

# Metrics & Scoring Committee Equity Impact Assessment

May 2021

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# Common Definitions

To ensure shared understanding, below are definitions of terms used in this report.

## Health Disparities/Inequalities

Health disparities mean the same thing as health inequalities. They reflect differences in the presence of disease, health outcomes, or access to health care between population groups. For example, male babies are generally born at a heavier birth weight than female babies. This is a health disparity and we expect to see this difference in birth weight because it is rooted in genetics and an unavoidable difference.

## Health Equity (Oregon Health Policy Board and Oregon Health Authority definition)

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

## Health Inequities

Health inequities are differences in health that are not only unnecessary and avoidable but, in addition, are considered unfair and unjust. Health inequities are rooted in social injustices that make some population groups more vulnerable to poor health than other groups. For example, babies born to Black women are more likely to die in their first year of life than babies born to White women. A higher percentage of Black mothers are poor and face hardships associated with poverty that can affect their health. Research has shown links between the stress from racism experienced by Black women and negative health outcomes. This is a health inequity because the difference between the populations is unfair, avoidable and rooted in social injustice.

## Observed Disparity

The term 'observed disparity' is used throughout this report to describe the pre-post differences on measures' impacts on different population groups. This is important because not all disparities constitute inequities and we did not directly measure inequities in this assessment and may not be able to draw such causal inferences.

## **Priority Populations and Communities**

Refers to the following population groups: Black, Indigenous, People of Color (Asian, Pacific Islander and Latino/Latina/Latinx) and American Indian/Alaska Native people; people with low-income; people with disabilities; people who identify as LGBTQ+; people who live in rural areas.

## **Social Justice**

As used in this report, Social Justice is synonymous with Distributive Justice. This concept is based on John Rawls *A Theory of Justice* and emphasizes that the root causes of inequities can be addressed by transforming social structures and power. In the context of health care, Potts and Brown (2005) suggest that transforming the way health care resources and relationships are produced and distributed would improve access to health care services and health.

# Executive Summary

**This report describes findings from an Equity Impact Assessment (EIA) of the Metrics & Scoring Committee's work in selecting measures for the coordinated care organization (CCO) Quality Incentive Program.** The Oregon Health Authority (OHA) has set the ambitious and necessary goal of eradicating health inequities by 2030. The CCO Quality Incentive Program (also known as the quality pool) is a pay-for-performance program in which CCOs can earn incentive funds for improving quality for Oregon Health Plan members. As one of the strongest levers available for improving care and health for members of the Oregon Health Plan, it is imperative that equity principles are followed in selecting and implementing the measures included in the program, and that we monitor and assess whether inclusion in the incentive program reduces health inequities.

**The EIA analyzed CCO incentive measures considering OHA's health equity definition, our strategic goal to eliminate health inequities by 2030, and questions from the Metrics & Scoring Committee about how to leverage the incentive program to achieve health equity.** The EIA objective is to identify opportunities to use the incentive program and measures to address inequities in access to and outcomes of health care in the state's delivery system.

**The EIA used a mixed methods design to concurrently analyze qualitative and quantitative data.** A mixed method design was chosen to optimize the strengths of each method for evaluating the equity impacts of the incentive metrics. There is growing use of mixed methods in health services research. This design is justified because inequities exist at multiple levels and have multiple causal pathways and systems that create and reinforce inequities. The qualitative component of the EIA was designed to understand the context, content, and implementation (approval process) of CCO incentive measures. The quantitative component was designed to provide insights on the effects of individual incentive measures on priority population groups.<sup>1</sup> Case studies of four measures were conducted:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Access to Care (incentivized 2012 - 2019)
- Dental sealants on permanent molars for children (incentivized 2015 - 2019)
- Disparity measure: Emergency Department utilization for members with mental illness (incentivized 2018 - present)
- Effective contraceptive use (incentivized 2015 - 2019)

While the findings related to the individual case study measures are important, the purpose of this assessment is to identify opportunities to use the incentive program and measures to address inequities in access to and outcomes of health care. Multiple factors, including data availability, impacted the measures which could be included as case studies in this assessment. The analysis focused on process, specifically, so that processes overall could be improved. This means recognizing the findings related to these four specific measures, and

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<sup>1</sup> Priority groups are populations with evidence suggesting that the origins of their disparities are unjust social structures and manifest in increased exposures to health risks that result in poor health outcome.

focusing on how the learnings from these case studies can be used to improve Committee processes so the incentive program can be best leveraged to recognize, reconcile, and rectify historical and contemporary injustices.

**What did we find?** Convergence of qualitative and quantitative findings is summarized in the table below.

Incentive Measure	Qualitative		Quantitative	
	Does the framing consider differential impacts on priority populations?	Does the measure selection process integrate Health Equity principles?	Did <u>most</u> priority populations achieve increased benefits?	Did observed disparities decrease for <u>most</u> priority population groups?
Effective Contraceptive Use	No	No	Yes <sup>2</sup>	Yes
ED Utilization for Mental Illness	No	No	Yes	No
Dental Sealants for Children	Yes	Yes	Yes	Yes
CAHPS Access to Care - Adults	No	No	No	No
CAHPS Access to Care - Children	No	No	No	No

As shown above, **findings were mixed** in terms of whether integrating health equity principles into the measure selection process led to improvements for priority populations and decreased observed disparities. This may be due to several factors, including lack of a formal and consistent process for including equity principles in measure selection, and the disparate ways in which CCOs may choose to implement their quality improvement efforts in support of achieving the incentive measures.

- While the incentive program is powerful in terms of focusing quality improvement activities in a particular area, it currently **operates within the boundaries of what can be quantified and consistently measured**. This can have negative consequences on health equity and therefore caution must be used to ensure the Quality Incentive Program is the best lever for improvement.
- There is a need to **ensure the populations most impacted by current and potential incentive measures are meaningfully engaged in what is incentivized and how measures are operationalized**. This includes identification of what is considered a problem needing to be solved, and how it should be solved. We must include anti-colonial, anti-racist, indigenous knowledge to identify what the problems are and what the roots of the problems are.

<sup>2</sup> The rate of use of moderately and highly effective contraceptives increased for most priority populations. However, we do not know if this was entirely beneficial because the metric may have incentivized contraceptive coercion. See the “How measures were framed” section for further explanation.

- The quantitative analysis showed the **need to monitor and analyze incentive measures by Race, Ethnicity, Language, and Disability (REALD)**, as looking at aggregated data on incentive measures statewide can mask inequities in outcomes within and between for priority populations.
- Only two of the case study measures reduced inequities for most priority population groups, **suggesting that quality improvement activities may not be implemented using equity principles.**
- For most of the case study measures the quantitative analysis found lower level of inequities between race and ethnicity groups, patients with or without disabilities, and members living in rural or urban areas. However, the magnitude of inequities across different household language groups are large for most measures, indicating **meaningful access to health care with appropriate language services remains a key area to be addressed.**

While the findings identify a lack of focus on equity and health equity principles, they are not surprising given the entrenchment of power structures like racism that perpetuate and rely upon continued marginalization of priority populations and communities. Moreover, as a state and agency, our priorities have shifted to where they should have been all along. The adoption and development of these case study measures was done prior the Oregon Health Policy Board and OHA's adoption of a common definition of health equity in 2019, and OHA setting its strategic goal of eliminating health inequities by 2030. The health equity definition provides a clear framework for achieving this goal and is the foundation by which we move forward.

**The EIA is the necessary first step to ensure the Quality Incentive Program advances health equity.** The findings of this report, coupled with the foundation of the health equity definition, provide a path by which the Committee can check its assumptions moving forward, and ensure that health equity principles are included in measure selection and retirement and that the incentive program can be leveraged to meet the goal of eliminating health inequities by 2030. To ensure meaningful change, the following changes are recommended:

- **Include formal consideration of equity in measure selection and retirement criteria.** Update measure selection and retirement criteria to formally integrate health equity principles as criterion. This could also include setting a threshold proportion of number of measures in the program that must directly advance health equity, designating a 'must meet' criterion for individual measures related to health equity, and/or establishing a formal review process for each measure (and the set) to check assumptions about a measure's impact (or lack thereof) on health equity.
- **Program structure changes.** Explore changes to the program structure to focus on priority populations. As the program is currently structured, setting targets across the entire membership can mask inequitable outcomes. This includes prioritizing measures that address the social determinants of health and equity which can be at the root of unjust health outcomes.
- **Use of diverse knowledge and expertise.** Increase input from Medicaid members and priority populations who will be impacted by how the measures are framed, which

measures are selected, and how they are implemented, evaluated, and retired. This could include a paid Medicaid member consultation panel or inclusion of Medicaid members as members of the M&SC, for example. In addition, qualitative evaluation of member experience can be considered and integrated into the benchmark setting and measure retirement processes.

- **Education about inequities and using consistent language to address the identified problem.** Disparities and inequities were used interchangeably in the conversations in which equity was discussed (for example, the emergency department utilization for mental illness measure). It was not clear whether the focus was on addressing disparities (differences in health outcomes that may be rooted in genetics) or inequities (differences in health outcomes that are unfair, avoidable and rooted in social injustice). A shared understanding is needed across M&SC members, as well as staff. This might include anti-racism and other health equity trainings.
- **Consider implementation.** Once a measure is incentivized, emphasize opportunities for both OHA and CCOs to include implementation efforts rooted in health equity principles and focus on efforts which will reduce inequitable outcomes.
- **Additional ideas.** In addition to the ideas above, it is important for the Committee and staff to do the work to identify additional solutions and process changes to address historical and contemporary injustices and move forward. The authors of the assessment look forward to a dialogue and ongoing work with the Committee and staff to move this work forward together.

# Background

## Adoption of Health Equity Definition

The Health Equity Committee, a subcommittee of the Oregon Health Policy Board (OHPB) tasked with coordinating and developing policy that proactively promotes the elimination of health disparities and the achievement of health equity for all people in Oregon, worked closely with the Oregon Health Authority's (OHA) Equity and Inclusion Division staff to develop the health equity definition in the box to the right. The development process included feedback from various groups including the tribes, community-based organizations, OHPB committees, coordinated care organizations (CCOs), and community advisory councils.

In October 2019 the definition was formally adopted by both the OHPB and OHA as a shared definition for use agency-wide and the driving force behind OHA's strategic goal to eliminate health inequities by 2030. The health equity definition and principles enshrined in the definition provide a framework for program and policy evaluation across the agency.

## CCO Quality Incentive Program

The CCO Quality Incentive Program (also known as the quality pool) is a pay-for-performance program in which CCOs can earn incentive funds for improving quality of care for Oregon Health Plan members.

The program has been in existence since 2013 and is an important lever for quality improvement included in Oregon's Medicaid Demonstration Waiver agreement with the Centers for Medicare & Medicaid Services.

CCOs receive financial bonuses paid for year-over-year improvement on the healthcare quality measures included in program. In total, thirty (30) quality measures have been included in the program since its inception. The number of measures included in each year varies, ranging from 13 in 2020 to 19 in 2019. Payments for the total quality pool have ranged from \$47 million for 2013 performance to \$188 million for 2018 performance.

The Metrics and Scoring Committee (M&SC) was established in 2012 by Senate Bill 1580 for the purpose of identifying the specific measures included in the CCO Quality Incentive Program, as well as the targets and benchmarks that must be met to earn the bonus funds. Per statute, M&SC includes nine members: three members representing

## HEALTH EQUITY DEFINITION

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CCOs; three healthcare quality measurement experts; and, three members-at-large. The M&SC annually reviews and updates the measures and targets included in the program. The CCO Quality Incentive Program is one of OHA's strongest levers in terms of measuring performance and paying for improved care and outcomes for members of the Oregon Health Plan. Independent evaluation of the 2012-17 Medicaid Demonstration Waiver found a strong association between the incentive program and improvements in CCO measure performance.<sup>3</sup> Improvement was significantly greater on measures included in the incentive program versus those tracked by OHA but not incentivized. The relative improvement of incentivized versus non-incentivized measures was such that the evaluators recommended that:

- The size of the quality pool be increased (additional fees at risk);
- The benchmarks/standards for meeting measures be increased; and,
- New measures be added to the program.

## Equity Impact Assessment

Given the power of the incentive program to catalyze and accelerate quality improvement, the specific measures included in the program are very important. It is also imperative that equity principles are adhered to in selecting the measures for this focused quality

improvement work, and that we monitor and assess whether inclusion in the incentive program results in reduced disparities and increased equity. This analysis is a first step forward to realizing these goals and improving M&SC processes to ensure the work of the Committee and the incentive program can be best leveraged to further health equity.

“The State should increase the portion of CCO payments awarded for performance on quality measures and increase the level of performance needed to receive the full award. To raise the bar, the State could increase the benchmarks and improvement targets for existing quality measures, introduce new quality measures, or both. The State should use the larger quality pool and higher performance standards to drive improvement in areas with relatively little progress— such as access to primary care and integration of physical, behavioral, and oral health care—by raising standards or introducing new measures in these areas.”<sup>3</sup>

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<sup>3</sup>Evaluation of Oregon's 2012-2017 Medicaid Waiver, OHSU Center for Health Systems Effectiveness, Dec. 2017: <https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf>.

