

Oregon Metrics Technical Advisory Workgroup
March 27, 2014 Minutes

Attending

	Cynthia Ackerman (AllCare)		Jeanette Simms (PacificSource)
	Scott Munson (Cascade)		Sarah Kingston (PacificSource)
	Angela Leach (Cascade)		Molly Williams (PacifiCSource)
	Amit Shah (CareOregon)		Maggie Rollins (Primary Health of Josephine)
x	Hanten Day (Eastern OR)		Sharon Merfeld (Primary Health of Josephine)
	Resa Bradeen (FamilyCare)	x	Frank Wu (Trillium)
	Maureen Gaine (FamilyCare)	x	Katherine Caravelli (Trillium)
	Kevin Ewanchyna (FamilyCare)		Andy Jacobs (Trillium)
	Beth Brenner (FamilyCare)		Christine Seals (Umpqua)
x	Daniel Dean (Health Share)		John Sevier (WOAH)
	Helen Bellanca (Health Share)		Greg Fraser (WVCH)
x	Ellen Altman (IHN)		Cindi McElhane (Quality Corp)
	Tony Stuckart (Samaritan)	x	Chantel Pelton (Quality Corp)
	Jim Rickards (Yamhill)		Sara Hallvik (Acumentra)
	Ken House (Mosaic Medical)	x	Jody Carson (Acumentra)
	Lisa Bui (Clackamas County)	x	Stuart Bradley (WVCH)
x	Coco Yackley (Columbia Gorge Health Council)		

OHA/DHS Staff: Lori Coyner, Sarah Bartelmann, Terry Bequette (consultant), Jon Collins, Chris Coon, Mike Morris, Tonya Burckhardt, Crystal Nielson, Barbara Pizacani, David Dowler

USDOJ Measure Update

Mike Morris (AMH lead on USDOJ work) provided an overview of OHA work with USDOJ and update on the situation.

- USDOJ was investigating Oregon under the Olmstead act. 18 months ago, Oregon signed a letter of agreement between Oregon and USDOJ: year one – collect data; year two – discuss and identify gaps in mental health system; year three – identify outcomes; year four – review performance and progress toward the outcomes.
- Arrangement with USDOJ is more collaborative than other state agreements, as Oregon asked USDOJ / federal government to support health system transformation and to allow time for transformation to occur.
- Letter of agreement included an agreed-upon data matrix – 111 data items that Oregon would collect and report to USDOJ quarterly. As OHA worked with the data elements, realized very difficult to collect and slice in understandable ways. USDOJ asked many questions, asked for additional breakouts, additional data, etc.
- OHA had to rely on surveys to collect some of the data elements, and worked with the CCOs to collect 10 initial data elements where OHA had no system to collect data centrally. In subsequent quarters, this was reduced to 5 data elements and moving forward, OHA will not need to collect any additional information from CCOs to complete USDOJ reporting

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requirements.

- OHA met with USDOJ and brought propose to change the 111 data elements for reporting, based on year one experience with the data and interpretation. USDOJ agreed – initial matrix isn't helpful and the data elements should be changed. Through a collaborative process, a revised matrix is being finalized. OHA is waiting for approval from USDOJ on the revised matrix.
- The revised matrix is more focused on services and gaps at the community level and less focused on CCO services. Also interested in breaking out Medicaid and non-Medicaid to enhance USDOJ's understanding of what is happening in Oregon.
- Previously, OHA did not release this data publically until submitted and approved by USDOJ. Moving forward, Oregon will be more transparent with the data and will be sending data out to groups representing CCOs and community mental health programs for their review and feedback.
- Addictions and Mental Health (AMH) will be working with Lori Coyner and others on how best to coordinate with CCOs regarding the new matrix when it is finalized and additional information on the USDOJ reporting process.

Discussion

- Mental health residential is to be integrated into CCOs in July – is there crossover, or implications for the USDOJ measures?

Yes, there is some crossover, although USDOJ is . USDOJ is looking for decreases in those in the state hospital, and a reduction in use / reliance on licensed residential programs, as the focus is ultimately on people living in their own homes in the community with the supports needed for them to be successful.

