

Metrics Technical Advisory Workgroup

November 19, 2015

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

Today's agenda

- Updates
- Creating Healthy Communities – Dr. David Labby
- Health Equity Index measure development
- 2016 meeting schedule / workplan

November Dashboard

- Scheduled for release on Tuesday, Nov 24th
- Updated measurement period:
July 1, 2014 – June 30, 2015
- Data from this dashboard will be used to populate the Mid-Year Health System Transformation report, to be published in January 2016.

Updated Guidance Documents

- Adolescent Well Care Visits
- Dental Sealants
- Developmental Screening

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

Additional guidance documents and specifications will be updated and posted in coming weeks.

Committee Meeting Tomorrow

- Nov 20th, 9 am – noon
- Materials online at www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx

Hospital Transformation Performance Program (HTPP) Update

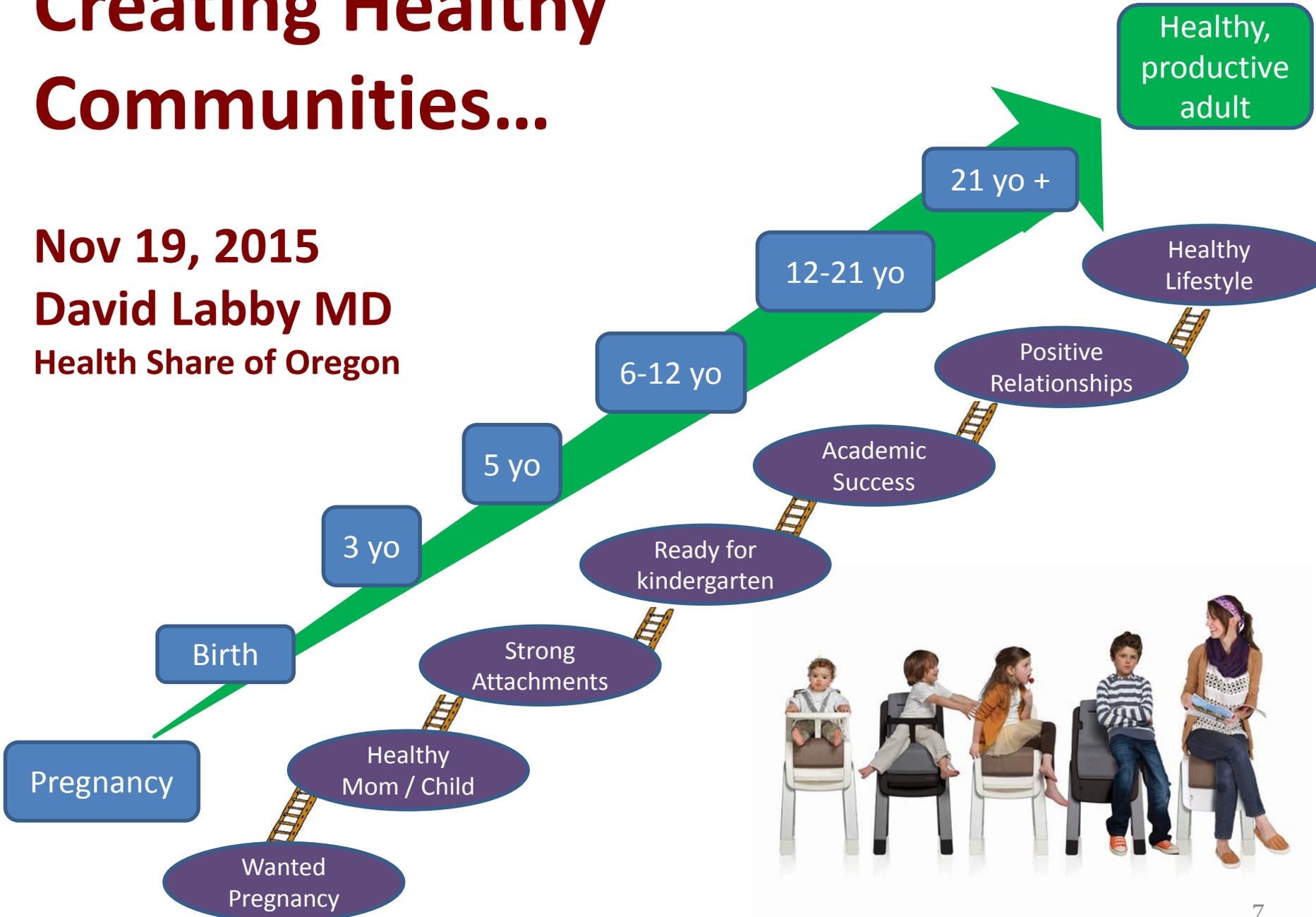
- Meeting tomorrow, Nov 20th from 1 – 4 pm
- Materials online at www.oregon.gov/oha/analytics/Pages/Hospital-Performance-Metrics.aspx

Creating Healthy Communities...

Nov 19, 2015

David Labby MD

Health Share of Oregon



What “High Needs / High Cost” Patients (aka “High Utilizers”) Have Taught Us

- It is not “What’s wrong with them”... but “What has happened to them:”

- High prevalence of reported “Adverse Childhood Experiences”

- ACE Study Categories : Parent Substance Use, Separation, Mental Illness, Domestic Violence, Criminal Behavior, Abuse, Neglect (Felitti, Anda. Amer J Prev Med 1998)

- **Formal qualitative study of “Adverse Life Events”**

- Health Resilience participant “open ended” interviews
- Survey now being sent to 9000 Health Share members
 - Can we identify common pathways to “high utilization?”

