

Metrics Technical Advisory Workgroup

January 28, 2016

**PLEASE DO NOT PUT YOUR PHONE ON
HOLD – IT IS BETTER IF YOU DROP OFF
THE CALL AND REJOIN IF NEEDED**

Today's agenda

- Oregon Medicaid Meaningful Use TA program
- Updates
- DHS Custody / 834s Q&A
- 2015 Health System Transformation Report Overview
- Dashboard survey results and future development
- Cigarette Smoking Prevalence and Childhood Immunization metric Q&A

Oregon Medicaid
Meaningful Use Technical
Assistance Program
(OMMUTAP)

Technical Assistance to Medicaid Providers

- With support of CCOs, OHA retained \$3 million of the Transformation Funds to leverage federal funds for investing in statewide HIT infrastructure
- Technical Assistance to support Oregon Medicaid providers/clinics to “meaningfully use” their EHR is one area of this investment
 - TA provided through contract with OCHIN; program available, January 2016 – May 2018
- Recently the Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP) was launched

OMMUTAP Services

Interoperability
Consulting and
Technical Assistance



Certified EHR
Assessment,
Implementation
and Upgrade
Assistance

Stage 1: Assessment

Stage 2: Planning

Stage 3: Selection

Stage 4: Implementation

Stage 5: Evaluation

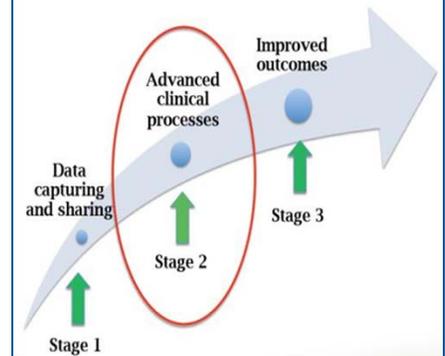
Stage 6: Improvement

Risk & Security
Training and
Assessment



Meaningful Use
Education &
Attestation
Assistance

Stages of Meaningful Use



Value of TA Services to CCOs



- Meet your EHR-based Incentive Measures by assisting your providers and clinics in capturing Clinical Quality Measures (CQM) data in a format that can be submitted to OHA electronically.
- Better position your CCO to meet EHR adoption benchmarks and EHR-based Incentive Measures from the Metrics and Scoring Committee in 2016 and 2017.
- Fully functional and interoperable EHRs can improve efficiency and quality in your CCO's participating clinics, which means lower costs, better outcomes and healthier communities.

Changing CQM Reporting Requirements

CCOs have to extract data directly from EHRs for reporting on three CQMs. Last year CCOs submitted aggregate clinic level data for clinics that covered 50% of their Medicaid population



Number goes to up 65% for CY 2016 (due spring 2017)



Number goes to up 75% for CY 2017 and **data will need to be extracted directly from providers' EHRs at patient level** (due spring 2018)



CCO CQM Reporting Requirements (part of Oregon's 1115 waiver from CMS)

17 metrics (4 relate to HIT)

- 1 - EHR adoption
- 3 - Clinical Quality Measures (hypertension, diabetes, depression screening and follow-up) that require CCOs to extract data directly from provider EHRs

New CQM metrics possible including tobacco cessation

TA Program Scope

Medicaid Eligible Professional Type – enrolled Medicaid provider who is a

- physician,
- dentist,
- nurse practitioner, including certified nurse midwife, or
- physician assistant in certain circumstances

Not in Scope:

- Any services outside of the Menu of Services
- Information Technology (licenses, systems, software, interfaces, etc.)
- Any activities outside of the Provider Agreement for TA Services
- Project implementation/project management
- Services previously supplied to a provider by the Regional Extension Center (REC)

Regions and CCOs

Region	CCO	Area of Oregon
Region 1	PacificSource Community Solutions CCO, Central Oregon Region	Central Oregon
Region 2	Eastern Oregon CCO	Eastern Oregon
Region 3	Trillium Community Health Plan	Eugene/Springfield
Region 4	PacificSource Community Solutions CCO, Columbia Gorge Region	Hood River/The Dalles
Region 5	Columbia Pacific CCO	Northern Coast
Region 6	<ul style="list-style-type: none"> • FamilyCare, Inc. • Health Share of Oregon 	Portland Metro
Region 7	<ul style="list-style-type: none"> • Intercommunity Health Network CCO • Willamette Valley Community Health 	Salem/Albany/Corvallis
Region 8	<ul style="list-style-type: none"> • Umpqua Health Alliance • Western Oregon Advanced Health 	Southern Coast
Region 9	<ul style="list-style-type: none"> • Allcare Health Plan • Cascade Health Alliance • Jackson Care Connect • PrimaryHealth of Josephine County 	Southern Oregon
Region 10	Yamhill Community Care Organization	Yamhill

Approach for TA Services

Engage CCOs in developing regional workplans

- Identify Needs and Priorities
- OCHIN will develop a regional workplan for TA services to address priorities

Engage priority practices in TA services

- Practices can select priority TA activities from the Menu of Services, up to a specific cap of hours per provider (maximum 10 providers per practice)
- OCHIN will develop a Provider Agreement for TA with each practice

Deliver and track TA services

Flow of Activities

- Develop Regional Workplans, ideally starting within the next 30 days
 - OHA, OCHIN, and CCO(s) meet to discuss vision for region
 - Identify priority practices and TA needs in the region
- Communication and outreach to priority practices
- Clinic/provider agree to participate; outline of TA activities and timeline
- Periodic meetings to discuss progress and priorities
- Program available: January 2016-May 2018

Updates

Clinical Quality Measures

- All CCOs successfully submitted Year 3 Data Proposals.
- OHA has finished reviewing and provided results to all CCOs.
- Next steps: Year Three data submission due to OHA no later than April 1st.

Updated Specification Sheets

(Nov – Jan)

- PQIs – corrected 2015 coding
- Adolescent Well Care Visits – 2016 benchmark added
- SBIRT – 2015/2016 “and” statement in denom clarified
- Dental Sealants – 2015 / 2016 anchor date added
- Effective Contraceptive Use – code tables corrected
- Controlling HTN – 2016 benchmark corrected
- PCPCH – 2016 reporting dates added

www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

New 2016 Specification Sheets (Jan)

- Appropriate testing for children with pharyngitis
- Cervical cancer screening
- Chlamydia screening
- Diabetes care: HbA1c and LDL-C screening
- Early elective delivery
- Health status (CAHPS)
- Immunizations for adolescents
- Medical assistance for smoking cessation (CAHPS)
- Physician Workforce Survey
- Well child visits

www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

New Guidance Document

- Strategies for improving childhood immunization rates

www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

PCPCH Enrollment update

Quarterly PCPCH enrollment online survey now has new (optional) field:

- Number of members assigned to NCQA-recognized medical homes.

These should ONLY be mutually exclusive members; members that are assigned to practices that are both OHA PCPCH certified and NCQA-recognized should be reported under the required PCPCH fields.

Immunization Data

- Intent to provide quarterly files to CCOs containing data from ALERT, beginning in March.
- Data will be broader than new childhood IZ metric – can be used to calculate metric, QI, etc.
- Files will be posted on Business Objects along with the metrics dashboard.
- Each CCO must complete a data use agreement by March 25th to receive these ALERT files. Return completed DUA to metrics.questions@state.or.us.

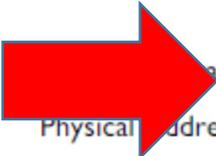
ALERT data use agreement (page 1)



ALERT IIS
800 NE Oregon Street, Suite 370
Portland, Oregon 97232
Phone: (800)980-9431
Fax: (971)673-0276
Web: www.alertiis.org
Email: alertiis@state.or.us

Authorized Site Agreement – Health Plans, IPAs, Parent Organizations

Please provide all of the information requested on both pages of this agreement.
Failure to provide information may delay your access to ALERT IIS.

 Organization: _____

Physical Address: _____ City, State, Zip: _____

Mailing Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Email: _____

Organization Type (check all that apply): Health Plan IPA Parent Org Other: _____

Primary Contact First Name: _____ Middle Initial: _____ Last Name: _____

Title: _____ Phone: _____ Email: _____

Authorized Representative (e.g., Executive Director, CEO, Managing Physician): _____

Title: _____ Phone: _____ Email: _____

ALERT data use agreement (page 2)

Will this organization be submitting and/or accessing data for multiple locations/sites? Yes No
If yes, please list on following page, or submit list of participating sites with location information
(note: these sites will also need to sign local specific Center for Organization Site Agreements)

Additional Clinic/Site Locations:

Name of Organization: _____ Name: _____
Physical Address: _____ State, Zip: _____

This form must be signed by both the organization's Primary Contact and Authorized Representative.

Failure to abide by this agreement may result in immediate termination, suspension, or revocation of access to ALERT
of ALERT IIS data will be reported to the appropriate licensing body.

Signature of Primary Contact: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Dashboard Release Schedule

- January 27th
 - September 1, 2014 – August 31, 2015
 - Final chart review samples
- No February dashboard
 - Skipping month to allow dashboard conversion to ICD10
- March 30th
 - December 1, 2014 – November 30, 2015
 - First data files from ALERT

Metrics & Scoring Committee: January 20th Meeting

Materials online at

www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx

Hospital Transformation Performance Program (HTPP) Update

- Year 2
- Year 3 Planning (CMS / H-TAG)
- Hospital Performance Metrics Advisory Committee meeting, 22 January 2016

DHS CUSTODY / 834 Q&A

Why is OHA still providing notification files? When will the files stop?