# **Aims and Methods**

# Aims and Methods

The purpose of this Equity Impact Assessment (EIA) is to analyze CCO incentive measures considering OHA's health equity definition and questions from the M&SC about how to leverage the incentive program to achieve health equity. The objective of the EIA is to identify opportunities to use the incentive program and measures to address inequities in access to and outcomes of health care in the state's delivery system.

## Methods

To evaluate the incentive measures from multiple perspectives, this research used a concurrent mixed methods design. With this design, qualitative and quantitative data are analyzed independently, then the results are triangulated and interpreted together. The strengths of a concurrent mixed method design include using multiple data sources (qualitative and quantitative) to identify patterns, themes, associations, and relationships that expand our understanding of the incentive program and identify opportunities for leveraging the program to achieve the agency's health equity goals (Creswell & Pablo-Clark, 2011).

The qualitative component comprises case studies of four measures chosen by a purposive sampling of current and previously incentivized measures. The measures are:

- **Effective contraceptive use (incentivized 2015 - 2019).** Percentage of women (ages 15-50) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraceptive injection, contraceptive pills, sterilization, patch, ring, or diaphragm.
- **Disparity measure: Emergency Department utilization for adult members with mental illness (incentivized 2018 - present).** Rate of patient visits to emergency department for members ages 18+ with mental illness. Rates are reported per 1000 member months; lower is better, indicating greater care coordination.
- **Dental sealants on permanent molars for children (incentivized 2015 - 2019).** Percentage of children ages 6-14 who have sealants on permanent molars.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Access to Care (incentivized 2012 - 2019).** Percentage of members responding to survey who thought they received appointments and care when they needed them.

The maximum variation approach to purposive sampling was used for selecting measures from the broad spectrum available in the incentive program, and to ensure that our results provide deeper understanding of the incentive program (Etikan, Abubakar, & Alkassim, 2016). Elements of the sampling strategy included the availability of adequate sample size of individual member-level data through claims, hybrid/attestation, or survey for conducting both the qualitative and quantitative analysis; population groups by age cohort (children, adolescents, and adults); care types (physical, behavioral, oral); and, length of time in the incentive program.

## Qualitative Research Strategy

The qualitative component of this research seeks to understand:

- How are the chosen incentive measures framed? How are populations most affected by inequities differentially affected by this framing?
- How does the measure selection process integrate health equity principles? Where are opportunities to align this process with these principles?

This analysis combined case study method with the Intersectionality Based Policy Analysis (IBPA) framework. Case study method was selected because the metrics are bounded phenomena studied in their real world contexts using multiple data sources (Yin, 2014). A strength of case study is that it allows for the tracing of events through time, so is an ideal strategy for researching a process such as the measure selection process (ibid).

IBPA provided a framework to evaluate the incentive measures through an intersectional lens and to describe the broader equity implications of the measures (Hankivsky et al., 2014). IBPA was selected because it aligns with principles of OHA's health equity definition including the distribution of power and resources, using diverse knowledges, valuing different social locations, and promoting social justice (ibid).

Data collected for analysis included:

- Measure guidance documents
- M&SC meeting minutes and meeting recordings
- CCO metrics Technical Advisory Group (TAG) minutes and meeting recordings
- Other related documents used to create, maintain, or retire the measure
- Background literature related to the specific issue addressed by the measure
- Key informant interviews

Two analysts selected, reviewed, and coded all documents. The analysts developed a coding structure using directed content analysis as described by Hsieh and Shannon (2005). Directed content analysis was selected because of our focus on the “content or contextual meaning” of the texts through an intersectional lens (ibid, p. 1283).

To ensure validity of the findings, the analysts kept a chain of evidence documenting analysis decisions so that others could trace their steps (Yin, 2014). Triangulation among multiple data sources was used to ensure our findings fit a larger pattern (Yin, 2014). Throughout the research process the analysts reflected on their social positions (positionality) and strove to understand how their world views shape the project. The purpose of ongoing positionality is to make the researchers' bias explicit and understand how their bias affects analysis decisions, thereby improving the rigor of the study (Bourke, 1990).

## Quantitative Research Strategy

The quantitative component of this research is designed to provide insights on the effects of individual incentive measures on priority populations:

- How did improvements on incentive measures compare by race, ethnicity, language, and disability across the measures in the Quality Incentive Program?

To systematically observe pre- and post-measure movements by demographic factors such as race/ethnicity groups, the analysis included:

- Defining and comparing performance on each measure before and after it became incentivized.
- Difference in difference within measures by race/ethnicity groups:
  - Examining if all or most race and ethnicity groups show improvement – counts and percentage of racial and ethnic groups seeing improvement.
  - Measuring the spread (observed disparities) using an average percentage distance to the mean (PDTM) calculation among different racial and ethnic groups. Lower average PDTM means lower levels of observed disparities and if the average PDTM is decreased from the baseline year to the post-incentive year, we consider the spread is reduced.
- Additional intersectional analyses by household language, gender, disability, and rural versus urban comparisons as data allowed.

Table 1 provides an overview of quantitative analyses by measure:

## AVERAGE PERCENTAGE DISTANCE TO THE MEAN

The percentage distance to the mean (PDTM) method calculates the percentage distance for the measure result of a given demographic group to the statewide average performance of the measure.

For example, in 2014 the Dental Sealant rate for female members was 12.6%, which is 5.4% higher than the statewide average at 12.0%; at that time the sealant rate for male members was 11.4%, which is 4.9% lower than the statewide average. Regardless of higher or lower, the average PDTM between the two groups is 5.1%.

In 2019 the statewide average for the Dental Sealant measure reached 26.9%. In reviewing by binary gender, the rate for female members was 27.8% which is 3.4% higher than the statewide average, while the rate for male members was 26.0%, 3.2% lower than average. The average PDTM of the two groups became 3.3%, which is a 1.7-point reduction from the average PDTM in 2014. Therefore, we consider ‘the spread’ (observed disparity) between female and male for this measure reduced.

Table 1. Quantitative Analysis by Measure

Measure	Years Incentivized	“Pre” Year (baseline before incentivized)	“Post” Year (comparison year once incentivized)
Effective contraceptive use (ages 15-50)	2015-19	2014 REALD <sup>4</sup> R/E Disability Language Rural/urban	2019 REALD R/E Disability Language Rural/urban
Disparity measure: emergency department utilization for adult members with mental illness	2018+	2017 REALD R/E Gender Disability Language Rural/urban	2019 REALD R/E Gender Disability Language Rural/urban
Dental sealants	2015-19	2014 REALD R/E Gender Disability Rural/urban	2019 REALD R/E Gender Disability Rural/urban
CAHPS access to care composite; separate analyses for Adult and Child <sup>5</sup>	2013-19	2014 CAHPS R/E Gender <sup>6</sup> Health Status	2019 CAHPS R/E Gender Health Status

It should also be noted that the term ‘observed disparity’ is used throughout this report to describe the pre-post differences on measures’ impacts on different population groups. This is important because not all disparities constitute inequities and we did not directly measure inequities in this assessment and may not be able to draw such causal inferences.

### Demographic Data Source

For the CAHPS Access to Care measure, demographic information (race/ethnicity, gender, and health status) is based on members’ responses to the survey. For the rest of the claims-based measures, individual-level gender, disability, household language, and rural/urban indicators are based on their records in the Medicaid Management Information System/Decision Support/Surveillance and Utilization Review System data warehouse (MMIS/DSSURS) at the time of the measurement year production. Members’ disability status in MMIS/DSSURS is based on their Medicaid eligibility category.

While we recognize the importance of disaggregating data to identify and address inequities that exist within and across all REALD categories, due to data constraints and scope of this assessment, we were unable to conduct full subgroup analysis, especially for members with disabilities. The disability analysis was therefore limited to data from members’ Oregon

<sup>4</sup> REALD Repository pilot data base, compliant with REALD (race, ethnicity, language, and disability) data standards

<sup>5</sup> Because of the way the CAHPS survey is administered, quantitative results for adults and children are presented separately.

<sup>6</sup> Stratification by gender only available for adult comparison

Health Plan eligibility which includes a field indicating only their disability. Cognizant of the systemic data quality issues, OHA is creating a REALD Repository dataset which will leverage existing data systems and imputation methods to achieve full REALD compliance including all disability categories. We hope to utilize the completed REALD Repository dataset for future research projects.

Furthermore, given the large proportion of missing/unknown race/ethnicity in MMIS/DSSURS in recent years, we utilized OHA's REALD Repository pilot dataset for the race/ethnicity breakout analyses for the claims-based measures. The REALD Repository pilot dataset links each member's race/ethnicity information collected in the ONE enrollment system with other historically reported race/ethnicity records from past interactions with Oregon Health Plan or other state agencies (data linked by Integrated Client Service, ICS data warehouse), as well as data collected by Medicare and other health plans that report to the Oregon All Payer All Claims (APAC) database. A single race category is assigned for each person using the following method (based on the Most Identify/Rarest Group methodology [Mays *et al*, 2003]):

- Data from the ONE enrollment system is prioritized. Members with reported race/ethnicity in ONE are assigned the self-identified primary race/ethnicity, or the rarest race/ethnicity if a primary race/ethnicity is not identified.
- People with no reported race/ethnicity in ONE are assigned the rarest race/ethnicity from ICS and APAC data sources.
- The rarest Race/Ethnicity group is selected based on the order below:
  - Native Hawaiian or Pacific Islander
  - Middle Eastern or North African
  - Black or African American
  - American Indian or Alaskan Native
  - Asian
  - Hispanic/Latino
  - White
  - Other

As an example, for members in the Emergency Department Utilization for Adult Members with Mental Illness measure in measurement year 2019, the race/ethnicity information is missing/unknown based on the MMIS/DSSURS data for 32% of the members in the denominator; using the REALD Repository pilot dataset we are able to determine a race category for 99% of the members.

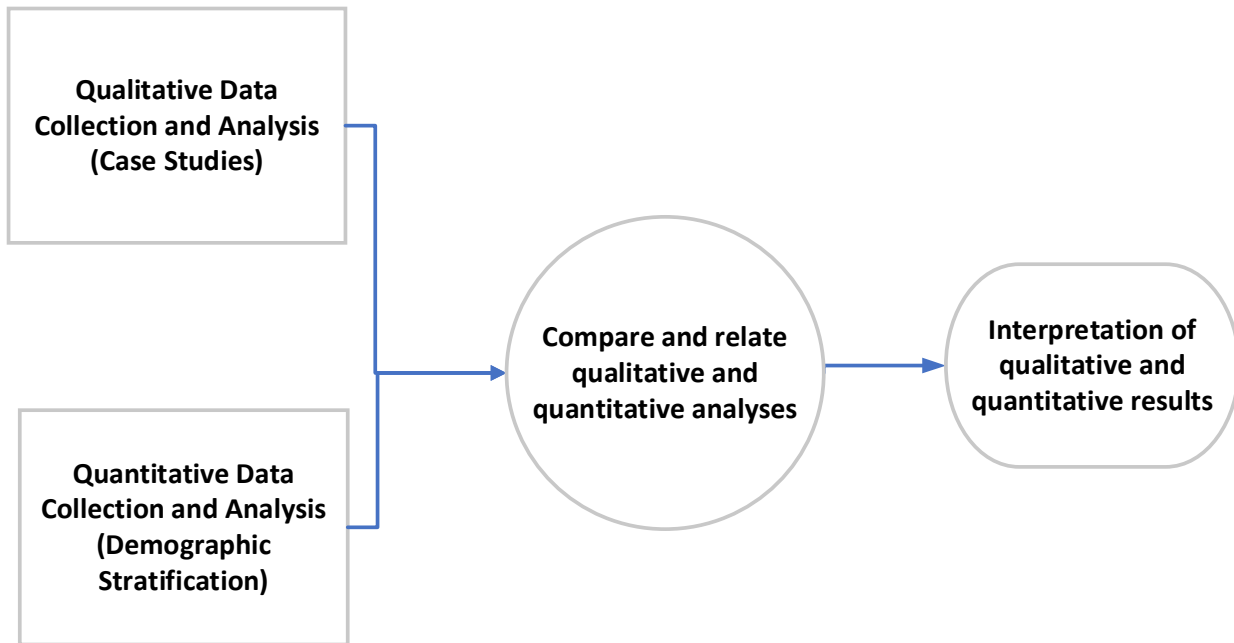
## Overall Research Strategy

While the findings related to the individual case study measures are important, the purpose of this assessment is to identify opportunities to use the incentive program and measures to address inequities in access to and outcomes of health care. Multiple factors, including data availability, impacted the measures which could be included as case studies in this assessment. The analysis focused on process, specifically, so that processes overall could be improved. This means recognizing the findings related to these four specific measures, and focusing on how the learnings from these case studies

can be used to improve Committee processes so the incentive program can be best leveraged to recognize, reconcile, and rectify historical and contemporary injustices.

As noted earlier, the overall research strategy involves a mixed methods approach in which findings from the qualitative and quantitative components are analyzed concurrently to formulate answers to the research questions. This utilizes the strengths of both approaches and is summarized in Figure 1.