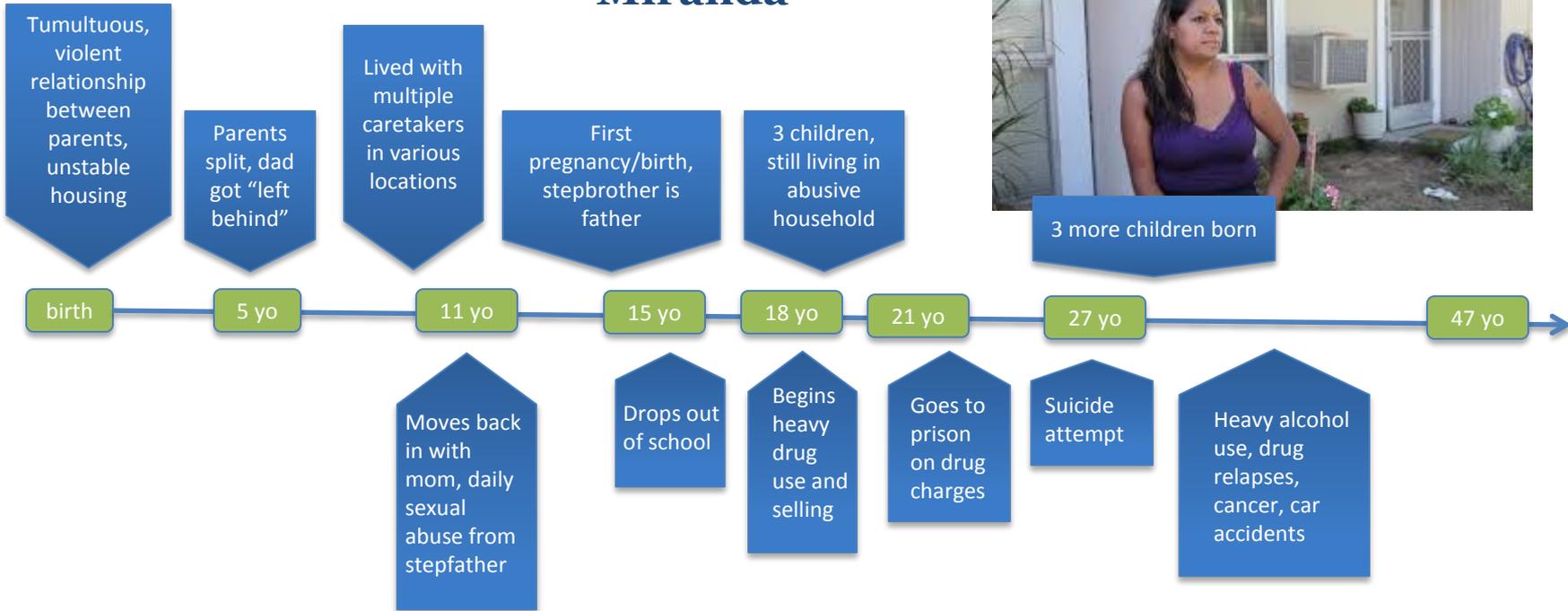


What we learned: Life stories with chain reactions of adversity

Miranda



3 more children born



Age 47

6 children age 15-32

No GED/diploma, no employment

In recovery from severe substance use

Chronic pain, cancer, multiple surgeries, no teeth or dentures

Multiple psychiatric medications

0-6 yo

30% Suffered repeated physical, sexual or emotional abuse in early childhood

47% Neglect

17% Had unmet basic needs (food, clothing)

13% Lived with an adult with a substance use issue

17% Were separated from parents



The Prevalence of Adverse Life Experiences

7-19 yo

54% struggled in school
50% dropped out of school

28% Ran away or left home early

30% Became teen parents

15% Became homeless at some point

46% Were substance users



19-30 yo

30% Were arrested or incarcerated at some point

52% Were substance users

26% Were homeless

74% Report job insecurity or become unable to work at all

28% Were separated from their children



What the Numbers Tell Us

Before Age 19:

63% experienced some form of abuse;
52% experienced extended maltreatment

30+ yo

40% Struggle with mental health

70% Describe struggling to get needed healthcare

30% Struggle to manage their medication

NONE able to work

30% Describe being socially isolated

Lauren Broffman, Center for Outcomes Research and Education (CORE)

Age Greater Than 30

Age/Gen Race	0-5	6-12	13-19	20-30	30+
48 F AA	Abuse (e)	Abuse (e)	Drugs/ Alc, Loss, DV, Sex work	Sex Work, Drugs, Arrest	DV, Drugs
57 M AA	Parent SU	Rape, Drugs	Aband, Quit Sch, Abus, Drugs, Loss	Jobless	Drugs, Arrest
68 F	Abuse (e)	In State Home for Dev Delay	Abuse (P)	Unable to work	Disabled
34 M	Parent SU	Loss	Leaves Home, Expelled	Drugs	Drugs
35 F AA	Adopted	Abuse (p)	Drugs, Quit School	Drugs, DV	Alc
51 F	Sibling SU	Drugs/ Alch	Drugs, Quit Sch, Homeless	Drugs, Arrests	Drugs, Suicide At
44 M	Parent SU, Abuse (p/e)	Abuse (p/e)	Abuse (s), Alc, Quit School, Homeless	Jail, Suicide At	Probabtion
36 F	Parent SU	Abuse (s), Run Away, Homeless	Quit Sch (8), Foster care, Drugs, Dentition Home	Drugs, Homeless	Jobless
52 F	Abuse (p/v)	Abuse (s)	Abuse (s), Drugs, Alc, Quite School (9), jail	Drugs, Alc, Homeless, DV	Alc
73 F AA	Parent SU, DV		Quit School	Loss	Suicide At
55 F	Abuse (p/v)		Alc, Drugs	Sex Work, Abuse (s) DV, Drugs, Alc	Suicide At
35 M	Abuse (p)		Homeless	Prison	Homeless
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44 M AA			Abuse (e/p) Alc, drugs	Alc, Drugs, Sex Offender, Pris, Abuser	Prison
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41 M AA					Arrest
31 F				Rape, Homeless	

Adverse Life Events In “High Utilizers:” *Cumulative Burden Across Life Span*

- ✓ Abuse: Emotional, Physical, Sexual
- ✓ Substance Use: Drugs, Alcohol
- ✓ Abandonment
- ✓ Traumatic Loss
- ✓ School Failure
- ✓ Job Failure
- ✓ Homelessness
- ✓ Incarceration

Age Less Than 30

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Self reported life events from 30 Medicaid
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Adverse Life Events In “High Utilizers:” *Cumulative Burden Across Life Span*

✓ Abuse: Emotional, Physical, Sexual: 70%

✓ Substance Use: Drugs, Alcohol: 60%

✓ School Failure: 60% do not graduate HS; 1 College Grad

✓ Job Failure: none fully employed

✓ Homelessness: 23%

✓ Incarceration: 30% in jail / prison; 17% “been arrested”

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Adverse Childhood Experiences (ACE) Study

- 1998 Kaiser Permanente & the Centers for Disease Control
V. Felitti and R. Anda
- Demographics
 - Average age 57
 - “Solidly middle class”
 - White
 - Attended college
- Surveyed experience up to 18 yo
- “ACE Score” Computed based on positive response to each domain

Adverse Childhood Events / Rate:

- Substance Abuse 27%
- Parental Separation/Divorce 23%
- Mental Illness 17%
- Battered Mother 13%
- Criminal Behavior 6%
- Psychological Abuse 11%
- Physical Abuse 28%
- Sexual Abuse 21%
- Emotional Neglect 15%
- Physical Neglect 10%

