Metrics & Scoring Committee

November 20, 2020

To provide verbal public comment send a ZOOM chat message to meeting host Brian Toups, or text 971.304.6236 and request public comment.

Please do not submit written public comment through the ZOOM chat; we will unmute you when it is your turn to speak. Guidance on submitting public testimony is here: https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/testimony-guidelines.pdf

Oregon Health Authority

Today's Agenda

- ✓Welcome & consent agenda
- ✓Public testimony
- ✓Preventive dental measure specifications
- ✓Update and Committee input on two developmental measures:
  - ✓Social determinants of health (health related social needs)
  - ✓Health aspects of kindergarten readiness strategy, social-emotional health of young children measure development
- ✓Changing measure landscape: national and local context

Please note this meeting is being recorded. The recording will be made available on the Committee's webpage:
http://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx

Approve September Minutes

Acknowledge Consent Agenda Items (slides 4-6)

Questions?

Health Plan Quality Metrics Committee
November 2020 Updates

- At the November meeting, the Oregon Health Policy Board approved a proposal to stagger HPQMC membership over the next three years and to reconvene meetings **between now and April 2021** with the existing member roster.

<u>New membership structure</u>

- All newly appointed members will serve one term of 3 years.
- Current members will continue serving for 1 or 2 more years until either April 2022 or April 2023. This will set the stage for a staggered membership transition so that no more than 5 members will transition in any one year.
- All member terms will run from May to April.

- Beginning in January 2021, the Committee will meet on the 4th Tuesday of every month, from 1pm to 3pm.

FUTURE PLANNING

Measures being developed at request of Metrics & Scoring Committee by earliest date available for inclusion in program

Measure	Earliest Possible Implementation Dates	
	2022	2023
Revised multi-sector interventions to address obesity measure		
Kindergarten readiness strategy measure: Improving the social emotional health of children		
Kindergarten readiness strategy measure: Follow-up to developmental screening		
Social determinants of health (individual health related social needs screening)		

Standing Reminder / Center for Work: Definition Adopted by Oregon Health Policy Board and OHA

Health Equity 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, 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.

Public testimony

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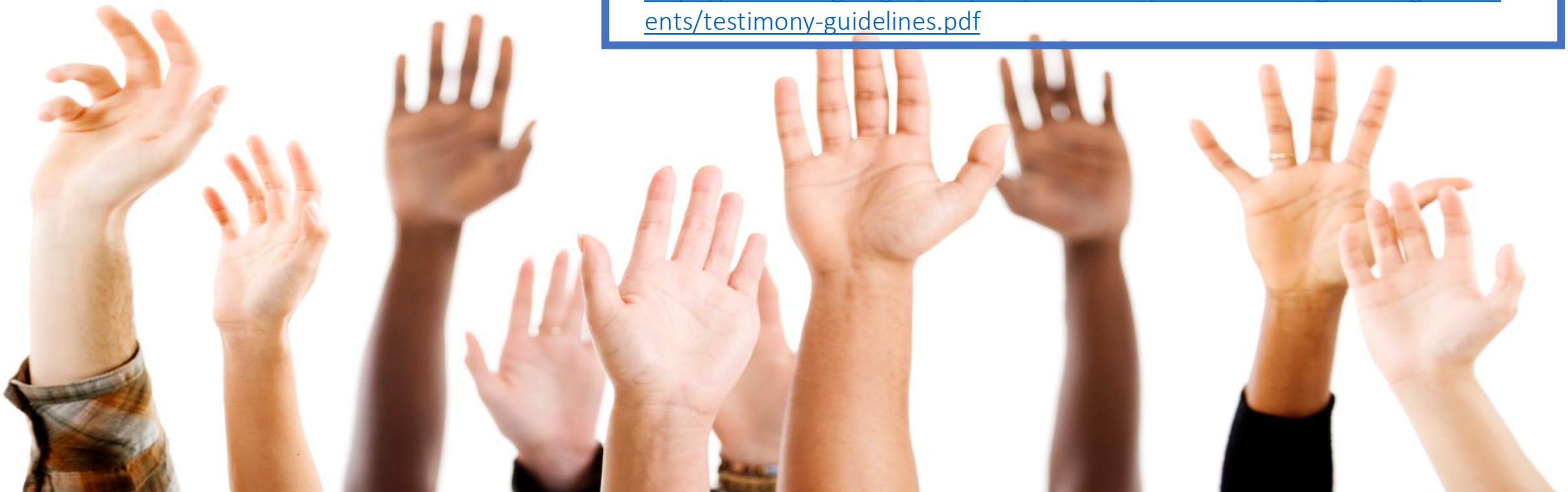


Health Aspects of Kindergarten Readiness

CCO System-Level Social-Emotional Health Metric: Measure Development Progress and Next Steps

For Metrics and Scoring Committee
November 20, 2020

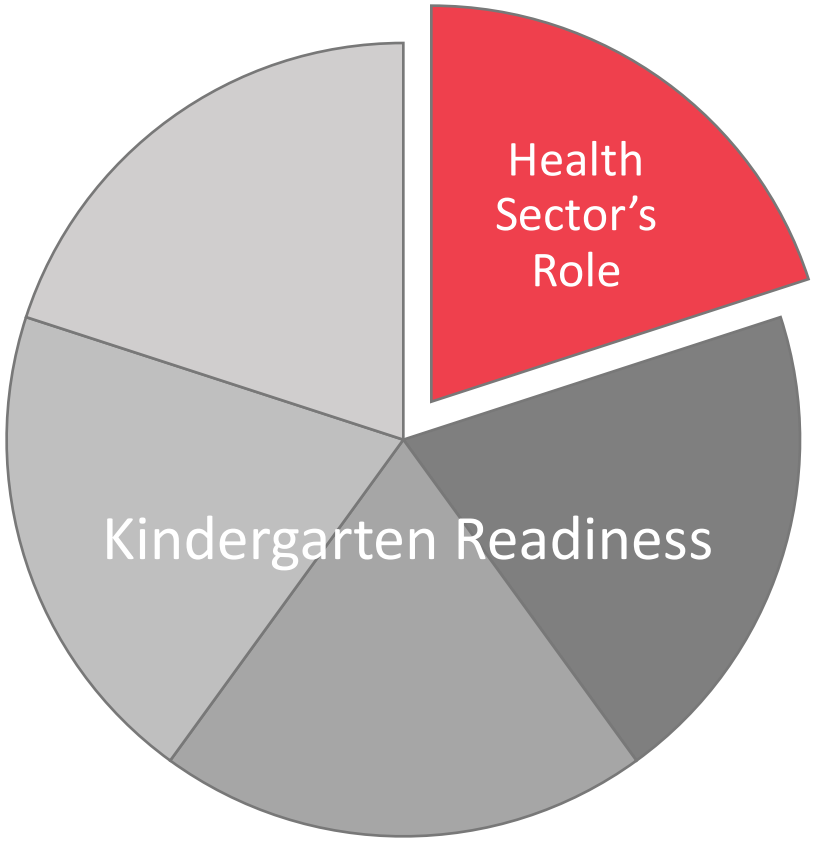
Dana Hargunani, MD, MPH, Oregon Health Authority
Colleen Reuland, MS, Oregon Pediatric Improvement Partnership
Elena Rivera, MPH, Children's Institute

Agenda

1. Refresher: Where We've Been, Committee's Previous Endorsement of Health Aspects of Kindergarten Readiness Recommendations
2. Update: CCO System-Level Metric Addressing Children's Social-Emotional Health
   - ➢Measure Development Progress
   - ➢How the Metric Works
   - ➢First Look at Testing Data
3. Moving Forward: Next Steps, Input Needed to Move this Metric Forward for Your Consideration in Spring 2021

Where We've Been

Oregon is leading innovative work to explore the health sector's role in children's kindergarten readiness



Health Aspects of Kindergarten Readiness Measurement Strategy Proposal

Stratification and reporting of metrics to examine disparities and for CYSHCN

Preventive Dental Visits for Children 1-5

- Data source: Claims.
- HAKR domain: Promotion/prevention.
- Mean score on HAKR measure criteria: 10.8 (out of 13)

Well-Child Visits for Children 3-6

- Data source: Claims.
- HAKR domain: Promotion/prevention.
- Mean score on HAKR measure criteria: 8.62 (out of 13)

CCO-Level Metric Focused on Social-Emotional Health

(To be developed)

- Data and information provided by the CCO.
- HAKR domain: Promotion/prevention, Follow-up, and CCO cross-sector collaboration.

Potential components:

- Screen for and identify factors that impact social-emotional health.
- Assess capacity and utilization of behavioral health services.
- Address policies and payment for behavioral health services.

Follow-Up to Developmental Screening*

(Existing practice-level metric to be adapted for a CCO metric; proposed to replace developmental screening metric)

- Data source: EHR.
- HAKR domain: Follow-up.
- Mean score on HAKR measure criteria: 11.5 (out of 13).

CCO-Level Metric Drives Toward a Child-Level Metric to Replace It

(Future) Child-Level Metric Focused on Social-Emotional Health

(To be developed, informed by CCO-level metric)

Potential examples:

- Screening for social-emotional health.
- Screening for social determinants of health and family factors impacting social-emotional health.
- Preventive care bundled metric.
- Dyadic behavioral health services for children 0–6.
- Metric(s) for children and youth with special health care needs.

GOAL

Health system behavior change, investments, and cross-sector efforts that contribute to improved kindergarten readiness.

Estimated Year Metrics Ready for Implementation

2020 → 2022 → 2022 / 2023 → TDB

Successes to date

- Strong support for the HAKR measurement strategy from the Metrics and Scoring Committee and Health Plan Quality Metrics Committee.
- First two recommended metrics were adopted for 2020 incentive measure set and are current CCO incentive metrics.
- Development underway for the third and fourth recommended metrics, which address gaps in priority cross-sector topic areas.
- Funding secured to support development of new measures, including from national funders interested in the implications of this work for other states.
- Ongoing national interest, including discussions with multiple states and national experts and conference presentations.

Thank you for your support!

