

Updates

May 15th Metrics & Scoring Committee Meeting

The recent Metrics & Scoring Committee meeting was primarily informational and focused on updating the Committee on measure progress, challenges, and status in advance of their selection of the 2016 CCO incentive measures and benchmarks.

Meeting content included:

- An update on the Patient-Centered Primary Care Home Program from Nicole Merrithew.
- An overview of work OHA is doing to identify barriers to improvement on the adolescent well care measure, such as adolescent confidentiality, from Dana Hargunani.
- An introduction to potential measurement frameworks, such as the new IOM Core Metrics.
- A report on the results of the metrics “deeper dive” survey on what interventions and quality improvement activities CCOs have implemented to reduce emergency department utilization and increase developmental screening.
- A status update on each of the 2016 “on-deck” measures. After discussion and public testimony on many of these measures, the Committee agreed some measures should be left-on deck for a future measurement year, as more development work is needed.

Measures	Status	Next steps
Kindergarten Readiness	On-deck for 2017 or beyond	Measure development needed
Any dental service	Remove from on-deck list	Explore additional dental measures
Assessment and management of chronic pain	On-deck for 2017 or beyond	Explore additional pain management measures
Childhood immunization status	On-deck for 2016	N/A
Childhood obesity prevalence	On-deck for 2017 or beyond	Measure development needed
Fluoride varnish	On-deck for 2016	N/A
Food insecurity	On-deck for 2017 or beyond	Measure development needed

Meeting materials are online at

<http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx>.

Metrics Deeper Dive Report

In their March 2015 meeting, the Metrics & Scoring Committee expressed interest in learning more about what was “under the hood” driving CCO performance on the incentive metrics. The Committee is interested in additional context, or case studies, from CCOs and clinics / practices to help determine where improvements in performance are due to improved coding practices, random variation, or specific interventions put in place by the CCO or practice.

The first two metrics identified for this “deeper dive” are developmental screening and emergency department (ED) utilization.

OHA developed and fielded a survey with CCOs in April and early May to learn more about their work on these two metrics. OHA received responses from 13 of the 16 CCOs and presented the results to the Metrics & Scoring Committee at their May meeting.

The initial deeper dive report is available online at:

www.oregon.gov/oha/analytics/MetricsTAG/Metrics%20Deeper%20Dive%20Report%20May%202015.pdf

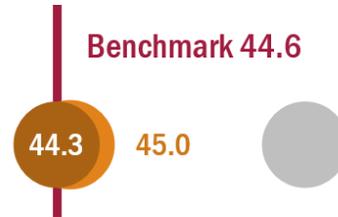
Next Steps

- 1) OHA would like to collect responses from the remaining CCOs and will work with Innovator Agents to connect.
- 2) OHA would like to develop CCO specific profiles based on these survey results that highlight all of the best practices / interventions that each CCO implemented. See PDF template.
 - OHA will not publish any CCO specific responses without working with the CCO to review the profiles and clarify any information needed.
 - OHA will work with the initial survey respondents and Innovator Agents to develop and review the profiles.

[CCO Name]

Emergency Department Utilization

[CCO Name / summary of performance on the measure between 2011, 2013, and mid-2014.]



Best practices and programs implemented

- ✓ Patient Education 2013
- ✓ Emergency Department Navigators 2013
- ✓ Increasing Emergency Department Capacity 2012
- ✓ Alternate payment methodologies 2014
- ✓ Pre-hospital diversion programs 2013
- ✓ Intensive case management Pre-2012
- ✓ Identification of high utilizers Pre-2012

["Sample text, in CCO's own words, what they did to improve on emergency department utilization. May include elaboration of the best practices / programs above, or description of partnership / collaborations, or other innovations locally. Key words / text will be **highlighted.**"]

Potential Specification Changes for 2015

OHA has received several questions that could lead to specification modification for 2015. These potential modifications are outlined in the table below. OHA is currently exploring these potential changes and has not yet made any official modifications for the specifications for 2015.

When any changes are finalized, OHA will update the specification sheets posted online and notify CCOs via TAG and the monthly metrics dashboard release cover letter.