Adults with “ACE Score” 4+

- 7x increase in alcoholism
- 3x increase in depression in men; 5x in women
- 13x increase in the prevalence of attempted suicide
- 10x increase in use of IV drugs; for males with 6+ACEs 46x increase
- 4.5x increase in intimate partner violence; 5x increase in risk of rape; with ACE 5, 9x

<http://www.cestudy.org/>

<http://www.cdc.gov/violenceprevention/cestudy/>

Other research - graded relationships between ACES and behavior problems:

- Early initiation of alcohol use. (Dube et al, 2006)
- Problem drinking behavior into adulthood (Dube et al, 2002)
- Increased likelihood of early smoking initiation (Anda et al, 1999))
- Continued smoking, heavy smoking during adulthood (Ford et al, 2011)
- Prescription drug use (Anda et al, 2008)
- Lifetime illicit drug use and self-reported addiction (Dube et al, 2003)
- Increased risk of suicide attempts during adolescence (Dube et al, 2004).
- Lifetime depressive episodes (Chapman et al, 2004).
- Sleep disturbances in adults (Chapman et al, 2011)
- Sexual risk behaviors (Hillis et al, 2001)
- Teen pregnancy (Hillis et al, 2004)

More

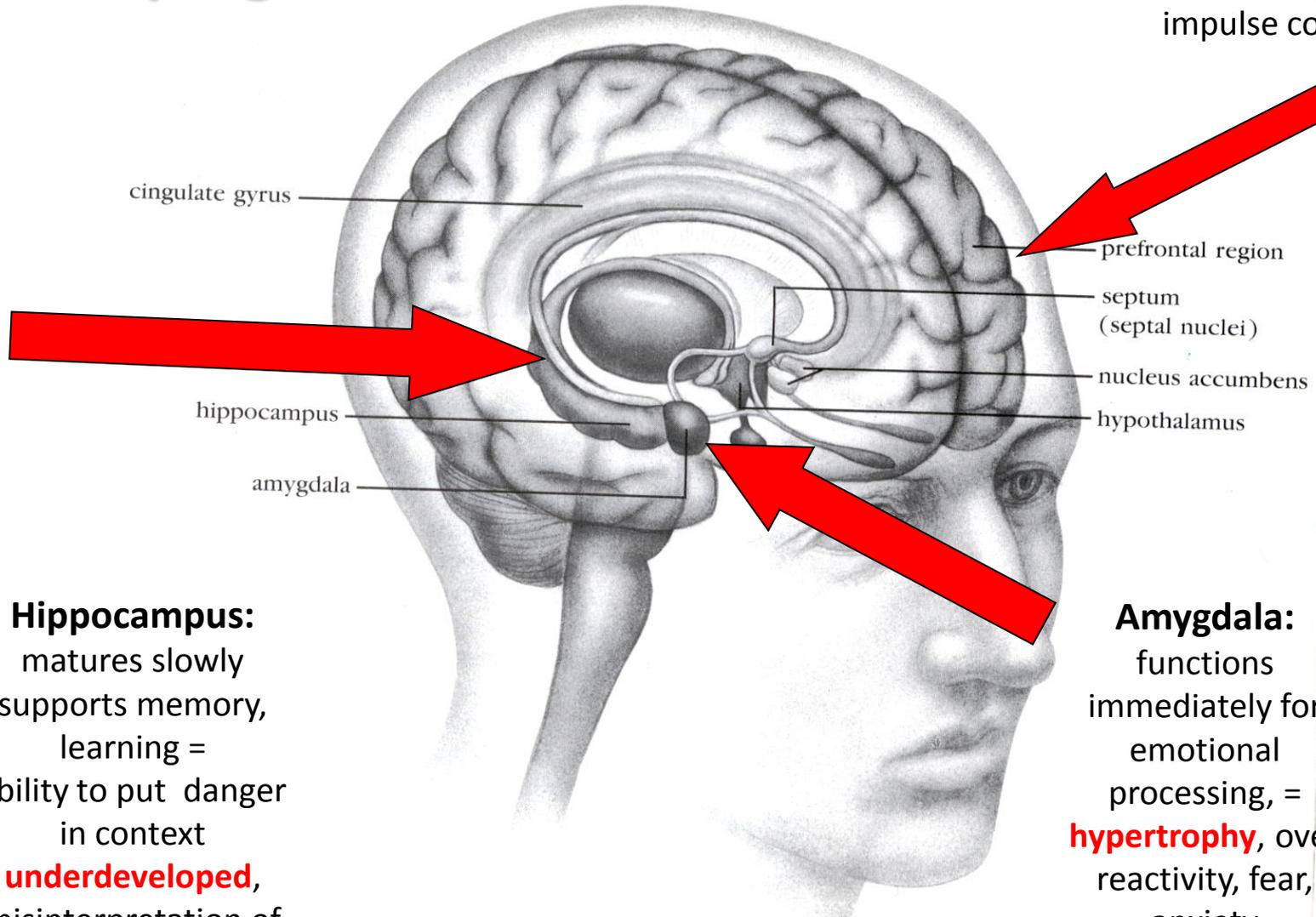
- 15 year follow up: people with 6+ ACEs died nearly 20 years earlier than those w/o (Brown, Am J Prev Med 2009)
- Other correlations with grade failure, language difficulty, job troubles, incarceration, being in substance abuse treatment, homelessness
- Incidence of ACES:
 - KP study “middle class” population: 16% had ACE Score 4+
 - Homeless population study: 58% had ACE Score 4+; 32% had ACE Score 6+ (Larkin and Park, 2009 ppt)

Bio-social Mechanisms

- Early neurological development: brain pathways develop in response to how others meet needs
 - “Wiring” develops in “use dependent” manner (Perry 2009)
- If others are experienced as unpredictable, a source of pain, anxiety, fear, pathways will develop to monitor for threat, for immediate reaction, to avoid risky attachment
- Toxic stress is thought to drive overproduction of stress hormones (cortisol, norepinephrine, adrenaline) effecting growth of differ parts of the brain.

Stress Hormones and the Developing Brain

Prefrontal Cortex:
executive function =
neuron loss, poor
impulse control



Hippocampus:
matures slowly
supports memory,
learning =
ability to put danger
in context
underdeveloped,
misinterpretation of
threat

Amygdala:
functions
immediately for
emotional
processing, =
hypertrophy, over
reactivity, fear,
anxiety

Just Childhood Adversity?

