

Oregon Metrics Technical Advisory Workgroup Meeting
February 26, 2015 Minutes DRAFT

Attending:

AllCare Alan Burgess Natalie Case Andrea Laura McKeane	Health Share Graham Bouldin	WOAH
Cascade Angela Leach Kasi Davi	IHN Ellen Altman Megan Underwood Roxanna Neuhaus Eryn Womack	WVCH Greg Fraser Andrea Franchi
CareOregon	Jackson	Yamhill Jim Rickards Jenna Harms
Columbia Pacific	PacificSource Coco Yackley Sarah Kingston Jeff Stevens Lindsey Hopper (Central Oregon Health Council),	Acumentra Sara Hallvik
DCOs	PrimaryHealth Sharon Merfeld	Quality Corp Cindi McElhaney
Eastern Oregon Hanten Day Susanna Lai	Trillium Katharine Carvelli DR Garrett	Guests Misty Mastin (GOBHI)
FamilyCare Kevin McLean Emileigh Canales Kari Benjamin	Umpqua Rose Rice Debbie Standridge Christine Seals Kelley Richardson Katrina Alspaugh	

OHA Staff: Crystal Nielson, Jon Collins, Lori Coyner, Milena Malone, Frank Wu, Sarah Bartelmann, Jennifer Davis, Summer Boslaugh, Rusha Grinstead, Lisa Bui, Susan Arbor, Nita Heimann, Bruce Gutilius, Stacey Schubert, Sheila Clauson
Cyndi Kallstrom, Angela Kimball

Updates

Sarah Bartelmann provided the following updates:

- February dashboard was released on Tuesday, February 24. Some members have experienced access problems related to an office move; please contact Sarah Bartelmann (sarah.e.bartelmann@state.or.us) or Jenn Davis (jennifer.c.davis@state.or.us) if you are having difficulties. Cost and utilization reports were also posted with this release.
- 2014 quality pool revised estimates were posted on January 15. Revised estimates are lower due to the removal of hospital reimbursement adjustment (HRA) dollars. OHA did not provide an official communication at that time of release and there have been many questions. An official memo will be distributed tomorrow or early next week, and a statement will be included in the next CCO Bulletin.

Update: after the TAG meeting and additional discussion, OHA leadership agreed to reinstate the HRA dollars into the 2014 quality pool estimates. Revised estimates incorporating HRA dollars were posted online on February 27th.

- There have been many questions about how/whether ICD-10 coding will be incorporated into 2015 measure specifications. NCQA has not yet officially updated HEDIS measures and it is unlikely they will until the 2016 manual is published. OHA will work with the proposed draft to produce a crosswalk and repost all measure specification sheets later this spring with ICD-10 codes added as a placeholder. Specifications will be officially updated if ICD-10 launches as planned. Note that HEDIS measures allow for obsolete codes to be included for the measurement year and at least one year prior to any look-backs periods, so ICD-9 will remain valid for measurement for a while longer. The 2015 specifications will pick up ICD-9 and ICD-10 codes.

Oregon Public Health Assessment Tool (OPHAT)

Nita Heimann (OHA Public Health Division) provided an overview of the Oregon Public Health Assessment Tool:

OPHAT is a web-based tool developed by the Public Health Division to display, analyze, and access population-based data sets. OHAT currently performs analyses at the state- and county level, and staff is in the process of adding functionality to analyze by CCO geography. The tool is free to local and state public health agencies, as well as CCOs and hospitals doing assessments. To access OHAT, complete a data use agreement (available in the meeting materials online here: www.oregon.gov/oha/analytics/Pages/Metrics-Technical-Advisory-Group.aspx) and contact Nita Heimann (juanita.a.heimann@state.or.us).

Nita walked through several examples. Key points included:

Overview of data in OPHAT – 8 separate datasets; 5 are population-based representing all of Oregon (birth, death records), 3 are population estimates. Potentially adding statewide Behavioral Risk Factor Surveillance System (BRFSS) data soon. All data represent either people or health events, not health care encounters. Infant mortality, mortality, population estimates, pregnancy and abortion data.

Example: birth risk factor data:

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- Select calculation – options available depend on previous selections and are only relevant to the data set you selected. % of total births, or % in which infant died < age1.
- Select geographic area – entire state, one or multiple counties. Can also customize by grouping counties together into one unit of analysis. Will include CCOs as unit of analysis in future. State total available as comparison.
- Race/ethnicity – depending on the data set, may have many options to slice. Further information about the data available to users in help / data notes.
- Age groups – pre-grouped, will be adding ability to create custom age groups in future update.
- Type – any relevant subgroups for a given data set. E.g., education, smoking, WIC enrollment, prenatal care, select conditions, method of payment for delivery (including Medicaid), etc.
- Analysis with cross-tab different factors – could limit to just singleton births, Medicaid, etc.
- Select year or years – individual years, roll up years (averages built in).
- Option to save query to use later.
- Amount of time to run depends on how complicated the query is. Can download output to CSV

Q&A:

- As providers move toward electronic health records / health information exchange, how can data be made available in real-time (or closer to real-time)?
 - Drawback of system like this – only updated annually, not real time – will always have lag when data are cleaned, closed and QA completed.
 - Even OPHAT is evolving technology – trying to figure out new ways to make the data available to new audiences, determine how it will work with new technologies. May be more real time in the future.
 - Development process – switching to data warehouse – will make it easier to use different software for data display, more user-friendly options (tables, charts, maps) through Excel, Business Objects, or SharePoint.
- Can users look up definitions for terms used in OPHAT?
 - Yes - Help and data notes page – some link to specific items right on the page, but can always go through page. Can always add more information if needed. Table describes everything in the dataset.
- Information about substance use during pregnancy?
 - Smoking during pregnancy is available, but it depends what is available on birth certificate records. Nita to follow up.
- Once function to search by CCO boundaries becomes available, will it be possible to update as CCO service areas change?

