

CCO Incentive Metrics

2017 Mid-Year Deeper Dive



February 2018

Introduction

2017 is the fifth year of Oregon’s pay for performance program, under which the Oregon Health Authority (OHA) utilizes a “bonus quality pool” to reward coordinated care organizations (CCOs) for the quality of care provided to Medicaid members. This model increasingly rewards CCOs for outcomes, rather than utilization of services, and is one of several key health system transformation mechanisms for achieving Oregon’s vision for better health, better care, and lower costs.

Since 2014, the Oregon Health Authority has published mid-year progress reports on CCO incentive metrics and other state quality measures. This year, we are expanding our analysis. Mid-year data (covering July 2016 through June 2017) are provided for claims-based CCO incentive measures as usual. We are also taking a “deeper dive” into the data on a few measures to gain a better understanding of potential drivers of quality improvement, and highlight areas where further analyses are needed. This year, the deeper dive focuses on three measures: Adolescent well-care visits, effective contraceptive use, and emergency department utilization.

Analyzing the utilization patterns of various subgroups helps reveal patterns of quality performance not easily observed in the larger reported groups. These data may help CCOs and providers target strategies for quality improvement or other programs to help meet improvement targets.

These analyses are not intended to uncover specific answers; rather, we hope to spark further conversation and encourage CCOs to dig more deeply into their own data and reveal potential areas for further analysis.

Deeper Dive: What we explored

Adolescent well-care visits (page 16)

This section explores health care utilization patterns among members who had an adolescent well-care visits, compared with members who did not have an adolescent well-care visit.

Effective contraceptive use (page 20)

The effective contraceptive use section focuses on contraceptive use among adolescents and young adults and explores patterns side-by-side with further analysis on the

adolescent well-care measure. The goal is to illuminate possible connections between these two measures and highlight possible areas where efforts in one area may have a compounding effect.

Emergency department utilization (page 24)

The emergency department utilization section provides a breakdown of utilization patterns by age and race; and explores primary diagnoses (i.e., the primary reason for the emergency department visit) among members with and without mental illness. Emergency department utilization among members experiencing mental illness is a new incentive measure beginning in 2018. We hope this section will help CCOs consider ways they might explore their own data to help close the gap in disparities.

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Contacts and Online Information

Notes about the data

Data sources

The metrics analyzed in this deeper dive report are measured using administrative (billing) claims data covering the period July 2016 through June 2017. Claims data are derived from reimbursement information or the payment of bills and are commonly used in health care measurement.

Rates

Some utilization data are presented as “rates per 1,000 or 100,000 member months.” This means that in one month, there are on average X visits occurring per 1,000 (or 100,000) CCO members.

Race and ethnicity data

This report breaks out performance by race and ethnicity. Caution should be used when interpreting these data. Race and ethnicity for a large proportion of the population included in this report is unavailable due to technical issues associated Medicaid information systems and many Medicaid members have declined to provide their race and ethnicity—which is voluntary. The portion associated with technical issues is expected to decrease in the future. Readers should keep these caveats in mind when reviewing the race and ethnicity data included in this report.

Measure specifications and more information

- ◆ Information about the CCO incentive program, including specifications for the measures included in this report, benchmark sources, and more can be found at: <http://www.oregon.gov/oha/hpa/analytics/Pages/CCO-Baseline-Data.aspx>
- ◆ Metrics and Scoring Committee: <http://www.oregon.gov/oha/hpa/analytics/Pages/Metrics-Scoring-Committee.aspx>
- ◆ This and other metrics reports: <http://www.oregon.gov/oha/hpa/analytics-mtx/Pages/HST-Reports.aspx>
- ◆ OHA Transformation Center CCO Incentive Metrics Technical Assistance: <http://www.oregon.gov/oha/HPA/CSI-TC/Pages/Resources-Metric.aspx>

Contact

For questions about these data or to provide feedback on this report, please contact the metrics team with the Office of Health Analytics, Oregon Health Authority at metrics.questions@state.or.us.

Mid-Year Performance at a Glance

The table below shows the eight incentive metrics for which mid-year data are available. Shaded cells indicate the CCO has made improvement on that measure during the rolling twelve months July 2016–June 2017, compared against calendar year 2016 performance.

Note: Incentive payments for this program are based on performance at the end of calendar year 2017, as measured against improvement toward a benchmark. The table below is only meant to give a rough “at-a-glance” overview of improvement across all 16 CCOs, as a supplement to the measure-specific pages in the following section, which show absolute performance by CCO.

	AWC	AMB-ED	CIS	DS	DEV	ECU	FUH	DHS
Statewide								
AllCare CCO								
Cascade Health Alliance								
Columbia Pacific								
Eastern Oregon								
FamilyCare								
Health Share of Oregon								
InterCommunity Health Network								
Jackson Care Connect								
PacificSource Central Oregon						*		
PacificSource Gorge			*				*	
PrimaryHealth of Josephine County		*			*			*
Trillium								
Umpqua Health Alliance				*				
Western Oregon Advanced Health	*							
Willamette Valley Community Health								
Yamhill Community Care								
* Indicates top performer (absolute value)								

ABBREVIATION LEGEND

AWC: Adolescent well-care visits

AMB-ED: Ambulatory care: Emergency department utilization

CIS: Childhood immunization status

DS: Dental sealants

DEV: Developmental screenings:

ECU: Effective contraceptive use

FUH: Follow-up after hospitalization for mental illness

DHS: Health assessments for children in DHS custody

Adolescent Well-Care Visits

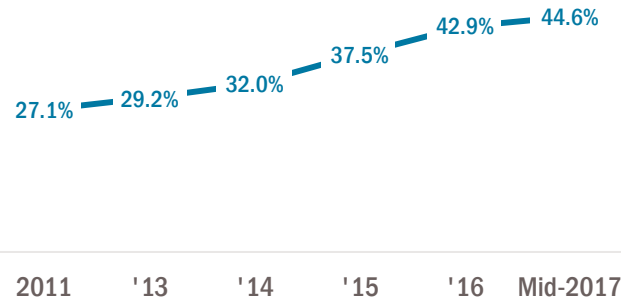
Percentage of adolescents and young adults (ages 12-21) who had at least one well-care visit during the measurement year.

Statewide percent change since 2016: **+4.0%**

Number of CCOs that improved: **12**

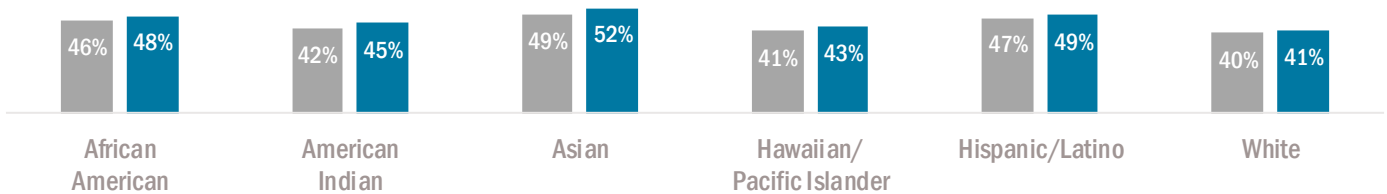
Transformation Center Focus Area

Statewide, adolescent well-care visits continue to improve.

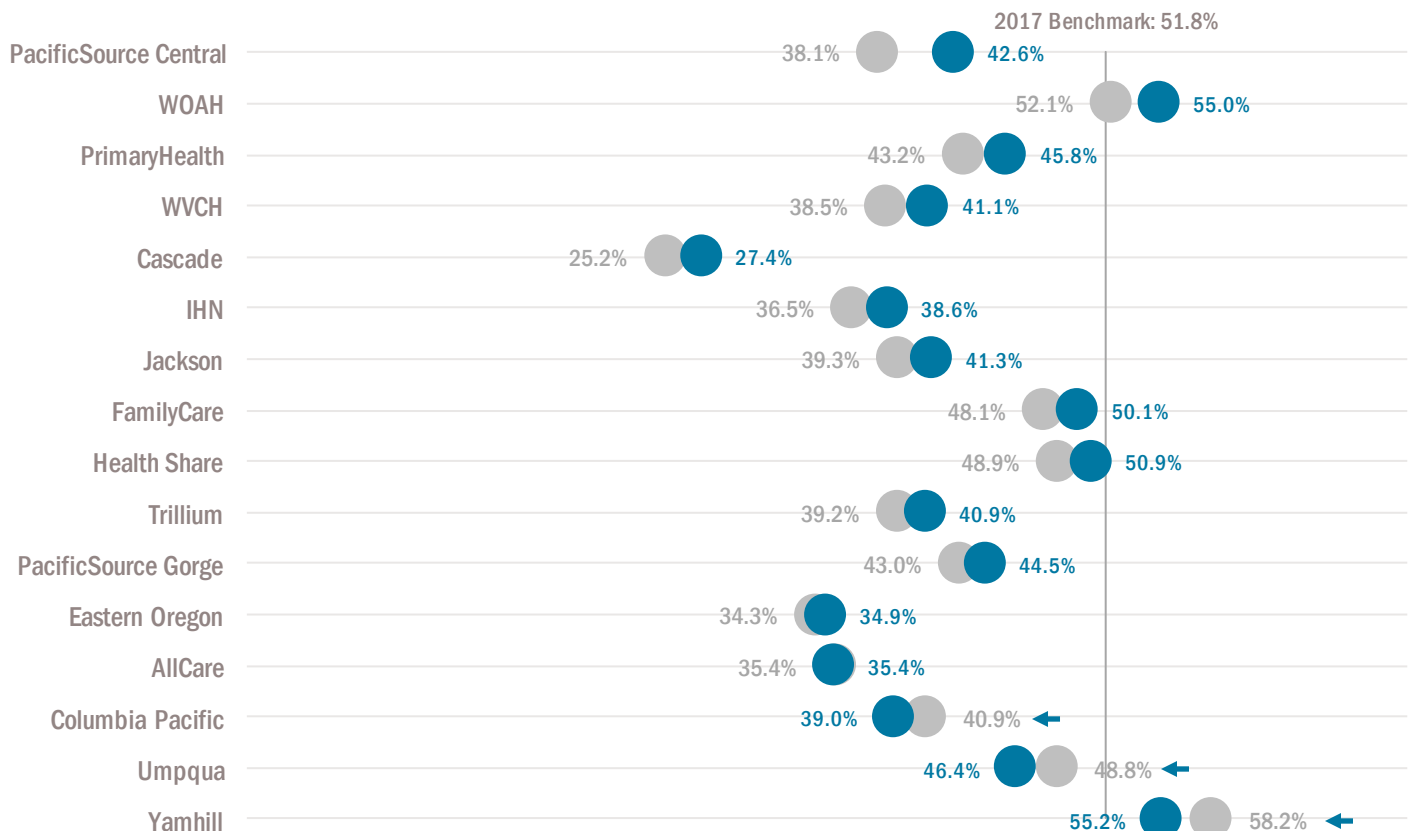


Adolescent well-care visits in 2016 and mid-2017, by race and ethnicity.

Race/ethnicity data are missing for 44.4% of members in this measure in mid-2017. The data below only report members for whom race/ethnicity is known.



Adolescent well-care visits in 2016 and mid-2017, by CCO.



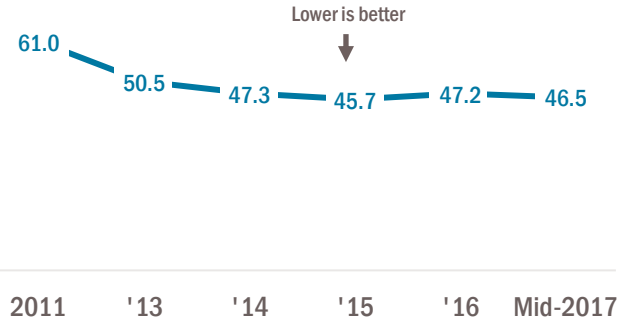
Emergency Department Utilization

Rate of patient visits to an emergency department. Rates are reported per 1,000 member months and a lower number suggests more appropriate use of care.

Statewide percent change since 2016: **-1.5%**
(lower is better)

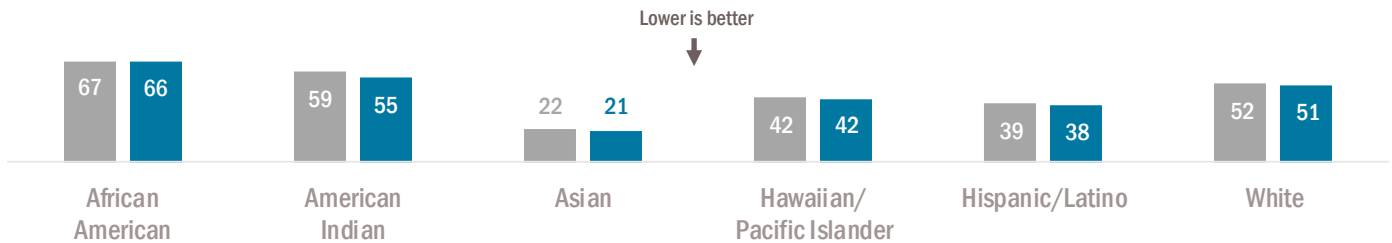
Number of CCOs that improved since 2016: **11**

Statewide, ED utilization declined when CCOs started and has remained fairly steady.