- Given the challenges using the 834s to identify children in foster care, OHA has continued to provide weekly notification lists to support CCO processes and validation efforts.
- OHA intends to stop providing the weekly notification files after March 31st.
 - For CY 2015 – the start date of the 60 day window is based on the notification file date.
 - For CY 2016 – the start date of the 60 day window is based on the 834s.

What happens when CCOs receive a child in 834 files on date 1, effective eligibility is on date 2, and date 3 in weekly notification file?

- For CY 2016, the 60 day window starts from date 1 – when the CCO receives notification via the 834s.
- If the effective eligibility date (date 2) is more than 7 days away from date 1, the child will be excluded from the measure (see previous “future enrollment” exclusion).

What happens when a CCO receives multiple notifications for a child, as their plan type changes (e.g., CCOG → CCO A)? Is the start date the date the child was enrolled in the CCO A AND has PERC code 19 or GA?

- Yes, the start date would be the date in which the CCO was notified (via the 834) that the child was enrolled in CCO A and has one of the qualifying PERC codes.
- Note the measure only includes children who are enrolled in CCO A.

What happens when CCO isn't responsible for all benefits (e.g., only covers mental and dental, or physical and mental)?

- The measure only includes children who are enrolled in CCO A, where the CCO is responsible for all benefits (mental, physical, and dental).
- Note state law requires children to receive all the assessments so in the event that a CCO is not responsible for all benefits, DHS is responsible for ensuring the child receives all assessments.

What happens with trial reunification?

- If the trial reunification results in the child moving to a different CCO, the child is excluded from the initial CCO's measure.
- If the trial reunification does not result in the child moving to a different CCO, the child remains in the measure and the CCO is still responsible for ensuring that all assessments have been completed.

What happens with out of area placements?

- If an out of area placement results in the child moving to a different CCO, the child is excluded from the initial CCO's measure.
- If the out of area placement does not result in the child moving to a different CCO, the child remains in the measure and the CCO is still responsible for ensuring that all assessments have been completed, even if the child is placed out of the CCO's region.

How are new DHS custodies identified in the 834s, since there are multiple notifications?
Does a PERC code change trigger a new 834?

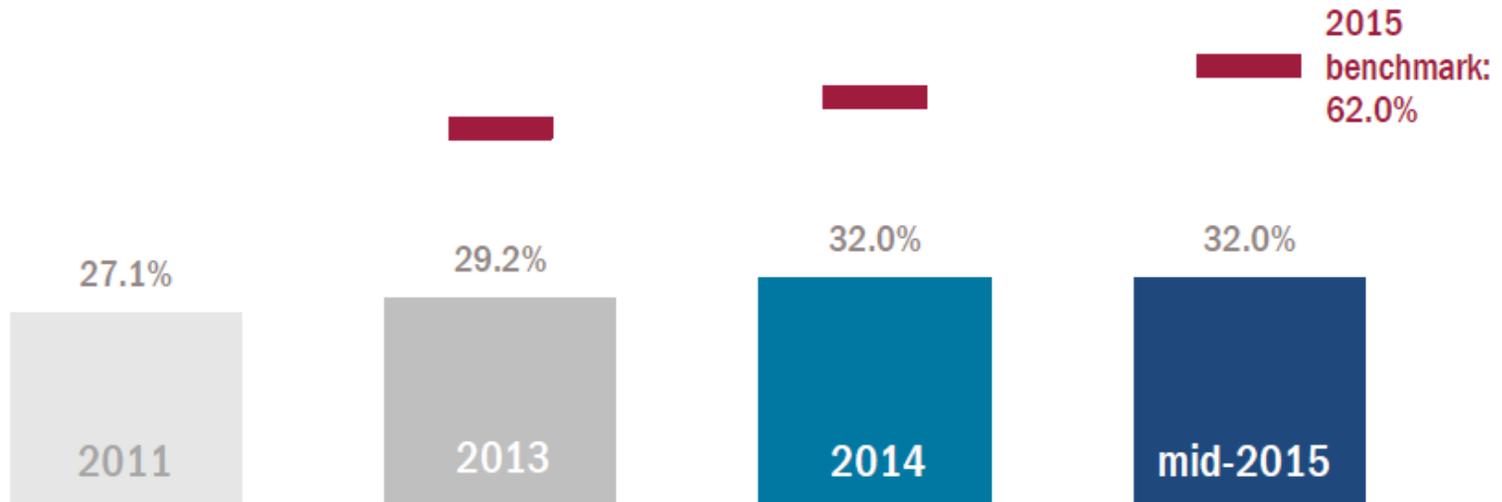
Oregon's Health System Transformation: CCO Metrics

 2015 Mid-Year Report

<http://www.oregon.gov/oha/Metrics/>

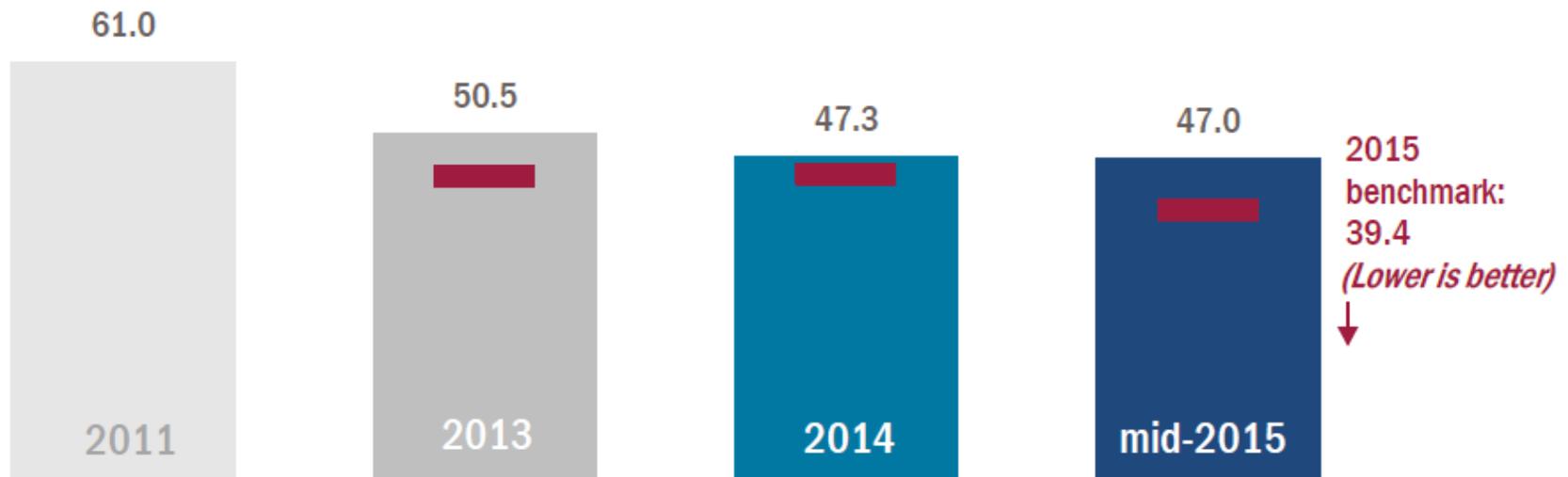
ADOLESCENT WELL-CARE VISITS

Statewide, the percentage of adolescents receiving well-care visits remained steady between **2014** and **mid-2015**.



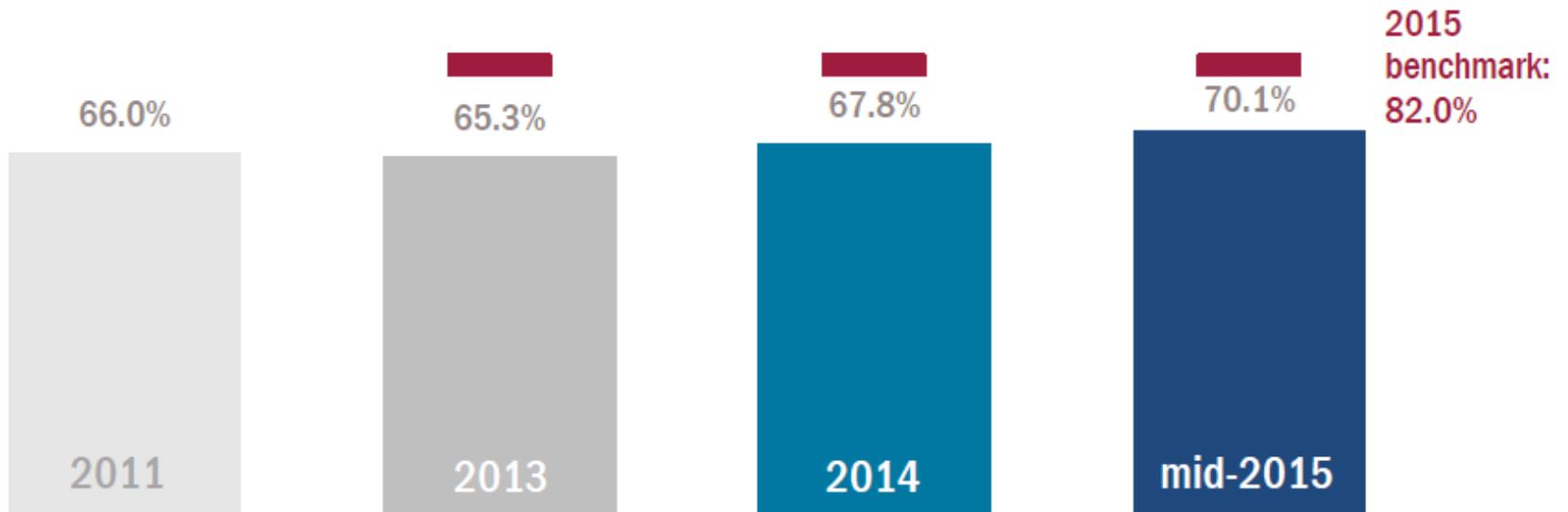
   **AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION**

Statewide, emergency department utilization remained steady between **2014** and **mid-2015**.