Health Aspects of Kindergarten Readiness Measurement Strategy Proposal

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CCO-Level Metric Drives Toward a Child-Level Metric to Replace It

(Future) Child-Level Metric Focused on Social-Emotional Health

(To be developed, informed by CCO-level metric)

Potential examples:

- Screening for social-emotional health.
- [illegible] or so[illegible] [illegible]s of [illegible] and family factors impacting social-emotional health.
- Preventive care bundled metric.
- Dyadic behavioral health services for children 0–6.
- Metric(s) for children and youth with special health care needs.

GOAL

Health system behavior change, investments, and [illegible]ss-sector efforts [illegible]ntribute to improved kindergarten readiness.

We are here.

Estimated Year Metrics Ready for Implementation

2020 | 2022 | 2022 / 2023 | TDB

Why focus on children's social-emotional health?

- **Families** identified social-emotional health as the most important contributor to kindergarten readiness and an area they need the most support on.
- High priority for **Health Aspects of Kindergarten Readiness Technical Workgroup** members and stakeholders they engaged.
- Clear **role for the health system** and many health system barriers identified.
- Persistent **lack of social emotional supports for children with needs** despite CCO focus on integration of services, Patient Centered Primary Care Home efforts, and other community-based efforts focused on young children.
- Enhanced need and urgency for the metric given **COVID-19 and response impacts** on young children during a critical period of brain development.

Social Complexity Data for Publicly Ensured Children Birth to Five Shows High Need

Social Complexity Indicators **For data sources, see data dictionary*
Poverty –TANF (For Child and For Either/Both Parent), Below 37% of Poverty Level
Foster care – Child received foster care services
Parent death – Death of parent/primary caregiver in OR
Parental incarceration – Parent incarcerated or supervised by the Dept. of Corrections in Oregon
Mental Health: Child – Received mental health services through DHS/OHA
Mental Health: Parent – Received mental health services through DHS/OHA
Substance Abuse: Child – Substance abuse treatment through DHS/OHA
Substance Abuse: Parent – Substance abuse treatment through DHS/OHA
Child abuse/neglect: ICD-9, ICD-10 dx codes related used by provider
Potential Language Barrier: Language other than English listed in the primary language field
Parent Disability: Parent is eligible for Medicaid due to recognized disability

Number of Social Complexity Indicators	Children Ages 0-5 N= 140,086
0	**32.6%** (45,627)
1	**25.5%** (35,786)
2	**15.1%** (21,090)
3 or More	**26.8%** (37,583)

Population: Children Medicaid/CHIP insured in Oregon as of July 2020.
Data Source: ICS and Medicaid /CHIP data sourced from All Payer All Claims database

Alignment with State and National Priorities

- **Children's health, behavioral health, and health equity** are priorities of the Governor, the Oregon Health Policy Board, and the Oregon Health Authority (OHA).
- OHA is focused on addressing the findings in the **Secretary of State's September 2020 audit**, "Chronic and Systemic Issues in Oregon's Mental Health Treatment System Leave Children and Their Families in Crisis".
- New **CCO Performance Improvement Project** on behavioral health
- **Raise Up Oregon** names school readiness and family support goals, including ensuring children are connected to social-emotional health services
- **Cross-sector health equity priorities**
  - Access to existing services are inequitable by region, race/ethnicity, tribal affiliation
  - Need for a focus on culturally and linguistically appropriate services
  - Need to address systemic racism and bias in treatment of children with behavioral needs in early care and education settings, in schools, and in health care settings
- **Updated Bright Futures recommendations** on addressing social-emotional health
- **Public Health priorities for child health and school readiness** (E.g., Healthy People 2020)

2020-21 Measure Development Progress

Metric Vision and Purpose

Vision:

Children from birth to age 5, and their families, have equitable access to services that support their social-emotional health and are the best match for their needs.

Purpose:

Drive CCOs to address complex system-level factors that impact the services kids and families receive and how they receive them, and for which there may be payment or policy barriers that need to be addressed.

Address gaps in existing CCO incentive metric set.

Activities:

Build capacity within CCOs for enhanced services, integration of services, cross-sector collaboration, and future measurement opportunities.

Use child-level data to guide and inform efforts, assess the sensitivity and specificity of the child-level metric to those efforts.

Gathered input on barriers to access and opportunities for supporting children's social-emotional health from **families** (n=87), **health care and early learning providers** (n=673), and **cross-system leaders** (n=228).

Generated **list of themes, focusing on outcomes desired**, not specific strategies. Affirmed themes with stakeholders.

Identified **priority CCO activities** that address barriers and can fit as components of a CCO system-level metric within the scope of the incentive measure program.

Used **design parameters** to **narrow activities and draft measure specifications**, with careful attention to the **levers in the metric and how they interact** to build on, but not duplicate, other CCO levers.

Created plan for **piloting the metric** and **started data analysis**.

Identified Barriers and Opportunities

- Lack of understanding of young children's social-emotional health and services to address needs
  - Within health care system
  - Within families and communities
- Limited service capacity, especially parent-child dyadic services
- Workforce needs, including skills and training to serve children 0-5 and cultural and linguistic diversity
- Limited familiarity with data on service and provider capacity
- Limited pathways to community-based services
- Barriers to access, including location of services, transportation, and child care
- Payment barriers

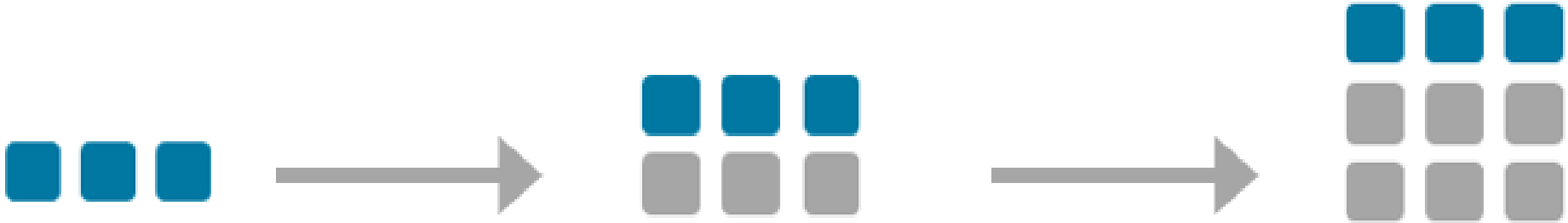
Design Parameters for CCO System-Level Metric

- Includes **varied components** that relate to **system-level** activities and use of **person-level data**
  - Ensure activities and attestation components line up to a child-level metric
- Set of items address **gaps in the current CCO Incentive metric set** and **sectors impacted**
- Set of items addresses the **continuum of services and supports** that address social-emotional health from prevention to treatment.
- Prioritizes efforts that **address integration of care and cross-sector** collaboration.
  - Includes a component of **community-level engagement** on the solutions, with a requirement to partner with early learning and leverage community advisory committees, including Early Learning Hub Parent Advisory Committees and CCO Community Advisory Councils.
- **Parsimonious** in number of components – prioritizes the most essential
- **Limited number** of items that would require auditing by OHA to ensure feasibility
- Ensure a focus on **health equity**

How the Metric Works

Creating a solid foundation for kindergarten readiness

> "I specifically went in to [child's provider] to say I need him to see a specialist because I don't know what to do at this point. I asked, "Who could you refer me to?" and they said, "We don't have anyone here and I don't really know anyone nearby." I just didn't know what to do at that point."



Year 1

- Use claims + utilization data to understand current access to behavioral health services for young children.
- Assess community assets that support social emotional health for young children.

Years 2-5

In later years CCOs will address the barriers identified in earlier years by attesting to specific interventions in areas such as:

- ✓ Community engagement
- ✓ Workforce
- ✓ Access
- ✓ Care coordination
- ✓ Payment

Future

Child-level metric focused on improving equitable access to social-emotional health services

Year 1: Building a data foundation by assessing current reach of services

- Child-level reach measure will capture a range of services provided across the spectrum of providers and to allow for innovative billing by early learning providers.
- Two components:
  - **Component A: Assessments**
  - **Component B: Services**
    - Services can be provided in an array of settings – integrated behavioral health, potentially home visiting, and in specialty mental health
- Built from review of other metrics (NCQA Mental Health Utilization Metric, Washington DSHS Mental Health Utilization Metric)
- Aligned with covered services and diagnosis in Oregon
  - Oregon's 0-5 diagnostic crosswalk
  - Integrated behavioral health in primary care: guidance used in improvement projects aligned with Primary Care Payment Reform Collaborative
  - Considered HERC prioritized list

Numerator: All members age 1-5 receiving a behavioral health assessment or service within the 12-month measurement year