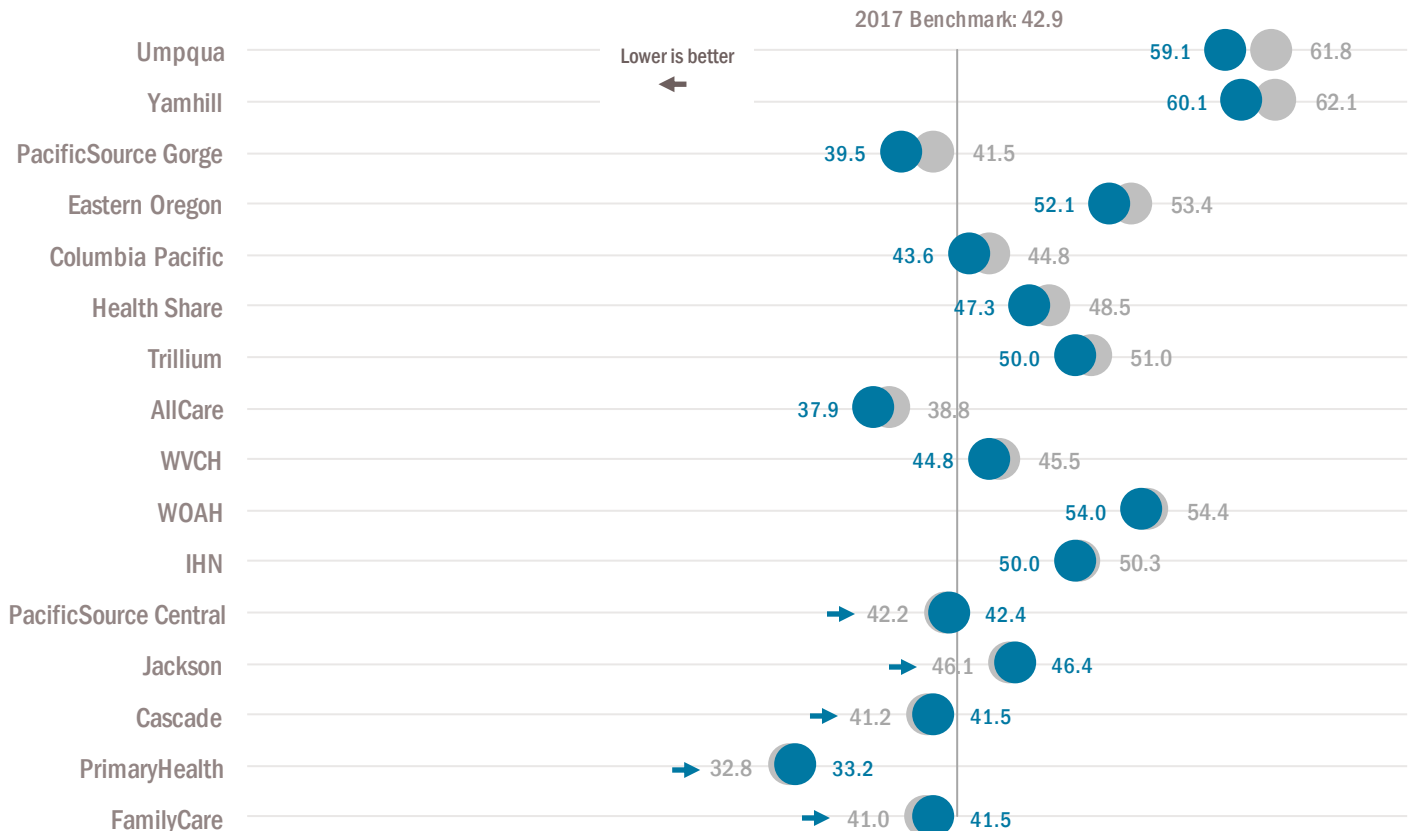


Emergency department utilization in 2016 and mid-2017, by race and ethnicity.

Race/ethnicity data are missing for 38.9% of members in this measure in mid-2017. The data below only report members for whom race/ethnicity is known.



Emergency department utilization in 2016 and mid-2017, by CCO.



Childhood Immunization Status

Percentage of children who received recommended vaccines (DTaP, IPV, MMR, HiB, Hepatitis B, VZV) before their second birthday.

Statewide percent change since 2016: **+2.8%**

Number of CCOs that improved since 2016: **14**

Transformation Center Focus Area

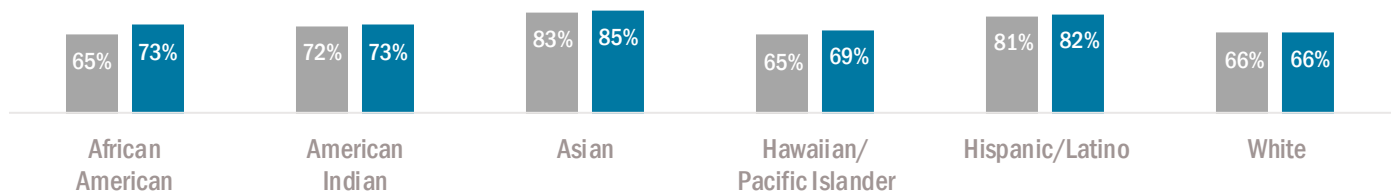
Statewide, childhood immunizations have increased slightly.

68.2% — 68.4% — 70.3%

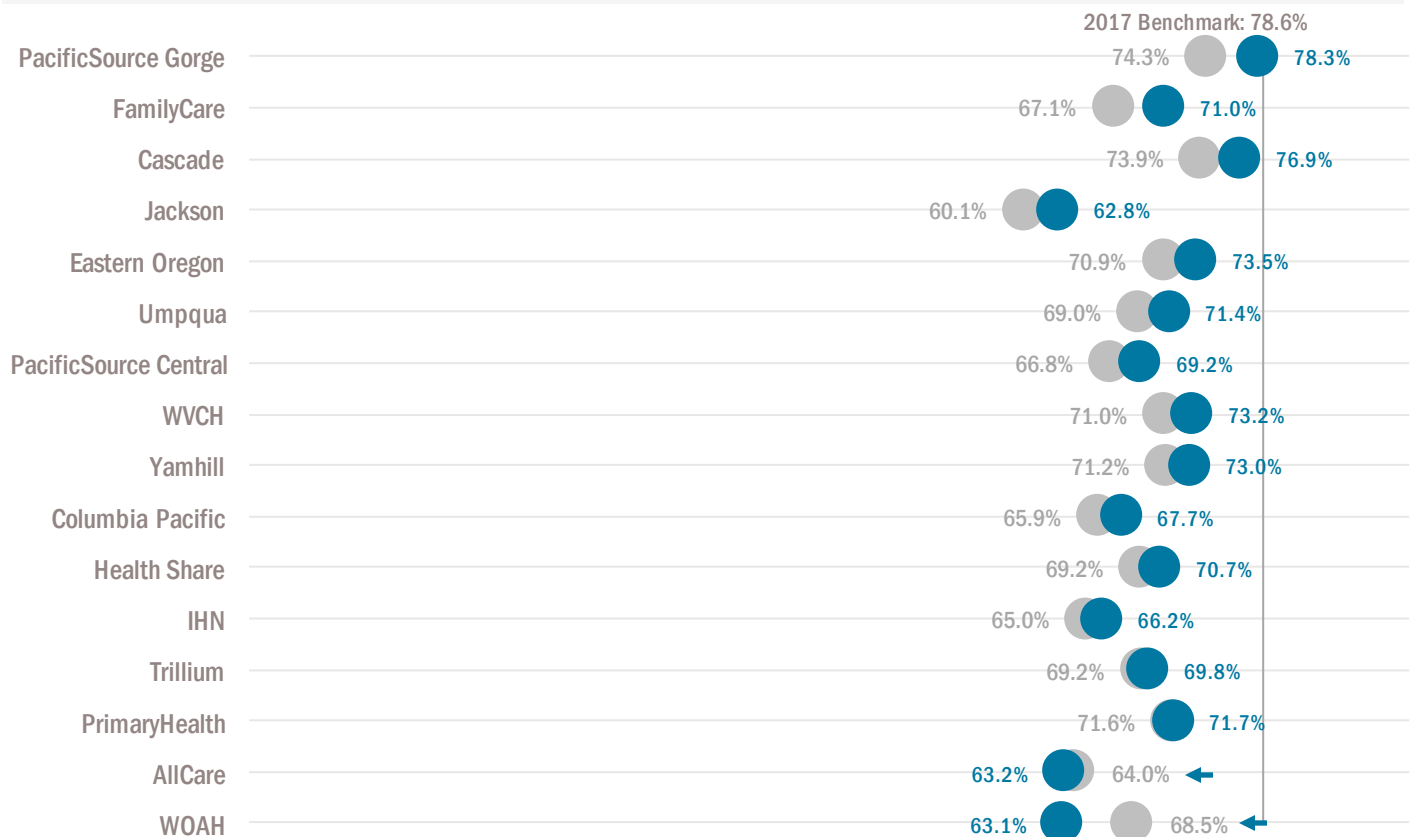
2015 2016 Mid-2017

Childhood immunization status in 2016 and mid-2017, by race and ethnicity.

Race/ethnicity data are missing for 48.7% of members in this measure in mid-2017. The data below only report members for whom race/ethnicity is known.



Childhood immunization status in 2016 and mid-2017, by CCO.



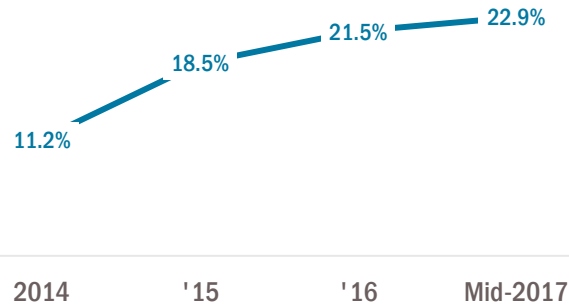
Dental Sealants

Percentage of children ages 6-14 who received a dental sealant during the measurement year.

Statewide percent change since 2016: **+6.5%**

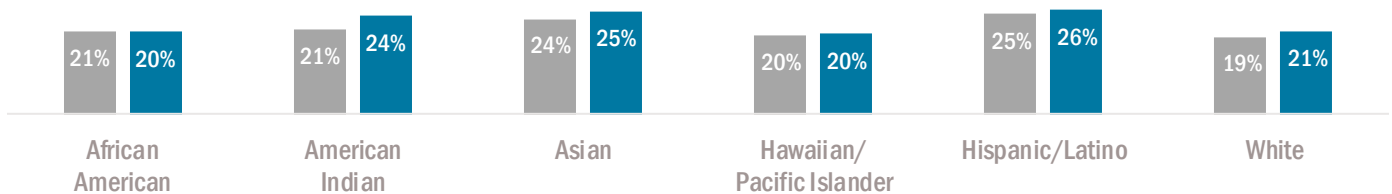
Number of CCOs that improved since 2016: **14**

Statewide, the percent of children receiving dental sealants has doubled since 2014.

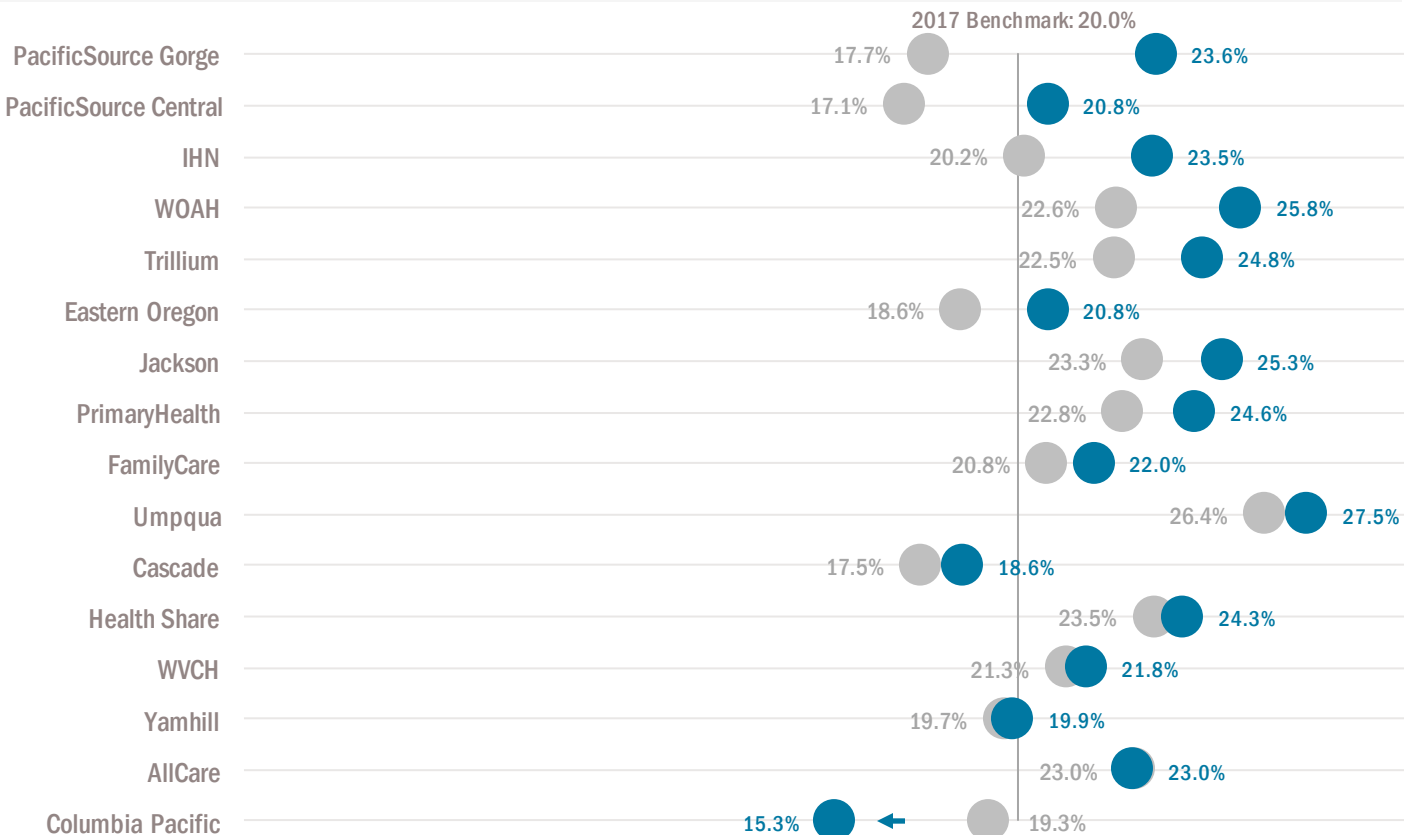


Dental sealants in 2016 and mid-2017, by race and ethnicity.

Race/ethnicity data are missing for 47.4% of members in this measure in mid-2017. The data below only report members for whom race/ethnicity is known.



Dental sealants in 2016 and mid-2017, by CCO.



