple departments have been collaborating on methodology and feasibility of a composite measure and hope to bring a proposal to the TAG this fall. Initial discussions have revealed that a measure is

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far too development to go live in 2016, and staff will recommend the Committee postpone consideration until 2017. If TAG members are interested in participating in measure development at this time, please let Sarah know (sarah.b.bartelmann@state.or.us).

NEXT MEETING

The next TAG meeting will be September 24th from 1:00 – 3:00 pm.