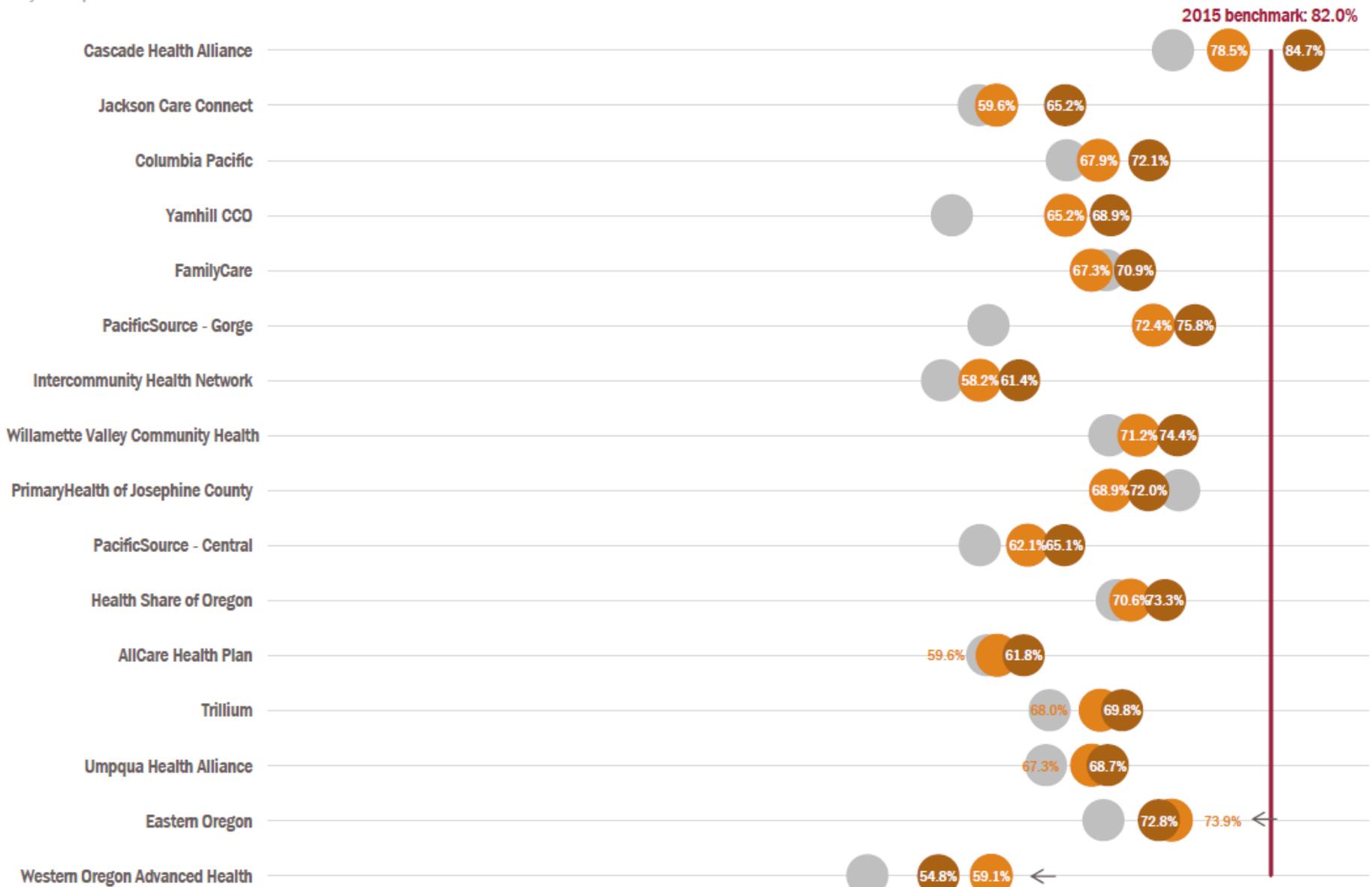
CHILDHOOD IMMUNIZATION STATUS

Statewide, the percentage of children who received recommended vaccines before their second birthday continues to improve.



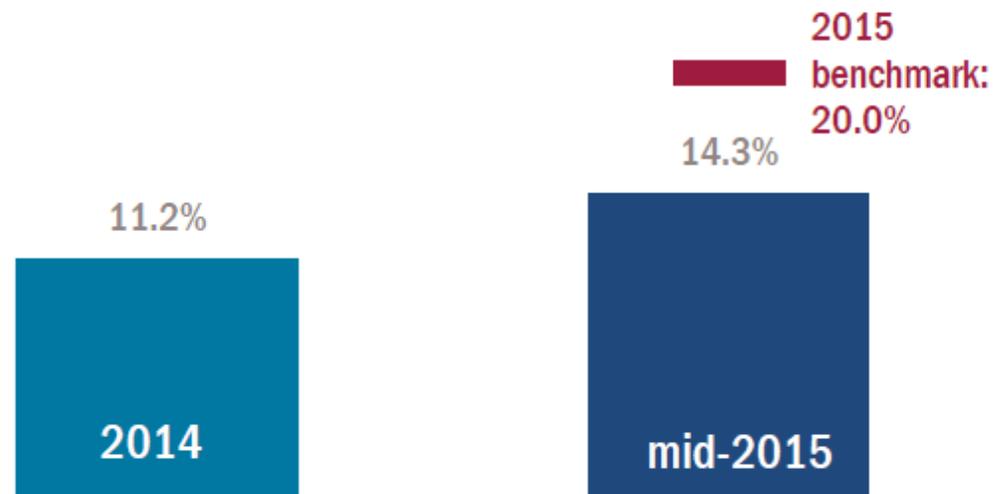
Childhood immunizations increased in 14 of 16 CCOs between 2014 & mid-2015.

Gray dots represent 2013.

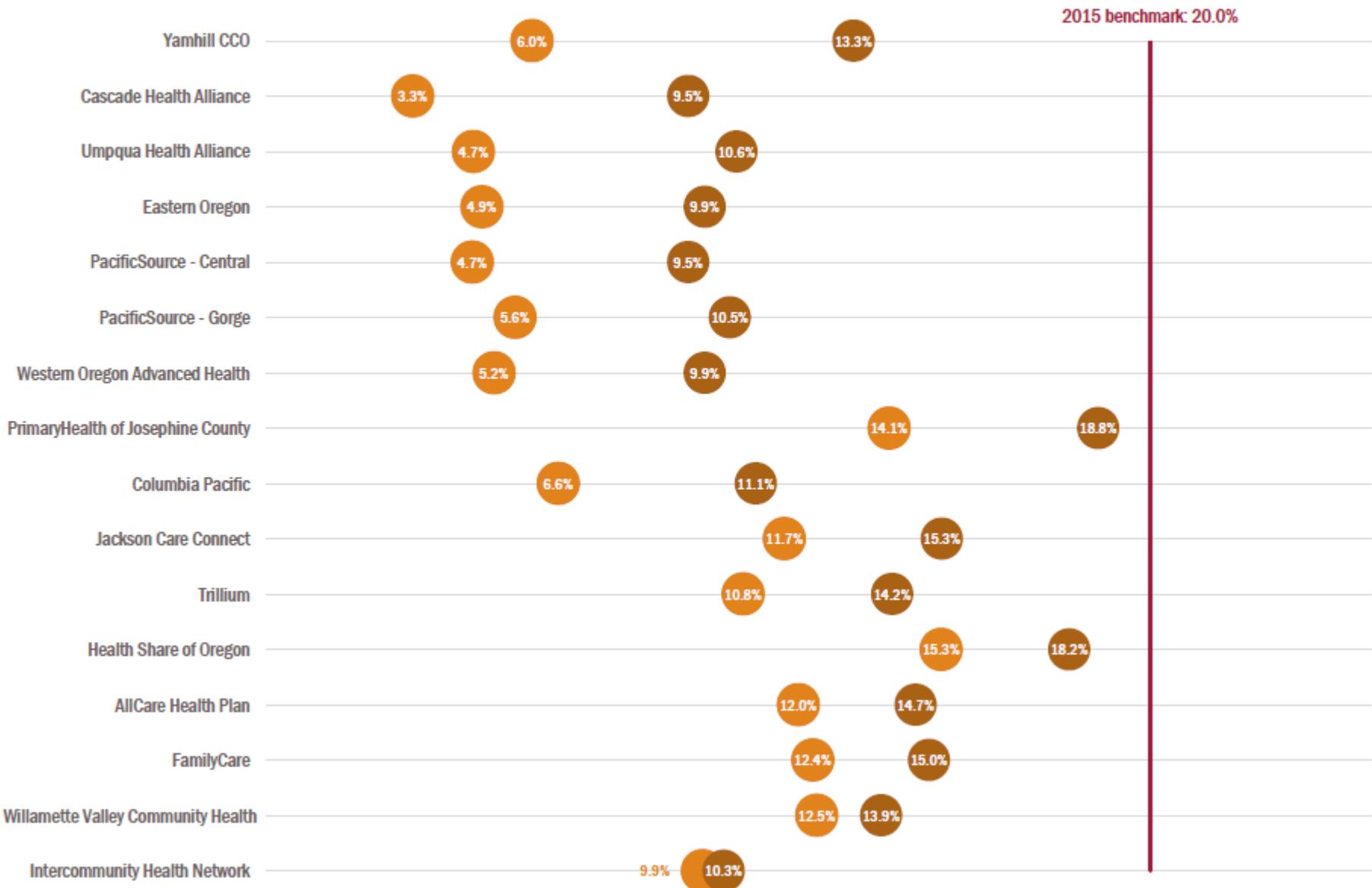


\$ DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN - ALL AGES (6-14)

Statewide, the percentage of children ages 6-14 who received dental sealants has increased.