Figure 1. Overall research strategy



# Findings

# How measures are framed

Framing refers to how social issues are constructed and the conceptual lenses through which we see the world (Russell, Greenhalgh, Byrne, & McDonnell, 2008). Analyzing how the measures were framed provides insight into the assumptions behind each measure and gives context for evaluating the equity impacts of the framing (Hankivsky et al., 2014). In this section, we consider how certain issues were defined as problems, and how incentive metrics were crafted to address these problems.

The results in tables 2-5 below focus on whether the framing of each measure aligned with health equity principles and the goal to eliminate inequities faced by priority populations. We focused on these population groups because of historical and contemporary evidence that the origins of the inequities are due to unjust social structures and manifest in increased exposures to health risks including racism, bigotry and bias that result in poor health outcomes. Where applicable, we point out how the framing of measures differentially affected specific priority population groups and communities.

## Effective contraceptive use

In July 2014, M&SC discussed the idea for a measure in the category of “contraception/unintended pregnancy” and adopted the Effective Contraceptive Use (ECU) measure in August 2014. The ECU measure addressed the issue of unintended pregnancy through incentivizing the prescription of specific contraceptive methods. Unintended pregnancy has been a public health focus for decades, however research suggests that pregnancy planning may be an imposed framework based in culturally-specific fertility-timing norms rather than a framework that is relevant to all people (Aiken, Borrero, Callegari, & Dehlendorf, 2016; Neiterman & LeBlanc, 2018; Wise, Geronimus, & Smock, 2017).

The ECU measure incentivized healthcare providers to prescribe specific contraceptive methods. These methods included the top two of the three tiers of contraceptives outlined by the Centers for Disease Control and Prevention:<sup>7</sup> female sterilization, intrauterine devices, diaphragms, implants, pills, patches, vaginal rings, and injections. The top two tiers are the subset of methods considered ‘effective’ that could be tracked via medical claims.

By only counting the top two tiers of contraceptive methods, the ECU measure excluded tier three methods: fertility awareness, withdrawal, and condoms. Although tier three methods are less effective at the population level and require user skill, they are effective at preventing pregnancy and may be a person’s preferred method for a variety of reasons. For example, the level of control the user has and whether the method contains hormones or interferes with sexual pleasure are considerations that may shape individual preferences for contraception (Fox et al., 2018; Higgins & Smith, 2016).

The ECU Guidance Document instructed healthcare providers to respect individual contraceptive preferences. However, by linking the bonus payment to specific methods, healthcare providers may have pressured patients to choose one of the incentivized methods to secure funding for their clinics. Research has described multiple forms of contraceptive coercion by healthcare providers, such as pressuring a patient to use a specific method or

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<sup>7</sup> See [https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/contraceptive\\_methods\\_508.pdf](https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/contraceptive_methods_508.pdf)

refusing to remove contraceptive implants (Amico, Bennett, Karasz, & Gold, 2016; Gomez & Wapman, 2017). At the August 2016 M&SC meeting, concern was raised about incentivizing contraceptive coercion. M&SC considered changing the framing of the metric, but did not directly address concern about contraceptive coercion, and the metric was not changed.

In 2017, M&SC voted to expand the age range of women counted for the denominator to include 15-17-year-olds (previously the metric was limited to women aged 18+). This prompted concern from CCOs and healthcare providers about targeting low-income women and women of color for fertility control. The metric was retired in 2019 based on concerns that the metric didn't address sexually transmitted disease, that the denominator included women not at risk for unintended pregnancy, and concerns about inequities.

Table 2. Framing of the effective contraceptive use measure

Framing of the measure	Equity impacts of this framing
<ul style="list-style-type: none"> <li>● Unintended pregnancies are a cause of poverty and poor health</li> <li>● Counts only Tier 1 and 2 contraceptives as effective methods</li> <li>● Improves access to contraception</li> <li>● Contraception is the responsibility of women</li> </ul>	<ul style="list-style-type: none"> <li>● Ignores the systemic roots of poverty and poor health</li> <li>● Ignores that Tier 3 contraceptives are also effective methods and may be preferred</li> <li>● The measure does not incentivize access but rather incentivizes the use of specific contraceptive methods. This may incentivize contraceptive coercion, which is problematic in light of historical reproductive oppression that targeted similar populations.</li> <li>● Ignores that conception requires a male and female component.</li> </ul>

**Disparity measure: Emergency Department utilization for adult members with mental illness**

Conversations about a health equity focused measure began at the M&SC and CCO Metrics TAG in August of 2014 and a measure representing health equity was selected for inclusion in the incentive menu set in 2018. A number of equity and/or disparity focused measures and approaches were explored and considered by M&SC and the TAG. The measure that was adopted focused on members with severe, persistent mental illness (SPMI) using an expansive definition of SPMI that had been agreed on by OHA and the Department of Justice,<sup>8</sup> which includes other related conditions such as major depression and anxiety. The name of the final measure excluded the SPMI language for clarity. People with mental illness have disparate physical health outcomes (e.g., people with mental illness die on average 25 years younger than people without mental illness). Therefore, the goal of the “disparities measure” was to address disparities in physical health outcomes, which can be related to stigma and lack of care coordination for members with mental illness. These inequalities were reflected in growing disparities in Emergency Department utilization for members with mental illness. Incentivizing the measure was expected to improve care coordination and integration generally, which would be indicated by decreases in Emergency Department utilization. Although at the time this was thought to be an equity metric, when viewed through

<sup>8</sup> <https://www.oregon.gov/oha/hsd/bhp/Pages/USDOJ-Agreement.aspx>

the lens of the adopted health equity definition, it is not in fact an equity measure, but rather an observed disparity measure.

Table 3. Framing of the disparities in Emergency Department utilization for members with mental illness measure

Framing of the measure	Equity impacts of this framing
<ul style="list-style-type: none"> <li>To address a gap in the incentive menu set.</li> <li>Incentivizing mental illness related ED utilization would help to improve care coordination and integration for physical and mental health care and reduce ED utilization for all groups including priority populations.</li> </ul>	<ul style="list-style-type: none"> <li>The measure calculation excludes members who may be receiving culturally specific care for their mental illness. This group may not be formally diagnosed and therefore excluded from the denominator. Disparities in the availability of culturally specific mental health providers and services disproportionately affect access and care coordination for priority populations.</li> </ul>

### Dental sealants on permanent molars for children

The dental sealants measure was crafted to hold CCOs and the dental community accountable for preventive dental care services, which were newly covered by Oregon Medicaid. In February 2014, the Dental Quality Metrics Workgroup presented two potential dental metrics for M&SC consideration: “sealants on permanent molars for children” and “any dental service.” The dental sealants metric was based on Dental Quality Alliance and CMS metrics. The benchmark was set based on EPSDT<sup>9</sup> data and Healthy People 2020 goals. There was debate over including all children in the denominator or only children at a higher caries risk level, a debate which was echoed in the literature (Kumar et al., 2018). In July 2019, this measure was retired because a new measure, Kindergarten Readiness: Preventative Dental Services, was adopted. This new measure accounts for a range of children’s preventive dental services instead of only focusing on sealants.

Table 4. Framing of the dental sealants on permanent molars for children measure

Framing of the measure	Equity impacts of this framing
<ul style="list-style-type: none"> <li>Children on Medicaid have higher rates of cavities compared with children not on Medicaid.</li> <li>Dental sealants are a way to prevent cavities.</li> <li>Low-income children have lower dental sealant rates than higher income children.</li> </ul>	<ul style="list-style-type: none"> <li>The measure included all children in the denominator, regardless of caries risk level (Kumar et al., 2018). This could mean that children who didn’t need sealants got them anyway, a topic which was discussed by M&amp;SC and considered in setting the benchmark.</li> <li>Communities who have limited English proficiency and low parental functional health literacy may face unique barriers to sealant use (Mejia et al., 2011)</li> </ul>

<sup>9</sup> Early and Periodic Screening, Diagnostic, and Treatment data from Medicaid

### CAHPS access to care measure

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is considered a standardized and reliable instrument for measuring perception of the healthcare delivery system and care experience of adult and child populations. Oregon has used CAHPS since 1998 for quality improvement and for federal reporting requirements. The Access to Care composite of the survey was included in the incentive menu set from 2013 to 2019. To identify gaps and opportunities for improving culturally appropriate care, the survey was modified in 2014 to include supplemental questions about cultural competency, health literacy, and interpretive services.

Table 5. Framing of the CAHPS access to care measure

Framing of the measure	Equity impacts of this framing
<ul style="list-style-type: none"> <li>A standardized instrument for measuring consumers and patients' health care experiences from multiple perspectives and evaluating their perceptions of access to services, timeliness of services, the quality of services received, and the communication skills of providers.</li> </ul>	<ul style="list-style-type: none"> <li>Accessibility of the survey to diverse audience. CAHPS is available only in English and Spanish which affects priority populations, some of whom may be more comfortable providing feedback in other languages.               <ul style="list-style-type: none"> <li>The comparatively lower response rate of minority patients to CAHPS surveys contribute to a potential bias in estimates of their health care experience. Their voice and perspectives may be underrepresented in how survey responses are utilized for quality improvement in health care.</li> </ul> </li> <li>While the oversampling method in CAHPS is designed to increase the size and weight of the health care experience of priority communities, the comparatively smaller sample sizes of such groups in the oversampling results suggest that this method is less effective in capturing feedback from diverse groups and communities.</li> </ul>

# How measures are chosen

The selection process provided insights on the context and adoption of the incentive measures and information for evaluating whether equity principles were considered and integrated into the problem identification phase of each measure. We evaluated the selection process under both OHA and M&SC control, including the measure selection and retirement checklists, measure endorsement (OHA developed or nationally endorsed), sources and uses of evidence (evidence based practice and practice based evidence), public testimony, and the intersectional effects of measures.

The specific equity principles we considered include the historical equity impacts of the ideas each measure is based on, including racism and racial and cultural differences in the evidence base for each measure, whether the implementation of measures resulted in differential impacts on priority populations, the distribution of resources and power, and established relationships to improve health outcomes for priority populations.

Tables 6-9 provide summary results on whether equity principles were considered and integrated into the selection process for each measure, and whether the following equity-related principles and concepts were addressed in the selection process: the role of power and use of diverse knowledge; time and space; and social justice.

## Effective contraceptive use

Equity principles were partially considered during the selection process but not fully integrated into the measure approval or specifications. The role of power and potential coercion was considered and discussed, especially regarding whether to include 15-17-year-olds in the measure, but the health equity related concerns were not addressed.

Table 6. Effective contraceptive use measure selection process

### Did the measure selection process...

Recognize and address role of power and use diverse knowledge?	Recognize and address the role of time and space?	Recognize the role of social justice?
<p>No.</p> <p>The voice of Medicaid members, especially women from priority communities who may be most impacted, was not included or considered.</p> <p>The diverse cultural knowledge about which methods of contraception are considered "effective" was not integrated into the process.</p>	<p>No.</p> <p>There was evidence available when the metric was created that described historical and recent reproductive coercion targeting priority populations (Roberts, 2017). However, this evidence was not effectively utilized to inform the development of the metric.</p>	<p>No.</p> <p>The process was based on increasing the use of specific contraceptives, but did not control for the potential for coercion (Senderowicz, 2019).</p> <p>For example, there is peer reviewed evidence documenting healthcare provider refusal to remove contraceptive devices when patients requested them removed (Amico, Bennett, Karasz, &amp; Gold, 2017).</p>

Recognize and address role of power and use diverse knowledge?	Recognize and address the role of time and space?	Recognize the role of social justice?
The power relationship between healthcare providers and patients and the effects of the measure on this relationship, such as eroding trust, was ignored.		Contraceptive coercion erodes trust in the relationship between patients and providers.

### Disparity measure: Emergency Department utilization for adult members with mental illness

Equity principles were considered in the process but not integrated into the final measure. The decision to include this measure was based on a need for addressing health equity, and various analyses of Emergency Department (ED) utilization patterns and stigma associated with ED utilization for mental health conditions was undertaken. However, the analysis did not consider the differential or intersectional effects of stigma and ED utilization by priority populations. Evidence suggests that mental illness is under-diagnosed for some Communities of Color and Tribal Communities, in part because of their preference for culturally specific mental health services and the shortage of a diverse mental health care workforce. Some population groups would therefore not be captured in the denominator of the measure (Kressler, Demler, Frank et al, 2003; Cook, McGuire, and Miranda 2000; McGuire and Miranda, 2008).

