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

Risk & Security Training and Assessment

Meaningful Use Education & Attestation Assistance
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

<table>
<thead>
<tr>
<th>Region</th>
<th>CCO</th>
<th>Area of Oregon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1</td>
<td>PacificSource Community Solutions CCO, Central Oregon Region</td>
<td>Central Oregon</td>
</tr>
<tr>
<td>Region 2</td>
<td>Eastern Oregon CCO</td>
<td>Eastern Oregon</td>
</tr>
<tr>
<td>Region 3</td>
<td>Trillium Community Health Plan</td>
<td>Eugene/Springfield</td>
</tr>
<tr>
<td>Region 4</td>
<td>PacificSource Community Solutions CCO, Columbia Gorge Region</td>
<td>Hood River/The Dalles</td>
</tr>
<tr>
<td>Region 5</td>
<td>Columbia Pacific CCO</td>
<td>Northern Coast</td>
</tr>
<tr>
<td>Region 6</td>
<td>• FamilyCare, Inc.</td>
<td>Portland Metro</td>
</tr>
<tr>
<td></td>
<td>• Health Share of Oregon</td>
<td></td>
</tr>
<tr>
<td>Region 7</td>
<td>• Intercommunity Health Network CCO</td>
<td>Salem/Albany/Corvallis</td>
</tr>
<tr>
<td></td>
<td>• Willamette Valley Community Health</td>
<td></td>
</tr>
<tr>
<td>Region 8</td>
<td>• Umpqua Health Alliance</td>
<td>Southern Coast</td>
</tr>
<tr>
<td></td>
<td>• Western Oregon Advanced Health</td>
<td></td>
</tr>
<tr>
<td>Region 9</td>
<td>• Allcare Health Plan</td>
<td>Southern Oregon</td>
</tr>
<tr>
<td></td>
<td>• Cascade Health Alliance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Jackson Care Connect</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• PrimaryHealth of Josephine County</td>
<td></td>
</tr>
<tr>
<td>Region 10</td>
<td>Yamhill Community Care Organization</td>
<td>Yamhill</td>
</tr>
</tbody>
</table>
## Approach for TA Services

<table>
<thead>
<tr>
<th>Engage CCOs in developing regional workplans</th>
<th>Engage priority practices in TA services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify Needs and Priorities</td>
<td>• 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)</td>
</tr>
<tr>
<td>• OCHIN will develop a regional workplan for TA services to address priorities</td>
<td>• OCHIN will develop a Provider Agreement for TA with each practice</td>
</tr>
</tbody>
</table>

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 1\textsuperscript{st}.
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.
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: ______________________________________________________
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 or specific Center or 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 31\textsuperscript{st}.

  – 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?
ADOLESCENT WELL-CARE VISITS

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

- 2011: 27.1%
- 2013: 29.2%
- 2014: 32.0%
- mid-2015: 32.0%

2015 benchmark: 62.0%
Statewide, emergency department utilization remained steady between 2014 and mid-2015.
Statewide, the percentage of children who received recommended vaccines before their second birthday continues to improve.

- 2011: 66.0%
- 2013: 65.3%
- 2014: 67.8%
- Mid-2015: 70.1%

2015 benchmark: 82.0%
Childhood immunizations increased in 14 of 16 CCOs between 2014 & mid-2015.

Gray dots represent 2013.

Cascade Health Alliance
Jackson Care Connect
Columbia Pacific
Yamhill CCO
FamilyCare
PacificSource - Gorge
Intercommunity Health Network
Willamette Valley Community Health
PrimaryHealth of Josephine County
PacificSource - Central
Health Share of Oregon
AllCare Health Plan
Trillium
Umpqua Health Alliance
Eastern Oregon
Western Oregon Advanced Health

2015 benchmark: 82.0%
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.

- Yamhill CC0: 6.0% (2015 benchmark: 20.0%)
- Cascade Health Alliance: 3.3%
- Umpqua Health Alliance: 4.7% (10.6%)
- Eastern Oregon: 4.5% (9.3%)
- PacificSource - Central: 4.7% (9.5%)
- PacificSource - Gorge: 5.6% (10.5%)
- Western Oregon Advanced Health: 5.2% (9.9%)
- PrimaryHealth of Josephine County: 6.6% (14.1%)
- Columbia Pacific: 11.1%
- Jackson Care Connect: 11.7% (15.3%)
- Trillium: 10.8% (14.2%)
- Health Share of Oregon: 12.9% (15.3%)
- AllCare Health Plan: 12.4% (15.0%)
- FamilyCare: 12.5% (13.9%)
- Willamette Valley Community Health: 9.9% (10.3%)
- Intercommunity Health Network
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.