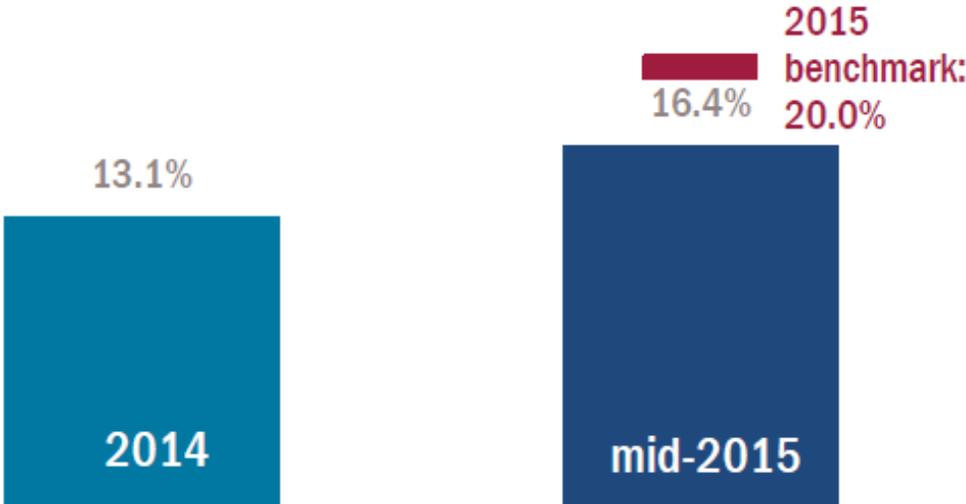


CCOs improved considerably on dental sealants for children (all ages) between 2014 & mid-2015.



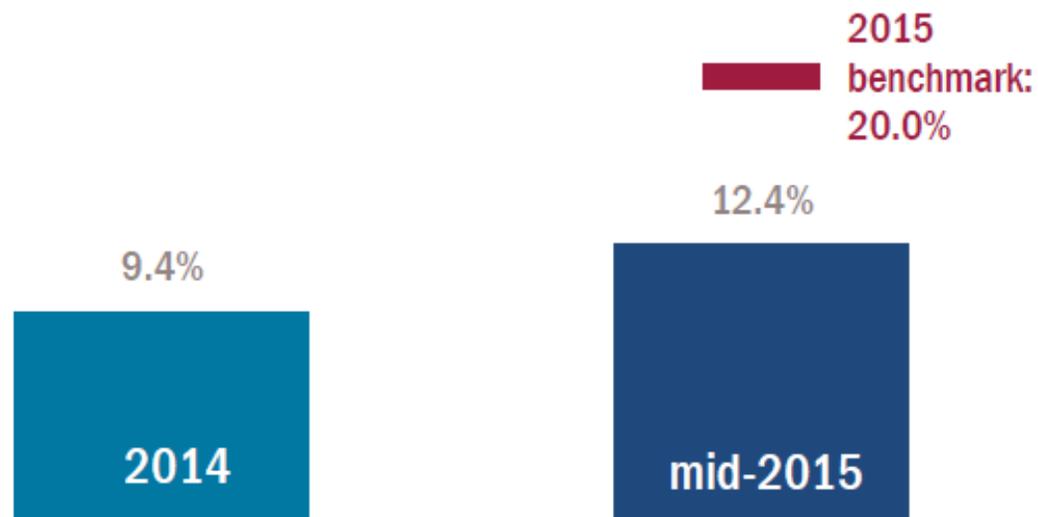
DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (AGES 6-9)

Statewide, the percentage of children ages 6-9 who received dental sealants increased between 2014 and mid-2015.



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (AGES 10-14)

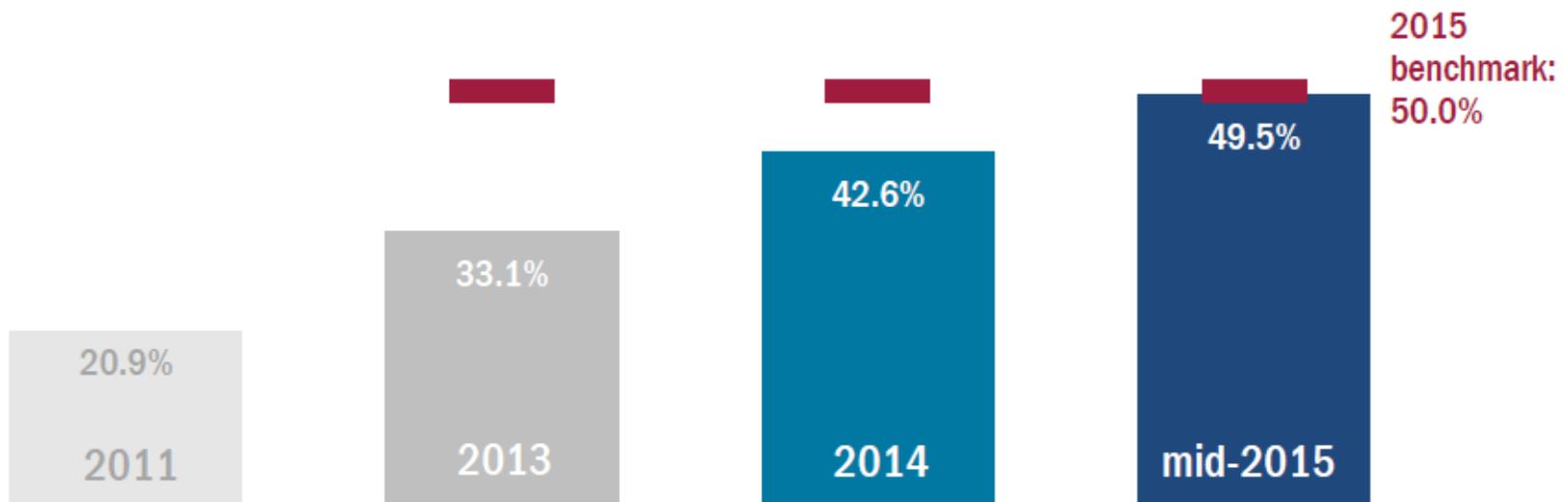
Statewide, the percentage of children ages 10-14 who received dental sealants has increased.





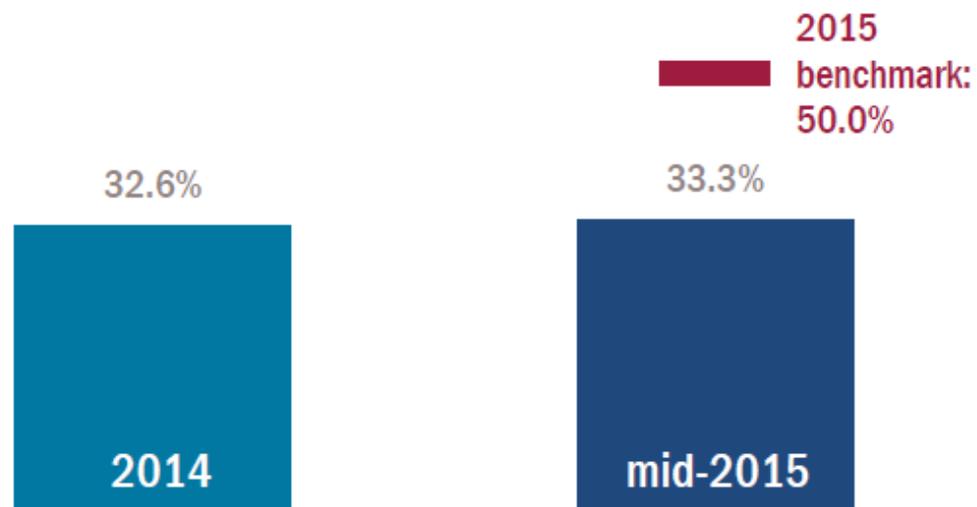
DEVELOPMENTAL SCREENING IN THE FIRST 36 MONTHS OF LIFE

Statewide, developmental screening continues to improve and is near the benchmark as of **mid-2015**.