Measure	Potential Change for 2015
Dental Sealants	<p>Use 12-months continuous enrollment in a CCO rather than 90 days, thus ensuring a child can only be attributed to one CCO during the measurement year.</p> <p>Currently testing this change to see how many children drop out of the measure under the lengthier continuous enrollment criteria.</p>
Effective Contraceptive Use	<p>Require CPT 96372 (injection) to be paired with diagnosis code or NDC to specify that the injection was for a contraceptive, rather than flu shot or other injection.</p> <p>Currently testing this change to see what code pairing is necessary to limit this CPT code to injections for contraceptives only</p>
Follow-up after Hospitalization for Mental Illness	<p>Add H0038 (peer support services) to the numerator as allowable follow up.</p>

Tobacco Prevalence using EHRs: Updated Survey Results

To learn more about electronic health record (EHR) functionality and how tobacco use status is collected and reported out of EHRs, OHA fielded a survey to collect additional information from CCOs and clinics to provide context for tobacco prevalence measure development.

The survey was initially fielded between the March 26th and April 23rd Metrics Technical Advisory Workgroup (TAG) meetings. OHA received 29 valid responses representing at least 28 practices, 10 EHR platforms, and 9 CCOs. At the April 23rd TAG meeting, OHA agreed to re-open the survey to allow additional CCOs and clinics time to respond. Between April 23rd and May 21st, OHA received an additional 15 valid responses, bringing the total to 44 valid responses, representing at least 12 CCOs

This revised report summarizes the survey results, including respondents, data collection, data reporting from Meaningful Use, data reporting from custom query, and resources needed to be able to report on tobacco prevalence from EHRs.

Respondents

OHA received 44 valid responses, representing at least 12 CCOs and 16 EHR platforms (see table below). Some responses are applicable to large groups of providers all on the same EHR or for all providers the CCO provides direct EHR support for.

OHA also received additional partially completed responses and responses for providers without EHRs. These responses are not included in this summary.

Represented CCOs	Represented EHRs	
<ul style="list-style-type: none"> ▪ AllCare ▪ Cascade Health Alliance ▪ ColumbiaPacific ▪ Eastern Oregon ▪ FamilyCare ▪ Health Share ▪ Jackson Care Connect ▪ PacificSource – Central ▪ PacificSource – Gorge ▪ Trillium ▪ WVCH ▪ Yamhill 	<ul style="list-style-type: none"> ▪ AllScripts Touchworks EHR ▪ Centricity ▪ Cerner-Anasazi ▪ CGM WebEHR ▪ ChiroTouch ▪ CPS12 ▪ CrystalPM ▪ eClinicalWorks ▪ Epic¹ ▪ Greenway 	<ul style="list-style-type: none"> • Mac-Practice ▪ Med3000 ▪ Meditec ▪ Mosaiq/Elekta ▪ NextGen ▪ Pro-filer

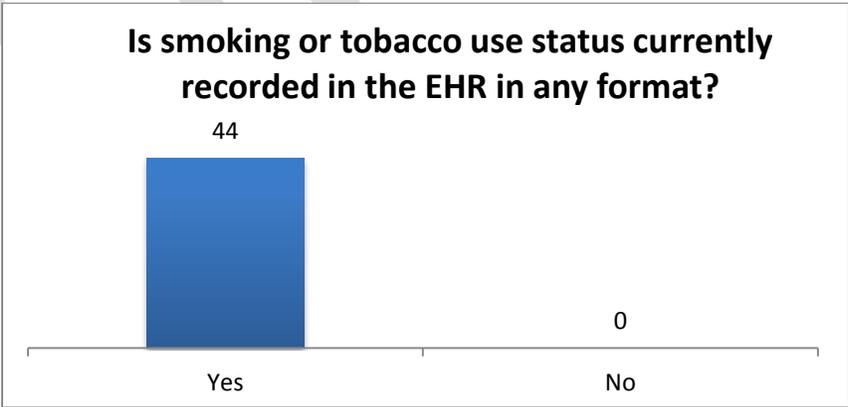
The majority of EHRs represented in the responses are 2014 certified (40/44); information provided in this summary may be less relevant to those 2011 certified EHRs.

Data Collection

Respondents were asked a series of questions about if smoking / tobacco use status is recorded in the EHR, and if yes, how it was recorded. The survey did not differentiate between cigarette smoking and other tobacco products; for the purposes of the survey and likely for an EHR-based prevalence measure, smoking and tobacco use will be used interchangeably.