- VA Study of Vietnam vet twins: incidence of coronary heart disease more than double in those with PTSD (22.6%) vs those without (8.9%) (Vaccarino, JACC 2013)
 - World Trade Center disaster victims: PTSD = 62% increased risk of CAD in men; 68% in women (Jordan et al, Prev Med 2011)
 - Multiple similar studies
- Emerging evidence from Iraq and Afghanistan Vets with trauma experience

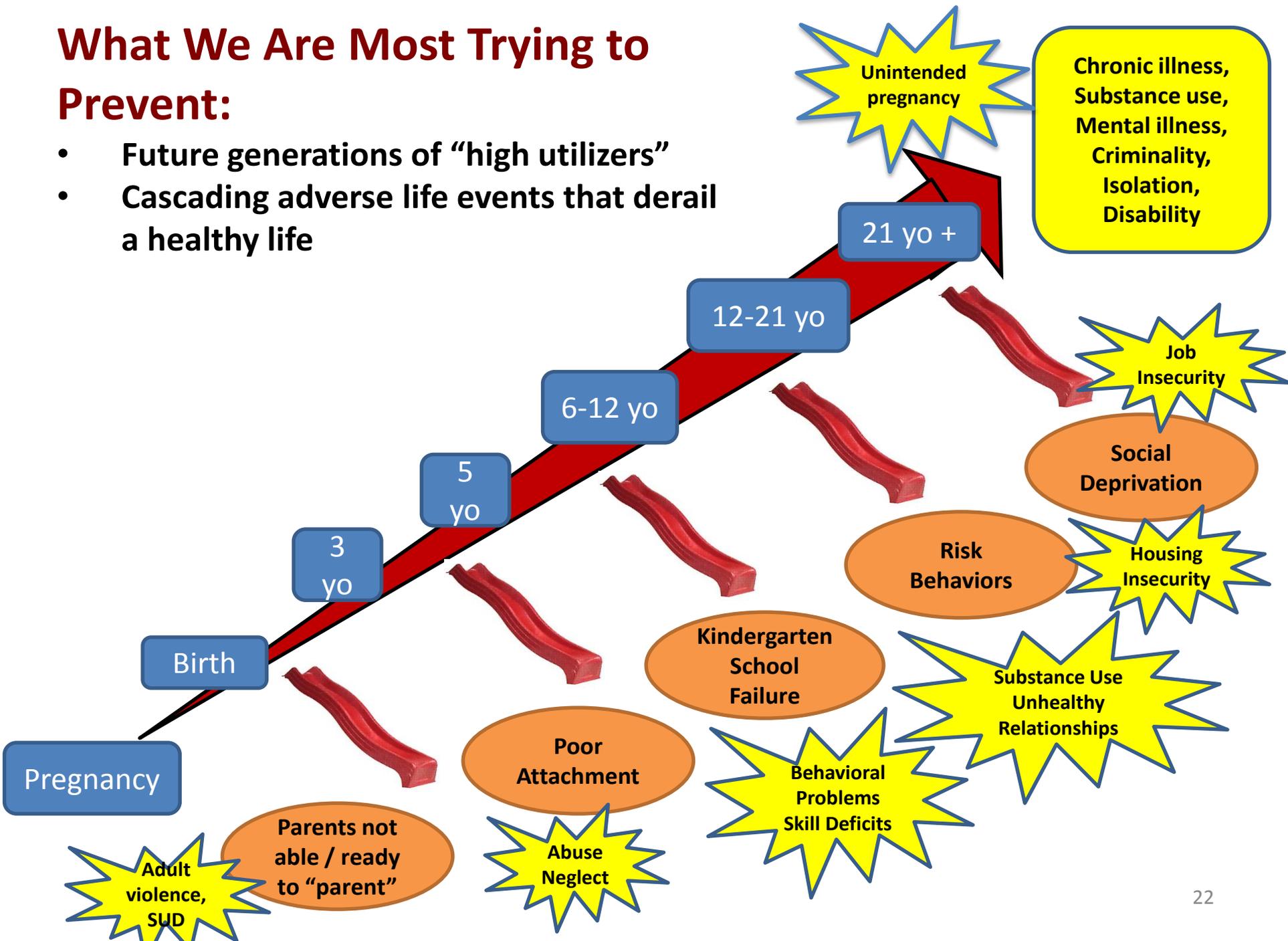


What Does This Mean For CCO “Population Health” Strategy?

Children in low SES households have 5 times the rate of maltreatment than other children: 3 times more likely to be abused, 7 times more likely to be neglected (NIS 2006)

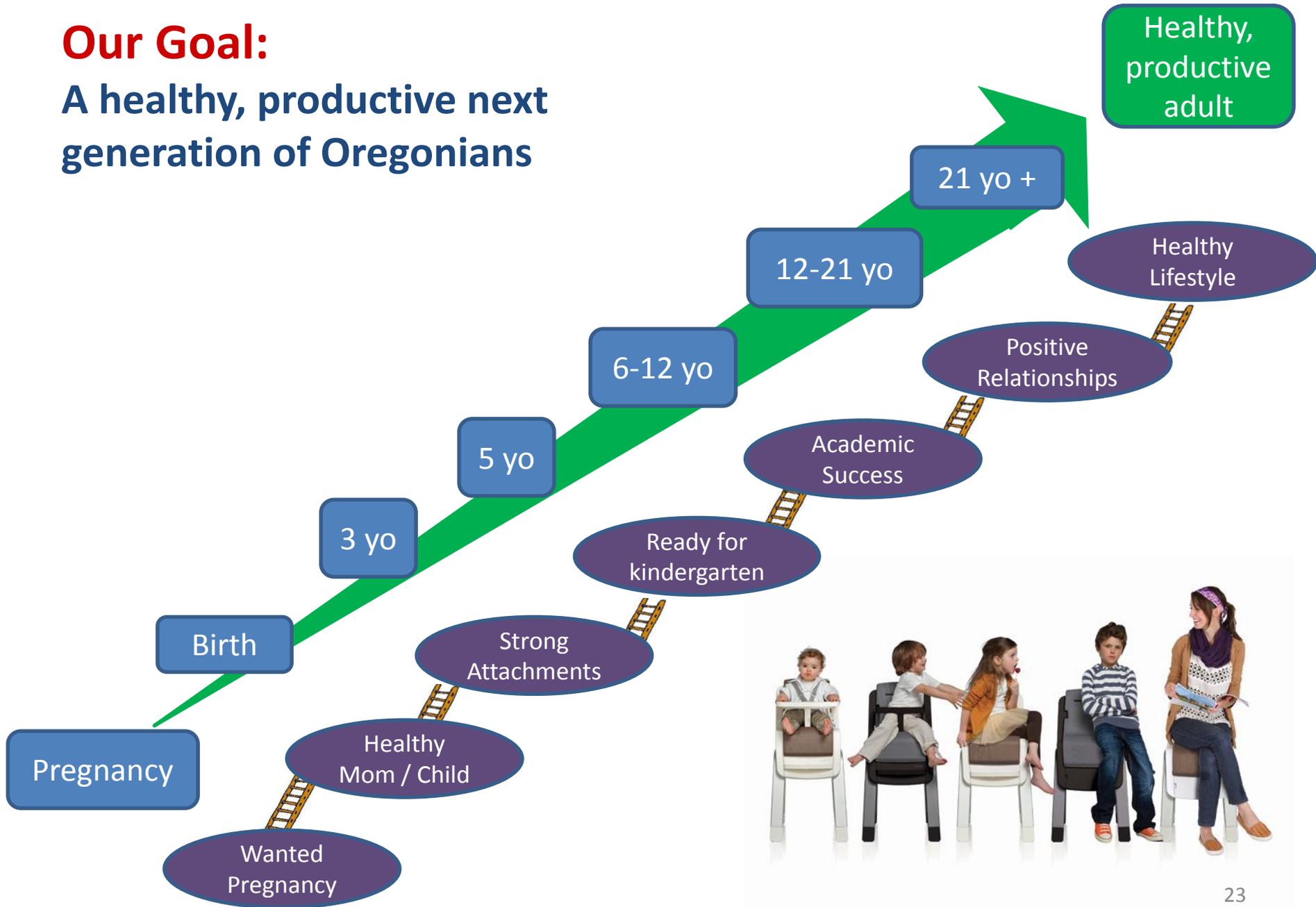
What We Are Most Trying to Prevent:

- Future generations of “high utilizers”
- Cascading adverse life events that derail a healthy life



Our Goal:

A healthy, productive next generation of Oregonians



What does this mean for a CCO prevention strategy?

- **Identify key touch points in the care delivery system where we can provide meaningful support:**
 - Promote stable families with healthy early attachments
 - Current: CCO P4P metric on effective contraception = desired pregnancy
 - Ensure that at risk families get the mental health, SUD treatment and social services they need to prevent adverse outcomes
 - Current: CCO charge to integrate care
 - Focus on highest risk children (Foster care)
 - Current: CCO metric on physical / behavioral / dental assessments
 - Help children be ready for kindergarten by age 5 to increase the likelihood of school success
 - Current: CCO P4P metric on developmental screening

What does this mean for a CCO Population Health strategy?

- Before entering school, the Health Care System is the social institution with the most contact with young children and their families (Bright Futures: 12 WCC before 3 yo)

	INFANCY								EARLY CHILDHOOD						
AGE ¹	Prenatal ²	Newborn ³	3-5 d ⁴	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●			
Weight for Length		●	●	●	●	●	●	●	●	●	●				
Body Mass Index ⁵												●	●	●	●
Blood Pressure ⁶		★	★	★	★	★	★	★	★	★	★	★	★	●	●

- Can we help make a difference for early families at risk?

Can CCOs Help Make A Difference?

Developmental Disabilities

- Children on Medicaid have 1.7 x the rate of “any developmental disability” than children with commercial insurance and 1.8 x the rate of “learning disabilities”
 - Do we need more developmental pediatricians? Or earlier interventions?

Condition	Health Insurance Coverage,%		
	Private	Medicaid or CHIP	Uninsured
Any developmental disability	12.10	20.28 ^k	11.61
ADHD	6.01	9.55 ^k	4.97 ^l
Autism	0.45	0.67	0.19
Blind/unable to see at all	0.10	0.17	0.17
Cerebral palsy ^a	0.61	0.60	0.33
Moderate to profound hearing loss	0.34	0.77	0.44
Learning disabilities	5.94	10.87 ^k	6.16 ^l
Intellectual disabilities ^b	0.44	1.68 ^k	0.38 ^l
Seizures in the past 12 months	0.49	1.31 ^k	0.46 ^l

K= p<.05

Can CCOs Help Make A Difference?

Ensuring Early (and Later) Life Success

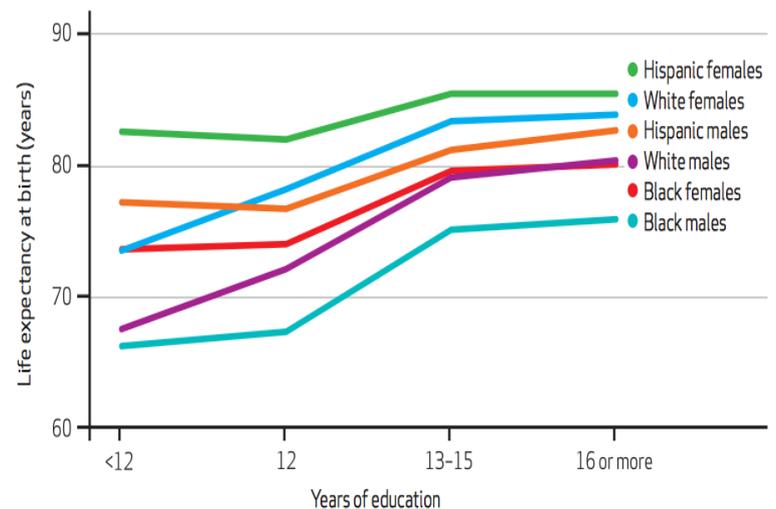
- School readiness:
 - Starting out poorly increases the likelihood of school failure and social failure
 - 15% of children with 2+ ACEs repeated a grade vs 5.7% with no ACE
(Bethell C Health Affairs Dec 2014)

- Not graduating high school correlates with poor health outcomes and shorter life:

- Decrease in life expectancy with <12 years of education vs ≥ 16 :

- Black men -9.7 years
- Black women -6.5
- White men -12.9
- White women -10.4
- Hispanic men -5.5
- Hispanic women -2.9

Life Expectancy At Birth, By Years Of Education At Age 25, By Race And Sex, 2008

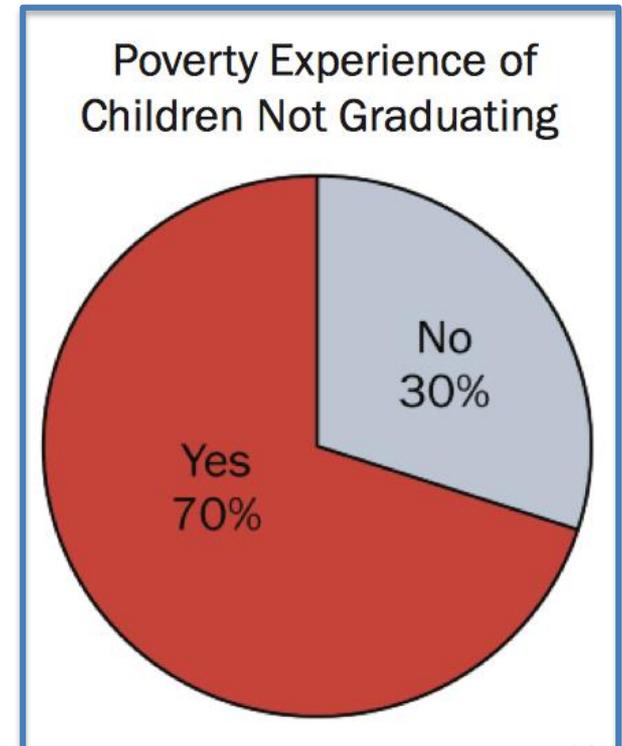


(Olshansky et al. Health Affairs Aug 2012)

Can CCOs Help Make A Difference?