Table 7. Disparities in Emergency Department utilization for members with mental illness measure selection

#### Did the measure selection process...

Recognize and address role of power and use diverse knowledge?	Recognize and address the role of time and space?	Recognize the role of social justice?
<p>No.</p> <p>Testimony from impacted communities was not included in the measure selection process. However, CCOs and provider views were actively sought, considered, and integrated into the selection process.</p> <p>Diverse knowledge including the expertise of health equity researchers or organizations such as Substance Abuse and Mental Health Services Administration (SAMHSA) were not sought or integrated to help address the design and measurement concerns</p>	<p>Partially.</p> <p>The focus of the measure changed several times to align with evolving national evidence suggesting the need and benefits from improving care coordination and integration for individuals experiencing mental illness. But it is unclear whether the changes improved upstream mental health services and outcomes for priority populations. For example,</p>	<p>No.</p> <p>The measure was not targeted at allocating resources to improve upstream mental health care for priority populations, despite existing evidence about disparities and inequities in access to mental health care for priority populations.<sup>10</sup></p> <p>The measure assumed incorrectly that "a rising tide will lift all boats" and that focusing on care coordination</p>

<sup>10</sup> Agency for Healthcare Research and Quality (2014) National healthcare quality and disparities report. Rockville (MD): (AHRQ Publication No. 15-0007) (<http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqdr/nhqdr14/2014nhqdr.pdf>).

Recognize and address role of power and use diverse knowledge?	Recognize and address the role of time and space?	Recognize the role of social justice?
<p>identified during the selection process. For example, issues associated with seeking culturally specific mental health services and their effects on potentially undercounting denominator visits were not addressed.</p> <p>Evidence about provider bias and discrimination in diagnosing the severity of mental health conditions for priority patient populations create inequities and should be addressed as part of the measure design and selection process (Balsa, McGuire, &amp; Meredith, 2005).</p>	<p>while the quantitative results of the EIA suggested that most priority populations achieved increased benefits, disparities remained.</p>	<p>and integration for physical and mental health care in the total denominator population would improve mental health care and consequentially reduce ED utilization by priority populations. This was contrary to existing evidence suggesting that “universal approaches to care are ineffective” but “tailoring the provision of care” removes barriers and improves access and outcomes of mental health care for priority communities (Algeria <i>et al</i>, 2016).</p> <p>For example, there was evidence suggesting that the lack of access including language, cultural and geographic barriers to mental health services for priority populations was problematic (Westen, Novotny, &amp; Thompson, 2004; Eden <i>et al</i>, 2012) but, the design and specifications of the measure were not adjusted to address these known inequities.</p>

### Dental sealants on permanent molars for children

Equity principles were included in the framing of the problem. It was recognized that children of lower Socio-Economic Status (SES) are more likely to have dental caries and historically have not had access to preventive care. It was also recognized that children from higher income households were more likely to have sealants compared with children from lower SES households.

Table 8. Dental sealants on permanent molars for children measure selection

Did the measure selection process...

Recognize and address role of power and use diverse knowledge?	Recognize and address the role of time and space?	Recognize the role of social justice?
<p>Partially.</p> <p>Knowledge from impacted communities was not included in the selection process.</p> <p>The American Dental Association and American Academy for Pediatric Dentistry recommend sealants to protect molars from developing caries.</p> <p>The selection process recognized that dental care may not be a priority for families experiencing social/economic issues, but that preventing caries could have a big impact on a child's future health and well-being.</p>	<p>Yes.</p> <p>The origin of the metric recognized that preventive dental care was not historically covered by Medicaid.</p> <p>The process recognized that preventive dental care may not be a part of people's culture and gave suggestions to partner with culturally specific community groups for outreach.</p> <p>Systemic issues in the healthcare system that impede patient access to dental care are noted in the guidance document.</p> <p>Patient-centered outreach strategies are included.</p>	<p>Yes.</p> <p>The process recognized that children of low SES are less likely to have sealants than children of high SES and this may contribute to health issues later in life.</p> <p>The guidance for the metric implementation included alternative care delivery ideas to reach more children, like bringing dental sealants to schools, using mobile sealant clinics, and incorporating dentists into primary care clinics.</p> <p>The guidance document recognized barriers to access built into the system and gave suggestions for changing the system to make it more accessible. A limitation of this work is that we don't know if these strategies were used by CCOs to improve access to dental sealants.</p>

CAHPS access to care measure

Equity principles were considered and integrated in the survey development process with a focus on capturing and measuring the healthcare experience of patients. The development of the survey instrument integrated diverse healthcare consumer perspectives. The inclusion of cultural competency, health literacy and interpreter services suites in the 2014 version of the survey was intended to align the measure with health equity. The survey is generally available in English and Spanish languages, but more can be done to improve accessibility

Table 9. CAHPS access to care measure selection

Did the measure selection process...

Recognize and address role of power and use diverse knowledge?	Recognize and address the role of time and space?	Recognize the role of social justice?
<p>No.</p> <p>The oversampling method is designed in theory to capture</p>	<p>Partially yes.</p> <p>The flexibility to add additional survey suites in 2014 and the</p>	<p>No.</p> <p>The language accessibility and methodological issues with over</p>

Recognize and address role of power and use diverse knowledge?	Recognize and address the role of time and space?	Recognize the role of social justice?
<p>the health care experience of diverse care recipients, but there continue to be concerns about whether the over-sampling approach fully captures the diverse voices and measures the experiences of priority populations. The evidence of continuing decline in the response rate of the survey supports this concern (Evans <i>et al</i>, 2020).</p> <p>There continue to be reliability and validity concerns with responses from different racial and ethnic groups which appear to be related to the accessibility of the survey. For example, the responses and results from the Spanish version are less reliable compared with the English version (Lurie <i>et al</i>, 2003).</p>	<p>process that led to including the additional suites, suggest adaptation to new evidence - capturing the cultural differences in the health care experiences of different racial and ethnic population groups.</p> <p>However, it is not clear whether results are actionable in terms of how measuring differences in experience translates into eliminating disparities and inequities (Davies <i>et al</i>, 2008; Quigley <i>et al</i>, 2019).</p>	<p>sampling impact data quality and quality improvement in the health care experiences of priority populations.</p> <p>The availability of the survey in other languages apart from English and Spanish can improve response rates, accuracy in measuring patient health care experience, and using the data to address disparities and inequities (Grob <i>et al</i>, 2009).</p> <p>Patient voice is a marker of health-care quality and validation of the effectiveness of the health-care system (Donabedian, 1966).</p>

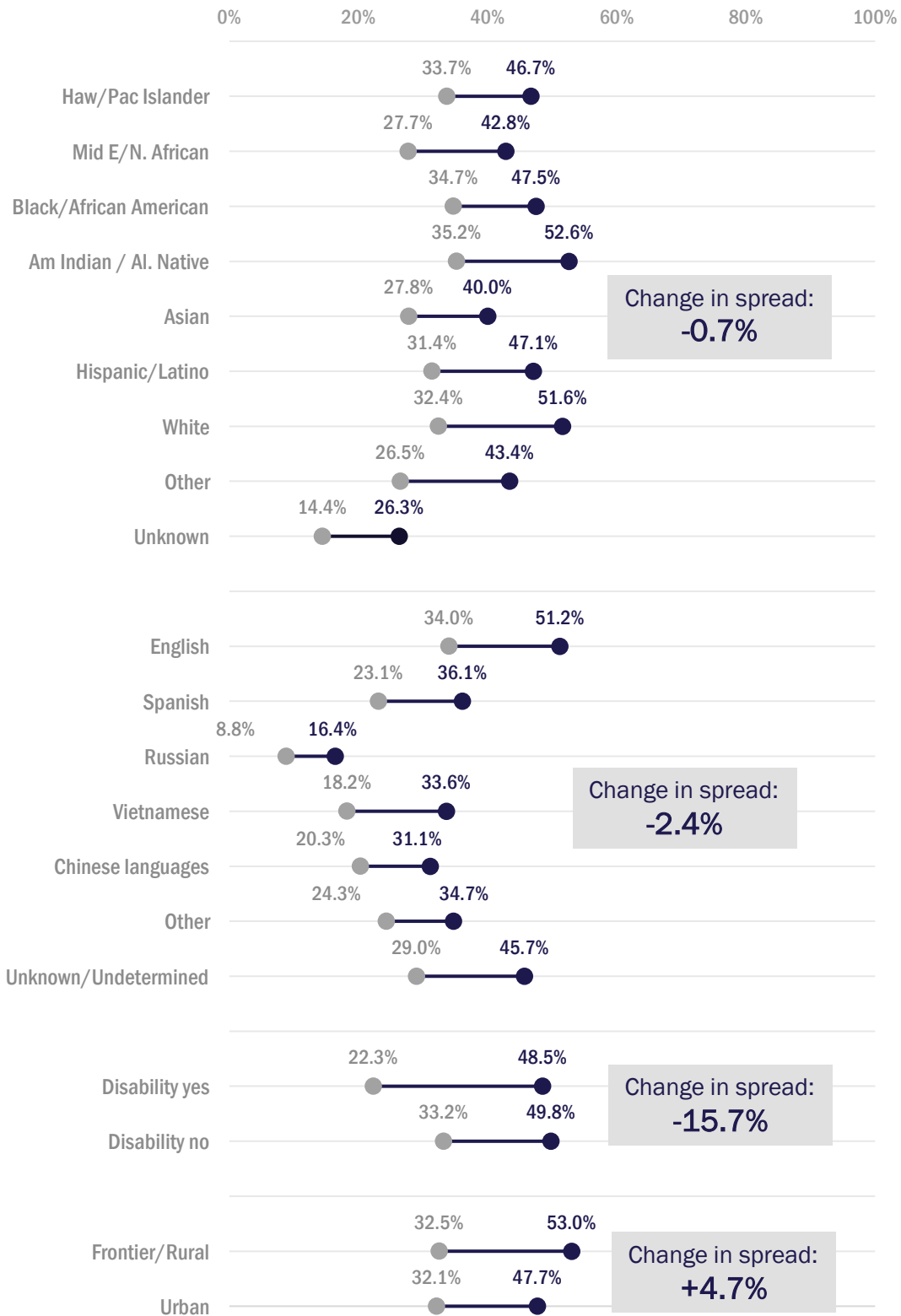
# Outcomes for priority groups

How did improvements on incentive measures compare by race, ethnicity, language, and disability across the measures in the Quality Incentive Program?

## Effective contraceptive use (ECU) – comparisons are 2014 to 2019

- Statewide the measure showed a 17.5 percentage point increase in utilization of higher tier contraceptive methods for women age 15-50 from 2014 to 2019 (32.3% to 49.7%).
- By race and ethnicity, all groups saw increases in ECU. The overall spread between groups also decreased by 0.7%, suggesting the observed disparity has reduced slightly. White members saw the largest increase of 19.3 percentage points; Asian members saw the smallest increase of 12.2 percentage points.
- All household language groups saw increases in the ECU measure. English-speaking members saw the largest ECU change (+17 percentage points), followed by the Vietnamese-speaking population (+15 percentage points). Russian-speaking members saw the smallest increase, (+8 percentage points). The spread between groups decreased by 2.4%, suggesting the observed disparity by household language has decreased.
- Members with or without disabilities all saw increases for ECU and the observed disparity was greatly reduced. In the baseline year (2014) the ECU rate for members with disabilities was 22.3%, significantly lower than members without disabilities (33.2%). By 2019 the ECU rates for both groups came close to 50%, less than a 2 percentage point difference between the two groups.
- Although both rural and urban groups saw increases in ECU, the observed disparity grew larger. In 2014, the difference between the two groups was less than one percentage point (rural 32.5%, urban 32.1%). Rural populations saw a larger increase and by 2019, the difference grew to 6 percentage points (rural 53%, urban 47.4%).