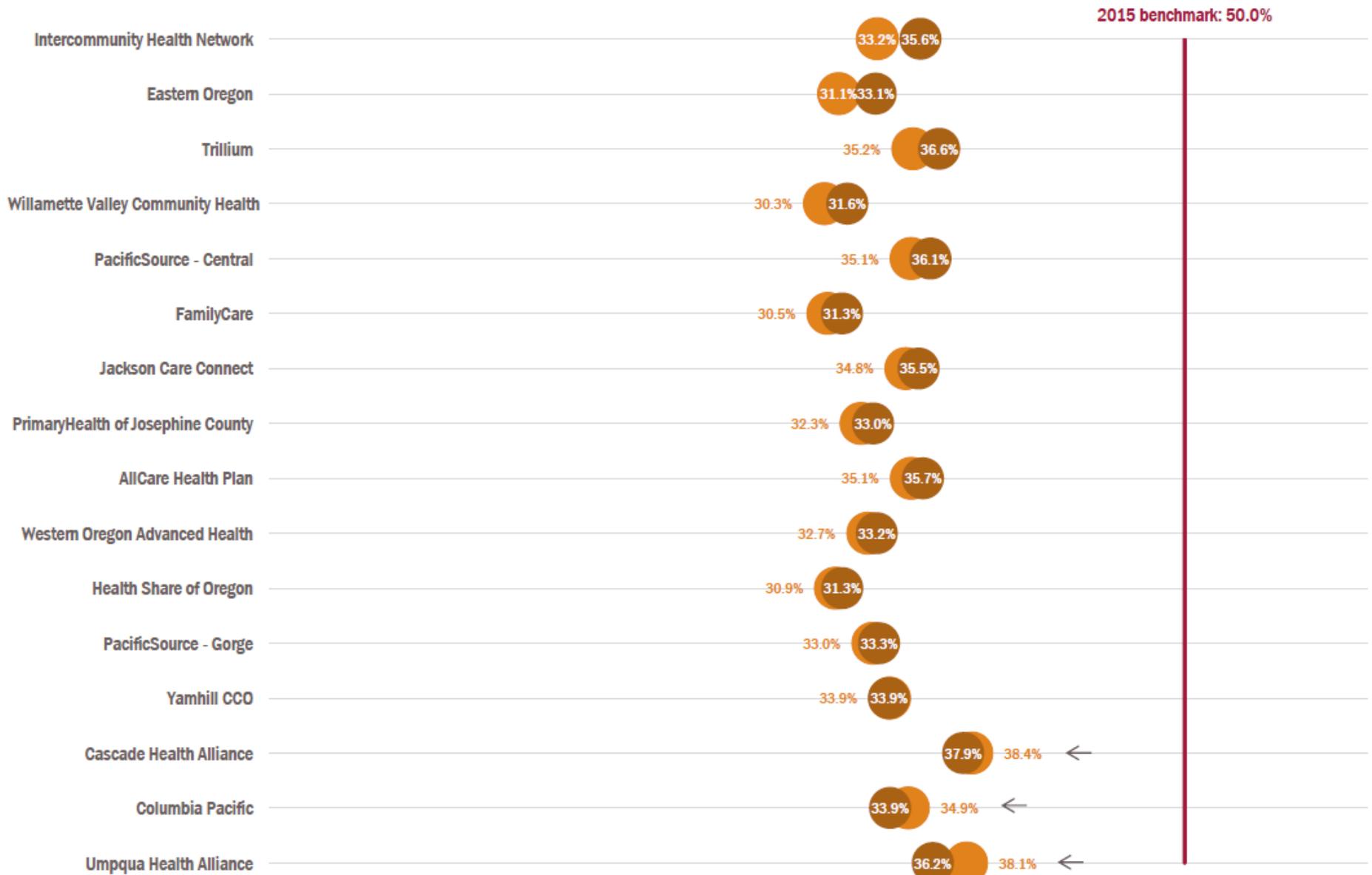


EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY - ALL AGES (15-50)

Statewide, effective contraceptive use among women at risk of unintended pregnancy remained fairly steady between **2014** and **mid-2015**.

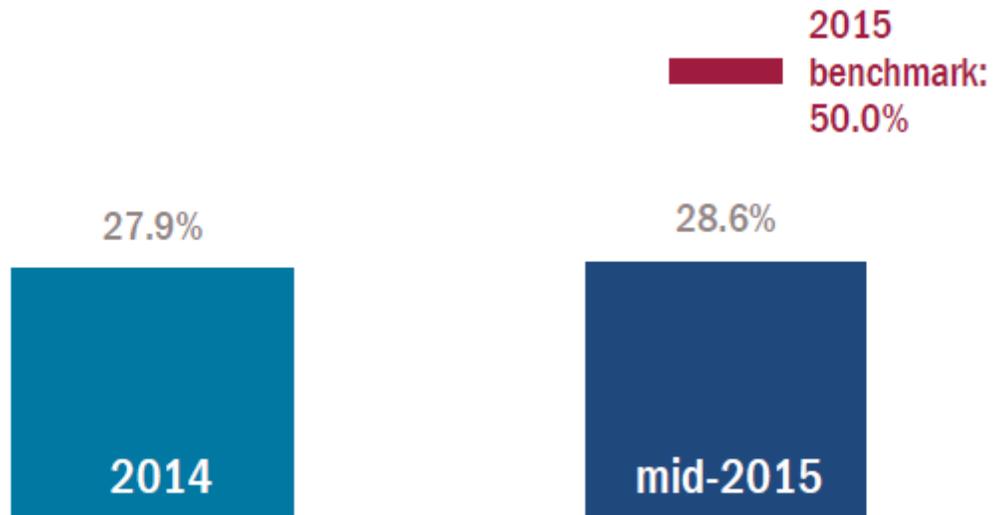


The percentage of women at risk of unintended pregnancy who used effective contraceptives was similar across CCOs in 2014 & mid-2015.



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (AGES 15-17)

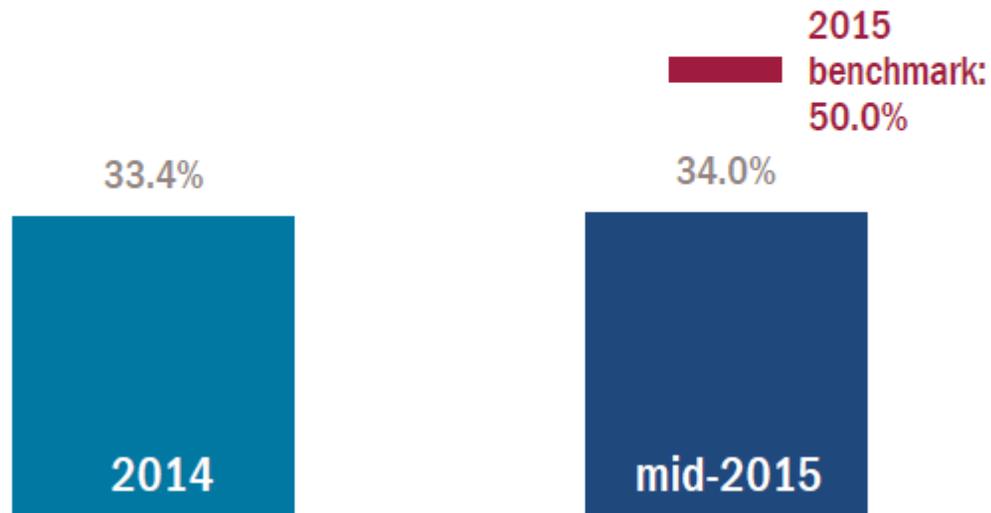
Effective contraceptive use among adolescents (ages 15-17) at risk of unintended pregnancy, statewide.





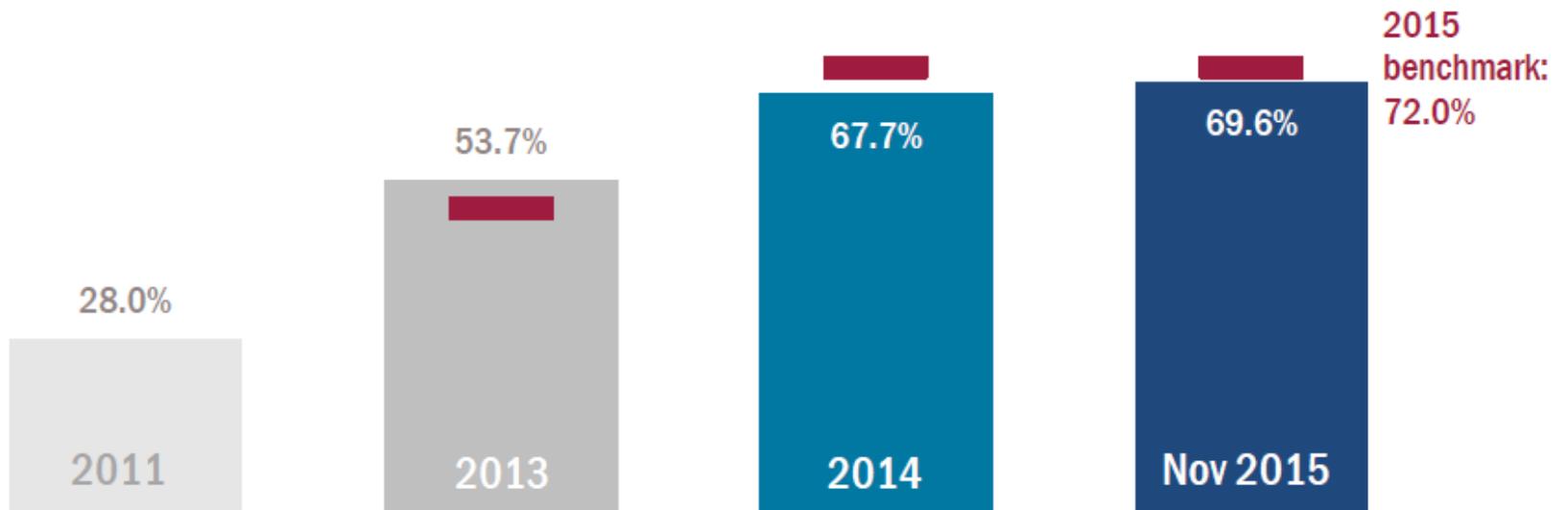
EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (AGES 18-50)

Statewide, effective contraceptive use among adults remained fairly steady between **2014** and **mid-2015**.