Developmental Screenings

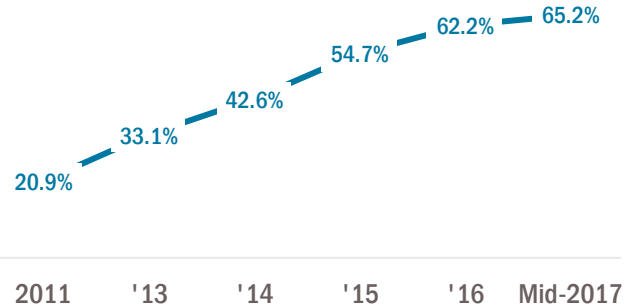
Percentage of children who were screened for risks of developmental, behavioral and social delays using standardized screening tools in the 12 months preceding their first, second or third birthday.

Statewide percent change since 2016: **+4.8%**

Number of CCOs that improved since 2016: **15**

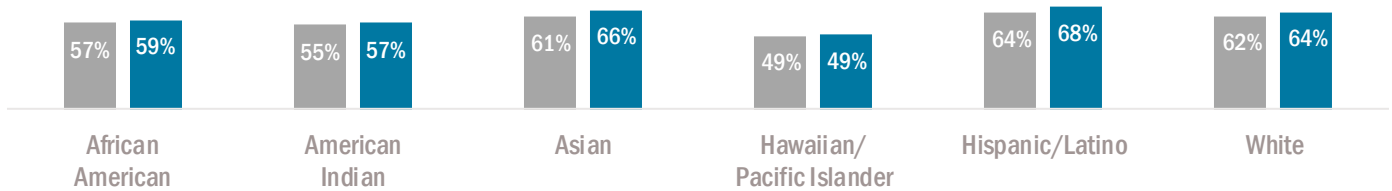
Transformation Center Focus Area

Statewide, the percent of children receiving screenings has more than tripled since 2011.

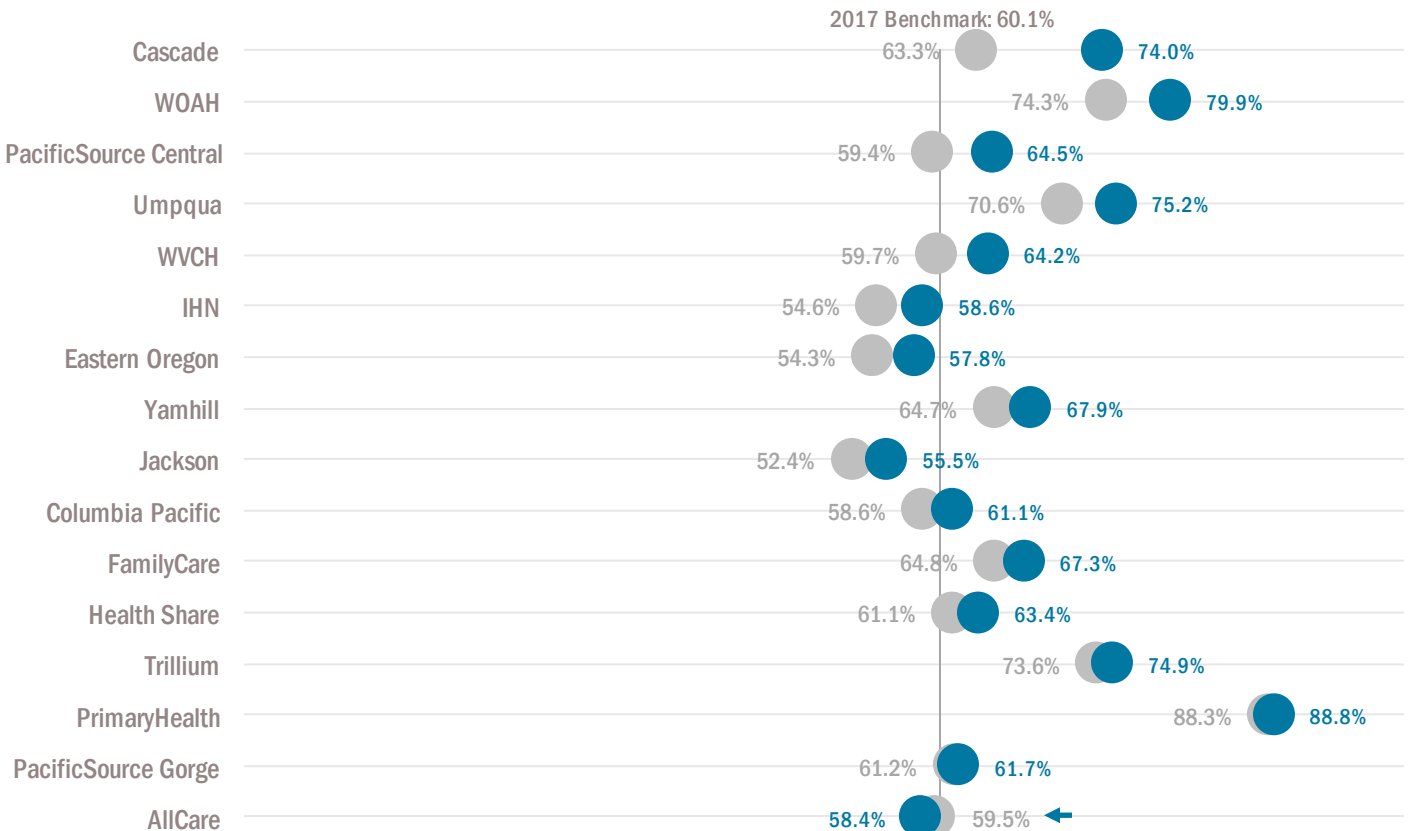


Developmental screenings in the first 36 months of life in 2016 and mid-2017, by race and ethnicity.

Race/ethnicity data are missing for 48.8% of members in this measure in mid-2017. The data below only report members for whom race/ethnicity is known.



Developmental screenings in the first 36 months of life in 2016 and mid-2017, by CCO.



Effective Contraceptive Use

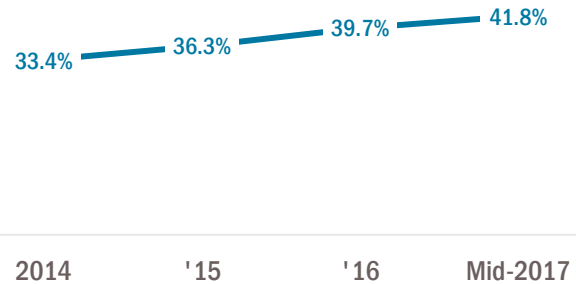
Percentage of adult women (ages 18-50) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

Statewide percent change since 2016: **+5.3%**

Number of CCOs that improved since 2016: **13**

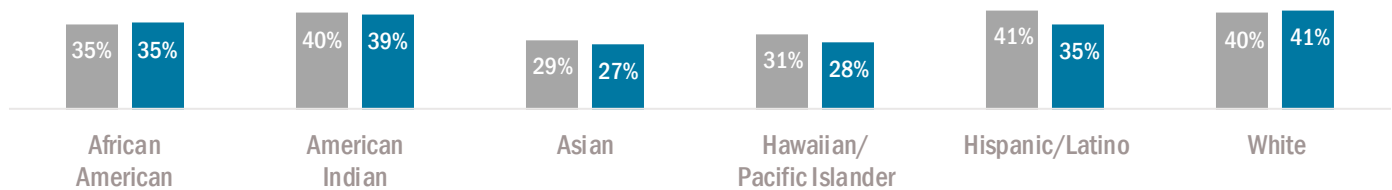
Transformation Center Focus Area

Statewide, effective contraceptive use continues to increase.

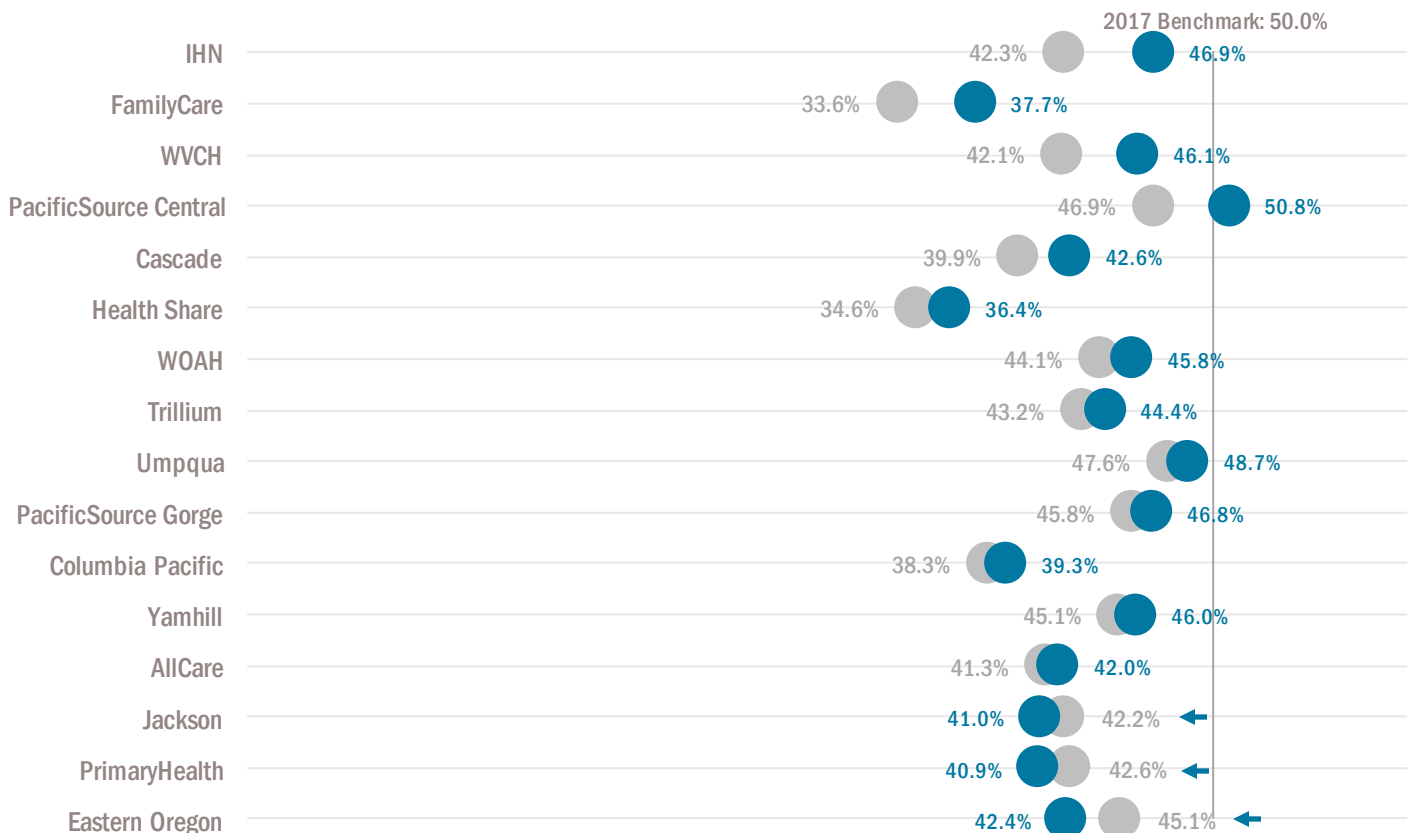


Effective contraceptive use among adult women in 2016 and mid-2017, by race and ethnicity.

Race/ethnicity data are missing for 38.5% of members in this measure in mid-2017. The data below only report members for whom race/ethnicity is known.



Effective contraceptive use among adult women in 2016 and mid-2017, by CCO.



Follow-Up After Hospitalization for Mental Illness

Percentage of members (ages 6 and older) who received a follow-up visit with a health care provider within seven days of being discharged from a mental illness-related hospitalization.

Statewide percent change since 2016: **+2.9%**

Number of CCOs that improved since 2016: **7**

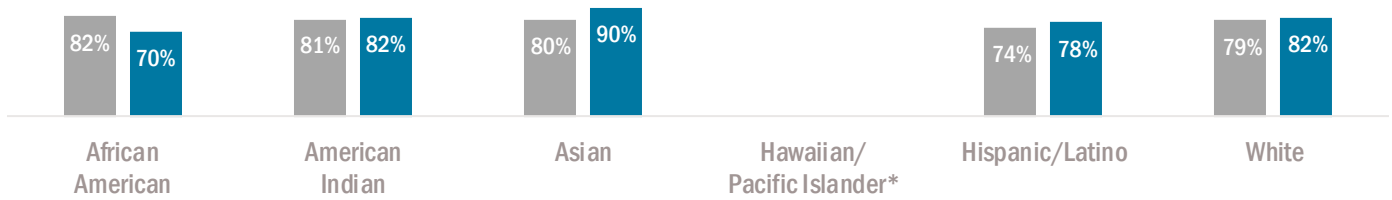
Statewide, follow-up after hospitalization for mental illness increased slightly.