Medicaid Behavioral Risk Factor Surveillance System (BRFSS)

Barbara Pizacani from Program Design and Evaluation Services (PDES) provided an overview of the upcoming Medicaid BRFSS survey:

- The last Medicaid BRFSS was done 9-10 years ago. This is an opportune time to field another Medicaid BRFSS and provide CCOs with baseline information on behavioral risks in their populations.
- The Medicaid BRFSS is a version of the BRFSS done every year on the entire population in all states and territories. BRFSS questions are not clinically based, not customer satisfaction or experience with health care. They are about behavioral patterns that affect health, including: tobacco, physical activity, nutrition, substance use, knowledge of and self-management of chronic conditions.
- The general / regular BRFSS survey asks if people are on Medicaid, so can report on a subset of the survey population as Medicaid, but the numbers are very small and cannot report at the

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CCO level.

- Oregon is able to field in 2014 due to the funds set aside for surveillance in the SIM grant (funded projects include Medicaid BRFSS, public health key indicators reported out by CCO, and a race/ethnicity oversample for the general BRFSS).
- The goal is 400 completed adult surveys per CCO, with a race/ethnicity oversample at the state level only to create 5 racial / ethnic groups for statewide estimates. The survey will field in the spring to hopefully include those in the expansion population.
- The majority of questions on the survey are standard BRFSS questions that are fielded every year, have been tested, and are in use across the country. Several questions have been pulled from other surveys, such as health access questions borrowed from the Oregon Health Insurance Survey.

Discussion

- When will the survey field?

Hoping for April 1, 2014, but may be later than that.

- How does the timeline and sampling overlap with CAHPS?

Originally planning to hold the Medicaid BRFSS until CAHPS ended in mid-May, but there may be some small overlap when both surveys are in the field. Will remove state and federal CAHPS survey samples from the Medicaid BRFSS sample where possible to reduce likelihood of members being contacted for multiple surveys. This may be more difficult for race/ethnicity oversample, as the CAHPS survey also included a racial/ethnic oversample.

CAHPS has a longer enrollment requirement (6 months) than Medicaid BRFSS (45 days enrollment from January 1, 2014) so the populations are already not contiguous.

The Medicaid BRFSS will contact both cell phones and landlines, depending on the phone number of record provided in OHP enrollment. This is not a random digit dial survey.

- Will the survey be conducted in any other languages?

The Medicaid BRFSS will be conducted in English, Spanish, Russian, and Vietnamese.

- How long is the survey?

The draft questionnaire piloted at 30 minutes. Many questions rely on the initial question in the module with skip patterns resulting in shorter surveys for some. The general BRFSS clocks in around 28 minutes.

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- Are members who were called for the general BRFSS excluded from the Medicaid BRFSS?

No, but they are free to refuse to participate in the Medicaid BRFSS if contacted again.

- How will Medicaid members be contacted regarding the Medicaid BRFSS?

A lead letter will be sent explaining the survey; the vendor will call on behalf of OHA within 2 weeks. OHA expects a 50 percent response rate (historically, general BRFSS is around a 50 percent response rate). If additional completed surveys are needed, will draw an additional sample and send new lead letters.

- Why is telephone the best mode for conducting this survey?

Length and skip patterns are too complex for a paper based survey. A 1:1 interview in person would be idea, but is cost prohibitive. CAHPS uses multi-modal (paper / phone), but does not have as many skip patterns as BRFSS.

- When will the survey wrap up?

The contract with the vendor states 3 months as the goal to achieve 400 completed surveys per CCO. The race/ethnic oversample may be in the field slightly longer (one extra month) if augmentation is needed.

- Given the length of the survey, has there been any discussion of potentially combining CAHPS and Medicaid BRFSS?

CAHPS is very standardized; vendor has to be certified to conduct CAHPS and the survey tool is very rigid in terms of modes and methods. Additionally, the eligibility criteria are different for the sample.

Potentially some of the Medicaid BRFSS questions could be added to CAHPS (as CAHPS will be conducted annually and the Medicaid BRFSS is not annual). It would be helpful to have CCO feedback on which Medicaid BRFSS questions would be most helpful / interesting to collect more frequently via CAHPS.