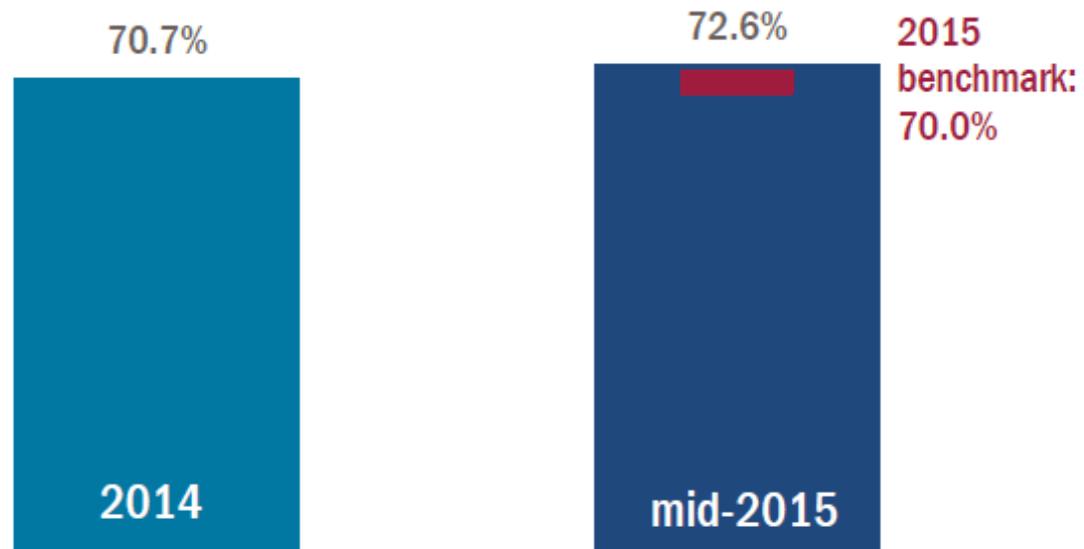
   **ELECTRONIC HEALTH RECORD ADOPTION**

Statewide, electronic health record adoption continues to improve.



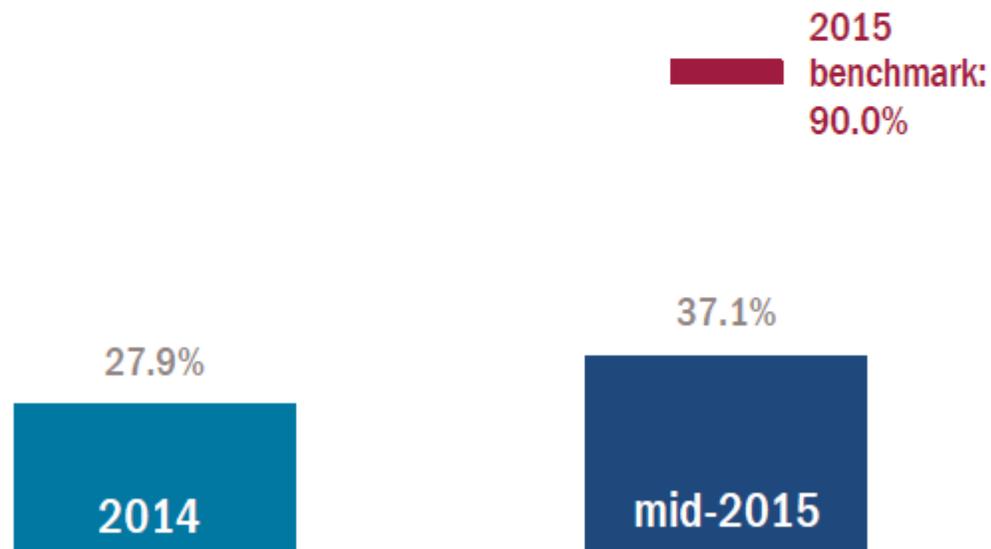
   FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Statewide, follow-up after hospitalization for mental illness has increased slightly, and exceeds the benchmark.



  MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Statewide, health assessments for children in DHS custody improved considerably between **2014** and **mid-2015**, but remain well below the benchmark.



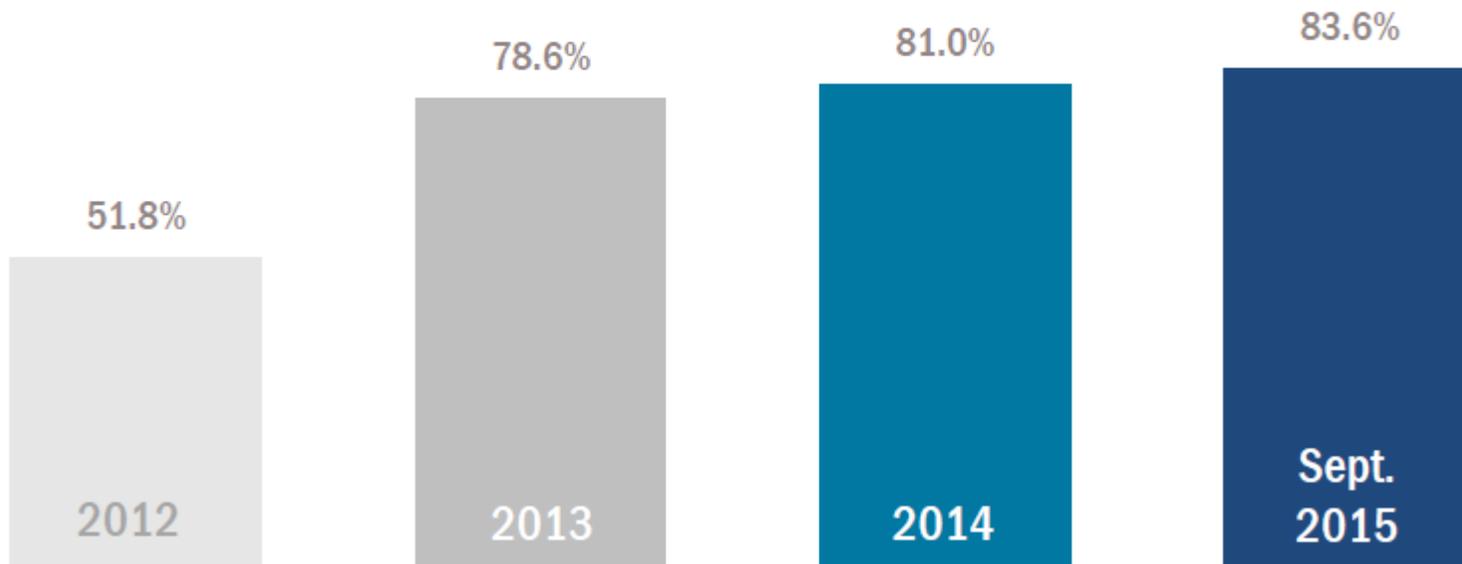
Overall, CCOs improved on this measure between 2014 & mid-2015, but remain well below the benchmark.

~ data suppressed (n<30)



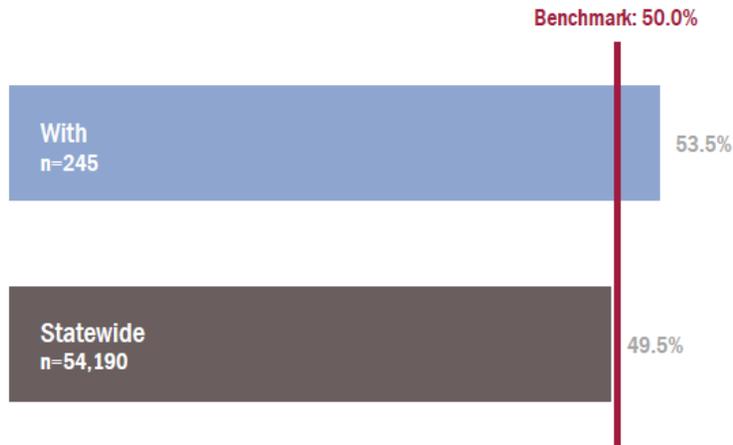
\$ **📈** **PATIENT-CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT**

Statewide, patient-centered primary care home enrollment continues to increase.

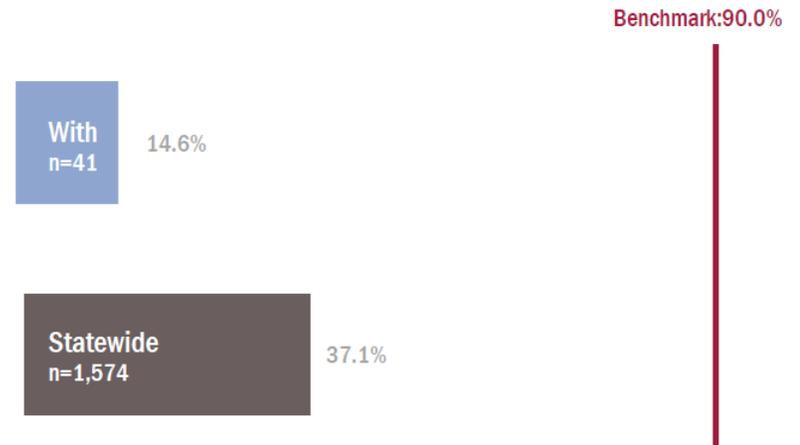


MEASURES BY DISABILITY

Children **with disability** received development screenings during the first 36 months of life more frequently than statewide.