# Effective contraceptive use, 2014 and 2019

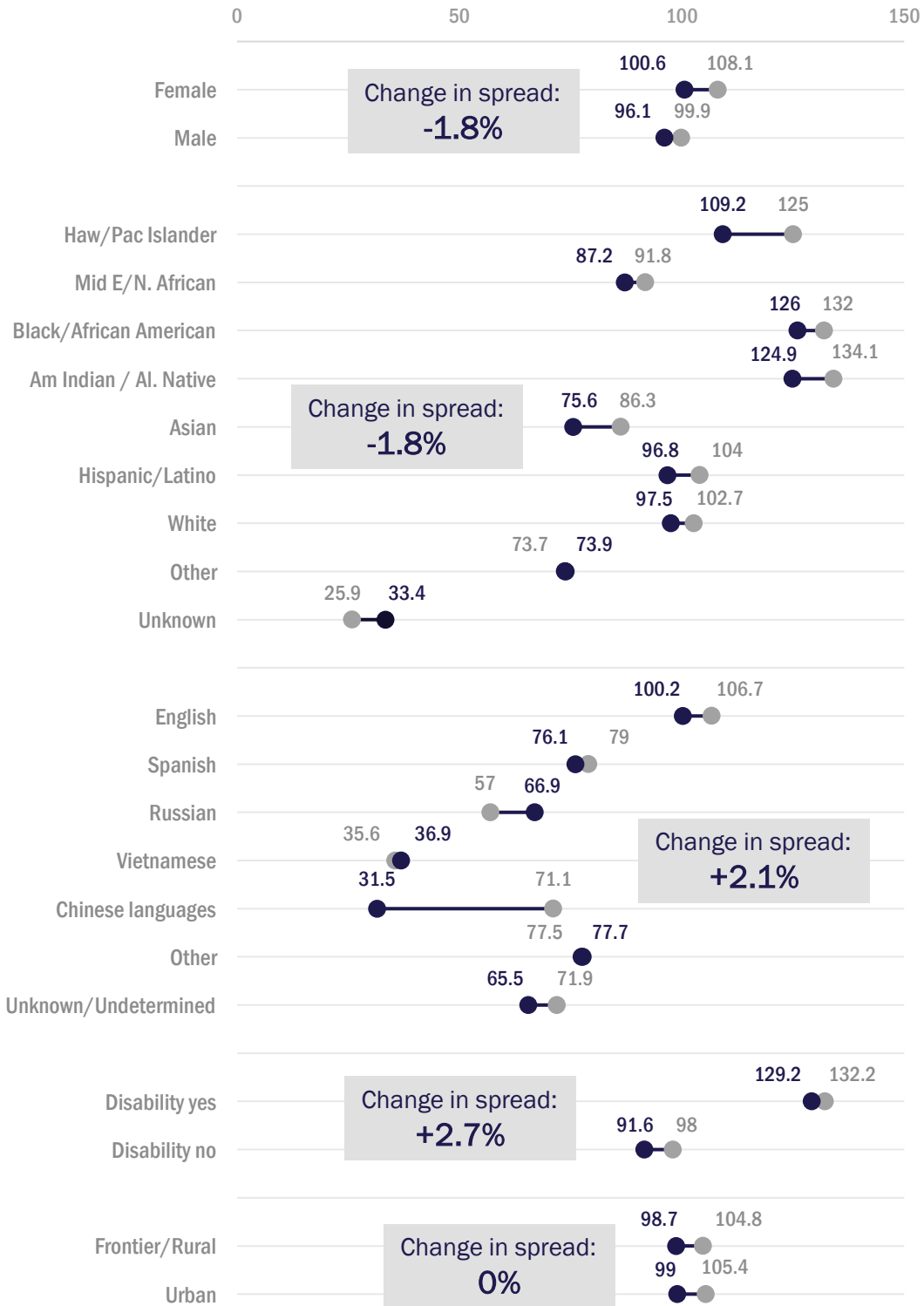


## Disparities in Emergency Department (ED) utilization for members with mental illness – comparisons are 2017 to 2019 (lower is better on this measure)

- Statewide the rate of ED utilization among members with mental illness went down 6% from 2017 to 2019.
- By binary gender, both male and female members with mental illness saw ED use reductions, and the utilization rates for both groups also got closer to the mean.
- By race and ethnicity, almost all groups saw ED reductions except for other and unknown. The overall spread between groups also decreased by 2%, suggesting the observed disparity by race and ethnicity has decreased.
- By members' household language, only half of major language groups (3 out of 6) saw ED use reductions. While ED utilization by Chinese-speaking members with mental illness reduced by more than half, ED utilization by Russian-speaking members with mental illness saw a large increase. The spread between groups increased by 2%, suggesting the observed disparity by household language grew larger.
- Members with or without disabilities all had reductions in ED use. However, the observed disparity grew larger as members without disabilities saw a larger improvement.
- The observed disparity in ED utilization between rural and urban members with mental illness was already small in 2017; both groups saw reductions in rates and the difference between the two groups remains negligible.
- Given this measure only looks at adult members with a history of mental illness, it is important to investigate whether there were underlying biases in terms of members receiving mental health care in the first place, and therefore being included in the measure denominator:
  - In 2019, in the CCO-statewide population, 32% of adults had a history of mental illness. American Indian/Alaskan Native had the highest rate of having mental illness history at 39%, followed by Whites at 34%. Asian American adults had the lowest rate of mental illness history at 18%, followed by Hispanic/Latino at 23%.
  - By language categories in 2019, 33% of English-speaking adults had mental illness history. Chinese-speaking adults had the lowest proportion of mental illness history at 7%, followed by Russian-speaking adults at 8%, and Spanish and Vietnamese-speaking adults both at 13%.

# Emergency department utilization for members with mental illness, 2017 and 2019

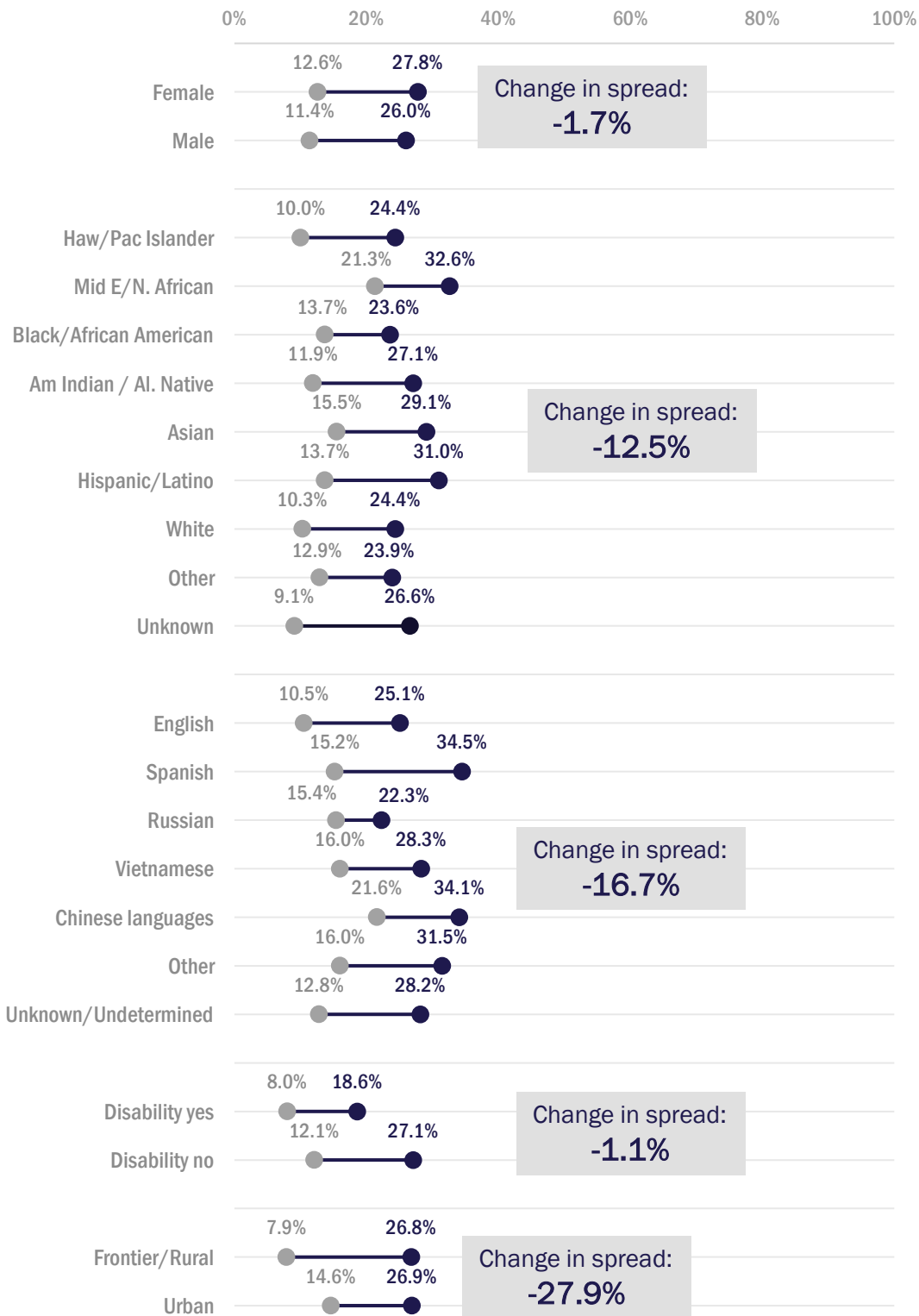
Rates are shown per 1,000 member months. A lower rate is better for this measure.



## Dental sealants on permanent molars for children – comparisons are 2014 to 2019

- Statewide the measure showed a 14.9 percentage point increase for children ages 6-14 receiving at least one dental sealant, from 2014 to 2019 (12.0% to 26.9%).
- By binary gender, both male and female members had improvements of about 15 percentage points, and the difference remains small (rate for female members is slightly higher).
- By race and ethnicity, all groups saw improvements in dental sealants. The overall spread between groups also decreased by 12.5%, suggesting the observed disparity was notably reduced. Hispanic/Latino members saw the largest improvement of 17.3 percentage points; Black/African American saw the smallest improvement of 9.9 percentage points.
- All household language groups saw improvements. Spanish-speaking members saw the largest improvement (+19.3 percentage points), followed by Other (15.5 percentage points), and English-speaking members (+14.6 points). Russian-speaking members saw the smallest improvement of 6.9 percentage points. The spread between groups decreased by 16.7%, suggesting the observed disparity by household language was largely reduced.
- Children with or without disabilities all saw improvement for getting dental sealants, and the observed disparity reduced slightly. In the baseline year (2014) the dental sealant rate for children with disabilities was 8%, lower than children without disabilities at 12.1%. Even though children without disabilities saw greater improvement by 2019, children with disabilities also got closer to the statewide average.
- Both rural and urban populations saw significant improvements in the sealants measure and the observed disparity greatly reduced (27.9% reduction in the spread). In 2014, the dental sealant rate for the rural population was 7.9%, about half of that for the urban population at 14.6%. By 2019, the rates for both groups saw large improvements and came close to 27%.

# Dental sealants on permanent molars for children, 2014 and 2019

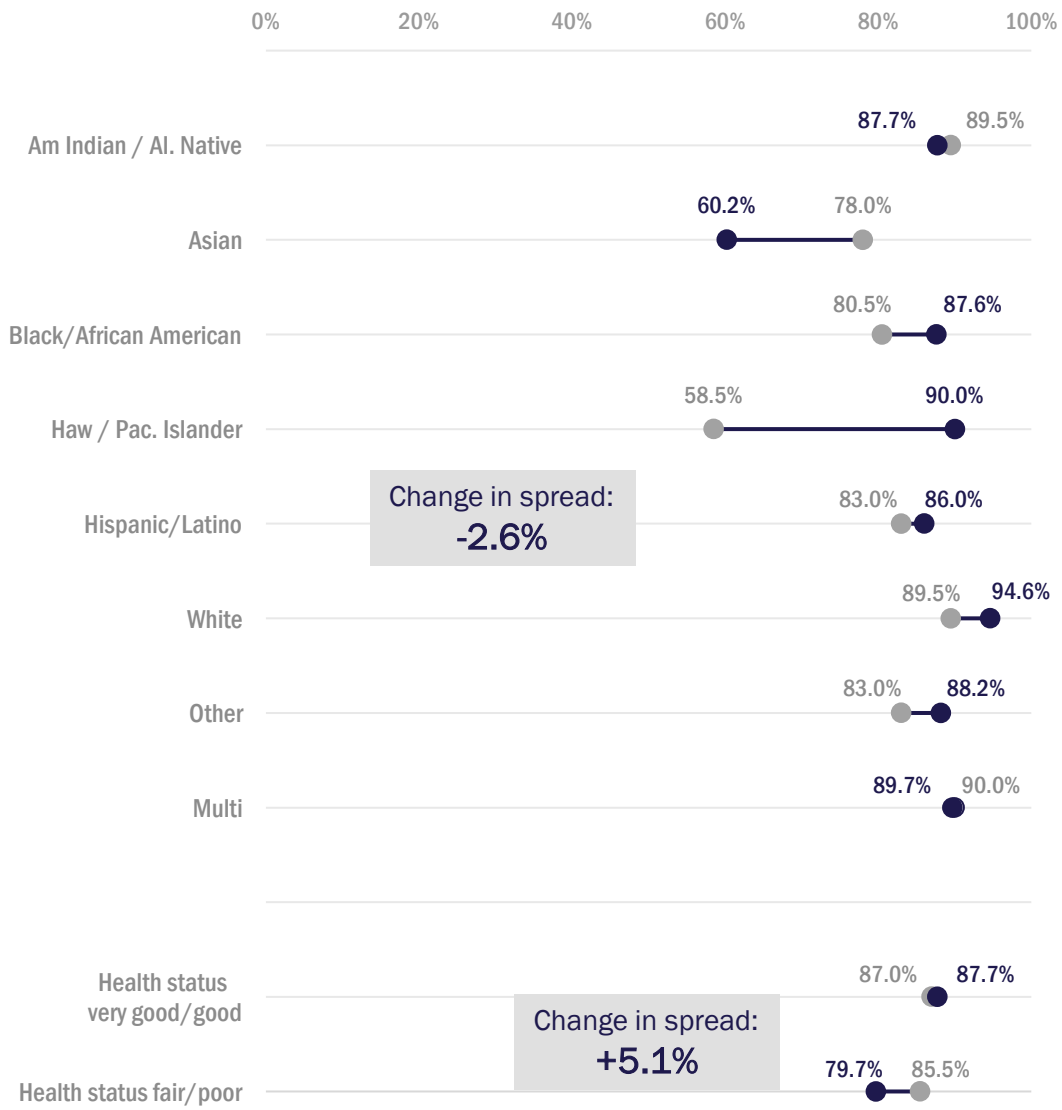


## CAHPS: Access to Care – Children

Note: Because of the way the CAHPS survey is administered, quantitative results for adults and children are presented separately. While children’s CAHPS survey data by binary gender is available for more recent years, it is not available for the baseline comparison year, so comparisons are not made in this report.