76.7% — 78.8% — 81.1%

2015 2016 Mid-2017

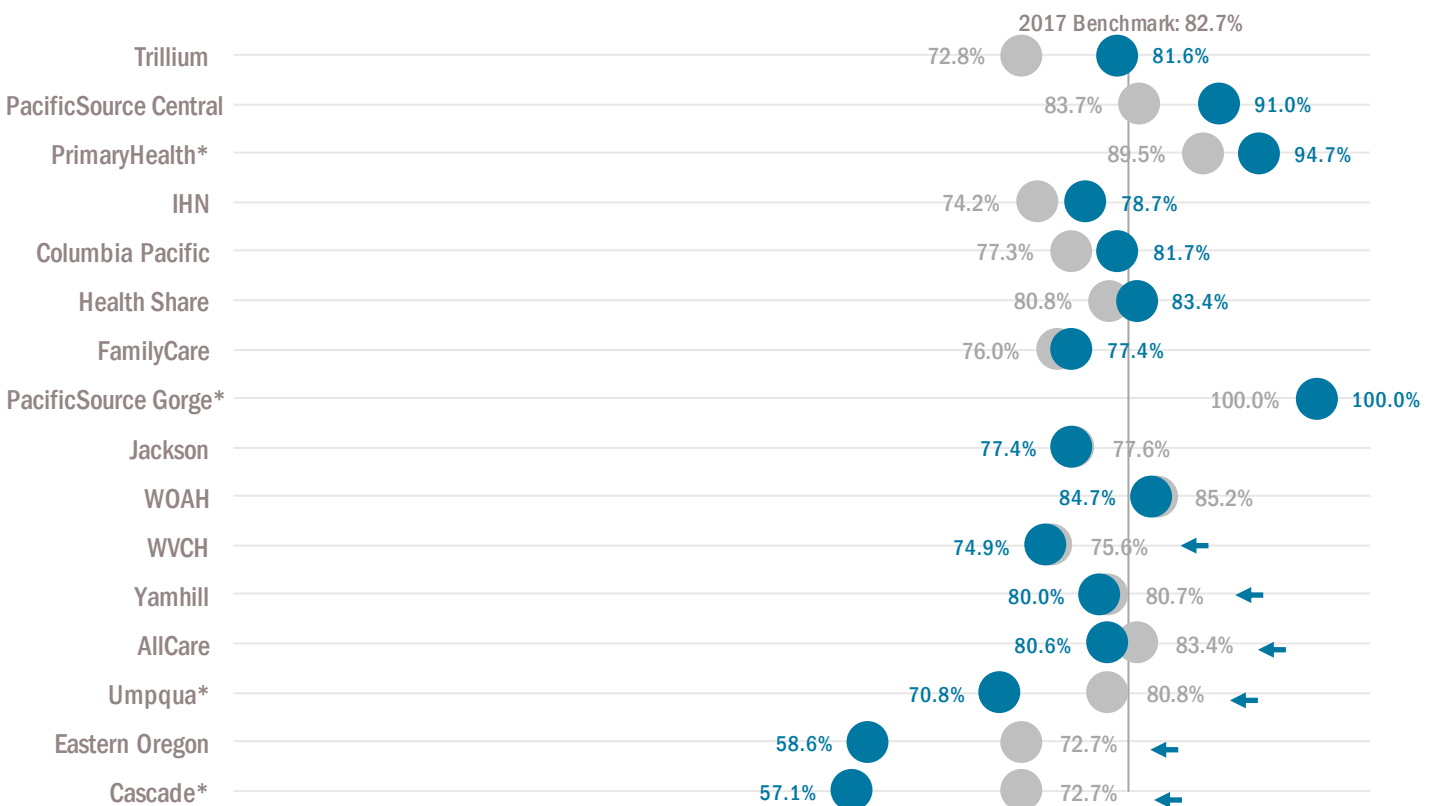
Follow-up after hospitalization for mental illness in 2016 and mid-2017, by race and ethnicity.

Race/ethnicity data are missing for 25.9% of members in this measure in mid-2017. The data below only report members for whom race/ethnicity is known.
*Data suppressed (n<30)



Follow-up after hospitalization for mental illness in 2016 and mid-2017, by CCO.

*Note small denominator (n<30)



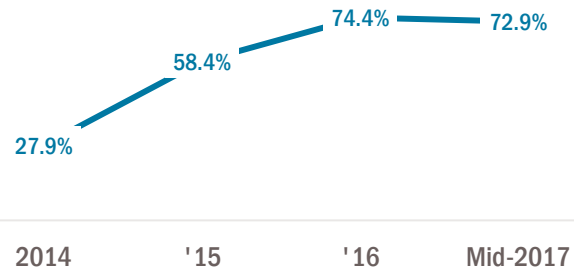
Health Assessments for Children in DHS Custody

Percentage of children ages 4+ who received a mental, physical, and dental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care). Physical and dental health assessments are required for children under age 4, but not mental health assessments.

Statewide percent change since 2016: **-2.0%**

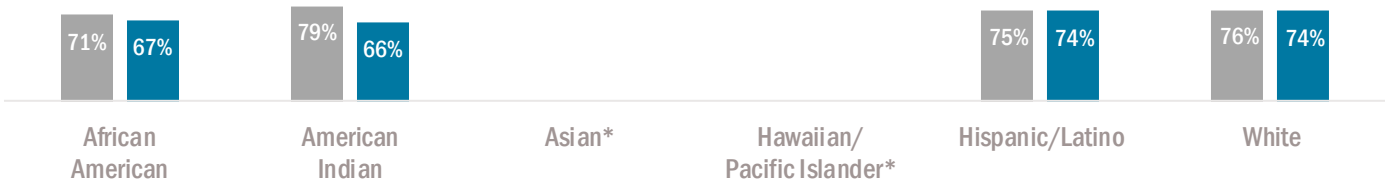
Number of CCOs that improved since 2016: **8**

Statewide, health assessments for children in DHS custody have improved overall but declined slightly since 2016.

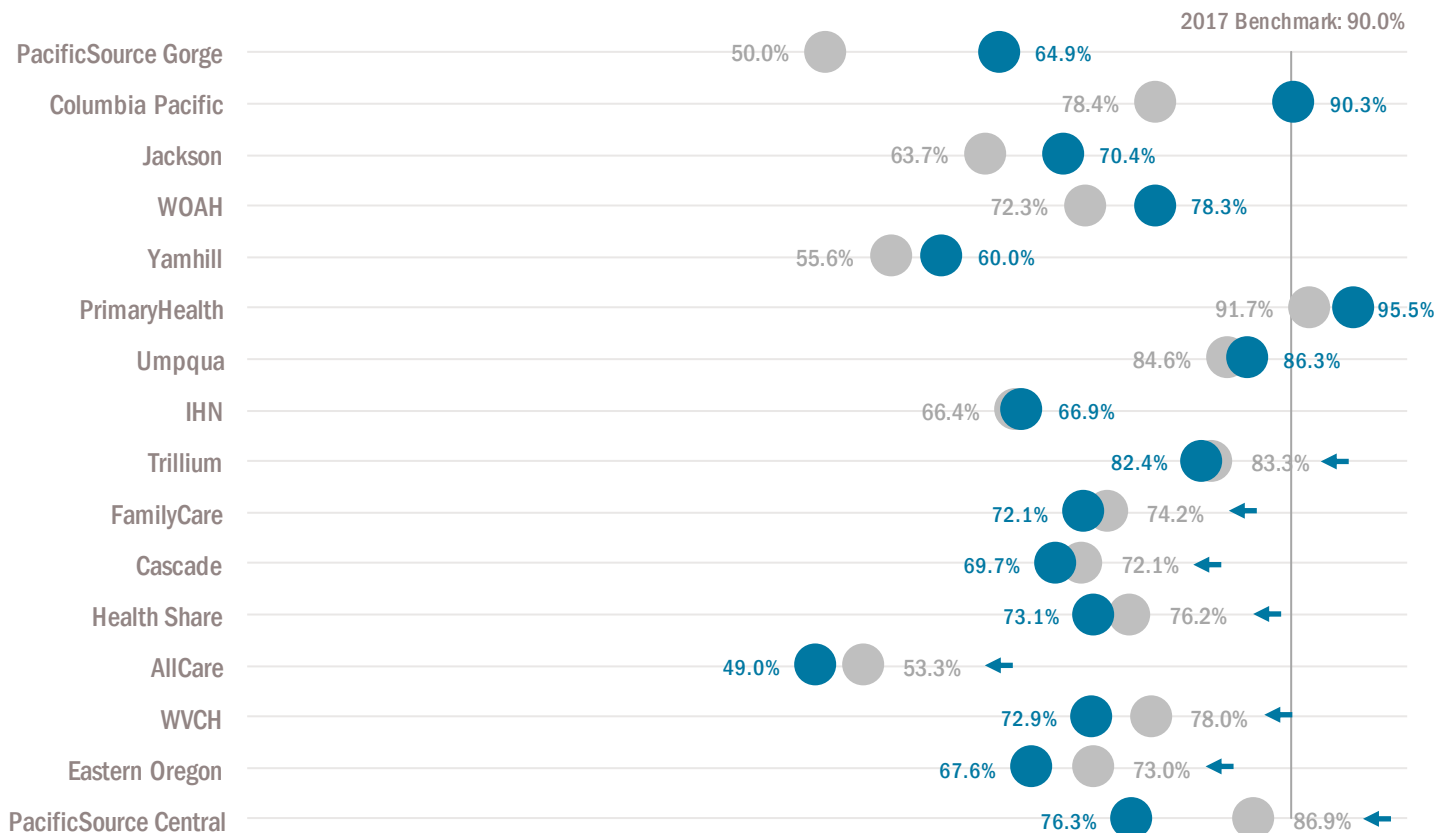


Health assessments for children in DHS custody in 2016 and mid-2017, by race and ethnicity.

Race/ethnicity data are missing for 11.2% of members in this measure in mid-2017. The data below only report members for whom race/ethnicity is known.
*Data suppressed (n<30)



Health assessments for children in DHS custody in 2016 and mid-2017, by CCO.



Patient-Centered Primary Care Home Enrollment

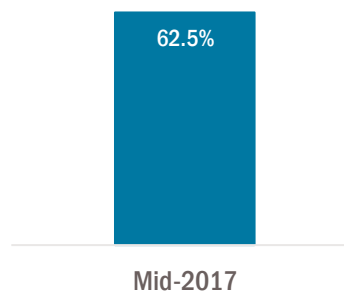
Percentage of CCO members who were enrolled in a recognized patient-centered primary care home (PCPCH).

Due to the addition of two new PCPCH designations (Tier 4 and 5 STAR) in 2017, measure results from earlier years are not comparable. Specifically, absolute performance should be expected to be lower beginning this year (i.e., the measure has become more challenging).

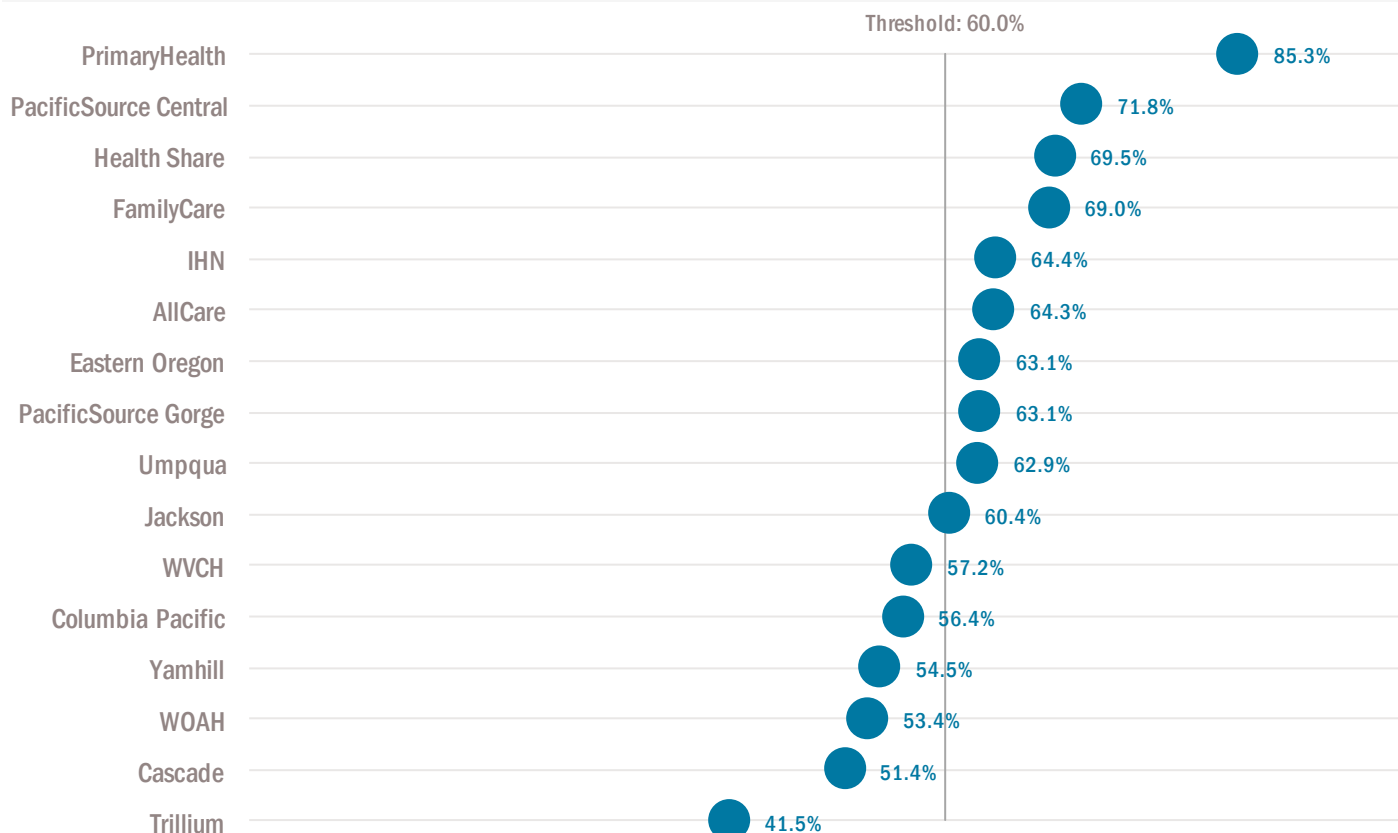
CCOs must achieve at least 60 percent PCPCH enrollment in calendar year 2017 to earn 100 percent of their quality pool.

PCPCH enrollment data are not available by race and ethnicity.

Patient-Centered Primary Care Home Enrollment, statewide.



Patient-centered primary care home enrollment in mid-2017, by CCO.



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“Deeper Dive”

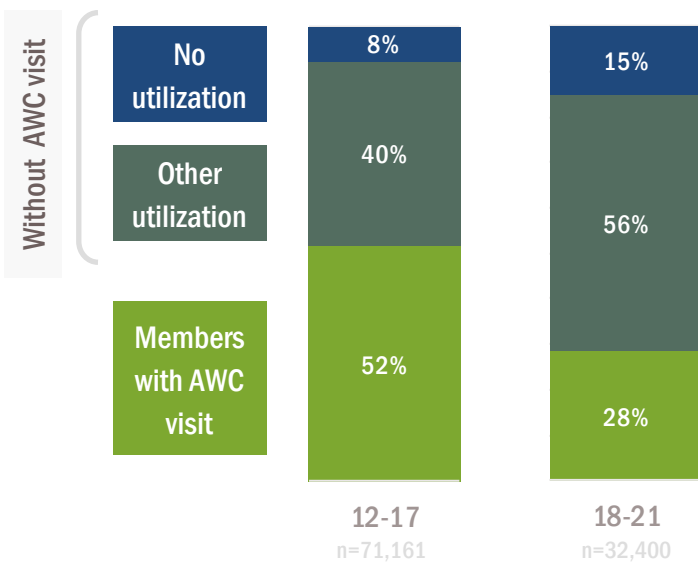
Deeper Dive Topic: Adolescent Well-Care Visits

Why dive deeper?