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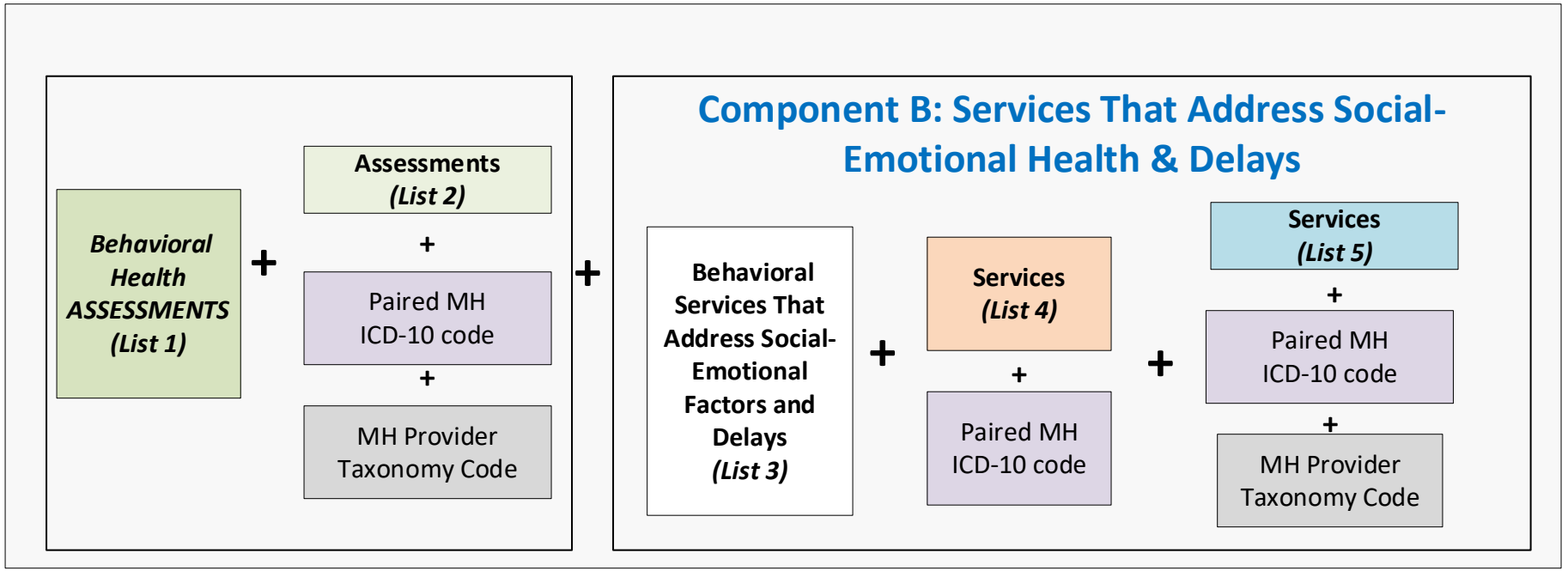
Denominator: All attributed Children ages 1-5 within the 12-month measurement year who meet a cont. enrollment requirement

=

REACH Percentage:
Proportion of attributed children age 1-5 who received an assessment (A) or services (B) in the last 12 months.



Version: 11-11-2020

Developed by Oregon Pediatric Improvement Partnership as part of the HAKR SE Metric Development in Partnership with Children's Institute and Oregon Health Authority.

Year 1: Building a data foundation by assessing community assets, gaps compared to data, family input

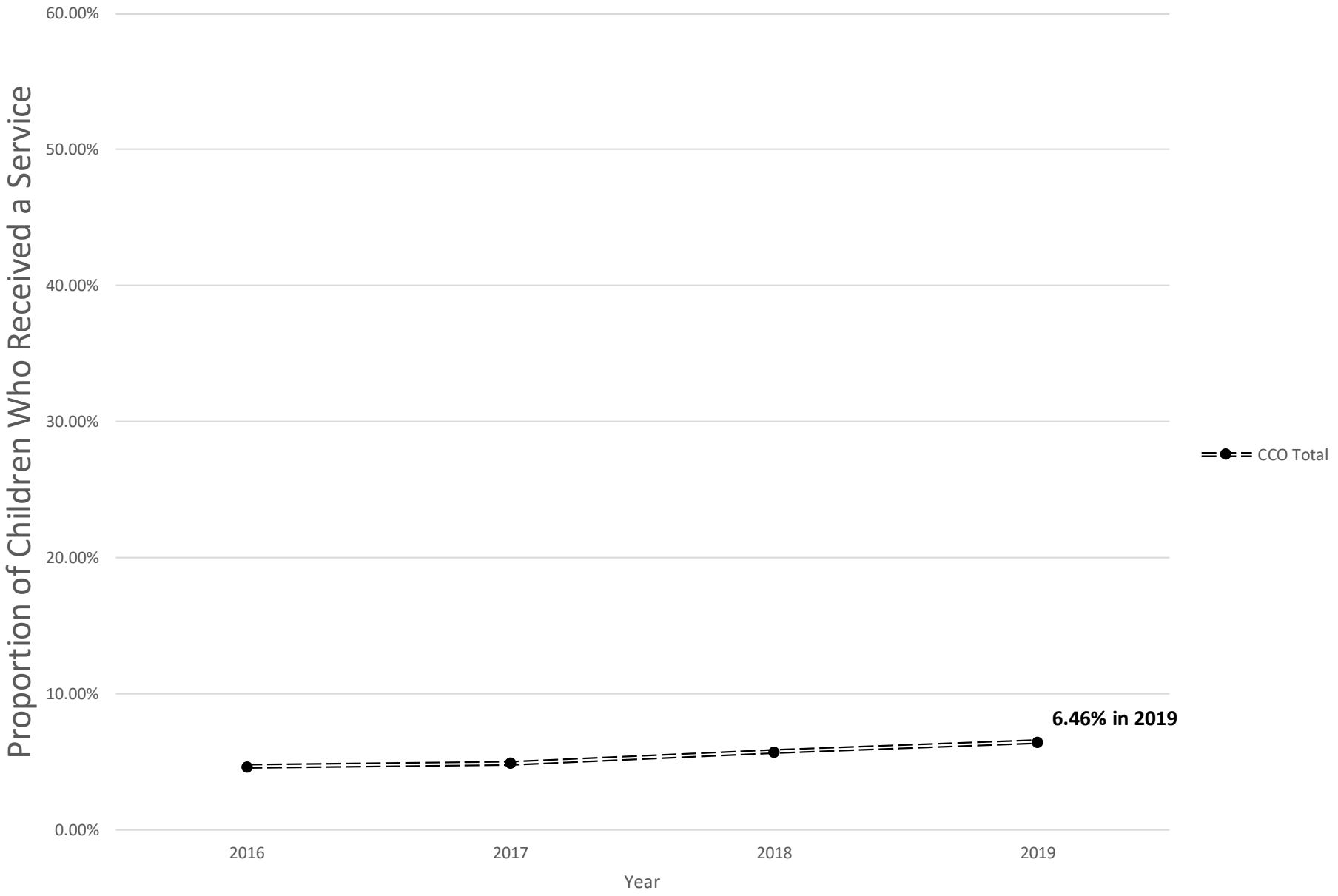
- Asset map will capture community resources and services that address social-emotional health. Will examine capacity by:
  - Setting (primary care, behavioral health, early learning, other community-based)
  - Staff who currently serve children birth to age 5
  - Race/ethnicity of providers
  - Languages spoken by providers
  - Location within the region
  - Service modality
  - Current capacity and availability (service slots available)
- Focus is on creating awareness of assets, building relationships across providers, and developing a plan to address gaps, especially for historically underserved children and families.
  - Requiring family engagement and partnership in development of community-driven solutions.
- Reach metric and health complexity data allow comparison of need vs. existing resources.
- Tools have been developed and tested by OPIP in multiple communities and will be refined.

Years 2-5: Building on data foundation to enhance capacity and services

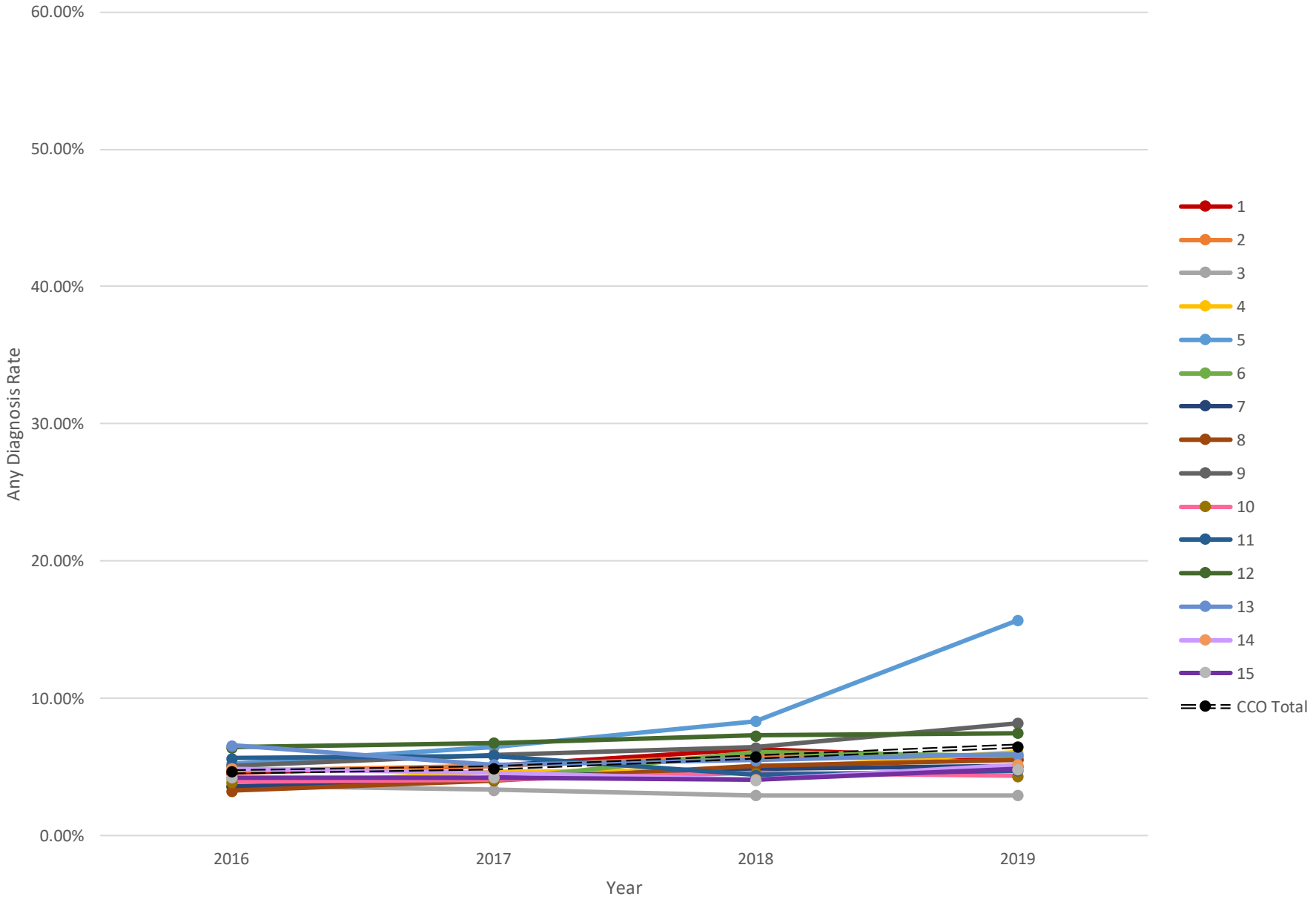
- Goal: Use multiple levers to address complex system barriers identified by stakeholders.
  - ✓Community engagement, including families and populations with inequitable outcomes
  - ✓Workforce, including a focus on diversity of workforce
  - ✓Access
  - ✓Care coordination
  - ✓Payment
- Addressing the barriers that families with young children who are most marginalized often experience = designing our system to produce equitable outcomes for children.
- Together, the levers in the metric will facilitate meaningful and transformative work within CCOs and extending out into communities.