“Kindergarten Readiness”

- 80% of children from low income families failed to achieve “proficient” reading by the end of third grade (Annie E Casey Foundation 2010)
- 35% of children from poor neighborhoods not reading proficiently at third grade do not graduate High School
- For those not reading proficiently but have never been poor it is 9% (~4x less)
 - For children reading proficiently, this drops to 11% for with any poverty, and 2% for those without. Percentages for minorities are worse.



A Prioritized Population



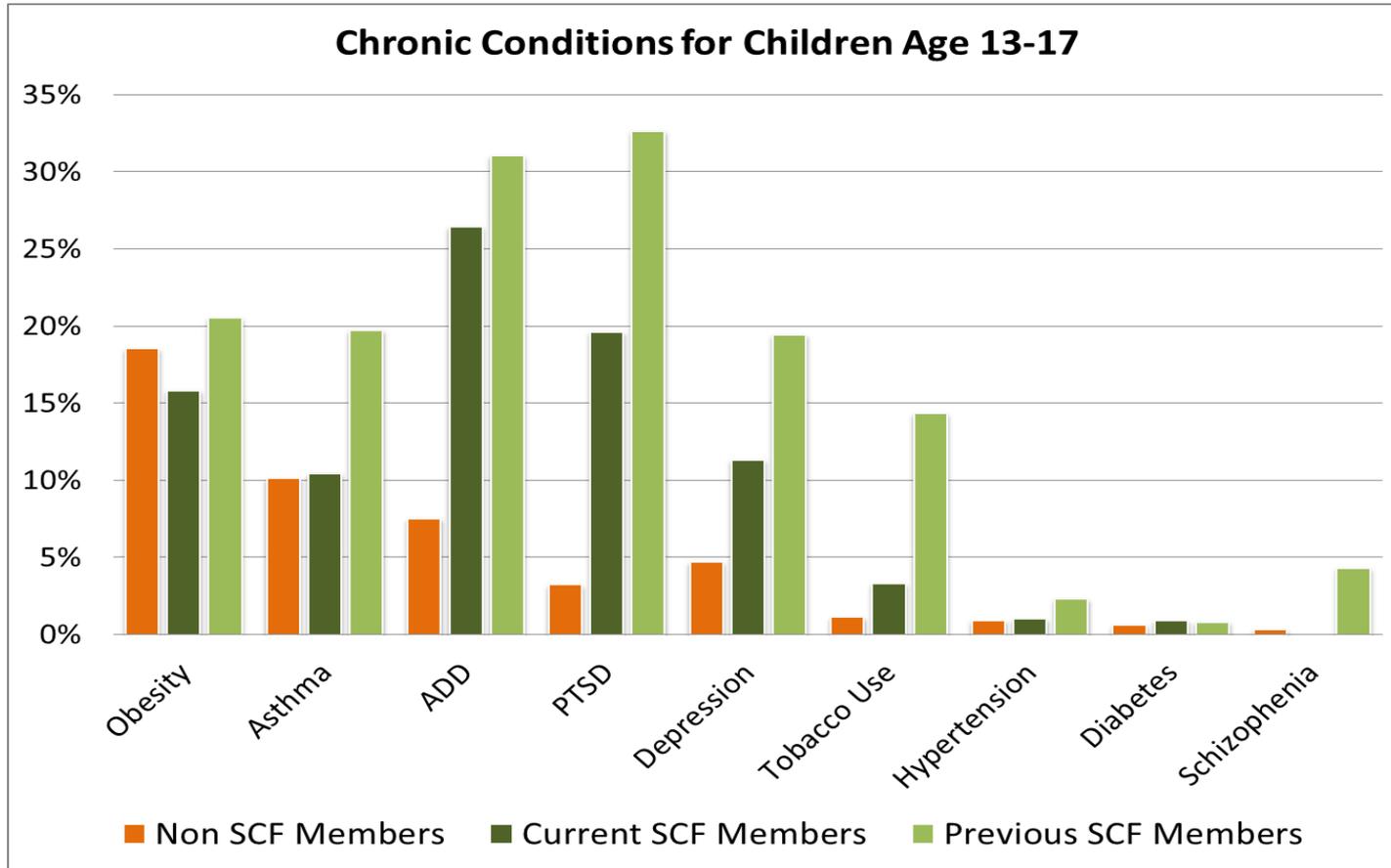
Reasons for Removal in Oregon

Oregon Child Welfare Data Book 2013		
Reason for Removal	Number	% of Entrants
Neglect	2381	63.8%
Parent Drug Abuse	1830	49.1%
Inability to Cope	475	12.7%
Incarceration of Parent	471	12.6%
Inadequate Housing	447	12.0%
Physical Abuse	427	11.4%
Parent Alcohol Abuse	396	10.6%
Child's Behavior	269	7.2%
Abandonment	127	3.4%
Sexual Abuse	126	3.4%
Child Drug Abuse	45	1.2%
Child's Disability	37	1.0%
Child Alcohol Abuse	35	0.9%
Death of Parent	30	0.8%
Relinquishment	8	0.2%
Total Number of Foster Care Entrants	3730	

Mental Health

- A National Child Traumatic Stress Network study of children in foster care found:
 - Over 70% of youth reported at least 2 of the traumas that constitute complex trauma, indicating greater risk for psychosocial maladjustment.
 - At least 83% of youth received at least 1 clinical diagnosis such as depression, anxiety disorder, ADHD, PTSD, etc.
- Adults who have been in Foster Care suffer PTSD rates at twice the rate of US Combat Veterans.