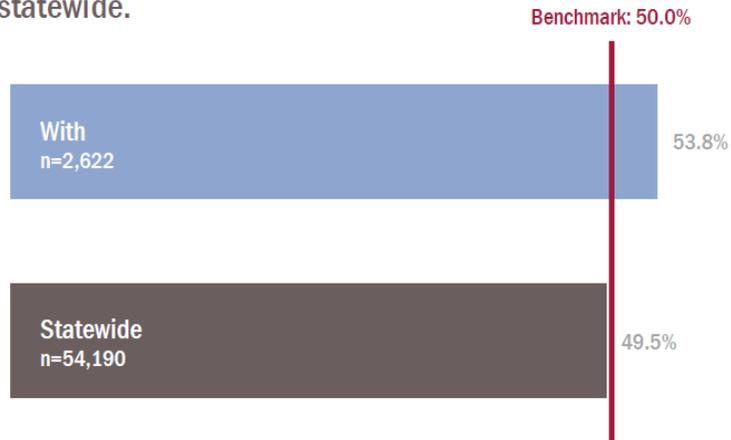


Children in DHS custody (foster care) **with disability** received mental, physical, and dental health assessments less frequently than the statewide average.

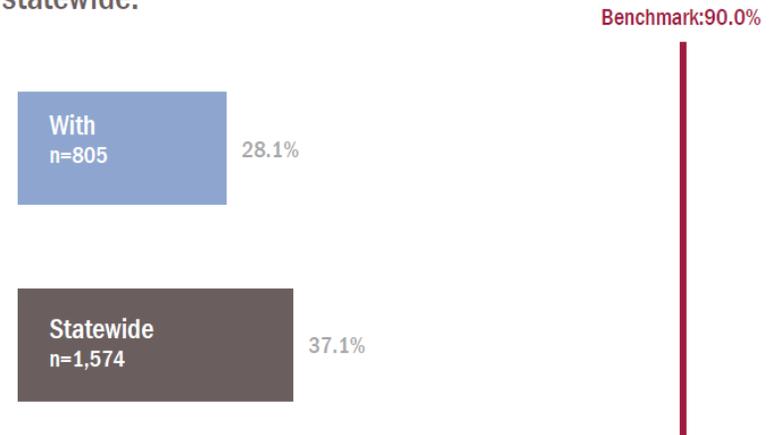


MEASURES BY MENTAL HEALTH DIAGNOSES

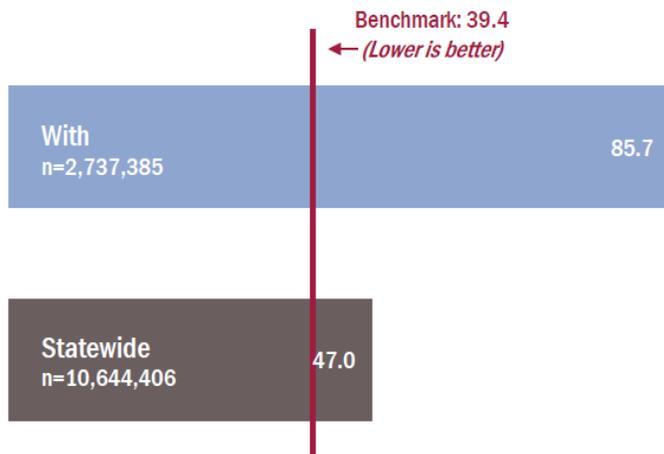
Development screenings during first 36 months of life for children **with mental health diagnoses** compared with statewide.



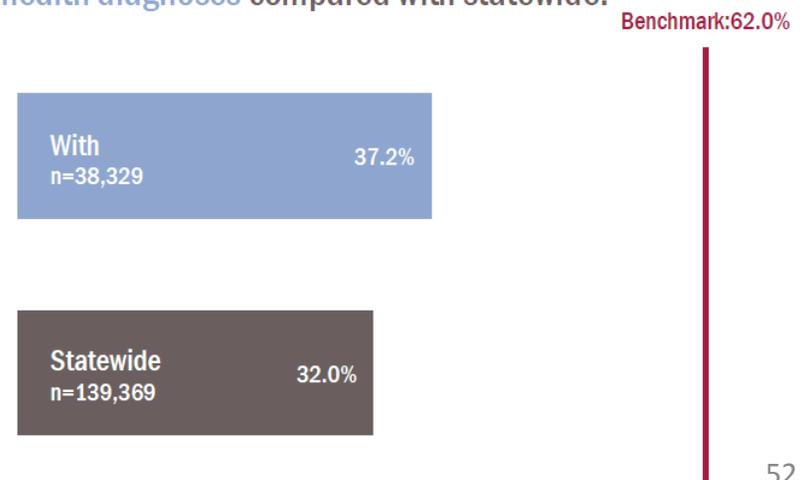
Mental, physical, and dental health assessments for children in DHS custody **with mental health diagnoses** compared with statewide.



Emergency department utilization among members **with mental health diagnoses** compared with statewide.



Adolescent well-care visits among members **with mental health diagnoses** compared with statewide.



MEASURES BY SEVERE AND PERSISTENT MENTAL ILLNESS

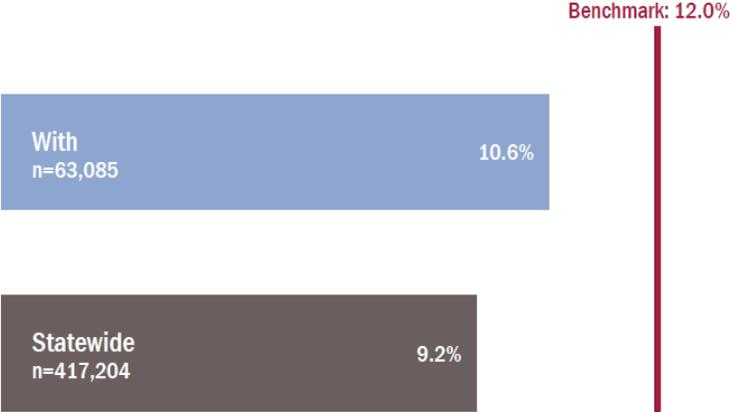
Emergency department utilization among members with severe and persistent mental illness compared with statewide.



Follow-up after hospitalization for mental illness for adult members with severe and persistent mental illness compared with statewide.



SBIRT for adults with severe and persistent mental illness compared with statewide.





Questions?

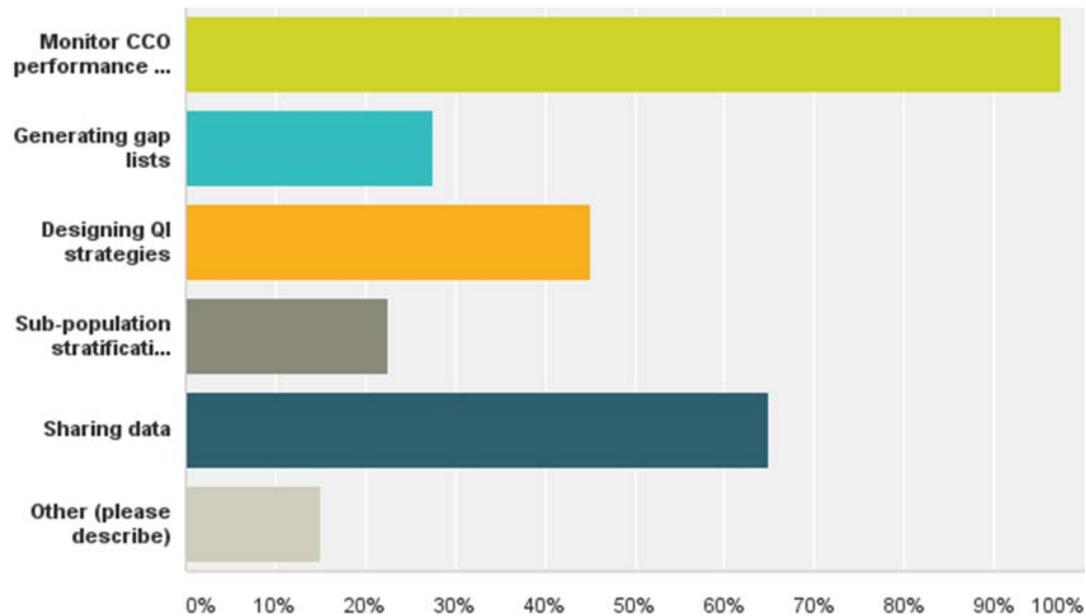
DASHBOARD SURVEY RESULTS & FUTURE DEVELOPMENT

Basic Stats

- 40 responses
- All CCOs represented
- Variety of job titles
 - Quality Specialist/Manager
 - Data Analyst
 - Medical Director
- Most people (63%) access the dashboard monthly
 - 28% access it more frequently
- All respondents share dashboard info with others
 - 90% - other CCO staff
 - 45% - providers
 - 35% - other community stakeholders
 - 10% - Community Advisory Council

Dashboard Usage

For what purposes do you use the dashboard? (select all that apply)



The 6 individuals who responded “other” all mentioned validating internal data in their open-ended responses.