First Look at Testing Data

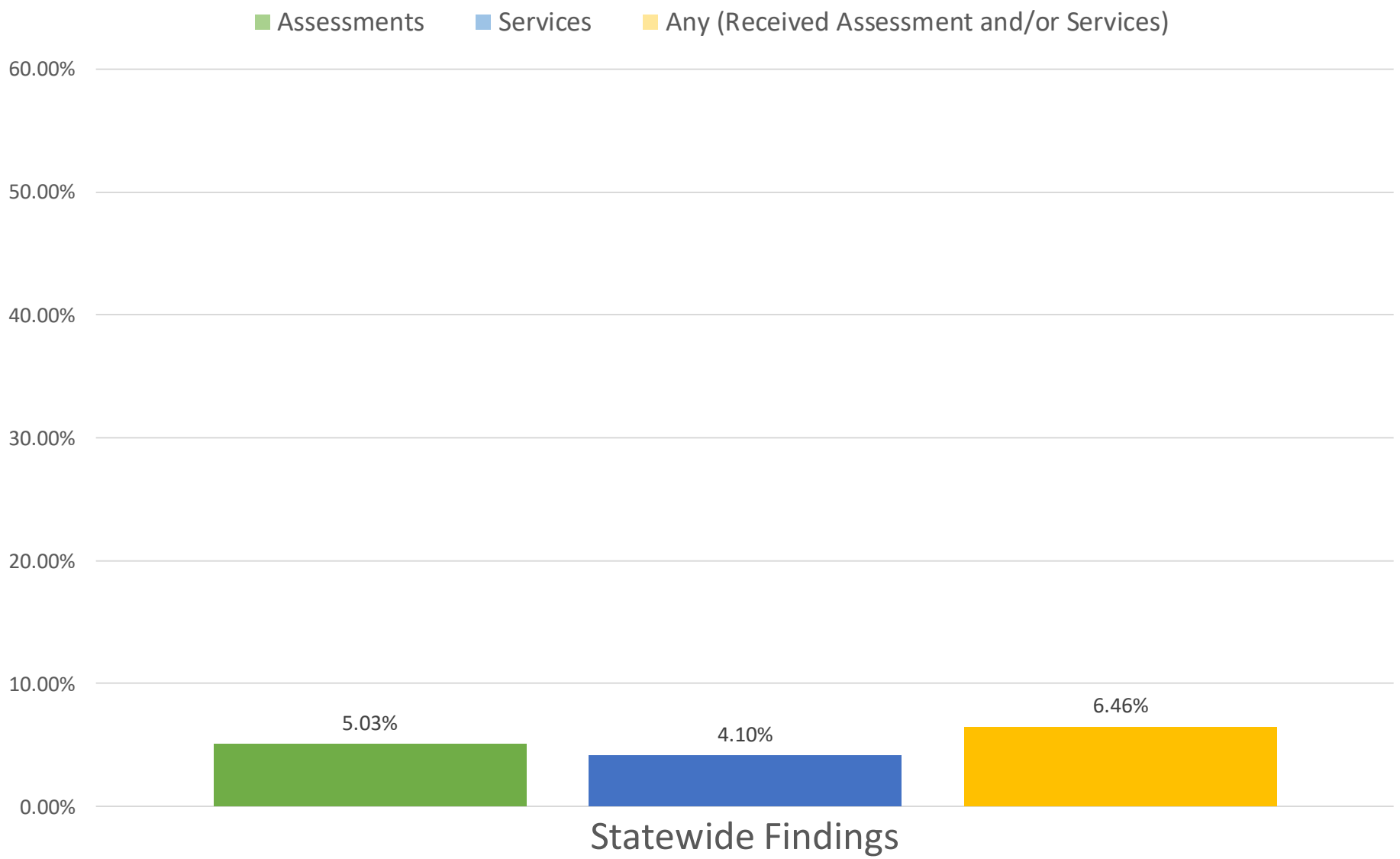
Statewide Reach Metric Findings



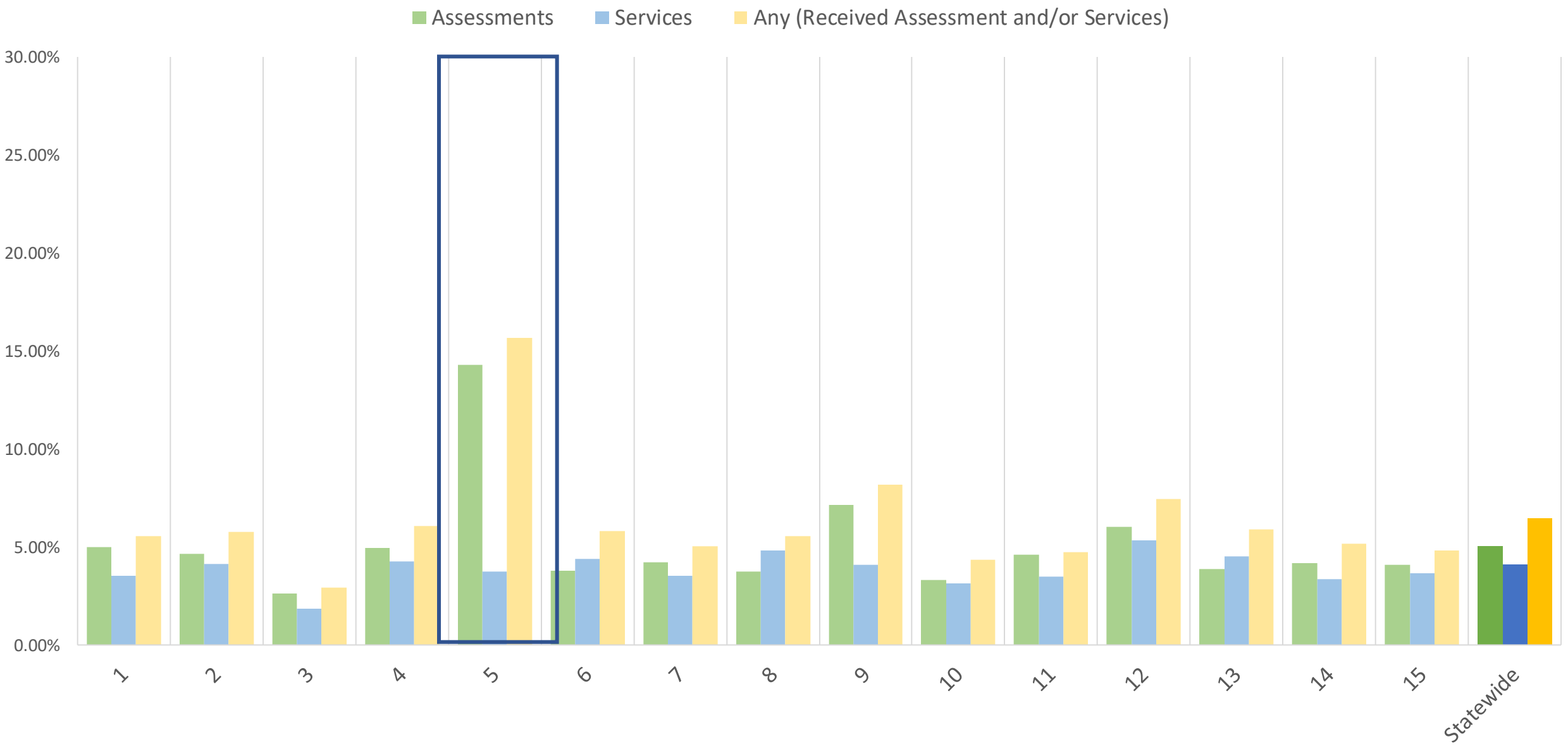
Reach Metric Findings by CCO Since 2016



2019 Rates:
Assessments vs. Services → Either

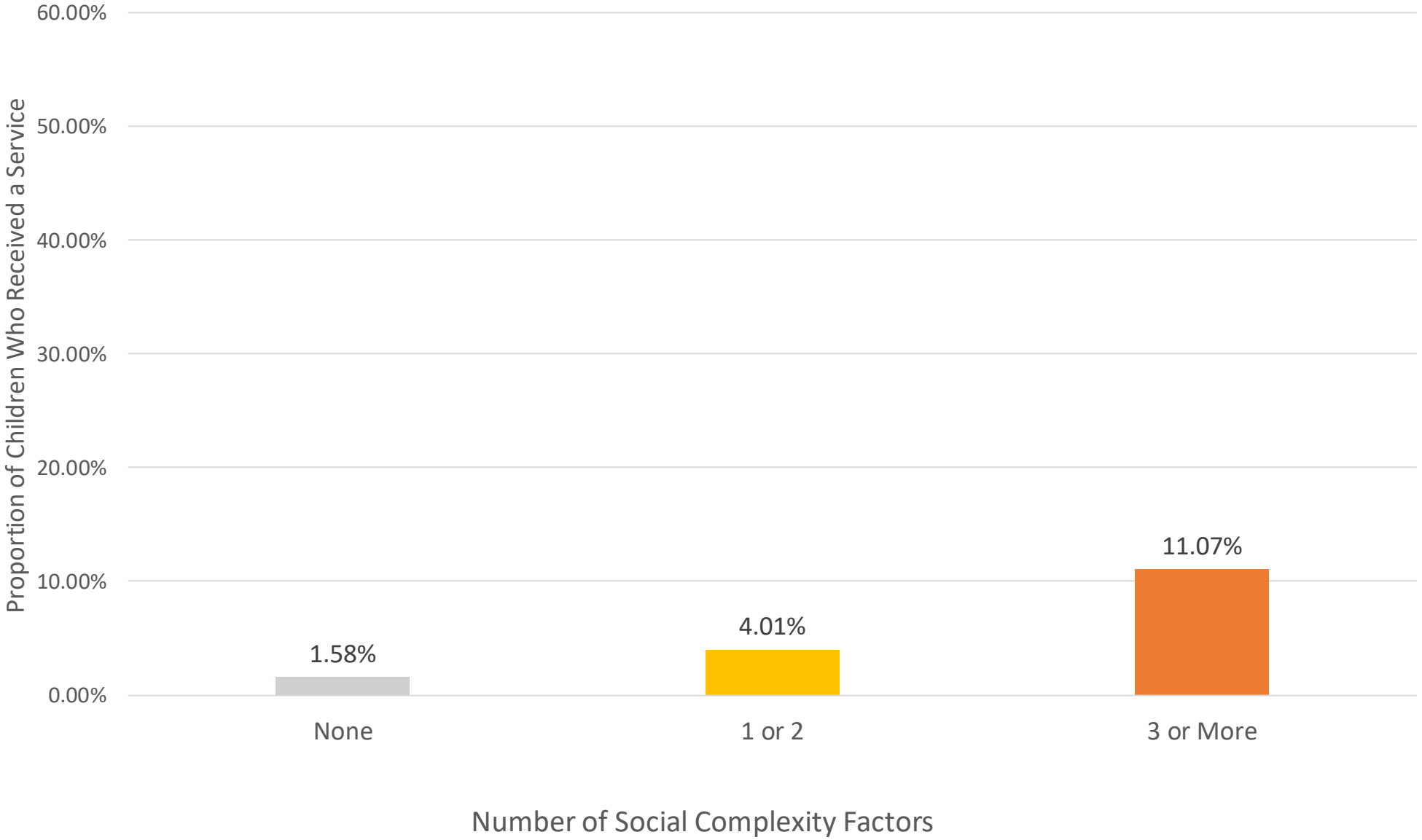


2019 Rates: Assessments vs. Services → Either By CCO and Statewide

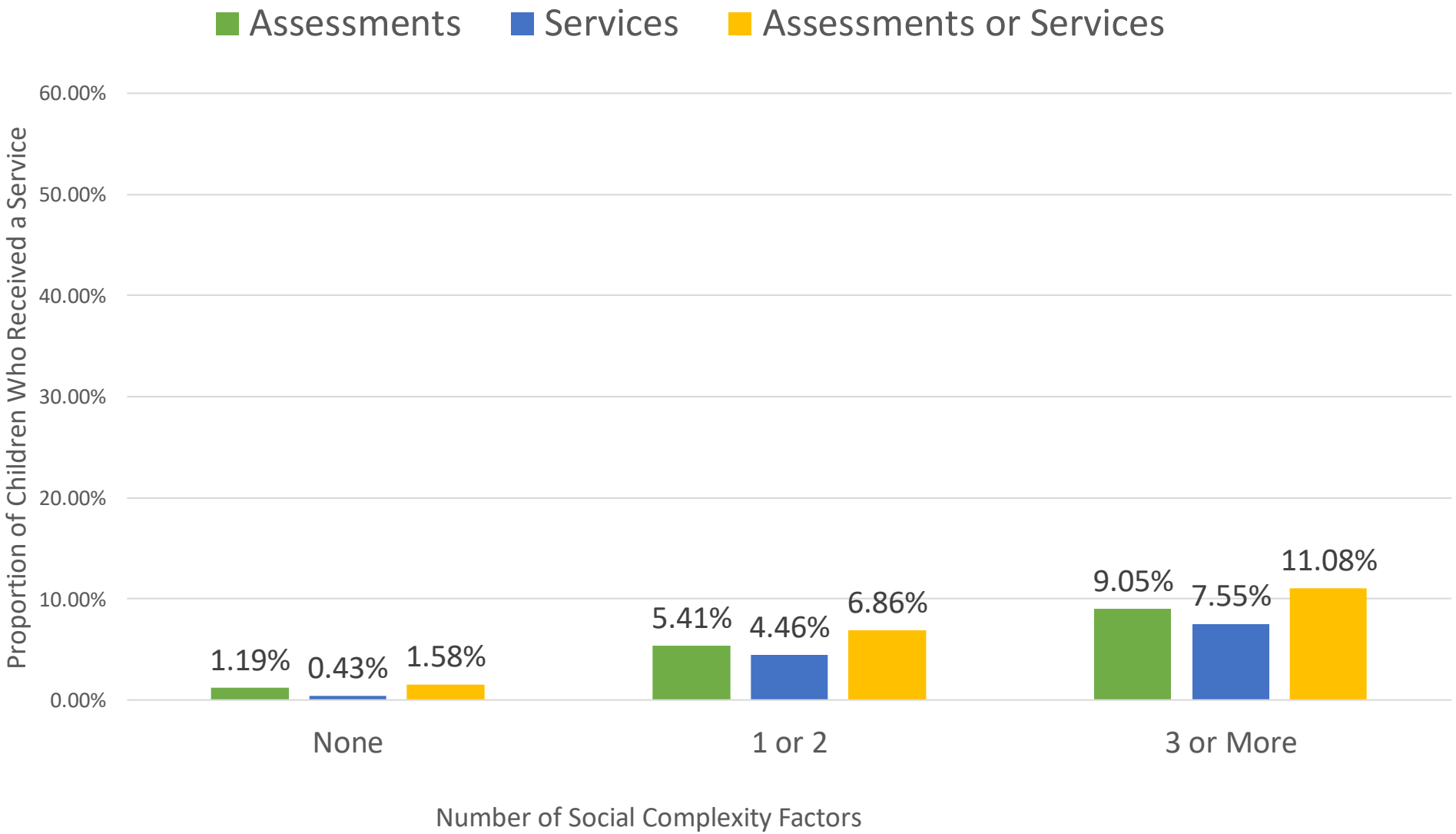


CCO Specific Findings

Reach Metric Findings by Children With System-Level Complexity Factors



Reach Metric Findings by Children With System-Level Complexity Factors



What's Next

Hear and incorporate input from Metrics and Scoring Committee and CCO Metrics Technical Advisory Group.

Continue data analysis to prepare for assessing the reach of services (one component of the CCO system-level metric).

Engage CCOs in piloting additional components of the CCO system-level metric.

(Work builds off community improvement pilots OPIP has led and is leading)

Refine the measure specifications and attestation tools to present to Metrics and Scoring Committee and Health Plan Quality Metrics Committee.

Goal: Propose Metric in 2021 for Inclusion in 2022 Incentive Measure Set

Why we believe the time for this metric is now

- Young children and families have faced barriers to accessing social-emotional health services that they critically need, and the need is growing in the pandemic.
- This has been a long-standing gap in the CCO incentive measure set and the HPQMC aligned measure menu.
  - Integrated behavioral health in primary care for children
  - Specialty, dyadic behavioral health for children that focuses on attachment between the child and parent
  - Transformative opportunity to support billable community-based services provided by public health and early learning partners
- Metric aligns with key statewide health equity priorities.
- Feasible, meaningful community and cross-sector engagement work for CCOs to engage in during COVID-19 pandemic

Given this urgency, we are seeking your support and input

- Are you supportive of the direction we're moving in? Will you continue to champion this metric?
- What additional pieces do you need to see in place when we come back to propose this metric to you next year?
- What further information do you need?

Thank you!

Dana Hargunani, MD, MPH, Oregon Health Authority

Colleen Reuland, MS, Oregon Pediatric Improvement Partnership

Elena Rivera, MPH, Children's Institute

Additional Slides for Reference

Component A: Assessments