Adolescence is one of the most dynamic periods of development, second only to infancy. A key developmental task of adolescence is transitioning to increased independence from parents and guardians. While most adolescents enjoy good health, dramatic physical, cognitive, social, and emotional change during this period calls for a unique approach to health care compared to adults or young children. The leading causes of death among adolescents (unintentional injury, homicide and suicide) are largely preventable. During this period of development, youth begin to make their own decisions regarding relationships, lifestyle and health behaviors.

Health behaviors established in adolescence tend to persist into adulthood, and many chronic diseases first emerge in this age. Annual, comprehensive well-visits are a strong vehicle to deliver screening, anticipatory guidance, and health education to support healthy development. It is an important opportunity to identify health conditions that commonly arise in this period early, such as mental health diagnoses and substance use issues. Additionally, annual well visits provide a training ground for youth to learn to navigate the health care system, and transition to independent and savvy consumers of health care services in adulthood. The process of supporting youth to transition from pediatric to adult care is an area of national focus.

While CCOs are making steady improvement on this measure (65 percent increase statewide since 2011), systemic improvement has proven difficult and performance remains stubbornly below the national 75th percentile. A number of challenges have been identified, including creating a culture shift to ensure care is youth-centered and culturally competent; missed opportunities to provide well care visits when adolescents present for care; and youth hesitancy to access care because of confidentiality concerns. In particular, older adolescents have proven difficult to engage, with rates much lower among members ages 18-21. The OHA Transformation Center provides technical assistance on this metric with a special focus on engaging this older age range.

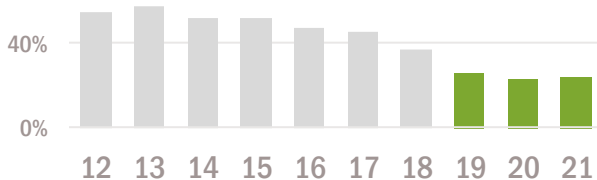


At the statewide level, more than half of younger adolescents (children 12-17) **had an adolescent well-care visit**, compared with fewer than one-third of older adolescents (adults 18-21).

Among 18-21 year-olds, 56 percent **did not have well-care visit, but utilized the health care system in some other manner**, while 15 percent **did not touch the health care system at all**.

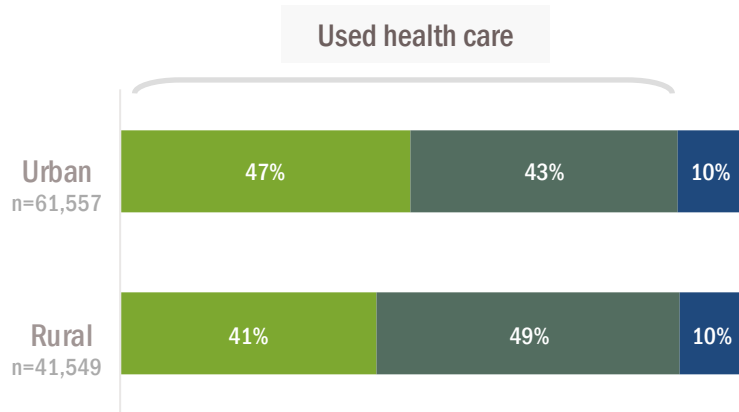
A smaller portion (8 percent) of younger adolescents (12-17) **did not use any health care**.

When stratified by age, **well-visit rates drop substantially among older adolescents.**



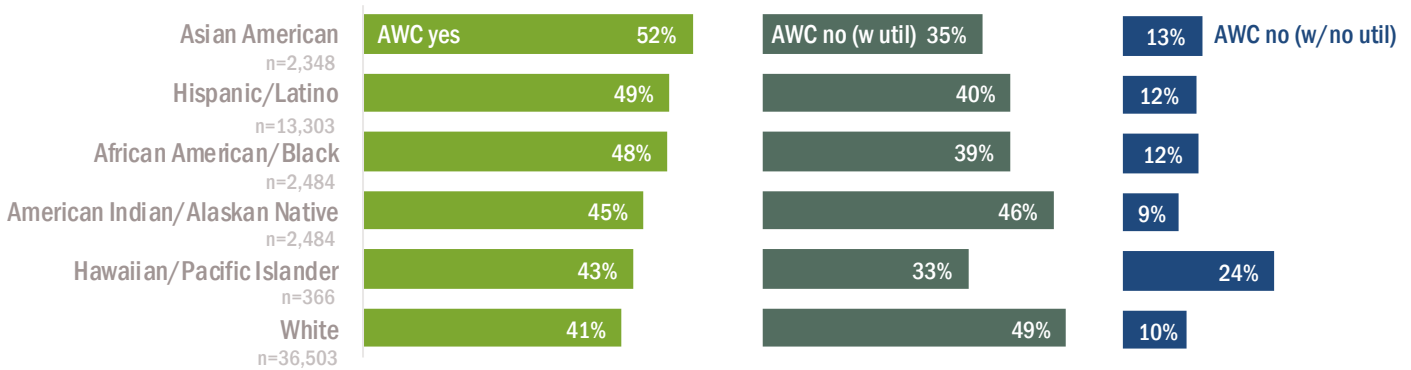
Statewide, among the 55 percent of members without an adolescent well-care visit, **one-fifth had either no utilization, or were filling prescriptions without seeing a provider.**

Deeper Dive Topic: Adolescent Well-Care Visits



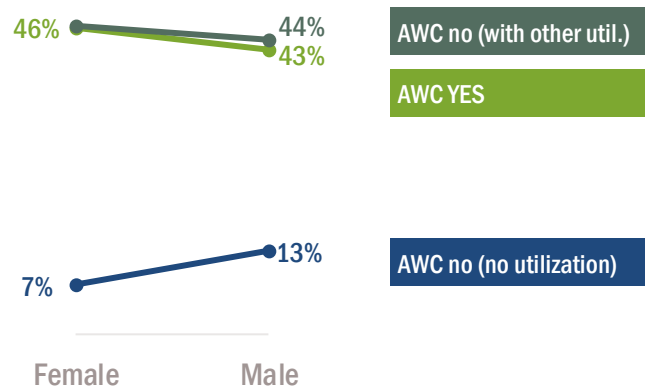
Although well-visit rates are lower among adolescents living in rural areas, their overall health care utilization rates are the same as urban adolescents.

While white members have the lowest rate of “AWC yes,” they have the highest rate of “AWC no (with some other utilization).” And, nearly one quarter of Hawaiian/Pacific Islander members have “no utilization at all.”



Note: Caution should be used when interpreting the race/ethnicity charts above. Race and ethnicity data are missing for 44.4% of the population in this set (see page 3 for more information).

When stratified by gender, males are almost twice as likely to have “no utilization at all.”

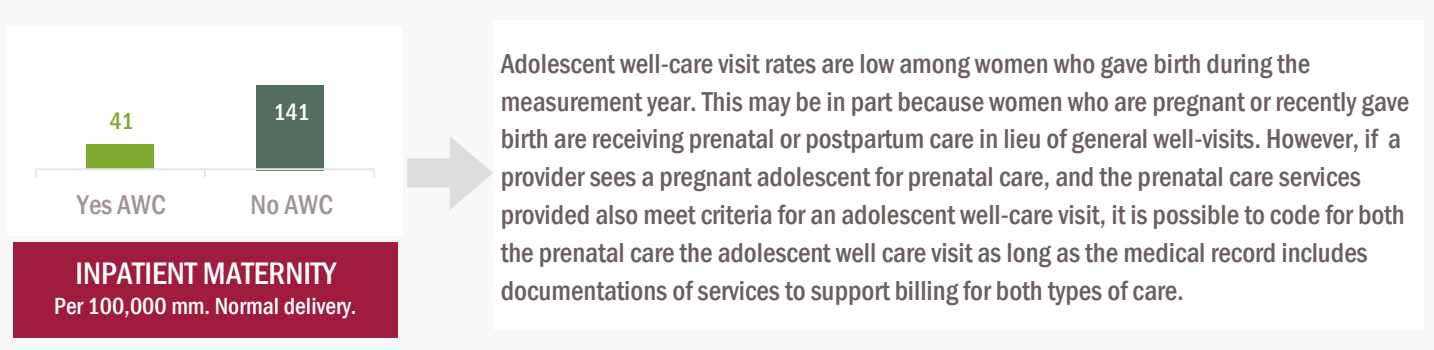
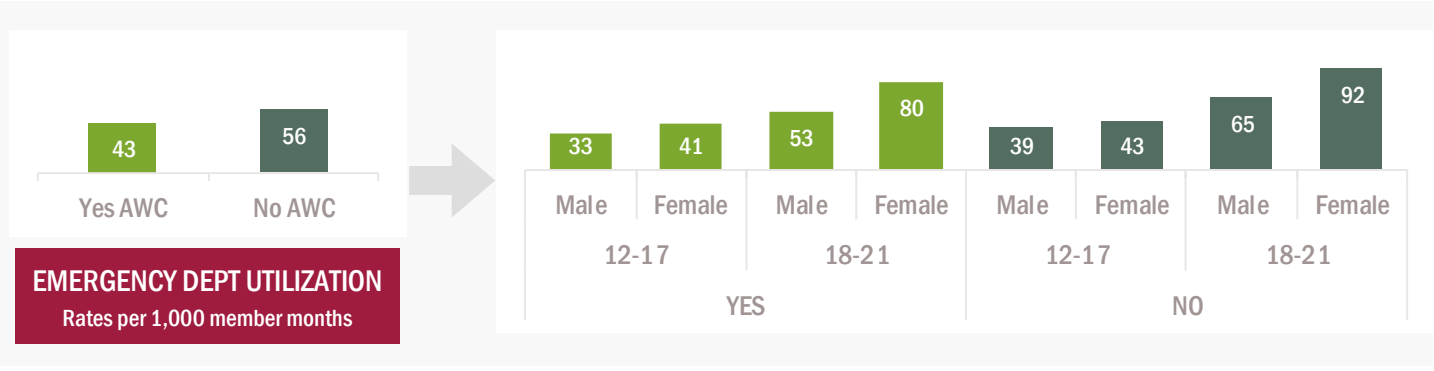
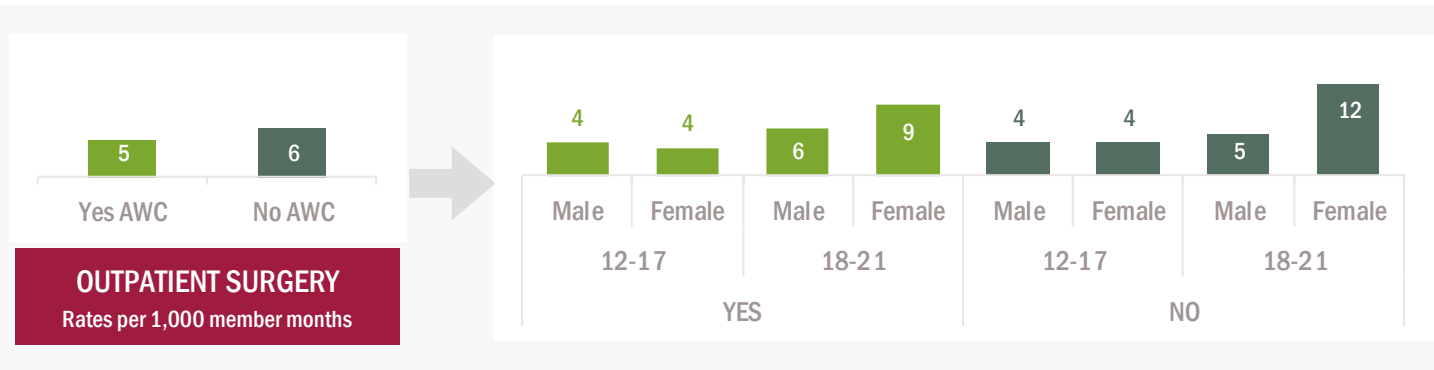


Deeper Dive Topic: Adolescent Well-Care Visits

These next three pages dive a little bit deeper, comparing utilization patterns among members who had an AWC visit with those did not (but still used some type of health care). We further break down those utilization rates by gender and age to help show how rates vary between sub-populations. Rates below are shown per 1,000 or 100,000 member months (mm). See page 3 for more information. The table below includes denominator sizes for each category breakout:

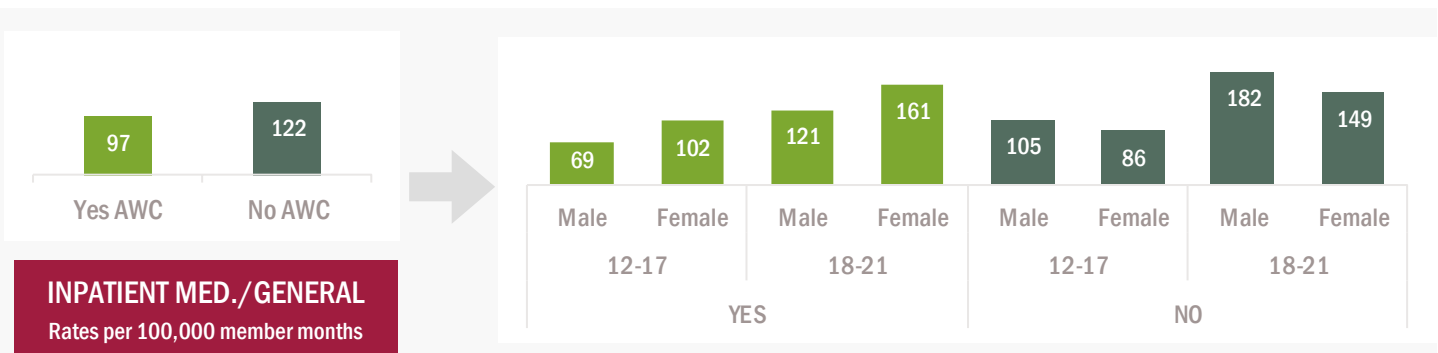
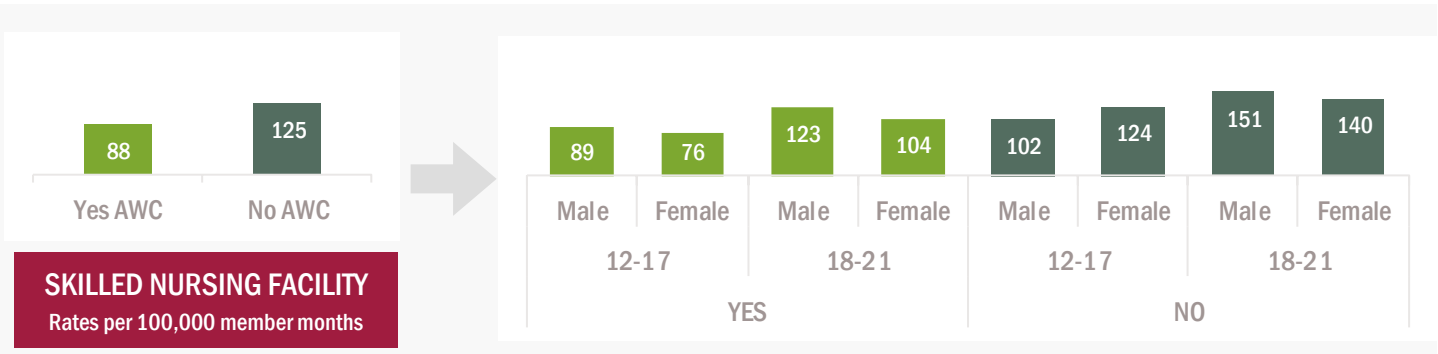
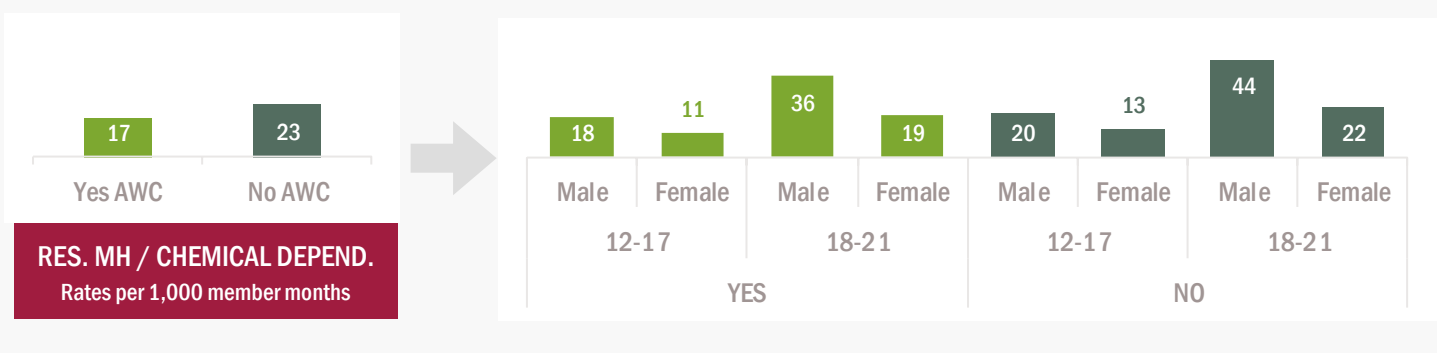
	AWC Yes		AWC No		AWC Yes				AWC No			
	Statewide		Ages 12-17		Ages 18-21		Ages 12-17		Ages 18-21			
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female		
N members	47,683	46,119	9,935	8,529	14,326	14,893	5,449	3,770	18,338	18,562		
Total mm	563,566	545,957	117,376	100,943	169,157	176,089	64,465	44,660	217,080	219,752		

When compared with those who **did have an adolescent well-visit**, those who **did not have a visit but had some other type of health care utilization** are **HIGHER** in....



Deeper Dive Topic: Adolescent Well-Care Visits

There are a few areas where **OLDER ADOLESCENT MALES** who did not have an adolescent well-visit stand out with higher utilization rates: Residential mental health/chemical dependency, skilled nursing facility, and inpatient medical/general:

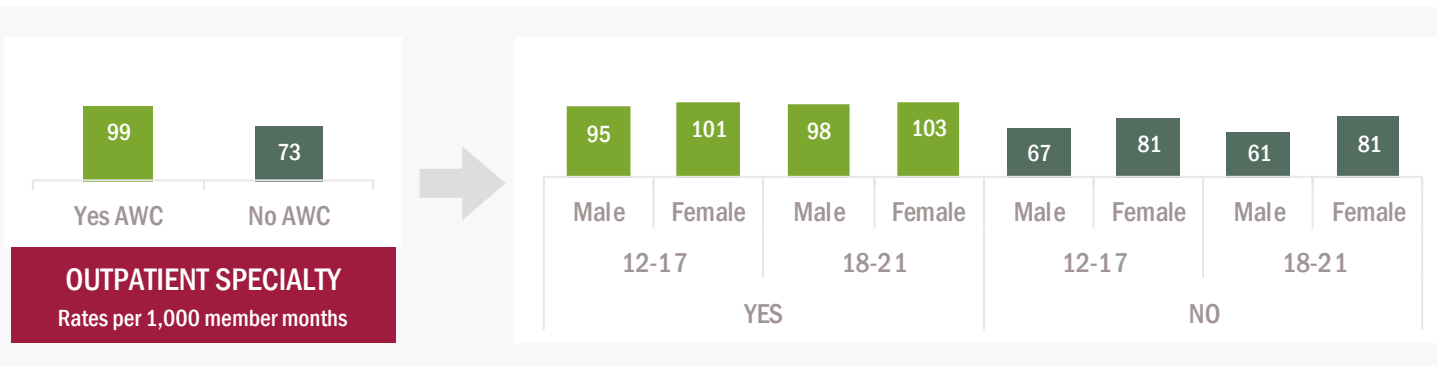
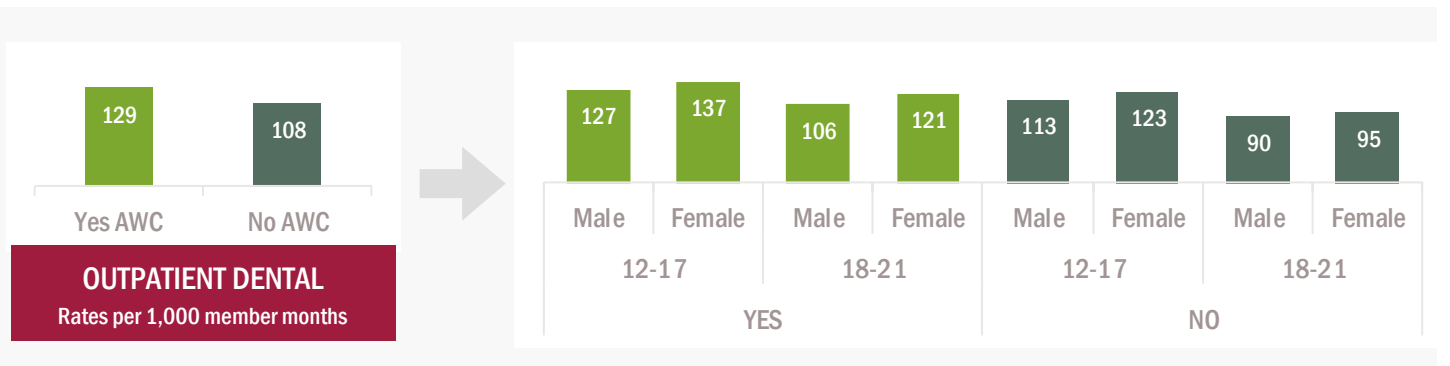
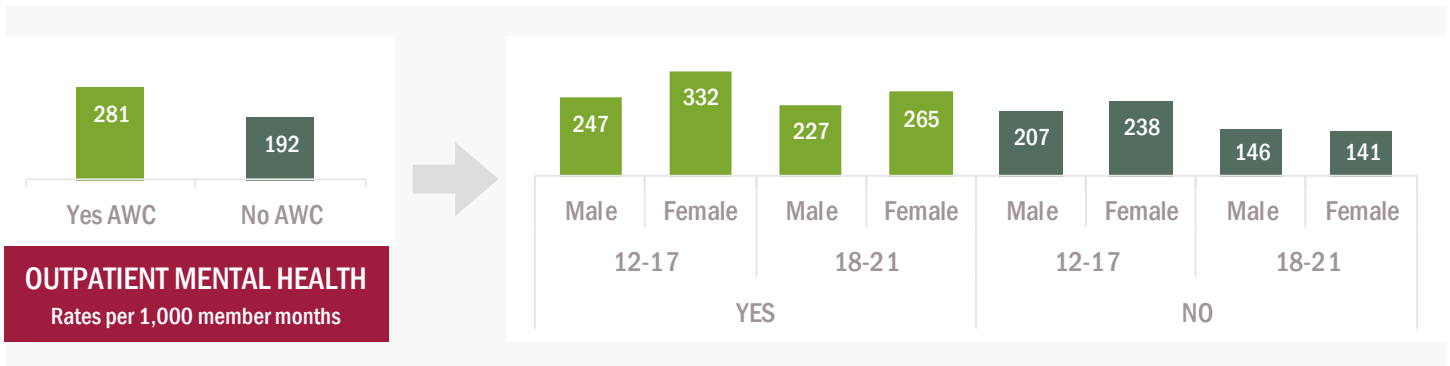
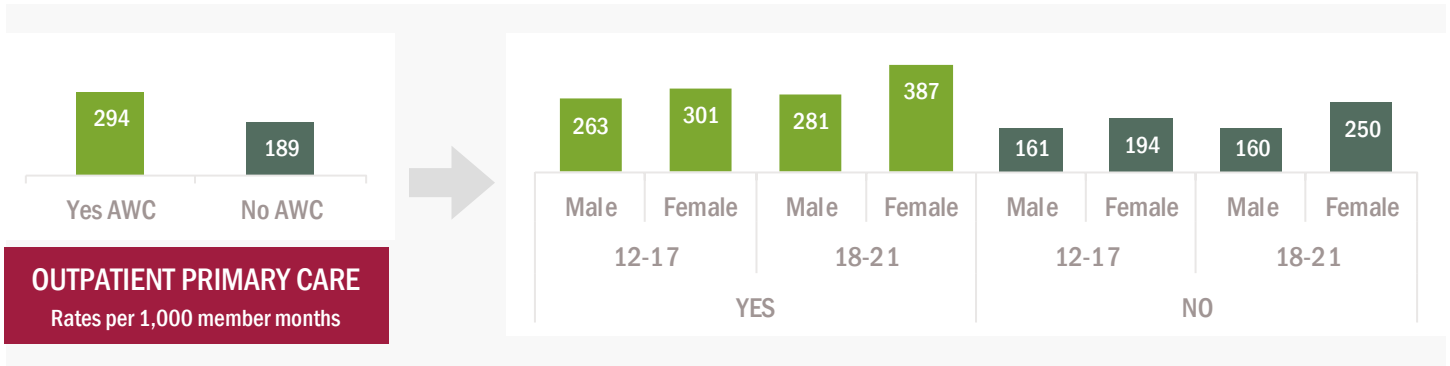


This pattern of older adolescent males showing higher utilization in intensive care settings raises a “chicken or egg” question: Are young men who receive these specialized treatment services not getting general well-care visits because they have these specialized health care needs? Or do they need specialized care services as a result of having missed their general medical visits, i.e., their primary care doctor did not have the opportunity to provide the supportive medical treatments that might have avoided the more intensive needs?

Identifying this population of young males as early as possible would be helpful for interpreting these types of patterns. CCOs that see a similar pattern among their own members might consider looking back a few years to see if these individual members missed AWC visits in the year or years before entering intensive care.

Deeper Dive Topic: Adolescent Well-Care Visits

When compared with those who **did have an adolescent well-visit**, those who **did not have a visit but had some other type of health care utilization** are **LOWER** in....



Deeper Dive Topic: Effective Contraceptive Use

Why dive deeper?

For women between the ages of 15 and 50, reproductive health care is an essential part of their overall health care. For many women, reproductive health concerns are the only reason they seek routine medical care. The average American woman who wants two children spends three to five years trying to conceive, being pregnant, postpartum and breastfeeding, and three decades trying to avoid pregnancy. Nationally, among women ages 19 years and younger, more than 4 out of 5 pregnancies were unintended.

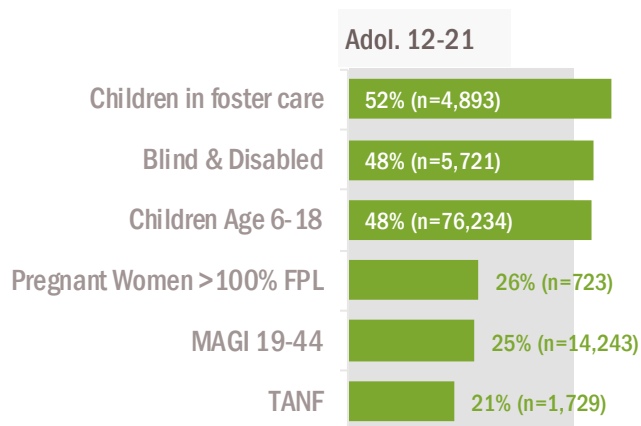
Effective contraceptive use for adults ages 18-50 has been a CCO incentive measure since 2015, and CCOs have shown steady improvement. Beginning in 2018, adolescents 15-17 will also be included in the incentive measure (adolescents were previously reported separately, but not incentivized).

By drilling down into the data and slicing out various subgroups, we hope to provide CCOs with ideas for further analysis into their own data and develop strategies for quality improvement. Specifically, this analysis looks at effective contraceptive use together with adolescent well-visits to help reveal areas where quality improvement in these areas might cross over.

The charts below show **adolescent well-visits** and **effective contraceptive use** by rate group, which are broad categories of Medicaid eligibility (i.e., the reason a person is eligible to receive Medicaid coverage).