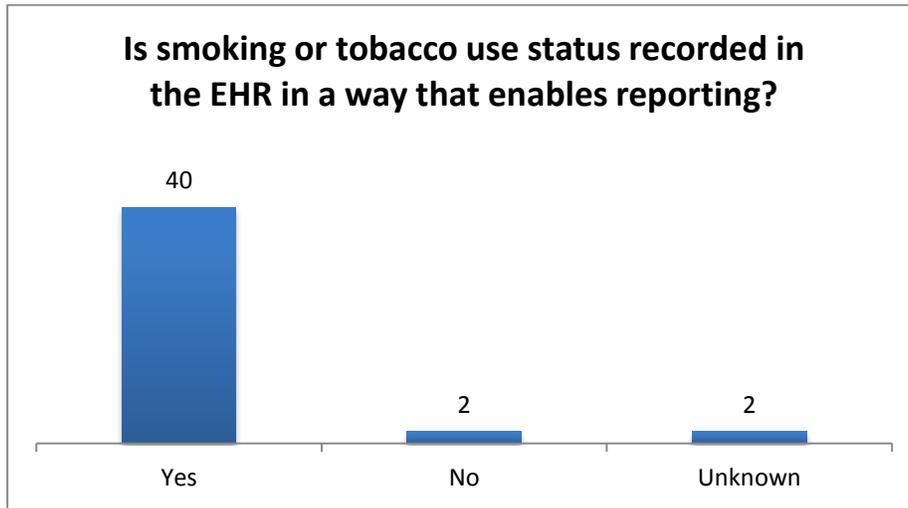
Is smoking or tobacco use status currently recorded in the EHR in any format?

All respondents indicated that smoking or tobacco use status is currently being recorded in the EHR somehow.



¹ Multiple installations of Epic are reflected in the survey responses, including a response from OCHIN on behalf of CCOs that may be using the current OCHIN reporting solution for the three existing clinical measures. Apart from this list, all Epic responses are treated individually in the summary.

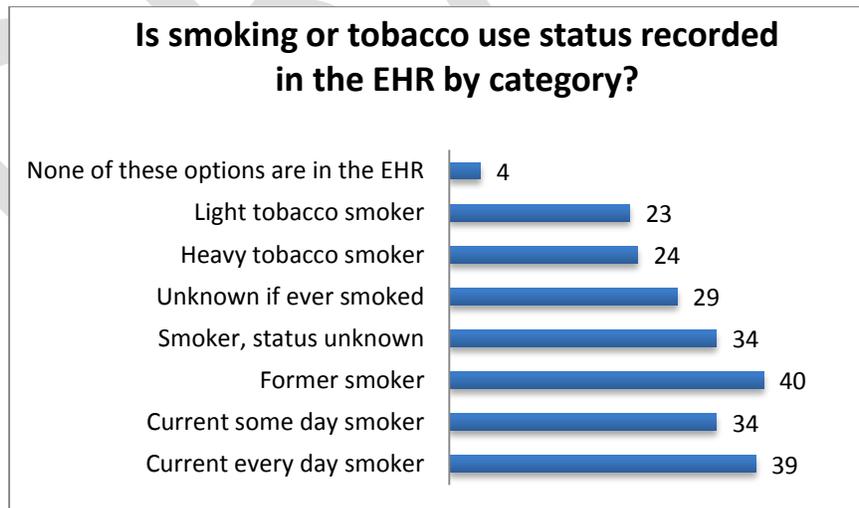
Is smoking or tobacco use status currently recorded in the EHR in a way that enables reporting (i.e., as structured data)?



The majority of respondents indicated that smoking or tobacco use status was being recorded in the EHR in a way that enables reporting, i.e., as structured data. See Appendix A for a more detailed description of how smoking or tobacco use status is recorded in these EHRs.

Is smoking or tobacco use status recorded in the EHR using any of the following categories? Please select all options that are available.

These categories align with Meaningful Use standards required for EHRs in 2014. Specifically, Standards Criteria §170.207(h).



Of those respondents who indicated none of these responses are in the EHR, smoking or tobacco use status is recorded as:

- Free text narrative.