List 1: Examples of Assessment, no DX Required

Example CPT Codes	Description	Examples Provider/Entity
96127	Brief behavioral or emotional assessments, may include any standardized screening instruments	• Primary Care Providers • Integrated behavioral health in primary care • Specialty behavioral health • Neuropsychologists, developmental pediatricians • Potential eligible community based providers that can bill
96150 - 96151	Health and Behavior Assessment	
96116	Neurobehavioral status exam	

Component A: Assessments

List 2: Examples of Assessment, DX and Provider Taxonomy Required

Example CPT Codes	Description
96111	Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments)
99381 - 99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures

Component B: Services

List 3: Services that Don't Require Diagnosis

Example CPT Codes	Description	Example Provider/Entity
90832 -90838 90847 90853	Individual psychotherapy Family psychotherapy with patient present Group psychotherapy	• Integrated behavioral health in primary care • Specialty behavioral health • Potential eligible community based providers

Component B: Services

List 4: Services That Would Require a Diagnosis

Example CPT Codes	Description	Example Provider/Entity
99341 - 99345	Home visits, new patient	• Potential eligible community based providers • Integrated behavioral health in primary care • Specialty behavioral health
99401 - 99404	Preventive medicine counseling and/or risk factor reduction intervention(s)	

Component B: Services

List 5: Services That Would Require a Diagnosis + Provider Taxonomy

Example CPT Codes	Description
99201 - 99205	Office or other outpatient visit for the evaluation and management of a new patient
99211 - 99215	Office or other outpatient visit for the evaluation and management of an established patient
99281- 99285	Emergency department visit for the evaluation and management of a patient

Preventive dental measure specifications

Preventive Dental Measure - Options

- At its last meeting the Committee voted to change the measure and allow preventive dental **and** oral health services from any provider to count.
  - **Option 1**: Drop provider taxonomy requirements; count D-codes only.
  - **Option 2**: Drop provider taxonomy requirement AND count any analogous CPT codes (CPT 99188) → **requires HPQMC review**
- **At a minimum, OHA plans to implement Option 1 for 2021**
- Committee must decide if it feels Option 1 is sufficient, or if it would like to pursue Option 2 specification changes.