Adolescent well-visits by rate group

Light grey bars represent AWC statewide average



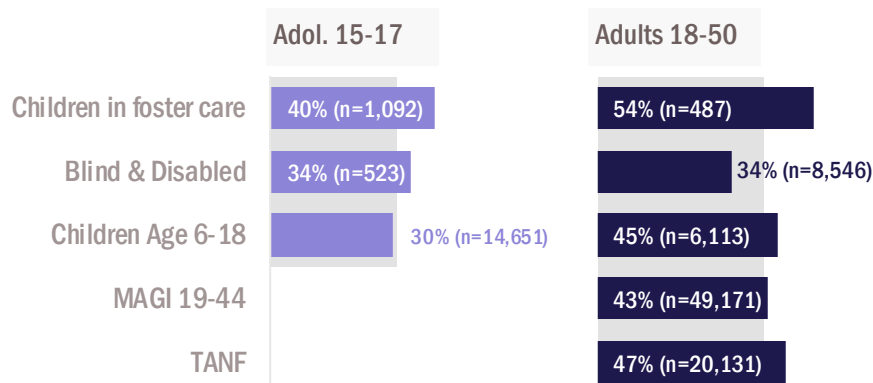
MAGI: Modified Adjusted Gross Income
TANF: Temporary Assistance for Needy Families

Adolescent well-care visits are especially low among:

- Pregnant young women (as seen also in on page 18)
- Young adults (19-21) who have Medicaid because of the ACA expansion (that's MAGI), and
- Low-income adults with children (TANF)

Effective contraceptive use by rate group

Grey bars represent ECU statewide average for each age group



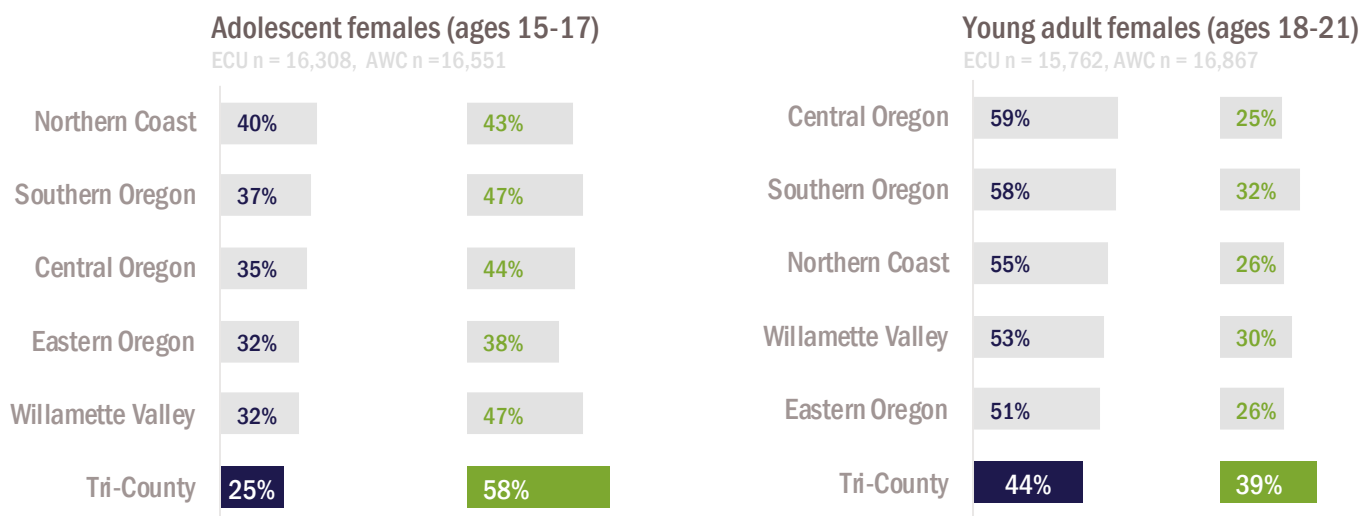
While effective contraceptive use shows less stark variation by eligibility category, rates are lower among adults receiving Medicaid because of blindness or disability. Meanwhile, adolescents in that eligibility group receive ECU at higher rates than the statewide average.

Deeper Dive Topic: Effective Contraceptive Use

At the individual level, having an adolescent well-visit is statistically correlated with having effective contraceptive use (correlation is significant at the .01 level). This makes sense, as well-visits with a doctor present an opportunity to talk about family planning and ensure effective contraceptives are prescribed for women who aren't trying to conceive.

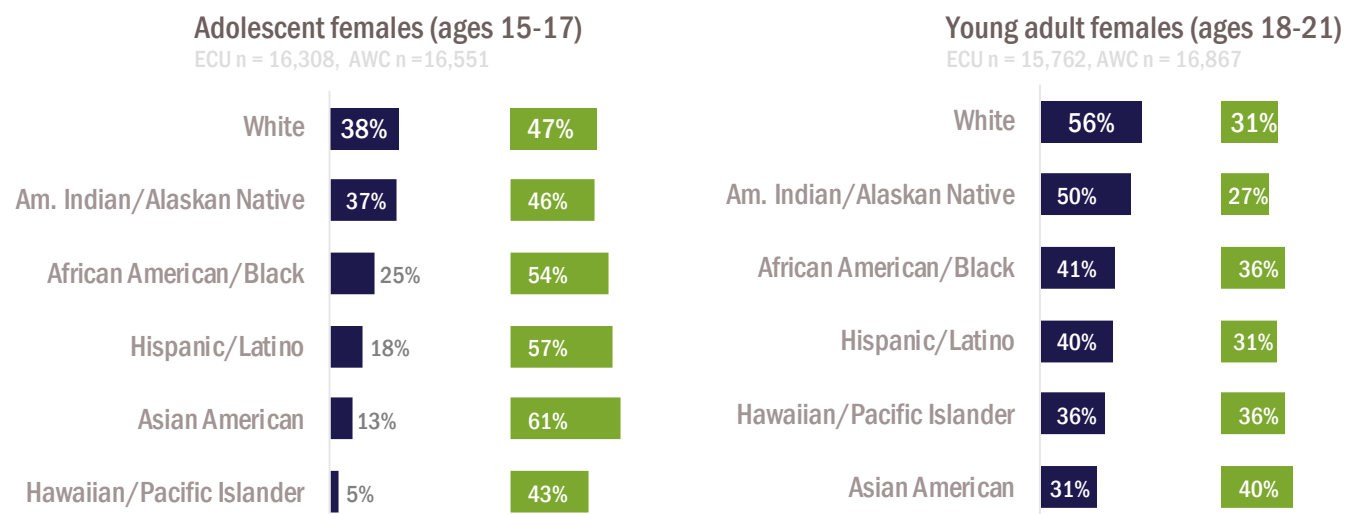
However when we compare adolescent well-care rates versus effective contraceptive rates among women at the regional level, an interesting pattern emerges: The tri-county metro area is highest in adolescent well-care visits, yet lowest in effective contraceptive use. This pattern is true among both adolescents ages 15-17 and young adults 18-21. (See Appendix B to see which counties are included in the regions below).

Effective contraceptive use and adolescent well-care visits among females, by geographic region.



Stratifying effective contraceptive use and adolescent well-care visits by race and ethnicity reveals that Asian American and Hawaiian Pacific Islander members have lower rates of effective contraceptive use. Interestingly, Asian American members have the highest adolescent-well care rates, suggesting that having an adolescent well-visit does not relate to meeting the ECU metric for this demographic.

Effective contraceptive use and adolescent well-care visits among females, by race and ethnicity.

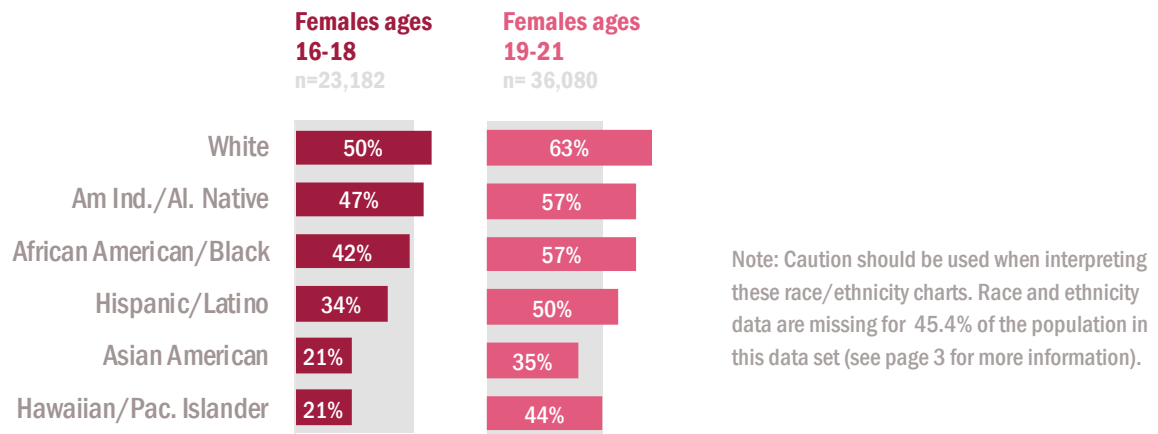


Deeper Dive Topic: Effective Contraceptive Use

Looking at some different data sets may help contribute to this picture:

The charts below show the percent of members who are sexually active according to administrative claims data, i.e. women who had claims for pregnancy, pregnancy tests, or contraceptives that indicated sexual activity. While not a complete picture, it might reveal potential areas for CCOs to do further analysis.

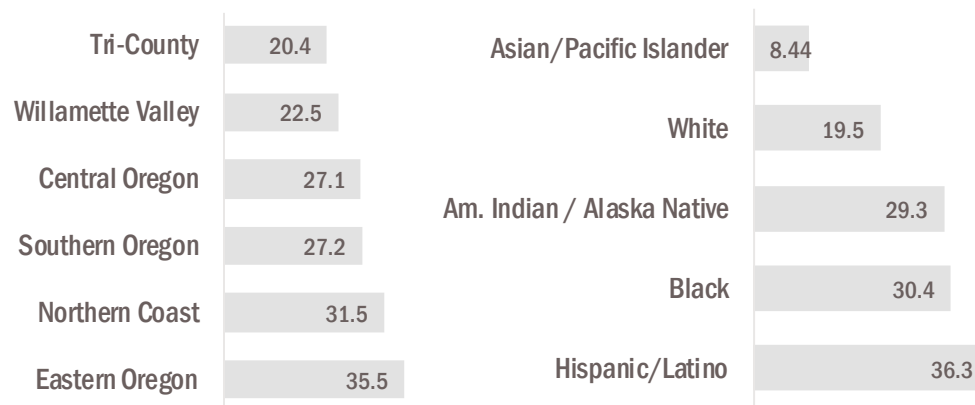
Percent of members identified as sexually active using administrative claims*, by race/ethnicity.
Grey area represents statewide average.



*The method uses the denominator in HEDIS Chlamydia Screening in Women measure which identifies sexual active members using claims, compared to total number of females who were continuously enrolled.

We can also consider Vital Statistics data, which include all Oregon women, not just those enrolled in CCOs. Here, we see that the Tri-County area had the lowest rate of teen pregnancy in the state in 2016. When stratified by race and ethnicity, Asian/Pacific Islander women had the lowest rate of teen pregnancy, and Hispanic/Latino women the highest.

Teen pregnancy rates (ages 15-19) by race/ethnicity and by geographic region.
Per 1,000 females. Source: Vital Statistics



See Appendix B for maps showing which Oregon counties are included in each region, as well as the race and ethnicity make up of Medicaid members each region.

Deeper Dive Topic: Emergency Department Utilization

Why dive deeper?

Emergency departments (EDs) are sometimes used for problems that could have been treated at a doctor's office or urgent care clinic. Reducing inappropriate emergency department use can help to save costs and improve the health care experience for patients. Emergency department utilization has been a CCO incentive measure since the beginning of the pay-for-performance program in 2013. Rates declined steadily in the first few years (25 percent reduction between 2011 and 2015) and appear to be leveling off, with 46.5 visits per 1,000 member months in mid-2017. Lower is better on this metric.

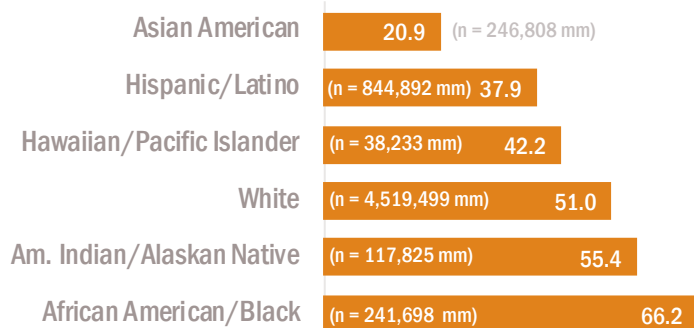
Beginning in 2018, a new measure addressing disparities will be incentivized: Emergency department utilization among CCO members experiencing mental illness. Medicaid members with severe and persistent mental illness have higher rates of preventable health conditions and higher rates of ED utilization. Improved coordination between physical and mental health care is a cornerstone of health system transformation.

Emergency department utilization among members experiencing mental illness is a new Transformation Center focus area.

While the data used in this report define mental illness as "severe and persistent" (SPMI), it's important to note that this definition includes a broader set of mental health conditions than is traditionally considered SPMI. Detailed measure specifications are available online at: <http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx>.

Emergency department utilization varies by race and ethnicity, with rates among African American members more than triple that of Asian American members.