Chronic conditions in children 13-17



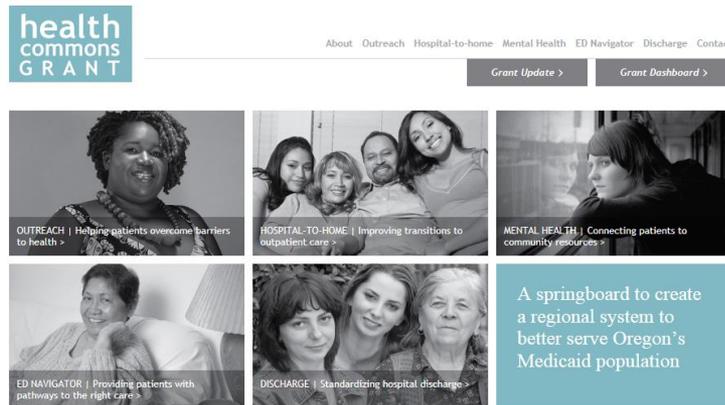
Long-Term Outcomes

- Many children transition from foster care without the needed network of support and experience very poor outcomes at a much higher rate than their peers in the general population.
 - More than one in five will become homeless after age 18
 - Only 58% will graduate high school by age 19 (compared to 87% of all 19 year olds)
 - 71% of young women are pregnant by 21
 - At the age of 24, only half are employed
 - Fewer than 3% will earn a college degree by age 25 (compared to 28% of all 25 year olds)
 - One in Four will be involved in the justice system within two years of leaving the foster care system



Thank You!

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Health Equity “Meta-Measure”

- Background
- Proposed framework for health equity index
- Pros and cons
- Next steps

Background

- Metrics & Scoring Committee interest in developing a health equity “meta-measure”, for potential use as an incentive measure.
- Internal working group convened to begin development, consisting of Office of Health Analytics, Office of Equity and Inclusion, Transformation Center, and Program Design & Evaluation Services, with additional support from Center for Health Systems Effectiveness at OHSU.
- Began with initial lit review and exploration of national and state / health plan work.
- Internal group has gone through several iterations of a proposed approach.

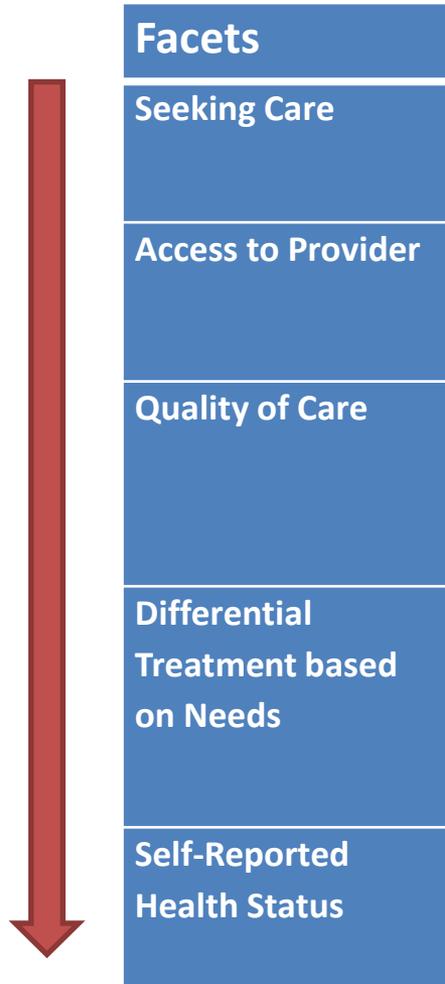
Parameters for Health Equity Index

- Must address Medicaid population.
- Must use available data.
- Must be statistically feasible.
- Must address multiple factors (e.g., race, ethnicity, gender, geography...)

- Ideally based on current measures (CCO incentive, state performance)
- Ideally index will generate meaningful result
- Ideally index methodology is understandable!

- Will allow for tracking equity over time, along with other CCO measures
- Will allow visualization of variation between subpopulations within a CCO, which will help determine how equitable services are within a CCO.

Proposed Framework for Index: Facets



It is important to look at health equity across a variety of domains (or facets), as looking at only one facet provides an incomplete or inaccurate picture of equity.

The framework is adapted from:

- Institute of Medicine. Access to Health Care in America: A Model for Monitoring Access, 1993
www.ncbi.nlm.nih.gov/books/NBK235891/
- Institute of Medicine. Unequal Treatment: What Healthcare Providers Need to Know About Racial and Ethnic Disparities in Health Care, 2002.
<https://iom.nationalacademies.org/~media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/Disparitieshcproviders8pgFINAL.pdf>

Proposed Framework for Index: Measures

Facets*	Measures
Seeking Care	Measure 1
Access to Provider	Measure 2
	Measure 3
	Measure 4
Quality of Care	Measure 5
	Measure 6
Differential Treatment based on Needs	Measure 7
	Measure 8
Self-Reported Health Status	Measure 9

Each facet can have one or more measures.

The framework is flexible in accommodating a changing number of measures.

Measures for the index TBD, but criteria include:

- Measure is currently in use
- Measure is evidence-based
- Measure promotes alignment
- Measure is actionable / timely
- Measure has high impact
- Measure is transformative
- Measure is appropriate / meaningful

*If there are not measures currently in use that meet a facet, facet may be excluded from the index.