- Statewide the measure saw an improvement of 2 percentage points from 2014 to 2019. The improvement was slightly larger for accessing routine care (CAHPS Question 6) compared to urgent needs (Question 4, needed care right away).
- Five of the race and ethnicity groups saw improvement in the Access to Care composite and the observed disparity decreased (the spread reduced by 2.6%). However, CAHPS does contain small sample sizes for several race and ethnicity groups. Of groups with larger sample sizes: White and Hispanic/Latino members saw improvements in both accessing urgent and routine care; Asian members saw a large improvement in accessing routine care.
- Access to care worsened for children with fair or poor health status, particularly for accessing routine care (declined by 10 percentage points). The disparity between children of different health statuses increased.

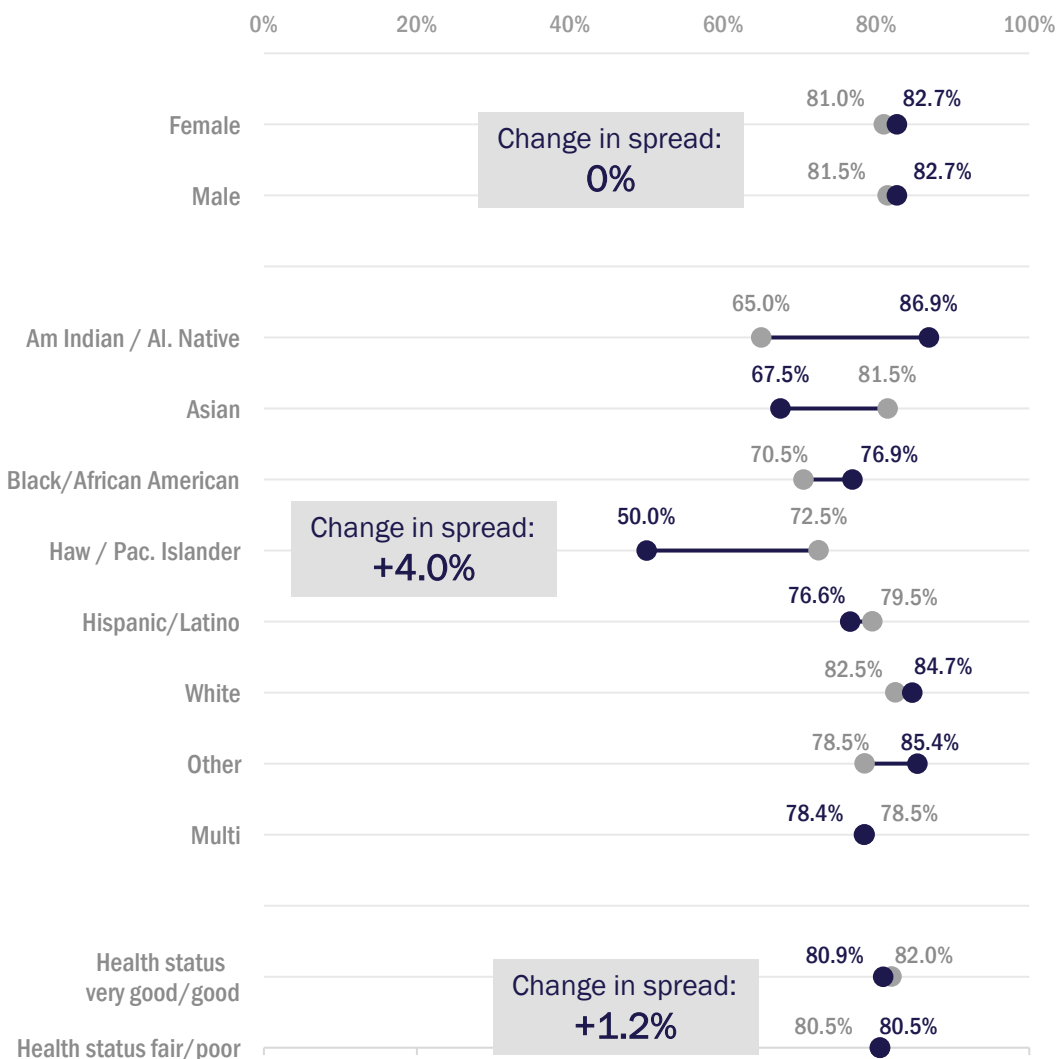
# CAHPS: Access to Care - Children, 2014 and 2019



## CAHPS: Access to Care – Adults

- Statewide the measure saw a small improvement of 1 percentage point from 2014 to 2019. The improvement was slightly larger for accessing routine care (CAHPS Q6) compared to urgent care (Q4 needed care right away).
- Access to care improved for both male and female members, and the observed disparity between the two groups remained negligible.
- Half of the racial and ethnic groups saw improvement in Access to Care composite and the observed disparity grew larger (the spread increased by 4%). However, CAHPS does contain small sample sizes for several racial and ethnic groups. White saw improvements in both accessing urgent and routine care. Hispanic/Latino saw a large decrease in accessing routine care.
- Access to care worsened for members with good/very good self-reported health status but maintained the same for members with fair/poor health status.

## CAHPS: Access to Care - Adults, 2014 and 2019



# Convergence of qualitative and quantitative findings

## What do we find when quantitative and qualitative findings are combined?

Table 10 integrates the qualitative and quantitative results to evaluate the following hypothesis statement:

- If the selection process for a measure integrated health equity principles and considered the differential impacts of the framing on priority populations, then most priority populations would realize increased benefits and reductions in observed disparities.

Note that the questions in the convergence table were rephrased to be more direct and focused on priority populations who are most impacted by inequities.

- **Qualitative columns.**
  - Framing. Results summary is based on evaluating the equity impacts of the framing and populations affected by framing. A designation of 'yes' means the framing not only considered, but integrated issues faced by priority populations and did not exclude such groups from benefiting. A designation of 'no' means the framing negatively impacted priority populations and excluded some groups from benefiting.
  - Integration of health equity principles into measure selection. A designation of 'yes' indicates that the results of at least two-thirds of the questions about equity principles were evaluated as a 'yes' by reviewers.
- **Quantitative columns.** The quantitative section of the table focuses on three categories: race and ethnicity; language; and, disability. A designation of 'yes' means that at least two of the three categories show improvements and decreases in observed disparities.

Table 10. Convergence of qualitative and quantitative results

Incentive Measure	Qualitative		Quantitative	
	Does the framing consider differential impacts on priority populations?	Does the measure selection process integrate Health Equity principles?	Did <u>most</u> priority populations achieve increased benefits?	Did observed disparities decrease for <u>most</u> priority population groups?
Effective Contraceptive Use	No	No	Yes <sup>11</sup>	Yes
ED Utilization for Mental Illness	No	No	Yes	No
Dental Sealants for Children	Yes	Yes	Yes	Yes
CAHPS Access to Care - Adults	No	No	No	No
CAHPS Access to Care - Children	No	No	No	No

As illustrated in Table 10, **findings were mixed** in terms of whether integrating health equity principles into the measure selection process led to improvements for priority populations and decreased observed disparities. This may be due to several factors, including lack of a formal and consistent process for including equity principles in measure selection, and the disparate ways in which CCOs may choose to implement their quality improvement efforts in support of achieving the incentive measures. Health equity principles may be absent when a measure is selected, but CCOs may utilize these principles in their implementation plans; the reverse may also be true, in which equity principles are included in measure selection, but not in how CCOs implement their quality improvement efforts.

Integration of the qualitative and quantitative findings also highlighted the following:

- While the incentive program is powerful in terms of focusing quality improvement activities in a particular area, it currently **operates within the boundaries of what can be quantified and consistently measured**. This can have negative consequences. For example, the ECU measure was limited to numerator credit for contraceptives that can be captured in claims, meaning other effective measures that might be more culturally appropriate for some priority populations would not be counted, and could result in coercion to use contraceptive methods discordant with one’s preference or culture. Another example, again using ECU, is that men’s role in unintended pregnancies could not be addressed due to data capture limitations, which perpetuates patriarchal conceptions of women’s responsibilities for contraception.
- The measures included in the case studies here included consultation with providers, CCOs, and those working in healthcare, but a dearth of consultation with priority

<sup>11</sup> The rate of use of moderately and highly effective contraceptives increased for most priority populations. However, we do not know if this was entirely beneficial because the metric may have incentivized contraceptive coercion. See the “How measures were framed” section for further explanation.

populations and members most impacted by the incentive measures. There is a need to **ensure the populations most impacted by potential incentive measures have a say in what is incentivized and how measures are operationalized**. This includes identification of what is considered a problem needing to be solved, and how it should be solved. We must include anti-colonial, anti-racist, indigenous knowledge to identify what the problems are and what the roots of the problems are.

- The quantitative analysis showed the **need to monitor and analyze incentive measures by Race, Ethnicity, Language, and Disability (REALD)**, as looking at incentive measures statewide can mask inequities in outcomes for priority populations.
- Overall, three of the four case study measures saw improvements for most of the priority population subgroups. However, this could be due to very poor performance at baseline across all population subgroups (which might have been a reason the measure was selected for the incentive program in the first place). Only two of the case study measures reduced observed disparities for most priority population groups, **suggesting that quality improvement activities may not be implemented using equity principles**.
- For most of the case study measures the quantitative analysis found lower level of observed disparities between race and ethnicity groups, patients with or without disabilities, and members living in rural or urban areas. However, the magnitude of observed disparities across different household language groups are large for most measures, indicating **meaningful access to health care with appropriate language services remains a key area to be addressed**.

While the findings identify a lack of focus on equity and utilization of health equity principles, they are not surprising given the entrenchment of power structures such as racism that perpetuate and rely upon continued marginalization of priority populations and communities. Moreover, as a state and agency, our priorities have shifted to where they should have been all along. The adoption and development of these case study measures was done prior the Oregon Health Policy Board and OHA's adoption of a common definition of health equity in 2019, and OHA setting its strategic goal of eliminating health inequities by 2030. The health equity definition provides a clear framework for achieving this goal, and is the foundation by which we move forward.

**What's Next**

# What's Next?

## Opportunities to align process with health equity principles

The EIA is the necessary first step to ensure the Quality Incentive Program advances health equity. The findings of this report, coupled with the foundation of the health equity definition, provide a path by which the Committee can check its assumptions moving forward, ensure that health equity principles are included in measure selection and retirement, and that the incentive program can be leveraged to meet the goal of eliminating health inequities by 2030. To ensure meaningful change, the following changes are recommended:

- **Include formal consideration of equity in measure selection and retirement criteria.** Update measure selection and retirement criteria to formally integrate health equity principles as criterion. This could also include setting a threshold proportion of number of measures in the program that must directly advance health equity, designating a 'must meet' criterion for individual measures related to health equity, and/or establishing a formal review process for each measure (and the set) to check assumptions about a measure's impact (or lack thereof) on health equity.
- **Program structure changes.** Explore changes to the program structure to focus on priority populations. As the program is currently structured, setting targets across the entire membership can mask inequitable outcomes. This includes prioritizing measures that address the social determinants of health and equity which can be at the root of unjust health outcomes.
- **Use of diverse knowledge and expertise.** Increase input from Medicaid members and priority populations who will be impacted by how the measures are framed, which measures are selected, and how they are implemented, evaluated, and retired. This could include a paid Medicaid member consultation panel or inclusion of Medicaid members as members of the M&SC, for example. In addition, qualitative evaluation of member experience can be considered and integrated into the benchmark setting and measure retirement processes.
- **Education about inequities, and using consistent language to address the identified problem.** Disparities and inequities were used interchangeably in the conversations in which equity was discussed (for example, the emergency department utilization for mental illness measure). It was not clear whether the focus was on addressing disparities (differences in health outcomes that may be rooted in genetics) or inequities (differences in health outcomes that are unfair, avoidable and rooted in social injustice).
- **Consider implementation.** Once a measure is incentivized, emphasize opportunities for both OHA and CCOs to include implementation efforts rooted in health equity principles and focus on efforts which will reduce inequitable outcomes.
- **Additional ideas.** In addition to the ideas above, it is important for the Committee and staff to do the work to identify additional solutions and process changes to address historical and contemporary injustices, and move forward. The authors of the

assessment look forward to a dialogue and ongoing work with the Committee and staff to move this work forward together.

# Appendix A - Bibliography

Agency for Healthcare Research and Quality (2014) National healthcare quality and disparities report. Rockville (MD): (AHRQ Publication No. 15-0007) (<http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqdr/nhqdr14/2014nhqdr.pdf>).

Aiken, A. R. A., Borrero, S., Callegari, L. S., & Dehlendorf, C. (2016). Rethinking the pregnancy planning paradigm: Unintended conceptions or unrepresentative concepts? *Perspectives on Sexual and Reproductive Health*, 48(3), 147–151. <https://doi.org/10.1363/48e10316>.

Amico, J. R., Bennett, A. H., Karasz, A., & Gold, M. (2017). “I wish they could hold on a little longer”: physicians’ experiences with requests for early IUD removal. *Contraception*, 96(2), 106–110. <https://doi.org/10.1016/j.contraception.2017.05.007>.