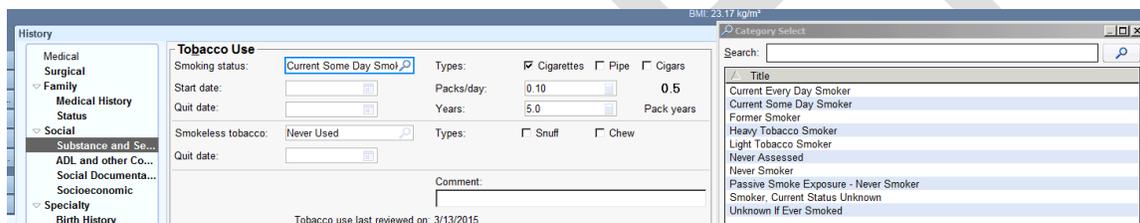
- Yes or no check boxes, with narrative.
- Tobacco use status: yes, never, not asked, quit, or passive.
- Tobacco use status: yes, no, unknown

Of those respondents who indicated at least one of the standards criteria categories above, many noted additional information is captured, as either structured data or in chart notes, including, but not limited to: type of tobacco, amount / level of addiction, exposure to secondhand smoke, intent to quit, and dates (e.g., start date, quit date).

Where tobacco use status is recorded in the EHR also varies. Tobacco use information may be recorded in multiple places within the same EHR. Responses included:

- In the patient’s social history
- In a structured risk factors form
- In the vitals section and/or in social history

Screenshot of tobacco use section in OCHIN Epic



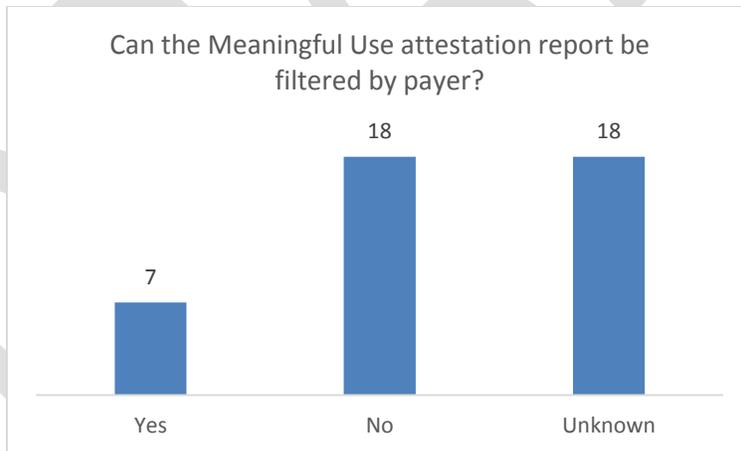
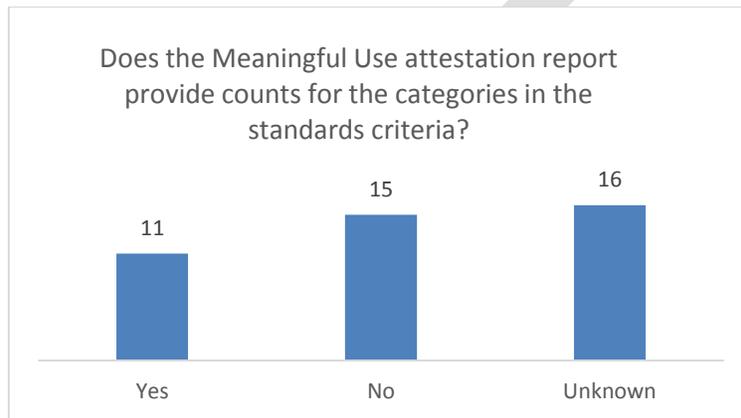
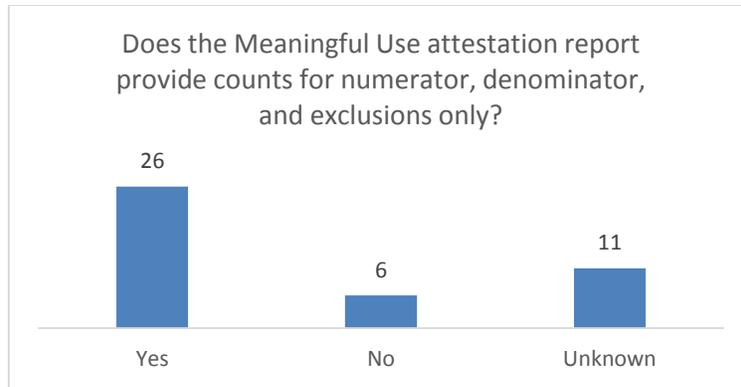
Data Reporting from Meaningful Use