Dashboard Usage – Filters

Which dashboard filters do you often use?
(select all that apply)

- County (59%)
- Age (49%)
- Chronic conditions (43%)
- Gender (43%)

56% of respondents use filters in combination.

Other Cool Filters!

- SPMI (Any disorder or stratified by disorder type)
- Substance Use Disorders
- Disability
- Household Language

Disability	Gender
Yes	Female
No	Male
Chronic Conditions	Adults or Children
Yes	Adults
No	Children
Mental Health Diagnoses	Age Category
Yes	<1-18
No	19-25
	26-64
	65+
Substance Use Disorders	Age
Yes	<1
No	1
	2
	3
	4
Any SPMI Disorder	Race/Ethnicity
Yes	African American/Black
No	American Indian/Alaskan N...
	Asian American
	Hawaiian/Pacific Islander
	Hispanic/Latino
SPMI - Schizophrenia and Other Psychotic Disorders	Household Language
Yes	Cambodian
No	Cantonese, Mandarin, Othe...
	Chamorro
	English
	Farsi
SPMI - Major Depression and Bipolar Disorders	
Yes	
No	
SPMI - Anxiety Disorders	
Yes	
No	
SPMI - Personality Disorders	
Yes	
No	

Dashboard Usage – Member Data

71% of respondents utilize the Member Data tab

- Validating internal reporting
- Generating gap lists
- Adding internal info to parse metric performance by partner organization

In-House Data Analytics

95% of respondents have their own in-house analytic capacity

- 92% of those use the dashboard in addition to or in conjunction with their in-house analytics
- Many use the dashboard to validate their in-house analytics
- In-house analytics are commonly used to assess measure performance more frequently (weekly) and to generate member lists/gap lists for providers

Additional Features Desired

26 total open-ended responses.

- More timely data

 - Beginning with March dashboard, reporting lag will decrease by 1 month.

- YTD reporting

 - OHA will continue rolling 12-month reporting in order to clearly and accurately indicate data trends.

Dashboard Performance

83% of respondents reported no issues with dashboard functionality

- Reported problems were slowness, freezing and not tolerating the application of multiple filters.

→ Dashboard vendor will assist those who reported problems 1:1

84% of respondents reported no issues accessing the dashboard through Business Objects

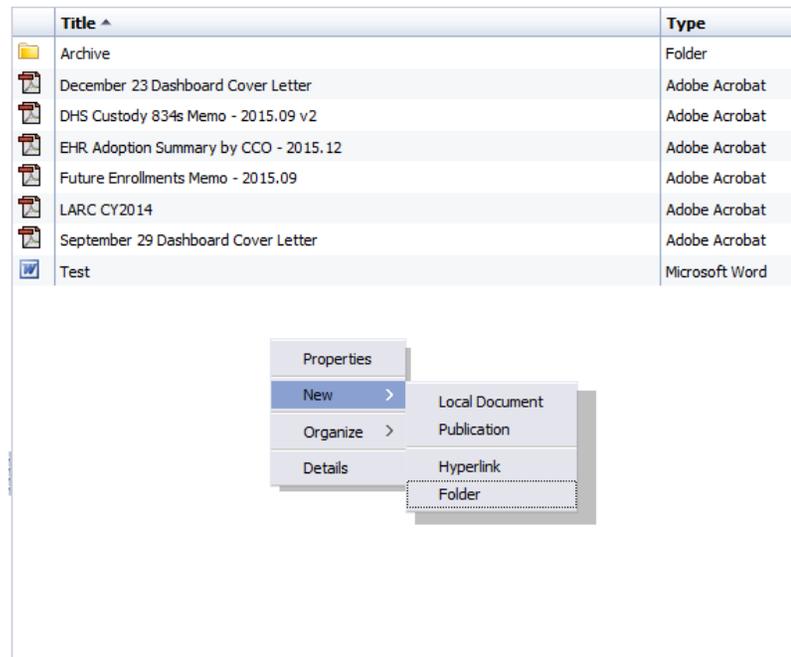
- Reported problems were difficulty navigating folders and files, frequent password expiration

→ Consistent naming conventions developed

Business Objects Folders

Create your own sub-folders to organize your Business Objects repository

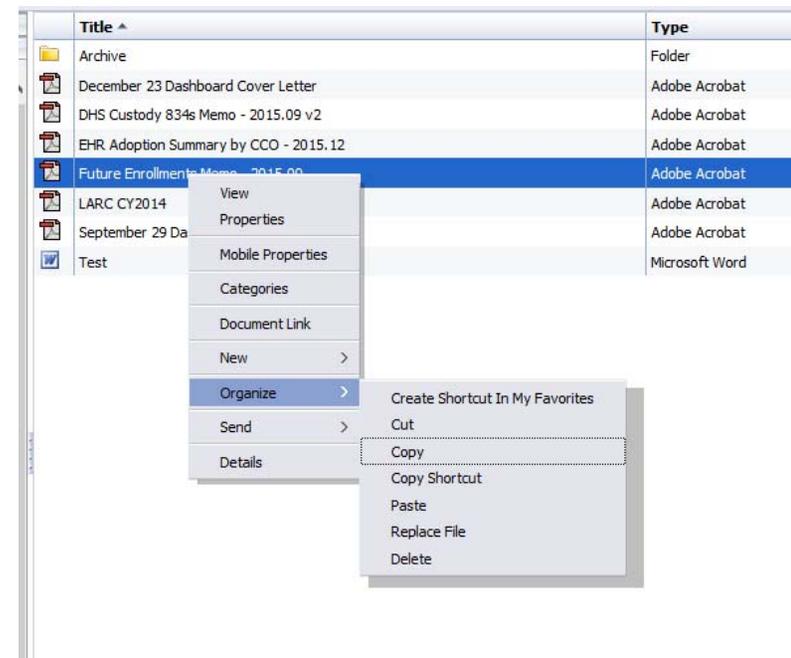
- Right-click
- “New”
- “Folder”



Business Objects Folders

Move files into subfolders

- Right-click a file name
- “Organize”
- “Cut”
- Open subfolder
- Right-click
- “Organize”
- “Paste”



Thank You

- Suggestions for next survey?
 - Timing?
 - Format?
 - Other questions?

METRIC Q&A

Cigarette Smoking Prevalence & Childhood Immunization Status

Does the new childhood immunization incentive measure exclude children with medical contraindications?

- No. OHA specifications do not incorporate the optional HEDIS exclusions.

Does the measure exclude children on delayed schedules or parental refusal?

- No

How can CCOs access ALERT?

- Short-term solution: quarterly files provided with metrics dashboard (see earlier slides)
- Immunization program considering longer-term solutions TBD.

Who should I contact for immunization questions?

- If specifications / measure validation / Business Objects Repository related – metrics.questions@state.or.us
- If quality improvement / practice-level technical assistance for ALERT / gap list related – Rex Larsen Rex.A.Larsen@state.or.us
- If related to ALERT data quality – Rex Larsen Rex.A.Larsen@state.or.us

What counseling is required for the minimum cessation benefit?

- To meet the minimum cessation benefit requirement, CCOs must cover all three types of counseling:
 - Individual
 - Group
 - Telephone
- Counseling coverage must include at least 4 sessions of at least 10 minutes each.

Is the quit line counseling available to all Oregonians through the state tobacco program sufficient for “telephone counseling”?

- No. CCOs must provide telephone counseling for their members, either through their own contract with Alere (or another quit line vendor), and/or through in-house staff to meet the minimum cessation benefit requirement.

Do all 7 cessation medications have to be available without prior authorization to meet the benefit requirement?

- No – only nicotine patches and nicotine gum must be available without prior authorization to meet the minimum cessation benefit requirement.

Why is the minimum quantity for nicotine inhaler longer than all other products (180 days compared to 90)?

- There is clinical evidence supporting longer duration for the nicotine inhaler than for the other products.

See table 3.5 in Treating Tobacco Dependence (clinical practice guidelines) for dosing recommendations.

www.ncbi.nlm.nih.gov/books/NBK63943/#A28430

Do CCOs have to cover bupropion on their formulary since it is a 711 drug?

- Yes – CCOs must cover bupropion (the specific generic for cessation) and/or Zyban on their formulary to meet the minimum cessation benefit requirement.
- See pages 9-11 of the specification sheet for more details.

www.oregon.gov/oha/analytics/CCOData/Cigarette%20Smoking%20Prevalence%20Bundle%20-%202016%20-%28revised%20Jan%202016%29.pdf

Would it be helpful to have a webinar in early February for additional time for metrics questions?

Please note this would be in addition to time being held on the February 8th QHOC afternoon agenda for similar questions.

Cigarette Smoking Prevalence: Specification Question

- How to handle patients in the denominator who do not have their smoking / tobacco use status recorded in the EHR?
 - As currently written, the measure specification would include these patients in the denominator (if they had the qualifying outpatient visit) and not include them in the numerator, resulting in an artificially lower rate (lower is better), potentially incentivizing practices NOT to record this information.
- Proposed solution:
 - Collect data on patients in denominator with smoking or tobacco use status not recorded as separate field. (2015 data collection template already modified).
 - Modify specifications to treat patients as exclusions; however, to avoid incentivizing practices to not record this information (e.g., for known tobacco users), also add ‘threshold’ – status must be recorded for at least **x%** of patients in the denominator.

Next Meeting

- February 25th, 1-3 pm
- Agenda:
 - Transformation Center technical assistance on metrics
 - Health Equity Index development update
 - Food Insecurity Screening white paper