Option 1 (to apply to CY 2021)

- Drop provider type taxonomy requirement; measure continues to only count C**D**T codes (D1000-D1999)
  - Dental billing codes only; primary care providers can bill these codes.
  - Potentially service providers more likely to be dental providers, including co-located dental hygienists (not medical providers who strictly bill medical claims)
  - Does not require HPQMC review
  - Baseline & benchmark value for 2021 would be recalculated.

Option 2 (to apply to CY 2021, per HPQMC)

- Count CDT *and* CPT (medical) billing codes in three rates as below (preventive dental and oral health services):
  - Component Rate 1: Dental services (dental providers only, D1000-D1999)
  - Component Rate 2: Oral health services (*non-dental* providers utilizing D1000-D1999 or CPT 99188)
  - Component Rate 3: Dental and oral health services from any provider (dental AND non-dental providers utilizing D1000-D1999 or CPT 99188)
- Allows tracking of where services occur across three components
- Allows Metrics & Scoring Committee, PEBB, and OEBB to choose which rate (or combination) they would like to incentivize in future years
- Requires review and approval of Health Plan Quality Metrics Committee
- Requires baseline & benchmark value recalculation for 2021.

Data – CY 2019, ages 1-5

Baseline (current specs: Taxonomy Required, CDT D1000-D1999)		Option 1 Test (No Taxonomy Req, CDT D1000-D1999)			Option 2, Component Rate 3 Test (No Taxonomy Req, CDT D1000-D1999 + CPT 99188)		
CCO	**Rate**	**Rate**	**% Diff - Num**	**# Pt Diff - Rate**	**Rate**	**% Diff - Num**	**# Pt Diff - Rate**
CCO 1	50.0%	50.8%	1.6%	0.8%	52.9%	5.8%	2.9%
CCO 2	45.9%	46.8%	2.0%	0.9%	57.4%	25.0%	11.5%
CCO 3	37.2%	38.1%	2.4%	0.9%	45.1%	21.2%	7.9%
CCO 4	44.4%	48.2%	8.4%	3.8%	50.3%	13.4%	5.9%
CCO 5	46.9%	52.7%	12.4%	5.8%	58.1%	23.9%	11.2%
CCO 6	46.5%	46.8%	0.7%	0.3%	52.4%	12.7%	5.9%
CCO 7	43.0%	43.6%	1.5%	0.6%	51.7%	20.4%	8.7%
CCO 8	51.1%	51.5%	0.8%	0.4%	59.9%	17.4%	8.8%
CCO 9	46.6%	47.5%	2.0%	0.9%	50.8%	9.1%	4.2%
CCO 10	46.7%	47.2%	1.1%	0.5%	48.6%	4.1%	1.9%
CCO 11	53.1%	53.7%	1.2%	0.6%	53.7%	1.2%	0.6%
CCO 12	48.3%	51.6%	6.7%	3.3%	54.2%	12.2%	5.9%
CCO 13	47.2%	47.6%	0.9%	0.4%	47.7%	1.1%	0.5%
CCO 14	42.5%	43.2%	1.7%	0.7%	51.2%	20.4%	8.7%
CCO 15	53.2%	54.0%	1.5%	0.8%	56.7%	6.5%	3.5%
Statewide	46.9%	48.2%	2.8%	1.3%	52.8%	12.5%	5.9%
Num.	48,861			50,221			54,956
Denom.	104,088			104,088			104,088

Data – CY 2019, ages 6-14

Baseline (current specs: Taxonomy Required, CDT D1000-D1999)		Option 1 Test (No Taxonomy Req, CDT D1000-D1999)			Option 2, Component Rate 3 Test (No Taxonomy Req, CDT D1000-D1999 + CPT 99188)		
CCO	**Rate**	**Rate**	**% Diff - Num**	**# Pt Diff - Rate**	**Rate**	**% Diff - Num**	**# Pt Diff - Rate**
CCO 1	66.3%	66.7%	0.6%	0.4%	66.8%	0.7%	0.5%
CCO 2	62.6%	63.5%	1.4%	0.9%	63.5%	1.4%	0.9%
CCO 3	57.3%	57.7%	0.7%	0.4%	58.0%	1.3%	0.7%
CCO 4	65.2%	65.9%	1.1%	0.7%	66.0%	1.2%	0.8%
CCO 5	63.9%	64.5%	0.8%	0.6%	64.5%	1.0%	0.6%
CCO 6	65.3%	65.6%	0.4%	0.3%	66.0%	1.1%	0.7%
CCO 7	61.0%	61.6%	1.0%	0.6%	61.7%	1.2%	0.7%
CCO 8	67.6%	68.1%	0.8%	0.5%	68.3%	1.0%	0.7%
CCO 9	61.6%	62.1%	0.9%	0.5%	63.4%	3.0%	1.8%
CCO 10	61.3%	62.0%	1.1%	0.7%	62.0%	1.1%	0.7%
CCO 11	73.6%	74.2%	0.9%	0.6%	74.2%	0.9%	0.6%
CCO 12	70.3%	70.7%	0.7%	0.4%	70.8%	0.7%	0.5%
CCO 13	70.9%	71.4%	0.7%	0.5%	71.4%	0.7%	0.5%
CCO 14	59.2%	60.3%	1.9%	1.1%	60.4%	2.1%	1.2%
CCO 15	65.6%	66.3%	1.0%	0.7%	66.4%	1.2%	0.8%
Statewide	65.3%	65.8%	0.7%	0.5%	66.0%	1.1%	0.7%
Num	119,335			120,183			120,657
Denom.	182,726			182,726			182,726

Discussion & Decision

Which option to pursue for update to CY 2021 specifications:

Option 1: Drop provider taxonomy requirements; continue to limit to CDT codes

Option 2: Drop provider taxonomy requirements AND count CPT 99188 (requires HPQMC review)

OHA Social Determinants of Health: Social Needs Screening Measurement

Metrics & Scoring Committee Meeting
November 20, 2020

Chris DeMars
Director, Transformation Center
Deputy Director, Delivery Systems Innovation Office

Oregon Health Authority

Presentation today

1. History
2. Timeline
3. Progress to date
4. Measure concepts
5. Early feedback from public workgroup
6. Potential glide path for the measure
7. Discussion

History

- **2015:** Metrics & Scoring Committee began considering measurement around SDOH, which resulted in development of a clinic-level food insecurity screening measure (not adopted)
- **September 2017:** Governor Brown directed CCO 2.0 to include broad goals and requirements for CCOs related to SDOH and health equity
- **Late 2018/early 2019:** Metrics & Scoring and Health Plan Quality Metrics Committees endorsed development of broader, plan-level SDOH measure (to include, but not be limited to, food insecurity)
- **June 2019:** Letter to from Governor Brown to Metrics & Scoring Committee called for the CCO quality incentive program to include transformational measures aligned with CCO 2.0 goals, including addressing SDOH & health equity

Metrics and Scoring Committee request

- Metrics & Scoring Committee approved SDOH measurement direction in 2019
- Includes social needs screening completion and reporting of data, possibly referral data
- Aligns with:
  - Prior committee interest in food insecurity screening
  - National social needs screening trend (RI, MA, NC)
  - OHA priorities:
    - 10-year strategic plan: eliminate health inequities
    - State Health Improvement Plan
    - CCO 2.0 social determinants of health & health equity goal

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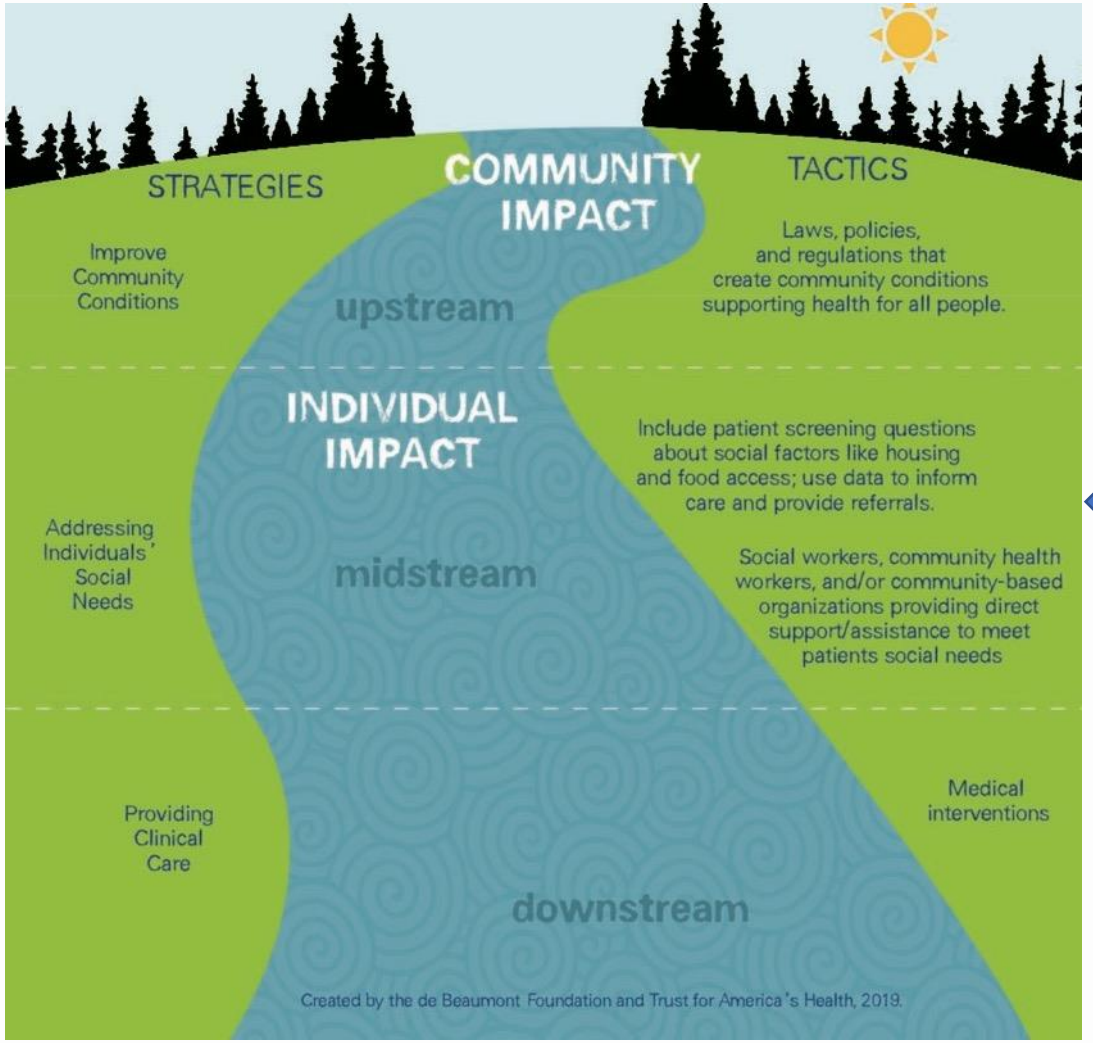
Social determinants of health vs. health-related social needs