All EHRs used for Meaningful Use provide an attestation report that includes (at minimum) counts for the numerator, denominator and exclusions for the measures. Some EHRs may provide additional reports to support meaningful use.

Note the Meaningful Use measure is *not* a prevalence measure, but rather a measure of how many patients who had an office visit have their smoking status recorded as structured data.

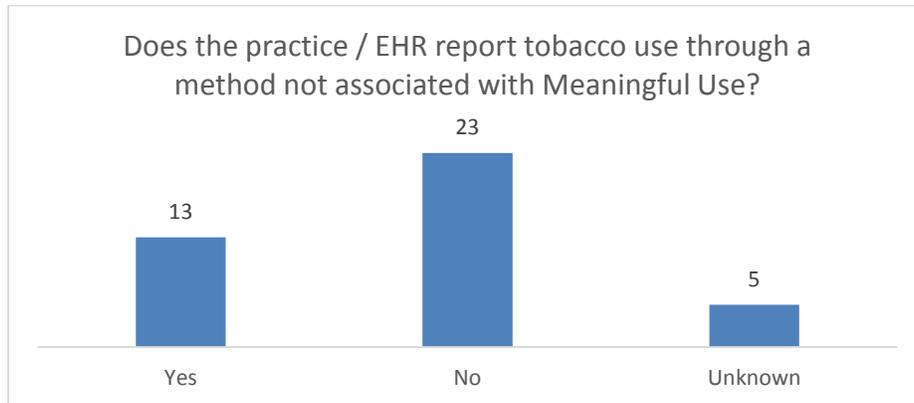
The attestation report is likely only useful for a prevalence measure if the information in the Meaningful Use measure numerator (those patients with smoking status recorded as structured data) can be accessed to determine how many of those patients actually are smokers / tobacco users.

This series of questions asked about what the Meaningful Use attestation report looks like and what level of granularity is available within that report to determine if it can be used as a starting place for a prevalence measure.



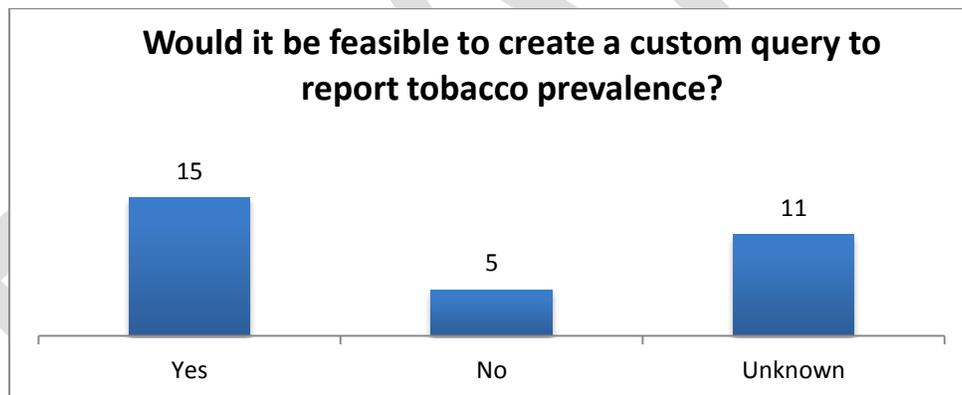
Data Reporting from Custom Query

Respondents were also asked about any reporting of tobacco prevalence outside of the Meaningful Use reports.



Examples of these other options include UDS reports, internal quality improvement or performance reporting, PQRS reports, and a customized datamart for clinical quality measurement.

If not currently reporting tobacco prevalence through any method, would it be feasible to create a custom query to report this data?