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- Staff is working on process to address this issue. Would eventually like to also add smaller units (e.g., zip codes) that can be built / combined into custom geography.

Tobacco Prevalence Measurement

In August 2014, the Metrics and Scoring Committee adopted “rate of tobacco use among adult members” as a CCO incentive measure for 2015. However, in October the Committee reconsidered this decision in light of whether CCOs and providers can produce measureable change in a one-year period, and ultimately removed the measure from the 205 incentive set. The Committee is still considering a tobacco prevalence measure for 2016 and, in the meantime, is soliciting input from CCOs and asking OHA to address methodology concerns. The TAG is being asked by OHA to review several measure options, discuss pros/cons of each, and provide feedback to inform conversations at the March 20th Metrics and Scoring Committee meeting.

Option 1: Calculate tobacco use prevalence rate from the annual CAHPS survey, use year-over-year comparison (e.g., 2016 rate compared to 2015 baseline). Discussion included:

- CAHPS question used is “do you use tobacco” versus “did your doctor ask you about tobacco use.”
- CAHPS data cannot be analyzed by specific facility, only at aggregate CCO-level.
- Range of error is serious drawback; not sure how to get beyond this issue.

Option 2: Combine multiple years of CAHPS data to calculate tobacco use prevalence. (e.g., 2015+2016 rate, compared to 2014 baseline, or 2014+2015 baseline). Discussion included:

- Margin of error reduced, but not halved.
- Methodology difficult to explain.
- Changes in measure likely due largely to new members coming/going each year (variability in population).
 - Additional option to address this issue: Create cohort/subset from CAHPS sample; instead of looking at total prevalence for all respondents, only look at those who were also in previous year’s data.
 - This would ensure looking at members with year-to-year experience. However, numbers would likely be very small.
- Consider increasing continuous enrollment criteria from six months to 12 months: less restrictive than requiring two years of CAHPS response, but eliminates members who are brand new to CCO.
 - This would be a subset of total number of surveys, thus increasing margin of error.

Option 3: Use either option 1 (year over year) or option 2 (combined years), but use an earlier year as baseline (e.g., 2013 baseline compared to 2015 performance). Discussion included:

- There is already pre-existing momentum around tobacco cessation.
 - Giving credit for historical / existing projects raises the question of whether the incentive measure would actually be changing anything versus just measuring.
 - Or is the existing momentum a result of the Committee talking about / considering an incentive measure? (Perhaps, but it also a nationwide phenomenon).

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- Giving CCOs credit for other initiatives or historical projects shouldn't be considered a con.
- All of these options only look at adult population, but teenage trends arguably more important. Excluding teens misses the biggest leverage point. However, data not currently available at teen-level by payer mix.

The workgroup suggested using electronic health records for a tobacco prevalence measure instead of CAHPS.

Discussion included:

- EHRs may in fact be better suited to this measure than to any of the current clinical measures.
- There is a Meaningful Use measure for tobacco use, but it is combined with counseling (which is not well-defined) and thus deviates from a strict prevalence measure.
 - Could try to create custom measure that excludes counseling aspect, but not advisable.
- Would allow analysis at provider/facility level.
- Additional burden to CCOs, but this is the direction CCOs are headed. First couple of years of EHR-based reporting were dedicated to building knowledge base and infrastructure.
- If tobacco prevalence does become a new Clinical Quality measure, a phased-in approach is advised. However staff cannot guarantee that is possible, as CMS is unlikely to approve another pay-for-reporting measure as part of the incentive measure set.
 - Suggest OHA offer a reporting-only option for 2015 for any CCOs that wish to begin building their capacity to report on this measure from EHRs. Sarah will coordinate with Crystal.
- EHR only captures members who visit doctor; not necessarily population as a whole (however, CAHPS survey also limited).
- EHR is the direction CCOs are headed. The data are actionable.

The workgroup would like to review Meaningful Use specifications for this measure at the next TAG meeting (March 26th). At that meeting, staff will also provide an update on the March 20th Metrics and Scoring Committee discussion.

If CCO members are interested in being on the panel which presents at the March 20th meeting, please contact Sarah (sarah.e.bartelmann@state.or.us).

2014 Timeline

Jen Davis provided an overview of the timeline to finalize the CY 2014 data and distribute the 2014 quality pool. See presentation in the meeting materials online here: www.oregon.gov/oha/analytics/Pages/Metrics-Technical-Advisory-Group.aspx.

Next meeting

Thursday, March 26th
1:00-3:00 pm