Social determinants of health:
The social determinants of health refer to the social, economic, and environmental conditions in which people are born, grow, work, live, and age, and are shaped by the social determinants of equity. Examples: housing availability/quality, access to healthy foods, income



Health-related social needs:
The social and economic barriers to an individual's health. Examples: housing instability, food insecurity

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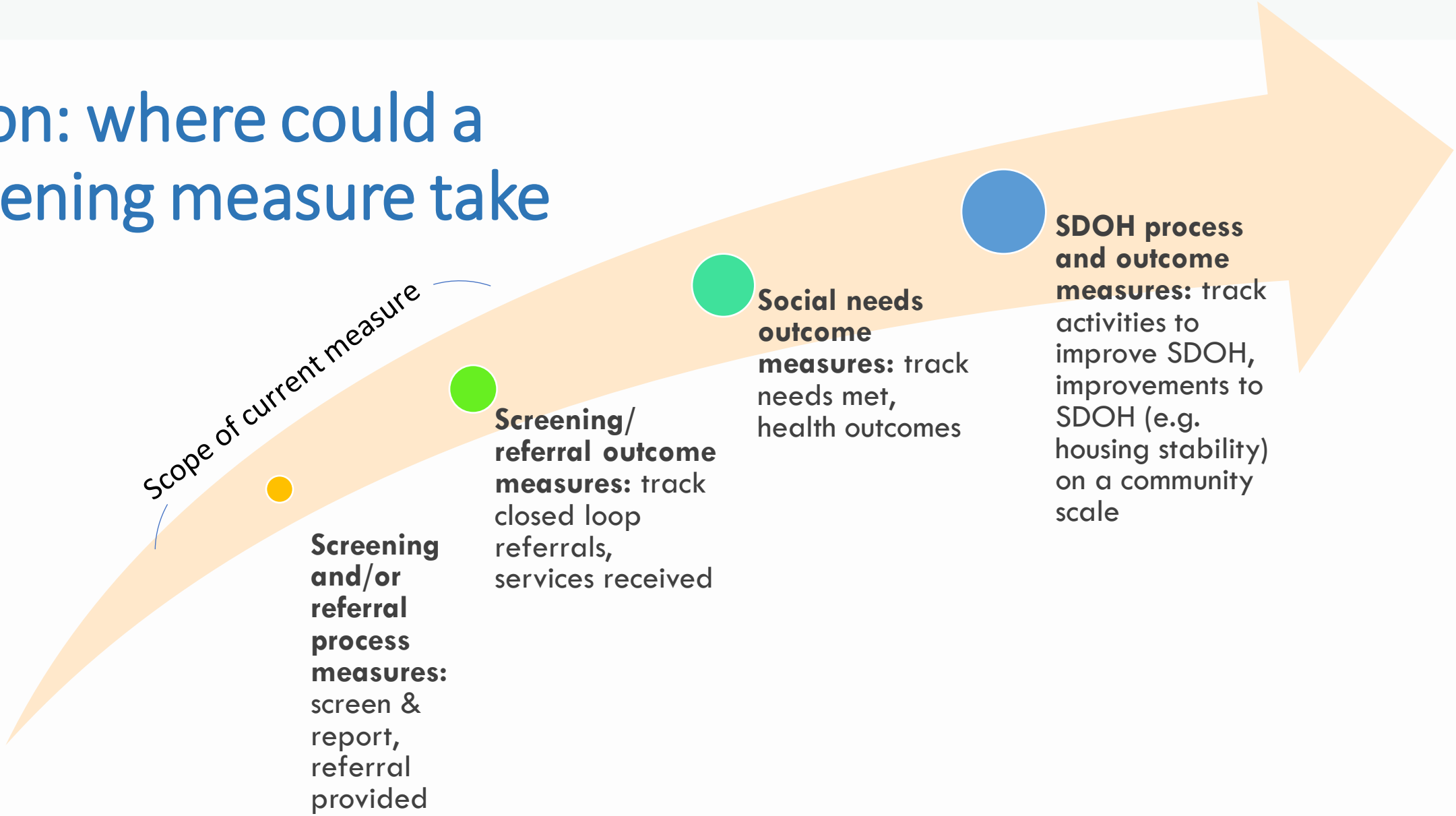
Vision: where could a screening measure take us?



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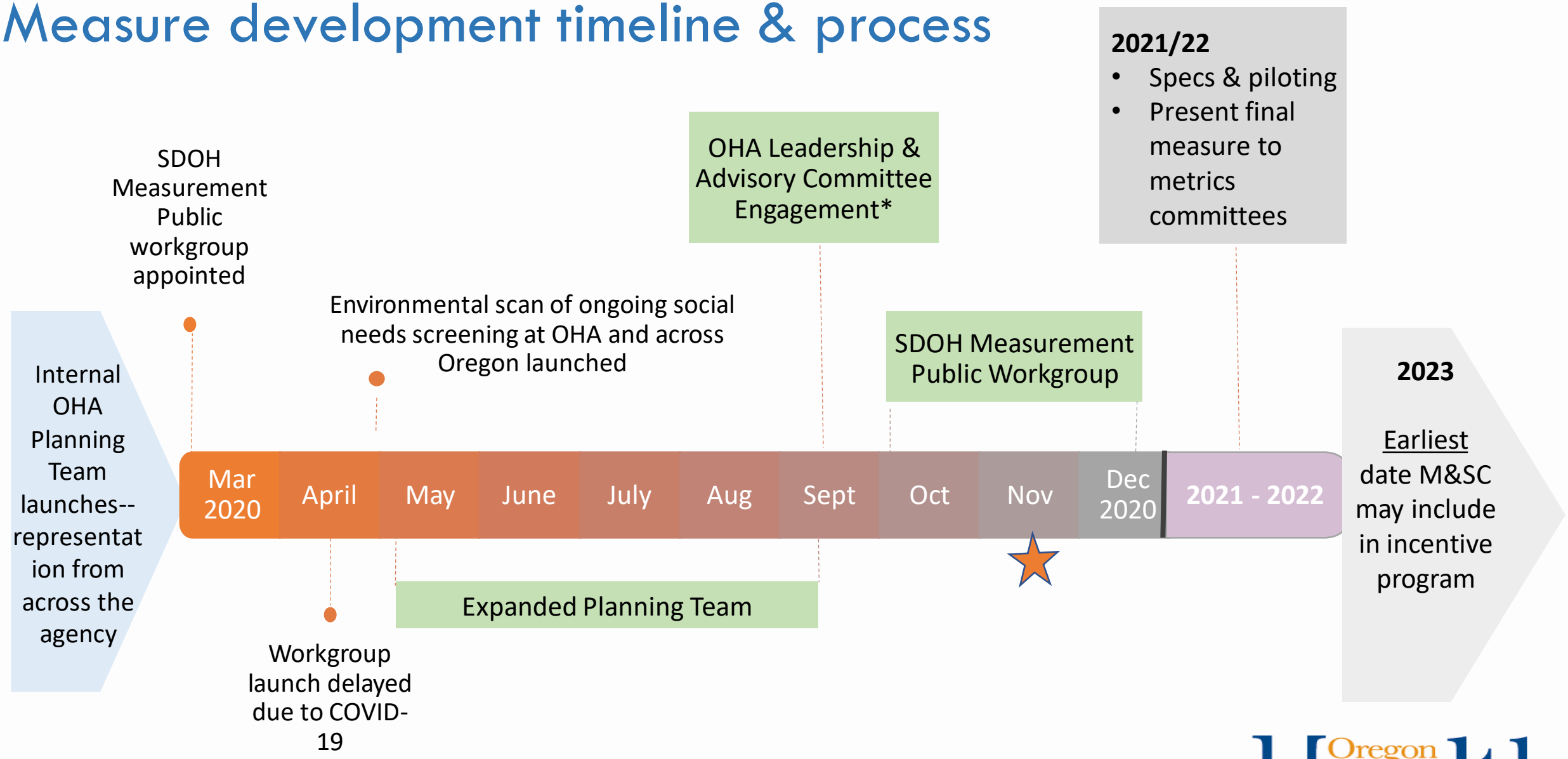
Measure development timeline & process



*Public Health Advisory Board, Medicaid Advisory Committee, Health Equity Committee

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Measure development partners

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ORPRN Associate Director

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Principal

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Consultant

Expanded Planning Team

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Angela Leet, DHS Directors Office
Britteny Matero, Health IT Policy & Meaningful Use
Nikki Olson, Integrated Care for Kids
Lisa Parker, Health IT
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National Committee for Quality Assurance (NCQA)
Rachel Harrington
Eric Musser
Kristine Toppe