Comments included:

- It may be possible to create a custom query, but unsure that the custom reports will provide all of the details needed.
- It is feasible, but unclear how much work or resources it would take.
- Custom reporting is very expensive and time consuming for IT personnel. Also it requires at-minimum that the data are structured, and even then reports can be unreliable.
- Reporting on tobacco use status is relatively easy, especially compared to the depression screening and FU metric that we built last year. The customization is for CCO members only.

What resources would be needed to develop a custom query to report tobacco prevalence from this EHR?

Select responses included:

- A different EHR system.
- Time.
- We currently have registry reporting that allows us to pull patients by at least some of the smoking status categories as well as a custom reporting tool. Would likely need to work with EHR vendor to work out any issues with accessing data to be able to use the custom reporting tool. Needs further testing.
- The functionality that we currently have to use for custom queries in our EHR allows us to include specifics in the request, but the output report does not provide us with details. We would have to run reports by each tobacco status category separately. We don't really have other options for this type of custom report that I am aware of so it would probably require more technology and resources on the vendor's end to build functionality.
- Data is reportable through a Cognos reporting tool, EBO.
- All resources are currently in place, minimal additional work would be involved.
- A report writer that understands writing reports in SQL and Crystal Reports. Would likely take a qualified report writer 2 hours to create and validate these reports if they have a solid understanding of the database the data is being pulled from.
- Would need resources to get the information into structured data and built into the process flow; would need IT personnel with expertise to write a report probably using Crystal Reports; and would need some kind of analysis to verify report accurate and a way to send the information securely.
- Would need money to fund an analyst and to have access to a person who knows eCW and can work with us to develop the report. We can pay the vendor to write reports for us, but they arrive not meeting the criteria that we need given that developing these types of reports is usually an iterative process.
- It depends on if the report would need to match the more detailed categories from the Meaningful Use standards criteria. If it did need to match, this would need to be built into the EHR (estimated 35-45 hours for the system build, report build, creation of training materials,

and training of staff on workflow changes, would use in-house IT and EHR team).

- The biggest thing is having very clear specifications of how the metric is to be defined. Assuming this is a simple measure of tobacco use within the CCO population that doesn't require a lot of discussion, it shouldn't take long to develop. Would only require time from the developer. If adding a new metric, this seems like a reasonable one to add.
- Prevalence results could easily be added to the current depression, diabetes, and hypertension by MOB file that is uploaded monthly. If we have to report a breakout by the level of smoking / not smoking from the MU standards criteria, that is much more complicated and would require a request for resources and would delay reporting by several months.

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Appendix A: Description of how smoking status is recorded in EHRs

EHR	Practice	Description
AllScripts Touchworks	St. Charles	Smoking status is recorded in the patient's social history.
AllScripts Touchworks	Treasure Valley Pediatrics	
Centricity	Physicians Medical Center	Data are recorded in a risk factors form.
Cerner-Anasazi	Mid-Columbia Center for Living	
CGM WebEHR	Gifford Medical	Data are recorded in the patient's social history.
Chiro Touch	A Family Healing Center	Smoking status is recorded as free text narrative.
CPS 12	HDH Family Care	Data are recorded by the provider on the CCC form.
CrystalPM	Central Oregon EyeCare	
eClinical Works	St. Charles Family Care Redmond	In addition to the structured categories, smoking status is also recorded in the social history in the progress notes.
eClinical Works	Deschutes Rim Clinic	Smoking status is recorded as structured data.
eClinical Works	Columbia Gorge Family Medicine	Smoking status is recorded through a structured eForm that Medical Assistant completes with patient, space for additional text comments.
eClinical Works	Springfield Family Physicians	Smoking status is recorded as structured data at every visit, under social history. The questions include how soon after waking do you smoke and how many cigarettes per day do you smoke.
eClinical Works	McKenzie Family Practice	Smoking status is recorded under social history in the body of the chart note, also lists current smoker as a diagnosis.
Epic	Mosaic Medical	Smoking status is confirmed with the patient at each visit, then recorded / updated in the "social history" section of Epic. All discrete fields indicate frequency, amount, and type of tobacco used. There is also a section for free text comments. Smoking status is encounter-based, to enable tracking of status over time (i.e., the data are not overwritten each time).
Epic	Columbia Gorge ENT & Allergy	Smoking status is recorded with radio buttons with space for text.
Epic	Deschutes County Public Health	Smoking status is recorded in the vitals section and documents the frequency, type, and whether or not the client is wanting to quit.
Epic	Crook County Health	
Epic	La Pine CHC	Smoking status is recorded as part of the vitals section. Additional details may be provided using the social history activity.
Epic	OHSU Primary Care Clinics	Tobacco use, including smoking and smokeless, is captured in a patient's social history. Tobacco use