Balsa AI, McGuire TG, Meredith LS. Testing for Statistical Discrimination in Health Care. *Health Services Research*. 2005; 40(1):227–252

Evans, R; Berman, S; Burlingame, E; Fishkin, S (2020) It’s Time To Take Patient Experience Measurement And Reporting To A New Level: Next Steps For Modernizing And Democratizing National Patient Surveys, *Health Affairs Blog*(<https://www.healthaffairs.org/doi/10.1377/hblog20200309.359946/full>).

Brown, S. S., & Eisenberg, L. (1995). *The Best Intentions: Unintended pregnancy and the well-being of children and families*. Washington (DC): National Academies Press (US). <https://doi.org/10.17226/4903>.

Collins, P. H. (2019). *Intersectionality as Critical Social Theory*. Duke University Press.

Cook BL, McGuire TG, Miranda J. Measuring Trends in Mental Health Care Disparities, 2000–2004. *Psychiatric Services*.

Davies E, Shaller D, Edgman-Levitan S, Safran DG, Oftedahl G, Sakowski J, and Cleary P (2008). Evaluating the Use of a Modified CAHPS Survey to Support Improvements in Patient-Centered Care: Lessons from a Quality Improvement Collaborative, *Health Expectations*, 11(2), 160-176.

Donabedian A. Evaluating the quality of medical care. 1966. *Milbank Q*. 2005;83(4): 691-729  
Eden J, Maslow K, Le M, Blazer D (2012) The mental health and substance use workforce for older adults: in whose hands? Washington (DC): National Academies Press.

Eden J, Maslow K, Le M, Blazer D (2012) The mental health and substance use workforce for older adults: in whose hands? Washington (DC): National Academies Press.

Etikan, I; Abubakar Musa, S; Alkassim, R.S(2016). Comparison of Convenience Sampling and Purposive Sampling. *American Journal of Theoretical and Applied Statistics*. Vol. 5, No. 1, 2016, pp. 1-4.

Evans, R; Berman, S; Burlingame, E; Fishkin, S (2020) It’s Time To Take Patient Experience Measurement And Reporting To A New Level: Next Steps For Modernizing And Democratizing National Patient Surveys, *Health Affairs Blog*(<https://www.healthaffairs.org/doi/10.1377/hblog20200309.359946/full>).

Fox, E., Reyna, A., Malcolm, N. M., Rosmarin, R. B., Zapata, L. B., Frederiksen, B. N., ... Dehlendorf, C. (2018). Client Preferences for Contraceptive Counseling: A Systematic Review. *American Journal of Preventive Medicine*. <https://doi.org/10.1016/j.amepre.2018.06.006>.

- Gomez, A. M., & Wapman, M. (2017). Under (implicit) pressure: Young Black and Latina women's perceptions of contraceptive care. *Contraception*, 96(4), 221–226. <https://doi.org/10.1016/j.contraception.2017.07.007>.
- Grob, R., Schlesinger, M., Barre, L. R., Bardach, N. et al. (2019). What Words Convey: The Potential for Patient Narratives to Inform Quality Improvement. *The Milbank quarterly*, 97(1), 176–227.
- Grob, R., Schlesinger, M., Barre, L. R., Bardach, N. et al. (2019). What Words Convey: The Potential for Patient Narratives to Inform Quality Improvement. *The Milbank quarterly*, 97(1), 176–227.
- Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., ... Clark, N. (2014). An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity, 1–16.
- Harris, L. H., & Wolfe, T. (2014). Stratified reproduction, family planning care and the double edge of history. *Current Opinion in Obstetrics and Gynecology*, 26(6), 539–544.
- [Health Equity Definition, Presentation to OHPB \(October 2019\)](https://www.oregon.gov/oha/OEI/HECMeetingDocs/Health%20Equity%20Definition_October%202019%20HEC%20Presentation%20to%20OHPB.pdf)  
([https://www.oregon.gov/oha/OEI/HECMeetingDocs/Health%20Equity%20Definition\\_October%202019%20HEC%20Presentation%20to%20OHPB.pdf](https://www.oregon.gov/oha/OEI/HECMeetingDocs/Health%20Equity%20Definition_October%202019%20HEC%20Presentation%20to%20OHPB.pdf)).
- Higgins, J. A., & Smith, N. K. (2016). The sexual acceptability of contraception: Reviewing the literature and building a new concept. *Journal of Sex Research*. <https://doi.org/10.1080/00224499.2015.1134425>.
- Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277–1288.
- Kessler RC, Demler O, Frank RG, et al. Prevalence and treatment of mental disorders, 1990 to 2003. *New England Journal of Medicine*. 2005;352:2515–2523.
- Kumar, S. V., Bangar, S., Neumann, A., Kookal, K. K., Yansane, A., Tokede, O., ... Walji, M. (2018). Assessing the validity of existing dental sealant quality measures. *Journal of the American Dental Association*, 149(9), 756-764.e1. <https://doi.org/10.1016/j.adaj.2018.05.001>.
- Lurie N, Zhan C, Sangl J, Bierman AS, Sekscenski ES (2003). Variation in racial and ethnic differences in consumer assessments of health care. *The American Journal of Managed Care*. ;9(7):502-509.
- Margarita Alegría et al (2016) Removing Obstacles To Eliminating Racial And Ethnic Disparities In Behavioral Health Care. *Health Affairs* 35(6): 991-999. (<https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0029>).
- Mays, Vickie & Ponce, Ninez & Washington, Donna & Cochran, Susan. (2003). Classification of Race and Ethnicity: Implications for Public Health\*. *Annual review of public health*. 24. 83-110.
- Margarita Alegría et al (2016) Removing Obstacles To Eliminating Racial And Ethnic Disparities In Behavioral Health Care. *Health Affairs* 35(6): 991-999. (<https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0029>).
- McGuire, T.G and Miranda, J (2008) Racial and Ethnic Disparities in Mental Health Care: Evidence and Policy Implications.
- Mejia, G. C., Weintraub, J. A., Cheng, N. F., Grossman, W., Pamela, Z., Phipps, K. R., & Gansky, S. A. (2011). Language and literacy relate to lack of children's dental sealant use. *Community Dent Oral Epidemiol*, 39(4), 318–324. <https://doi.org/doi:10.1111/j.1600-0528.2010.00599.x>.

Neiterman, E., & LeBlanc, Y. (2018). The timing of pregnancy: Women's interpretations of planned and unplanned pregnancy. *Qualitative Sociology Review*, 14(1), 52–66.

Potts, K. & Brown, L. (2005). Becoming an anti-oppressive researcher. In L. Brown & S. Strega (Eds.), *Research as resistance: Critical, Indigenous, and anti-oppressive Approaches* (pp. 255-268). Toronto: Canadian Scholars' Press.

Quigley DD, Elliott MN, Hambarsoomian K, Wilson-Frederick SM, Lehrman WG, Agniel D, Ng JH, Goldstein EH, Giordano LA, Martino SC (2019). Inpatient care experiences differ by preferred language within racial/ethnic groups. *Health Serv Res*. 54 Suppl 1(Suppl 1):263-274.

Rawls, J. (1971). *A theory of justice*. Boston: Harvard University Press.

Roberts, D. (2017). *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (Second Edi). New York: Vintage Books.

Senderowicz, L. (2019). "I was obligated to accept": A qualitative exploration of contraceptive coercion. *Social Science and Medicine*, 239. <https://doi.org/10.1016/j.socscimed.2019.112531>.

State of Oregon Equity Framework in COVID-19 Response and Recovery(2020)  
([https://www.oregon.gov/gov/policy/Documents/EquityFrameworkCovid19\\_2020.pdf](https://www.oregon.gov/gov/policy/Documents/EquityFrameworkCovid19_2020.pdf)).

Westen D, Novotny CM, Thompson Brenner H (2004) The empirical status of empirically supported psychotherapies: assumptions, findings, and reporting in controlled clinical trials. *Psychol Bull*. 2004;130(4):631–63.

Wise, A., Geronimus, A. T., & Smock, P. J. (2017). The best of intentions: A structural analysis of the association between socioeconomic disadvantage and unintended pregnancy in a sample of mothers from the National Longitudinal Survey of Youth (1979). *Women's Health Issues*, 27(1), 5–13.  
<https://doi.org/10.1016/j.whi.2016.10.006>.

Yin, R. K. (2014). *Case Study Research: Design and Methods* (5th ed.). Sage Publications.

# Appendix B – Full Quantitative Findings

Measure	Breakout	Most groups improved?	Observed disparity reduced?	Observations
Effective Contraceptive Care (ECU)	Statewide change			Statewide the measure saw a large increase in utilization of higher tier contraceptive methods of 17.5 percentage points for women age 15-50 from 2014 to 2019 (32.3% to 49.7%).
	REALD R/E	Yes (8/8 excluding unknown)	Yes	By race and ethnicity, all groups saw increases in ECU. The overall spread between groups also decreased by 0.7%, suggesting the observed disparity has reduced slightly. White members saw the largest increase of 19.3 percentage points; Asian members saw the smallest increase of 12.2 percentage points.
	Language	Yes (6/6 excluding unknown)	Yes	All household language groups saw increases in the ECU measure. English-speaking members saw the largest ECU change (+17 percentage points), followed by the Vietnamese-speaking population (+15 percentage points). Russian-speaking members saw the smallest increase, of 8 percentage points. The spread between groups decreased by 2.4%, suggesting the observed disparity by household language has decreased.
	Disability	Yes (2/2)	Yes	Members with or without disabilities all saw increases for ECU and the observed disparity was greatly reduced. In the baseline year (2014) the ECU rate for members with disabilities was 22.3%, significantly lower than members without disabilities (33.2%). By 2019 the ECU rates for both groups came close to 50%, less than a 2-point difference between the two groups.
	Rural/Urban	Yes (2/2)	No	Although both rural and urban groups saw increases in ECU, the observed disparity grew larger. In 2014, the difference between the two groups was less than one percentage point (rural 32.5%, urban 32.1%). Rural populations saw a larger increase and by 2019, the difference grew to 6 percentage points (rural 53%, urban 47.4%).

Measure	Breakout	Most groups improved?	Observed disparity reduced?	Observations
Disparity (MHED)	Statewide change			Statewide the measure saw a 6% reduction in ED use from adult members with mental illness, from 2017 to 2019.
	Gender	Yes (2/2)	Yes	By gender, both male and female members with mental illness saw ED use reductions, and the utilization rates for both groups also got closer to the mean.
	REALD R/E	Yes (7/8 excluding unknown)	Yes	By race and ethnicity, almost all groups saw ED reductions except for other and unknown. The overall spread between groups also decreased by 2%, suggesting the observed disparity by race and ethnicity has decreased.
	Language	No (3/6 excluding unknown)	No	By members' household language, only half of major language groups (3 out of 6) saw ED use reductions. While ED utilization by Chinese-speaking members with mental illness reduced by more than half, ED utilization by Russian-speaking members with mental illness saw a large increase. The spread between groups increased by 2%, suggesting the observed disparity by household language grew larger.
	Disability	Yes (2/2)	No	Members with or without disabilities all had reductions in of ED use. However, the observed disparity grew larger as members without disabilities saw a larger improvement.
	Rural/Urban	Yes (2/2)	N/A (observed disparity remain negligible)	The observed disparity in ED utilization between rural and urban members with mental illness was already small in 2017; both groups saw reductions in rates and the difference between the two groups remains negligible.

Measure	Breakout	Most groups improved?	Observed disparity reduced?	Observations
Dental Sealants (DS)	Statewide change			Statewide the measure saw a large improvement of 14.9 percentage points for children age 6-14 receiving at least one dental sealant, from 2014 to 2019 (12.0% to 26.9%).
	Gender	Yes (2/2)	Yes	By gender, both male and female members had improvements of about 15 percentage points for each group, and the difference remains small (rate for female members is slightly higher).
	REALD R/E	Yes (8/8 excluding unknown)	Yes	By race and ethnicity, all groups saw improvements in dental sealants. The overall spread between groups also decreased by 12.5%, suggesting the observed disparity was notably reduced. Hispanic/Latino members saw the largest improvement of 17.3 percentage points; Black/African American saw the smallest improvement of 9.9 percentage points.
	Language	Yes (6/6 excluding unknown)	Yes	All household language groups saw improvements. Spanish-speaking members saw the largest improvement (+19.3 percentage points), followed by Other (15.5 percentage points), and English-speaking members (+14.6 points). Russian-speaking members saw the smallest improvement of 6.9 percentage points. The spread between groups decreased by 16.7%, suggesting the observed disparity by household language was largely reduced.
	Disability	Yes (2/2)	Yes	Children with or without disabilities all saw improvement for getting dental sealants, and the observed disparity reduced slightly. In the baseline year (2014) the dental sealant rate for children with disabilities was 8%, lower than children without disabilities at 12.1%. Even though children without disabilities saw greater improvement by 2019, children with disabilities also got closer to the statewide average.
	Rural/Urban	Yes (2/2)	Yes	Both rural and urban populations saw significant improvements in the sealants measure and the observed disparity greatly reduced (27.9% reduction in the spread). In 2014, the dental sealant rate for the rural population was 7.9%, about half of that for the urban population at 14.6%. By 2019, the rates for both groups saw large improvements and came close to 27%.