Proposed Framework for Index: Subpopulations

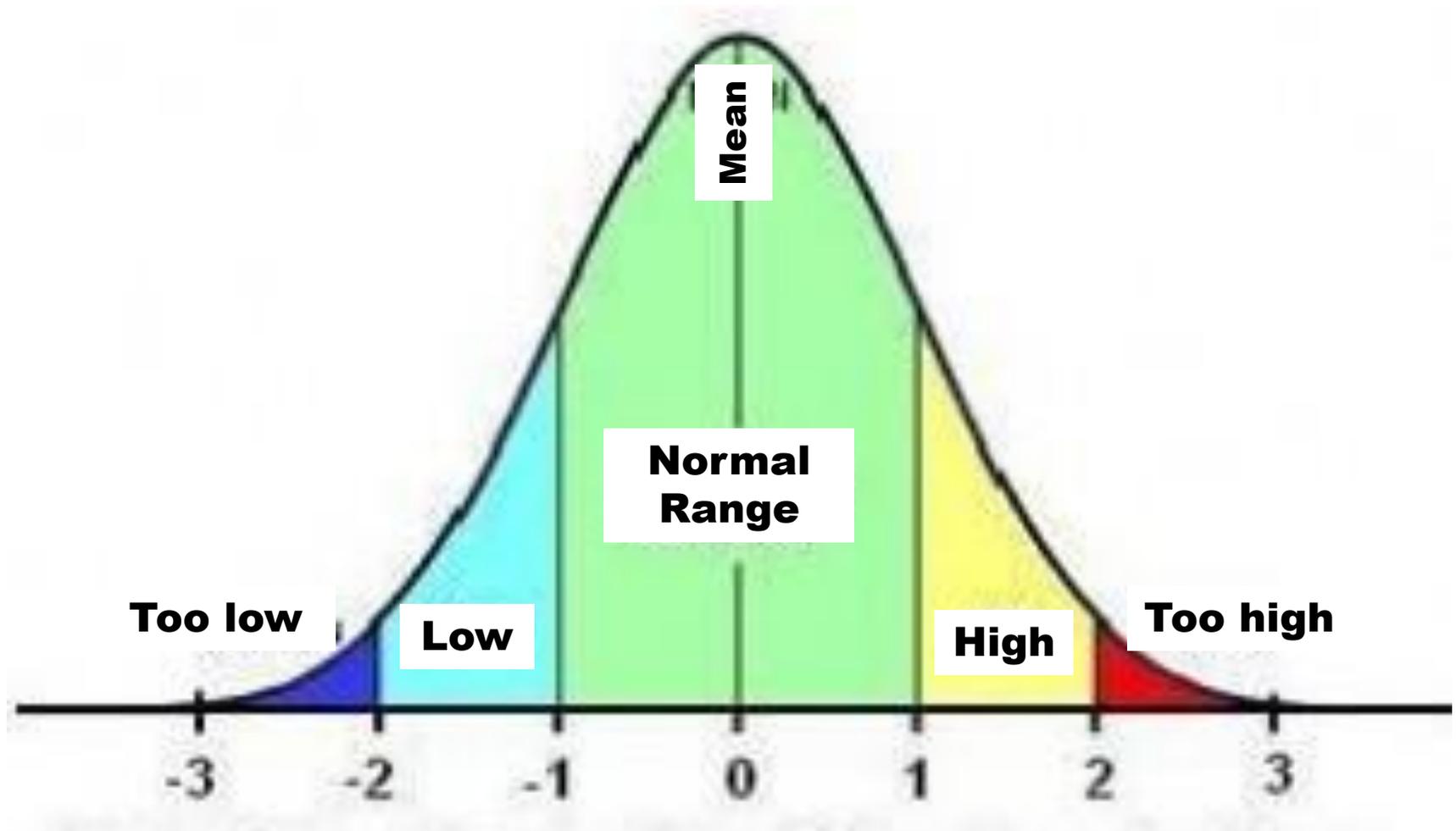
Facets	Measures	Variable 1	Variable 2	Variable 3	Variable 4	Variable 5
Seeking Care	Measure 1	<p>Each measure in the composite could be stratified in a variety of ways, including, but not limited to:</p> <ul style="list-style-type: none"> • Race / ethnicity • Language • Gender • SPMI • Disability • Geography • Etc... <p>Composite will likely start with race/ethnicity at minimum, then expand to include other variables.</p>				
Access to Provider	Measure 2					
	Measure 3					
	Measure 4					
Quality of Care	Measure 5					
	Measure 6					
Differential Treatment based on Needs	Measure 7					
	Measure 8					
Self-Reported Health Status	Measure 9					

Proposed Framework for Index: Standardized Scoring (z-scores)

Each measure will be assigned a standardized score (z-score), which will be based on the variation within each CCO

Facets	Measures	Race1	Race2	Race3	Race4	Race5
Seeking Care	Measure 1	1	0	-2	-3	-4
Access to Provider	Measure 2	1	-2	-3	4	3
	Measure 3	2	-1	4	-2	3
	Measure 4	1	-1	-3	2	4
Quality of Care	Measure 5	1	2	-2	-1	-1
	Measure 6	3	2	-2	-1	3
Differential Treatment based on Needs	Measure 7	-3	-4	0	4	0
	Measure 8	-1	0	1	2	1
Self-Reported Health Status	Measure 9	1	0	0	1	-1

Z-scores tell you where a score lies compared with the rest of the data, above/below mean.



Standard deviation is a yardstick and Z-score is a measurement expressed in terms of that yardstick.

Z-score example

- Standard deviation (SD) shows the variability within a population (i.e., how far away each group is from the mean).
- For example, the mean for a screening service in a CCO is 45%. The SD for the screening in the entire population is 3% (variation is 3% above / below the mean).
- For the Asian population, the SD is 6% (Asian population varies by 6% from the mean of 45%).
- The z-score for the Asian population is $6/3 = 2$.

Z-scores are used to make different groups and measures comparable

- By itself a score or rate provides little information about how that score compares with other values.
- A score may be relatively low or high or average, depending on the scores of other subpopulations within a distribution.
- For example, a CCO's Asian population may have a score of 53% on developmental screening – how does this compare to the other populations within the same CCO?
- This score can be transformed into a z-score, which tells us exactly where the score is located relative to all other scores within the CCO.

Reasons for Using Z-scores

- Address complexity of existing measures (some are rates, some are composites);
- Accounts for differences in the distribution of the subpopulations within each CCO;
- Allows future flexibility – substitution of measures, substitution of subpopulations, etc.

Proposed Framework for Index: Totals

Facets	Measures	Race1	Race2	Race3	Race4	Race5
Seeking Care	Measure 1	1	0	-2	-3	-4
Access to Provider	Measure 2	1	-2	-3	4	3
	Measure 3	2	-1	4	-2	3
	Measure 4	1	-1	-3	2	4
Quality of Care	Measure 5	1	2	-2	-1	-1
	Measure 6	3	2	-2	-1	3
Differential Treatment based on Needs	Measure 7	-3	-4	0	4	0
	Measure 8	-1	0	1	2	1
Self-Reported Health Status	Measure 9	1	0	0	1	-1
TOTAL		6	-4	-7	6	8

Positives & Challenges

Positives

- Allows for comparison across multiple measures, multiple populations in a standardized way.
- Framework approach supports drill down into where there are differences within the CCO.

Challenges

- Small numerators at CCO for some populations / variables will need to be addressed.
- Confusing methodology?
- Totals / composite score may not be meaningful.

Upcoming work

- Mechanism for attaching quality pool / challenge pool payments to total z-scores within index (and how to benchmark!)
- Identifying which measures should be included in the index.
- Testing the right mix of measures and variables.
- Determining if this index provides meaningful information.

Next steps

- OHA intends test the proposed approach in consultation with the internal working group.
- Will bring back updated information, revisions to TAG in Q1 2016 for continued discussion prior to presenting anything to the Committee.
- If CCOs would like to participate with the internal working group, please let us know (metrics.questions@state.or.us)

Questions for TAG

- Reactions to the framework approach?
- Potential ideas for collapsing the measures?
- Suggested measures to fit into the framework (for initial testing)?
- Alternate approaches?

2016 MEETING SCHEDULE & WORKPLAN

Meeting Schedule

- Propose cancelling December 17th meeting.
- Propose continuing monthly meetings in 2016.
 - Standing fourth Thursday afternoon?

2016 Potential Topics

- Health Equity Index measure development
- Food Insecurity measure development
- Alternate access measures
- Alternate patient experience measures
- Opioid and opioid PIP-related measures
- Provider reporting roundtable
- Review 2015 mid year and final results
- Review 2017 measure selection / benchmarks

WHAT ELSE?