EHR	Practice	Description
		types, amounts, start date, quit date, and longevity of usage are captured. Tobacco use reviewed and counseling given are also recorded in the EHR.
Epic	Legacy Medical Group	Smoking status is recorded as structured data, with drop downs for category.
Epic	Legacy	In addition to the categories above, EHR also includes never assessed, never smoker, passive smoke exposure – never smoker.
Epic	Adventist Health Medical Group	Smoking status is documented for each patient in the social history section of Epic. Data should be discrete, but have not attempted to pull data outside of the MU reports.
Epic	Providence	Tobacco use status: yes, never, not asked, quit or passive. Other fields indicate type of use and amount. Can probably create categories from MU standards criteria via a combination of existing fields.
Epic	Kaiser Permanente NW	
Epic	PeaceHealth	
Epic	Virginia Garcia McMinville	Smoking status is recorded as yes/no, and how much via check boxes with additional narrative.
Epic	Cascades East Family Medicine	
GE Centricity	Central City Concern – Old Town Clinic	Smoking status is recorded via radio button selection on vital signs form; choices are never smoker, current every day smoker, former smoker.
Greenway	21 providers in AllCare’s network	Smoking status is recorded as structured data.
MacPractice		
Med3000		Data are recorded in the patient’s social history.
Meditech		Data include smoking status, packs per day, smoking history with packs per day, chewing tobacco use, quit status, counseling received /given, and secondhand smoke exposure.
Mosaiq/Elekta	St. Charles Cancer Center	Smoking status is recorded in either Vital Signs or patient assessment tabs.
NextGen	Mid Columbia Outpatient Clinics	
NextGen	Multiple practices	In addition to the standards criteria, tobacco use can also be recorded in several other ways. The initial question is “have you ever used tobacco” with options to record no/never, yes, and unknown. Tobacco use other than smoking options include chewing, smokless, and snuff. Tobacco types include cigarette, cigarillo, cigar, and pipe. For each option, structured data fields are: daily use yes/no, usage quantity #/units, years used, age started, and age stopped. There is also a pick list for current tobacco use status separate from the smoking status categories, with 36 choices.

EHR	Practice	Description
OCHIN Epic	One Community Health	Smoking status is recorded with a pick list of 10 options, start date, quit date, tobacco type, and packs per day.
OCHIN Epic	CareOregon	Smoking/tobacco use, intent to quit, and follow up are all recorded. Tobacco use can be collected in the substance section of history and intent to quit and counseling given is documented in vitals and health history. Follow up plans and referrals can also be tracked.
Pro-Filer	Deschutes County Behavioral Health	Smoking status is collected in the MOTS data form. The statement is "tobacco use" and the response options are "yes" "no" or "unknown".

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Tobacco Use Prevalence (Bundled Measure)

Measure Basic Information

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

URL of Specifications:

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

Measure Type:

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

Measure Utility:

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

Data Source: Electronic Health Records, cessation benefit survey TBD

Measurement Period: 2016

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

2016 Benchmark: TBD by Metrics & Scoring Committee

Measure Details

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

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

Cessation Benefits Floor

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

Survey modality and timing TBD.

DRAFT cessation benefit floor:

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

EHR-based Prevalence

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

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

Other details on data submission process TBD.

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

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

Required exclusions for denominator: None.

Deviations from cited specifications for denominator: None.

Data elements required numerator: Unique patients 13 years old or older who were seen by the provider during the measurement period, who have their smoking / tobacco use status recorded as structured data, who are current smokers / tobacco users.

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

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

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

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

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

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

Step 2: those who are current smokers / tobacco users

Of those patients age 13 years and older, who have their smoking / tobacco use status recorded as structured data within the EHR, any combination of the following response categories is a positive numerator event:

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

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

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.

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

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

What are allowable gaps in enrollment: N/A

Define Anchor Date (if applicable): N/A

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