- What is the purpose of the Medicaid BRFSS?

To provide a good profile of health status and behavioral patterns of Medicaid members as they relate to health outcomes; to have data at state and CCO level.

- What data can be provided to CCOs and when will it be available?

There will be a statewide analysis, including the race/ethnic oversample analysis, as well as CCO specific reports. It is likely there will be additional analysis applying weighting and looking at statewide estimates for Medicaid compared to the general population.

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It would be good to continue talking about the CCO needs and interests for the Medicaid BRFSS report. Posting data online is most efficient, but what would be appropriate? What would be most useful for CCOs? What can OHA provide that would help CCOs, community advisory councils, community health assessments, etc...

- CCOs are required to address social determinants of health work in 2014 – the requirements are very vague at this point. Will the Medicaid BRFSS meet some of those requirements so CCOs do not have to do duplicative work?

The Medicaid BRFSS survey does include the ACES module, which should help inform this and some of the early learning council work.

PDES is also working on an associated project to report ~30 public health indicators for the entire community (not just Medicaid members) living in the CCO region (based on service area zip codes). This will provide some comparative information with the Medicaid BRFSS results.

DHS Custody – Outstanding Questions / Concerns

- How can OHA take 12 months' worth of data as the baseline and compare it to only three months of data in the 2013 measurement? Is this still an apples-to-apples comparison?

Yes. The shorter measurement period is not ideal, as it results in much smaller denominators, but the three months are acting as a sample for the full year of data.

- Some local branch offices are resisting establishing tracking systems, coordinating with CCOs to improve coordination and communication on this metric. Is work being done by DHS to improve tracking at state and branch office level for this metric? Similarly, branch office data differs from notification list received from OHA. Can OHA directly notify branch offices of this information, rather than the CCO?

OHA is unlikely to drop the notification list to the CCOs, as this is what the CCO incentive metric is now based on.

DHS needs to track assessment information for children in foster care. CCOs should send information on challenges / concerns with communications to Sarah and Chris Coon for tracking and resolution with staff at DHS (state level and district area managers meeting).

Clinical Guidelines / Measure Specification

Terry Bequette, consultant with Office of Health Information Technology, provided a brief update on the clinical quality metrics registry project and RFP development. As Metrics TAG members have participated in several conversations about requirements for the clinical quality metrics registry (CQMR) and plans for coordinating CQMR development with proof of concept and electronic reporting requirements, OHA would like to continue to hold these types of discussions with the Metrics TAG. CCOs may wish to invite other staff to participate in upcoming TAG conversations as appropriate.

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Technology Plan Status Update

Three CCOs have been approved; OHA has requested written addendums from remaining CCOs. As they come in, they will be reviewed and approved. CCOs that have already submitted addendums should hear from OHA on Monday. Those CCOs submitting addendums today should hear from OHA no later than April 14th. Proof of concept data are due to OHA May 1st. Sarah and Crystal Nielson available for questions and technical assistance as needed.

OHA asked CCOs to provide information on the bigger picture related to HIT / HIE in their year one technology plans. OHA – Office of Health Information Technology will be following up with CCOs on some of this information. Some technology plans referenced surveys that were fielded with key practices. If your CCO sent out a survey and you are willing / able to share this information, please send to Sarah or Crystal.

2013 Early Elective Delivery

OHA is collecting the 2013 early elective delivery rates directly from hospitals and facilities this time. CCOs do not need to contact any hospitals or facilities to collect these rates. OHA will provide 2013 EED rates in the April 30th report.

Other Discussion

If the CAHPS survey isn't going to be completed until mid-May, how will this affect the CCO incentive metrics?

- OHA will have data available for the April 30th report. Mid-May references the close out of all surveying. In the past, when the CAHPS survey was finished, it typically took several months to get the data / results back out. OHA has worked with the contractor to build in our timeline for the incentive measures and the contractor will be providing OHA with data quickly to inform the incentive measurement. CCOs should expect to see data on the two incentive measures in the April 30th reports, but the banner books will not be available until June.