Measure	Breakout	Most groups improved?	Observed disparity reduced?	Observations
Child CAHPS Access to Care Composite	Statewide change			Statewide the measure saw an improvement of 2 percentage points from 2014 to 2019. The improvement was slightly larger for accessing routine care (CAHPS Question 6) compared to urgent needs (Question 4, needed care right away).
	CAHPS R/E	Yes (5/8)	Yes	Five of the race and ethnicity groups saw improvement in the Access to Care composite and the observed disparity decreased (the spread reduced by 2.6%). However, CAHPS does contain small sample sizes for several race and ethnicity groups. Of groups with larger sample sizes: White and Hispanic/Latino members saw improvements in both accessing urgent and routine care; Asian members saw a large improvement in accessing routine care.
	Health Status	No (1/2)	No	Access to care worsened for children with fair or poor health status, particularly for accessing routine care (declined by 10 percentage points). The disparity between children of different health statuses increased.
Adult CAHPS Access to Care Composite	Statewide change			Statewide the measure saw a small improvement of 1 percentage point from 2014 to 2019. The improvement was slightly larger for accessing routine care (CAHPS Q6) compared to urgent care (Q4 needed care right away).
	Gender	Yes (2/2)	N/A (observed disparity remain negligible)	Access to care improved for both male and female, and the observed disparity between the two groups remain negligible.
	CAHPS R/E	No (4/8)	No	Half of the R/E groups saw improvement in Access to Care composite and the observed disparity grew larger (the spread increased by 4%). However, CAHPS does contain small sample sizes for several R/E groups. White saw improvements in both accessing urgent and routine care. Hispanic/Latino saw a large decrease in accessing routine care.
	Health Status	No (0/2)	No	Access to care worsened for members with good/very good self-reported health status but maintained the same for members with fair/poor health status.

### Effective Contraceptive Use (ECU) measure 2014 - 2019

Rate = percent of women age 15-50 utilizing higher tier contraceptive methods

	ECU_2014	ECU_2019	Change
Total	32.3%	49.7%	17.5%

REALD_RE	ECU_Rate14	ECU_Rate19	Change
Native Hawaiian or Pacific Islander	33.7%	46.7%	13.0%
Middle Eastern or North African	27.7%	42.8%	15.1%
Black or African American	34.7%	47.5%	12.7%
American Indian or Alaskan Native	35.2%	52.6%	17.4%
Asian	27.8%	40.0%	12.2%
Hispanic/Latino	31.4%	47.1%	15.7%
White	32.4%	51.6%	19.3%
Other	26.5%	43.4%	16.9%
Unknown	14.4%	26.3%	11.9%
Avg_PDTM	13.9%	13.2%	-0.7%

Language	ECU_2014	ECU_2019	Change
English	34.0%	51.2%	17.2%
Spanish	23.1%	36.1%	12.9%
Russian	8.8%	16.4%	7.7%
Vietnamese	18.2%	33.6%	15.4%
Chinese languages	20.3%	31.1%	10.8%
Other	24.3%	34.7%	10.4%
Unknown/Undetermined	29.0%	45.7%	16.7%
Avg_PDTM	31.7%	29.4%	-2.4%

Note for color coding: ECU rate increase is improvement

Average PDTM (spread) decrease is reduction of observed disparity - improvement

Green = measure improvement or observed disparity reduced

Red = measure declined or increased observed disparity

Yellow = change <0.5%

**Effective Contraceptive Use (ECU) measure 2014 - 2019**

**Rate = percent of women age 15-50 utilizing higher tier contraceptive methods**

Disability	ECU_2014	ECU_2019	Change
No	33.2%	49.8%	16.6%
Yes	22.3%	48.5%	26.3%
Avg_PDTM	17.0%	1.3%	-15.7%

RURAL_URBAN	ECU_2014	ECU_2019	Change
Rural	32.5%	53.0%	20.5%
Urban	32.1%	47.7%	15.6%
Avg_PDTM	0.6%	5.3%	4.7%

Note for color coding:

ECU rate increase is improvement

Average PDTM (spread) decrease is reduction of observed disparity - improvement

Green = measure improvement or observed disparity reduced

Red = measure declined or increased observed disparity

Yellow = change <0.5%

### Disparity MHED measure 2017 - 2019

Rate = ED visits per 1000 member months for adults with history of mental illness

	MHED_2017	MHED_2019	PCT Change
Total	105.3	99.1	-5.9%

Gender	MHED_2017	MHED_2019	PCT Change
Female	108.1	100.6	-6.9%
Male	99.9	96.4	-3.5%
<b>Avg_PDTM</b>	<b>3.9%</b>	<b>2.1%</b>	<b>-1.8%</b>

RE_REALD	2017	2019	PCT Change
Native Hawaiian or Pacific Islander	125.0	109.2	-12.6%
Middle Eastern or North African	91.8	87.2	-5.0%
Black or African American	132.0	126.0	-4.6%
American Indian or Alaskan Native	134.1	124.9	-6.9%
Asian	86.3	75.6	-12.4%
Hispanic/Latino	104.0	96.8	-6.9%
White	102.7	97.5	-5.1%
Other	73.7	73.9	0.2%
9_Unknown	25.9	33.4	29.0%
<b>Avg_PDTM</b>	<b>23.5%</b>	<b>21.6%</b>	<b>-1.8%</b>

Note for color coding:

MHED rate is lower the better

Average PDTM (spread) decrease is reduction of observed disparity - improvement

Green = measure improvement or observed disparity reduced

Red = measure declined or increased observed disparity

Yellow = change <0.5%

### Disparity MHED measure 2017 - 2019

Rate = ED visits per 1000 member months for adults with history of mental illness

	MHED_2017	MHED_2019	PCT Change
English	106.7	100.2	-6.2%
Spanish	79.0	76.1	-3.8%
Russian	57.0	66.9	17.5%
Vietnamese	35.6	36.9	3.4%
Chinese languages	71.1	31.5	-55.7%
Other	77.5	77.7	0.3%
Unknown/Undetermined	71.9	65.5	-8.9%
<b>Avg_PDTM</b>	<b>32.7%</b>	<b>34.8%</b>	<b>2.1%</b>

	MHED_2017	MHED_2019	PCT Change
Disability			
No	98.0	91.6	-6.5%
Yes	132.2	129.2	-2.3%
<b>Avg_PDTM</b>	<b>16.2%</b>	<b>18.9%</b>	<b>2.7%</b>

	MHED_2017	MHED_2019	PCT Change
RURAL_URBAN			
Rural	104.8	98.7	-5.8%
Urban	105.4	99.0	-6.1%
<b>Avg_PDTM</b>	<b>0.3%</b>	<b>0.3%</b>	<b>0.0%</b>

Note for color coding:

MHED rate is lower the better

Average PDTM (spread) decrease is reduction of observed disparity - improvement

Green = measure improvement or observed disparity reduced

Red = measure declined or increased observed disparity

Yellow = change <0.5%

**2019 Percent adult mbrs with history of mental illness (in MHED measure denominator)**

Total	31.8%
RE_REALD	
Native Hawaiian or Pacific Islander	30.3%
Middle Eastern or North African	24.9%
Black or African American	31.7%
American Indian or Alaskan Native	39.1%
Asian	18.0%
Hispanic/Latino	23.1%
White	34.3%
Other	28.5%
Unknown	15.3%
Language	
English	33.3%
Spanish	12.9%
Russian	8.0%
Vietnamese	12.6%
Chinese languages	6.9%
Other	22.9%
RURAL_URBAN	
Rural	31.1%
Urban	32.3%

**Dental Sealant (DS) measure 2014 - 2019**

**Rate = percent of children age 6-14 received at least one dental sealant in measurement year**

	DS_2014	DS_2019	Change
Total	12.0%	26.9%	14.9%

Gender	DS_2014	DS_2019	Change
Female	12.6%	27.8%	15.2%
Male	11.4%	26.0%	14.6%
Avg_PDTM	5.1%	3.3%	-1.7%

RE_REALD	DS_2014	DS_2019	Change
Native Hawaiian or Pacific Islander	10.0%	24.4%	14.4%
Middle Eastern or North African	21.3%	32.6%	11.3%
Black or African American	13.7%	23.6%	9.9%
American Indian or Alaskan Native	11.9%	27.1%	15.2%
Asian	15.5%	29.1%	13.6%
Hispanic/Latino	13.7%	31.0%	17.3%
White	10.3%	24.4%	14.1%
Other	12.9%	23.9%	11.0%
Unknown	9.1%	26.6%	17.5%
Avg_PDTM	22.3%	9.8%	-12.5%

Note for color coding:

DS measure rate increase is improvement

Average PDTM (spread) decrease is reduction of observed disparity - improvement

Green = measure improvement or observed disparity reduced

Red = measure declined or increased observed disparity

Yellow = change <0.5%

**Dental Sealant (DS) measure 2014 - 2019**

**Rate = percent of children age 6-14 received at least one dental sealant in measurement year**

Language	DS_2014	DS_2019	Change
English	10.5%	25.1%	14.6%
Spanish	15.2%	34.5%	19.3%
Russian	15.4%	22.3%	6.9%
Vietnamese	16.0%	28.3%	12.3%
Chinese languages	21.6%	34.1%	12.5%
Other	16.0%	31.5%	15.5%
Unknown/Undetermined	12.8%	28.2%	15.5%
STDEV	3.4%	4.5%	1.1%
Avg_PDTM	31.9%	15.2%	-16.7%

Disability	DS_2014	DS_2019	Change
No	12.1%	27.1%	15.0%
Yes	8.0%	18.6%	10.5%
STDEV	2.9%	6.0%	3.2%
Avg_PDTM	16.9%	15.8%	-1.1%

RURAL_URBAN	DS_2014	DS_2019	Change
Rural	7.9%	26.8%	18.9%
Urban	14.6%	26.9%	12.3%
STDEV	4.7%	0.1%	-4.7%
Avg_PDTM	28.0%	0.2%	-27.9%

Note for color coding:

DS measure rate increase is improvement

Average PDTM (spread) decrease is reduction of observed disparity - improvement

Green = measure improvement or observed disparity reduced

Red = measure declined or increased observed disparity

Yellow = change <0.5%

### Adult CAHPS Access to Care Composite

Average of Q4 and Q6

	Adult Access_2014	Adult Access_2019	Change
Total	81.5%	82.5%	1.0%

Gender	Adult Access_2014	Adult Access_2019	Change
Male	81.5%	82.7%	1.2%
Female	81.0%	82.7%	1.7%
<b>Avg_PDTM</b>	0.3%	0.3%	0.0%

Race	Adult Access_2014	Adult Access_2019	Change
American Indian or Alaskan Native	65.0%†	86.9%	21.9%
Asian	81.5%†	67.5%	-14.1%
Black or African American	70.5%†	76.9%	6.4%
Native Hawaiian or Pacific Islander	72.5%†	50.0%†	-22.5%
Hispanic/Latino	79.5%	76.6%	-3.0%
White	82.5%	84.7%	2.2%
Other	78.5%	85.4%	6.9%
Multi	78.5%	78.4%	-0.1%
<b>Avg_PDTM</b>	7.0%	11.0%	4.0%

†: sample size <30

Health Status	Adult Access_2014	Adult Access_2019	Change
Very good/good	82.0%	80.9%	-1.1%
Fair/poor	80.5%	80.5%	0.0%
<b>Avg_PDTM</b>	0.9%	2.1%	1.2%

Note for coloring:

Access to Care rate increase is improvement

Average PDTM (spread) decrease is reduction of observed disparity - improvement

Green = measure improvement or observed disparity reduced

Red = measure declined or increased observed disparity

Yellow = change <0.5%

**Child CAHPS Access to Care Composite**

Average of Q4 and Q6

	Child Access_2014	Child Access_2019	Change
Total	87.0%	89.0%	2.0%

Race	Child Access_2014	Child Access_2019	Change
American Indian or Alaskan Native	89.5%†	87.7%	-1.8%
Asian	78.0%†	60.2%†	-17.8%
Black or African American	80.5%†	87.6%†	7.1%
Native Hawaiian or Pacific Islander	58.5%†	90.0%†	31.5%
Hispanic/Latino	83.0%	86.0%	2.9%
White	89.5%	94.6%	5.1%
Other	83.0%	88.2%†	5.2%
Multi	90.0%	89.7%	-0.3%
<b>Avg_PDTM</b>	8.6%	6.0%	-2.6%

†: sample size <30

Health Status	Child Access_2014	Child Access_2019	Change
Very good/good	87.0%	87.7%	0.7%
Fair/poor	85.5%	79.7%	-5.9%
<b>Avg_PDTM</b>	0.9%	6.0%	5.1%

Note for coloring:

Access to Care rate increase is improvement

Average PDTM (spread) decrease is reduction of observed disparity - improvement

Green = measure improvement or observed disparity reduced

Red = measure declined or increased observed disparity

Yellow = change <0.5%