(Rates are shown per 1,000 member months)

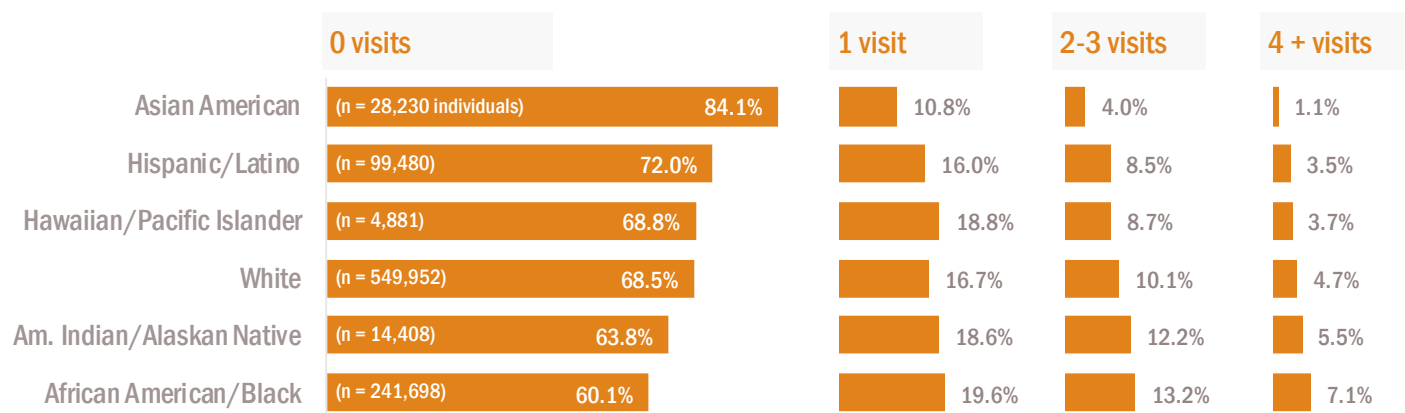


To help dive deeper, we look at members who are continuously enrolled during the measurement period, and stratify them by the percent of members who had:

- ✓ 0 visits;
- ✓ 1 visit;
- ✓ 2-3 visits; and
- ✓ 4 or more visits

Note: Caution should be used when interpreting these race/ethnicity charts. Race and ethnicity data are missing for 38.9% of the population in these data (see page 3 for more information).

Utilization patterns by race and ethnicity



Deeper Dive Topic: Emergency Department Utilization

Utilization patterns, by age and gender.

	0 visits	1 visit	2-3 visits	4 + visits
19-25 yrs.	MALE (n = 54,573) 76%	15%	7%	2%
	FEMALE (n = 67,944) 65%	18%	12%	5%
26-64 yrs.	(n = 253,525) 73%	15%	9%	4%
	(n = 291,173) 67%	17%	11%	5%
65+ yrs.	(n = 19,604) 72%	16%	9%	3%
	(n = 33,893) 68%	18%	10%	4%

Females ages 19-25 have an overall ED rate of **66.1** per 1,000 mm. By comparison, males in this same age range use the ED at just 37.4 per 1,000 mm.

Why are members visiting the emergency department?

Top conditions* for emergency department visits among adult CCO members

Rank	% of visits	Adults WITHOUT mental illness diagnoses	Adults WITH mental illness diagnoses	% of visits	Rank
1	7%	Abdominal pain	Abdominal pain	7%	1
2	5%	Skin and subcutaneous tissue infections	Nonspecific chest pain	5%	2
3	5%	Sprains and strains	Spondylosis; disc disorders; other back problems	4%	3
4	4%	Nonspecific chest pain	Headache; including migraine	4%	4
5	4%	Spondylosis; disc disorders; other back problems	Sprains and strains	4%	5
6	4%	Superficial injury; contusion	Skin and subcutaneous tissue infections	4%	6
7	4%	Other upper respiratory infections	Superficial injury; contusion	4%	7
8	3%	Disorders of teeth and jaw	Alcohol-related disorders	3%	8
9	3%	Headache; including migraine	Other upper respiratory infections	3%	9
10	3%	Urinary tract infections	Urinary tract infections	3%	10
11	3%	Open wounds of extremities	Other connective tissue disease	2%	11
12	2%	Other connective tissue disease	Disorders of teeth and jaw	2%	12
13	2%	Other non-traumatic joint disorders	Nausea and vomiting	2%	13
14	2%	Nausea and vomiting	Other non-traumatic joint disorders	2%	14
15	2%	Other injuries and cond. due to external causes	Substance-related disorders	2%	15
16	2%	Other lower respiratory disease	Other nervous system disorders	2%	16
17	2%	COPD and bronchiectasis	COPD and bronchiectasis	2%	17
18	1%	Other nervous system disorders	Open wounds of extremities	2%	18
19	1%	Alcohol-related disorders	Other injuries and cond. due to external causes	2%	19
20	1%	Other gastrointestinal disorders	Residual codes; unclassified	2%	20

*Categorization based on HCUP CCS; see next page for more information.

Deeper Dive Topic: Emergency Department Utilization

When comparing the **top 20 diagnoses among members with severe and persistent illness by CCO**, there is little overall variation. However, many CCOs have diagnoses in their top 20 that differ from the statewide top 20, including:

Suicide and intentional self-injury

Statewide among members with severe persistent mental illness (SPMI), this diagnosis ranks #22. However, in some CCOs the diagnosis ranks as high as #13, making up 2.6 percent of all ED visits. Statewide among members without SPMI, suicide and intentional self-injury ranks just #175 among all diagnoses and makes up 0.1 percent of ED visits.

Substance use disorders

Statewide among members with SPMI, substance use disorder ranks #15 among reasons for an ED visit and makes up 3 percent of all ED visits, but in one CCO substance use disorder ranks just #47 and makes up just 0.4 percent of total visits.

Note that while visits for mental health and alcohol or other drug use reasons are *excluded* from the incentive measure (both the overall ED utilization as well as the disparity measure), we have included visits for all reasons in this analysis.

Diving a little bit deeper, we can compare top diagnoses among members with severe and persistent mental illness by gender:

Top conditions* for emergency department visits among adult CCO members with SPMI

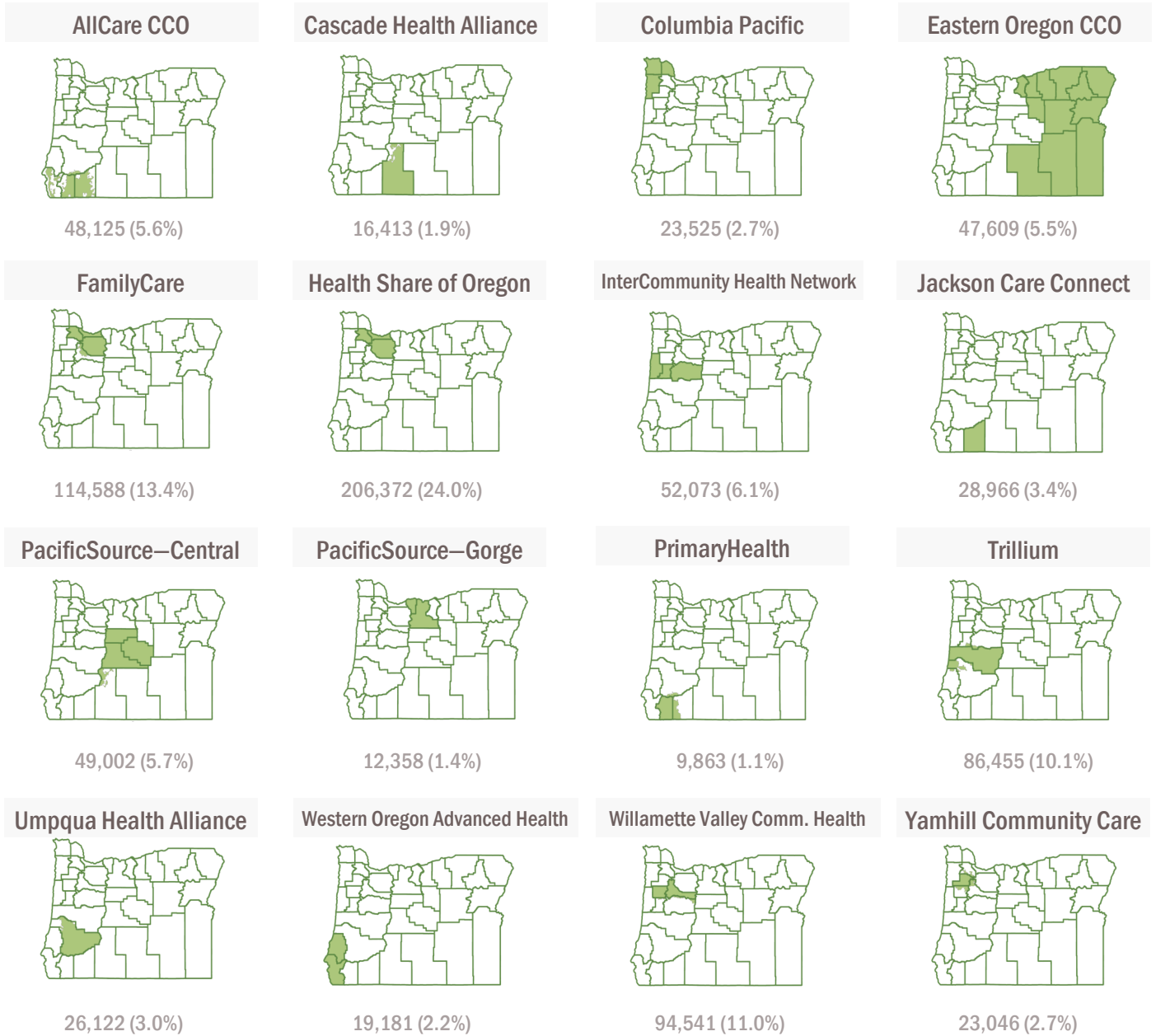
Rank	% of visits	Females	Males	% of visits	Rank
1	9%	Abdominal pain	Nonspecific chest pain	5%	1
2	5%	Headache; including migraine	Alcohol-related disorders	5%	2
3	5%	Spondylosis; disc disorders; other back problems	Skin and subcutaneous tissue infections	5%	3
4	4%	Nonspecific chest pain	Abdominal pain	5%	4
5	4%	Sprains and strains	Superficial injury; contusion	4%	5
6	4%	Superficial injury; contusion	Spondylosis; disc disorders; other back problems	4%	6
7	4%	Urinary tract infections	Sprains and strains	4%	7
8	4%	Skin and subcutaneous tissue infections	Substance-related disorders	3%	8
9	3%	Other upper respiratory infections	Headache; including migraine	3%	9
10	2%	Nausea and vomiting	Other connective tissue disease	2%	10

Among females, alcohol-related disorders ranks #16 (making up 1.8 percent of all visits) and substance-related disorders ranks #22 (1.3 percent of all visits).

*Categorization is based on HCUP, Clinical Classifications Software (CCS) ([link](#)). Note that these tables are based on *only the primary diagnosis* of each emergency department facility claim. Patients may have different chief complaints for the visit, or competing priorities.

Appendix A: CCO Service Areas

The maps below show CCO service area boundaries, overlaid county lines. Numbers below are total CCO enrollment as of June 2017, followed by percent of total CCO population in parentheses.

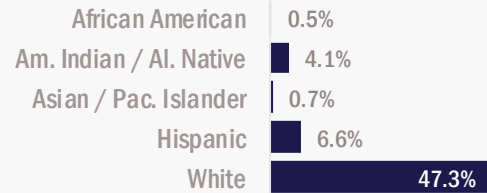
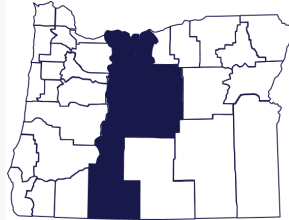


Appendix B: Region Maps and Demographics

Some analyses in this report use geographic regions as outlined below. Demographic makeup of Medicaid members for each region are shown at right. Note: Caution should be used when interpreting the race/ethnicity charts. Race and ethnicity data are missing for approximately 40% of respondents of the population in this data set (see page 3 for more information).

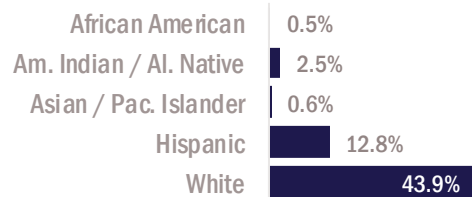
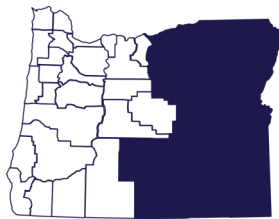
Central Oregon

Crook, Deschutes, Hood River, Jefferson, Klamath, Sherman, Wasco, Wheeler



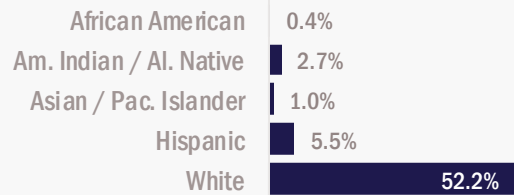
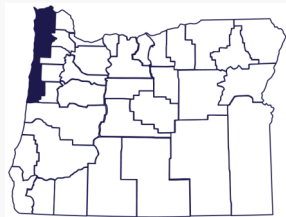
Eastern Oregon

Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Union, Wallowa



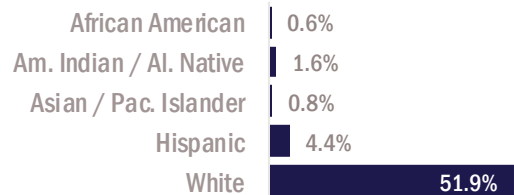
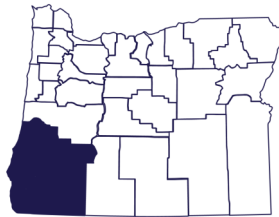
North Coast

Clatsop, Lincoln, Tillamook



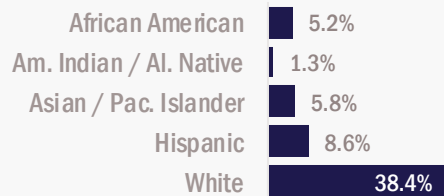
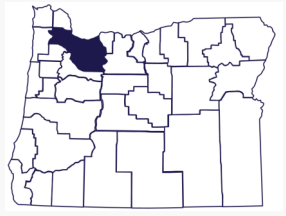
Southern Oregon

Coos, Curry, Douglas, Jackson, Josephine



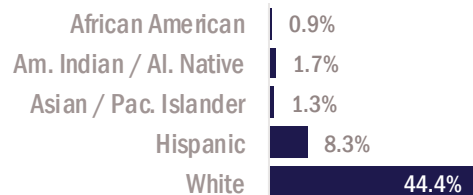
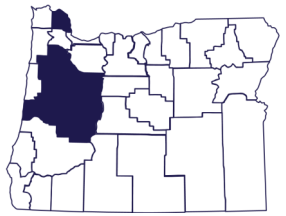
Tri-County

Clackamas, Multnomah, Washington



Willamette Valley

Benton, Columbia, Lane, Linn, Marion, Polk, Yamhill



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OHADirectorsOffice@state.or.us.**