- 2014: 13.1%
- Mid-2015: 16.4% (benchmark: 20.0%)
DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (AGES 10-14)

Statewide, the percentage of children ages 10-14 who received dental sealants has increased.
Statewide, developmental screening continues to improve and is near the benchmark as of mid-2015.
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.

- Intercommunity Health Network: 33.2% - 36.6%
- Eastern Oregon: 31.1% - 33.1%
- Trillium: 35.2% - 36.6%
- Willamette Valley Community Health: 30.3% - 31.6%
- PacificSource - Central: 36.1% - 36.1%
- FamilyCare: 30.6% - 31.3%
- Jackson Care Connect: 34.8% - 35.5%
- PrimaryHealth of Josephine County: 32.3% - 33.0%
- AllCare Health Plan: 35.1% - 35.7%
- Western Oregon Advanced Health: 32.7% - 33.2%
- Health Share of Oregon: 30.9% - 31.3%
- PacificSource - Gorge: 33.0% - 33.3%
- Yamhill CCO: 33.9% - 33.9%
- Cascade Health Alliance: 37.9% - 38.4%
- Columbia Pacific: 33.9% - 34.9%
- Umpqua Health Alliance: 36.2% - 38.1%
Effective contraceptive use among adolescents (ages 15-17) at risk of unintended pregnancy, statewide.

- 2014: 27.9%
- Mid-2015: 28.6%
- 2015 benchmark: 50.0%
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.

2011: 28.0%
2013: 53.7%
2014: 67.7%
Nov 2015: 69.6%

2015 benchmark: 72.0%
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

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

- 70.7% in 2014
- 72.6% in mid-2015

2015 benchmark: 70.0%
Statewide, health assessments for children in DHS custody improved considerably between 2014 and mid-2015, but remain well below the benchmark.

- **2014**: 27.9%
- **mid-2015**: 37.1%

**2015 benchmark:** 90.0%
Overall, CCOs improved on this measure between 2014 & mid-2015, but remain well below the benchmark.

- data suppressed (n<30)

2015 benchmark: 90.0%
Statewide, patient-centered primary care home enrollment continues to increase.

- 2012: 51.8%
- 2013: 78.6%
- 2014: 81.0%
- Sept. 2015: 83.6%
MEASURES BY DISABILITY

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

- With n=245: 53.5%
- Statewide n=64,190: 49.5%

Benchmark: 50.0%

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

- With n=41: 14.6%
- Statewide n=1,574: 37.1%

Benchmark: 90.0%
MEASURES BY MENTAL HEALTH DIAGNOSES

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

- With n=2,622: 53.8%
- Statewide n=54,190: 49.5%

- Benchmark: 50.0%

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

- With n=805: 28.1%
- Statewide n=1,574: 37.1%

- Benchmark: 90.0%

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

- With n=2,737,385: 85.7%
- Statewide n=10,644,406: 47.0%

- Benchmark: 39.4 (Lower is better)

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

- With n=38,329: 37.2%
- Statewide n=139,369: 32.0%

- Benchmark: 62.0%
MEASURES BY SEVERE AND PERSISTENT MENTAL ILLNESS

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

- **With**: 119.6
  - **Statewide**: 47.0

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

- **With**: 10.6%
  - **Statewide**: 9.2%

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

- **With**: 73.4%
  - **Statewide**: 72.0%

Benchmark: 39.4
(Lower is better)
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)

- Monitor CCO performance...
- Generating gap lists
- Designing QI strategies
- Sub-population stratification...
- Sharing data
- Other (please describe)

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
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

_dashboard vendor will assist those who reported problems 1:1_

> 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.
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 25\textsuperscript{th}, 1-3 pm

• Agenda:
  – Transformation Center technical assistance on metrics
  – Health Equity Index development update
  – Food Insecurity Screening white paper