Bailit Health
Michael Bailit
Jennifer Sayles
Rachel Issacson

Oregon Health Leadership Council, HIT Commons
Liz Whitworth
Michael Pope

Measurement feasibility experts
Ned Mossman, OCHIN
James McCormack

SDOH Measurement Workgroup Members

- Megan Cahn, Legacy Health
- Krista Collins, Health Share of Oregon
- Frank Franklin, Multnomah County Health Department
- Lavinia Goto, Oregon Wellness Network/Northwest Senior & Disability Services
- Julie Harris, Children's Health Alliance
- Alyson Hererra, Klamath Tribal Health Youth & Family Guidance Center
- Laurel Hoffmann, Oregon Health & Sciences University
- Courtney Kenney, Oregon Primary Care Association
- Lynn Knox, Oregon Food Bank
- Joveny Lopez, Yakima Valley Farmworkers Clinic
- Matthew Mitchell, Central City Concern
- Giselle Naranjo-Cruz, Kaiser Permanente
- Jorge Ramirez-Garcia, EOCCO/GOBHI
- Shelley Yoder, Providence Health & Services
- Kiara Yoder, Marion & Polk Early Learning Hub

Workgroup expertise

Measurement and screening

- Measurement theory
- SDOH measurement
- Social needs screening
- Data collection & analysis

Serving priority populations

- People with special needs, ACES and complex medical problems
- People experiencing homelessness
- Pediatrics

Improving systems

- Integration of community organizations and Health Systems
- Bridging clinical and community supports
- Quality improvement measures & practices
- Health equity

In these settings…

- Clinics and Hospitals (including FQHCs)
- Community-based organization
- Health Systems
- Federal organizations (CMS, NQF)
- Community Information Exchanges

Guiding principles for measure concept

EQUITY

- Centers equity and trauma-informed practice
- Remains focused on the ultimate outcome of improved health and wellbeing for all Oregonians
- Acknowledges limitations and potential harms (especially to patients/members) that could result from our work

ALIGNMENT

- Aligns with broader agency SDOH goals (and waiver)
- Is driven by a shared definition of and framework for addressing SDOH
- Lays the foundation to spur meaningful and sustainable action to address social needs into the future
- Builds collective action toward shared goals and standardization in priority/approach
- Considers alignment with other OHA (and partners) current social needs screening practices

FEASIBILITY

- Is feasible, especially for the health system to report or collect data on

Designing an equitable and trauma-informed metric

Design for the most underserved/marginalized communities

- Promotes equitable distribution of resources and power
- Avoids disadvantaging due to race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class or intersections between these factors
- Recognizes, reconciles and rectifies historical and contemporary injustices
- Linguistic & cultural appropriateness

Center those screened

- Patient-centeredness (promotes autonomy & respect, focuses on strengths)
- Family-centeredness
- Includes people with lived experience in process

Encourage equitable/trauma-informed screening practices

- Prioritizes trust between screener & patient
- Clarity & accessibility of questions and format
- Ensures adequate training for screeners
- Avoids inability to address needs identified

Align with and support community initiatives

- Supports ongoing work of Community Based Organizations (CBO)
- Promotes accessibility of information by CBOs
- Avoids overburdening CBOs
- Prioritizes local knowledge & allows for local flexibility
- Avoids the potential of retraumatization due to re-screening

Environmental Scan of Social Needs Screening in Oregon

The goal of the environmental scan was to collect information about ongoing health-related social needs screening efforts in the State of Oregon to help inform the Oregon Health Authority and its SDOH Measurement Workgroup in their process to develop a social needs screening metric for consideration by the Metrics and Scoring Committee.

ORPRN Oregon Rural Practice-Based Research Network

OHSU

NANCY GOFF & ASSOCIATES PUBLIC HEALTH CONSULTING

Environmental Scan: Interviews & Surveys

SURVEYS (n=17)

Coordinated Care Organization

- Advanced Health
- Cascade Health Alliance
- Columbia Pacific CCO
- Eastern Oregon CCO
- Health Share of Oregon
- InterCommunity Health Network CCO
- Jackson Care Connect
- PacificSource- Central Oregon Region
- PacificSource- Columbia Gorge Region
- PacificSource- Lane County
- PacificSource- Marion/Polk Counties
- Trillium Community Health Plan
- Yamhill Community Care

Health Systems (HealthShare Partners)

- Kaiser Permanente NW
- Legacy Health
- Oregon Health and Science University
- Providence Health

INTERVIEWS (n=14)

Governmental

- Benton County Health Department
- Jefferson County Health Department
- Oregon Department of Human Services
- Oregon Housing and Community Services
- Oregon Health Authority, Maternal and Child Health
- Oregon Health Authority, Women and Infant Children Program
- Oregon Health Authority, Office of Health Information Technology
- Oregon Health Authority, Addictions and Mental Health
- Portland VA Medical Center

Community Organizations

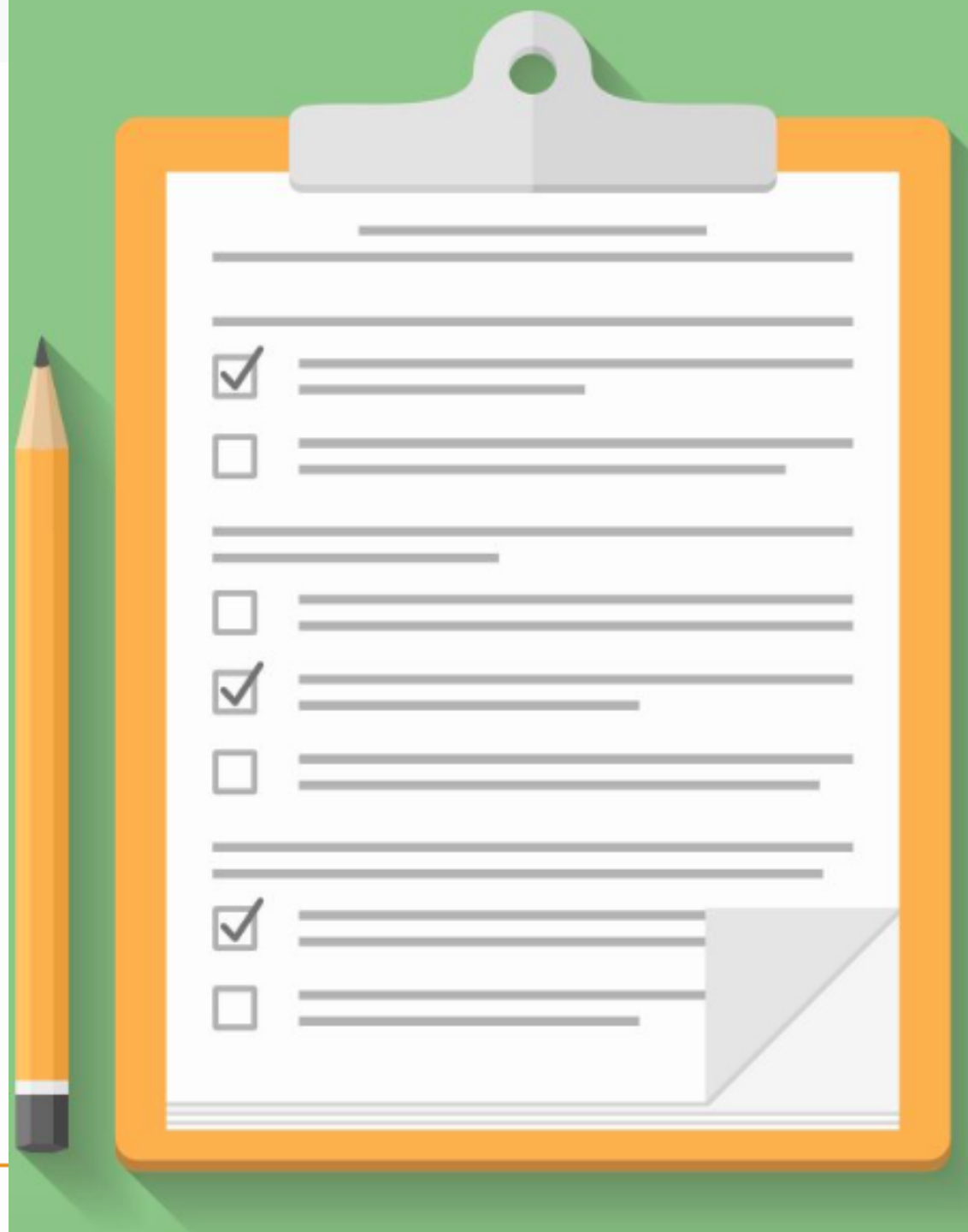
- Association of Oregon Community Mental Health Programs
- Oregon Food Bank
- Oregon Health Leadership Council
- Oregon Pediatric Improvement Partnership
- Oregon Primary Care Association
- Project Access Now
- Virginia Garcia Memorial Health Center

Oregon Health Authority

Environmental Scan Questions

Interviews and surveys asked about:

- Current screening practices:
  - Tools
  - Domains
  - Workflows
- Referrals and service provision
- Equity & trauma-informed practices
- Data collection and storage
- Feedback for metrics committee
- Other related/known efforts
- Referrals and service provision



Environmental Scan: Key Takeaways

- **Rapidly evolving landscape.** Much has changed, and organizations have lots of activities planned for the next few years
- **Many social needs screening efforts planned and underway:** CCOs, health systems, State programs, individual clinics
- **Multiple screening questions and tools-** some alignment in domains, limited alignment in questions
- **Interest in a more standardized, coordinated statewide system** for screening and data collection
- **Health Information Technology advances:** social needs in EHRs, Community Information Exchange (CIE) efforts
- **Importance of centering the needs of communities and health equity**

Social need screening practices

- All governmental programs and community partners interviewed conduct screening of some patients or clients-with different tools and limited alignment

- Screening of every patient/client is rare

of CCOs surveyed conduct screening at the CCO level (does not systematically include all members)

of health systems surveyed screen for social needs (again not systematically)

Screening tools & domains

- Home-grown tools
- Published tools (PRAPARE, AHC)
- Funder-mandated questions

- 77% of CCOs surveyed primarily use a home-grown tool

Domains CCOs screen for (N=10):

Housing

Food

Transportation

Utilities

Safety

Financial Strain

Who conducts social needs screening?

CCO-level screening is conducted by:

- Care management team
- Community health workers
- Members screen themselves

Health Systems screening is conducted by:

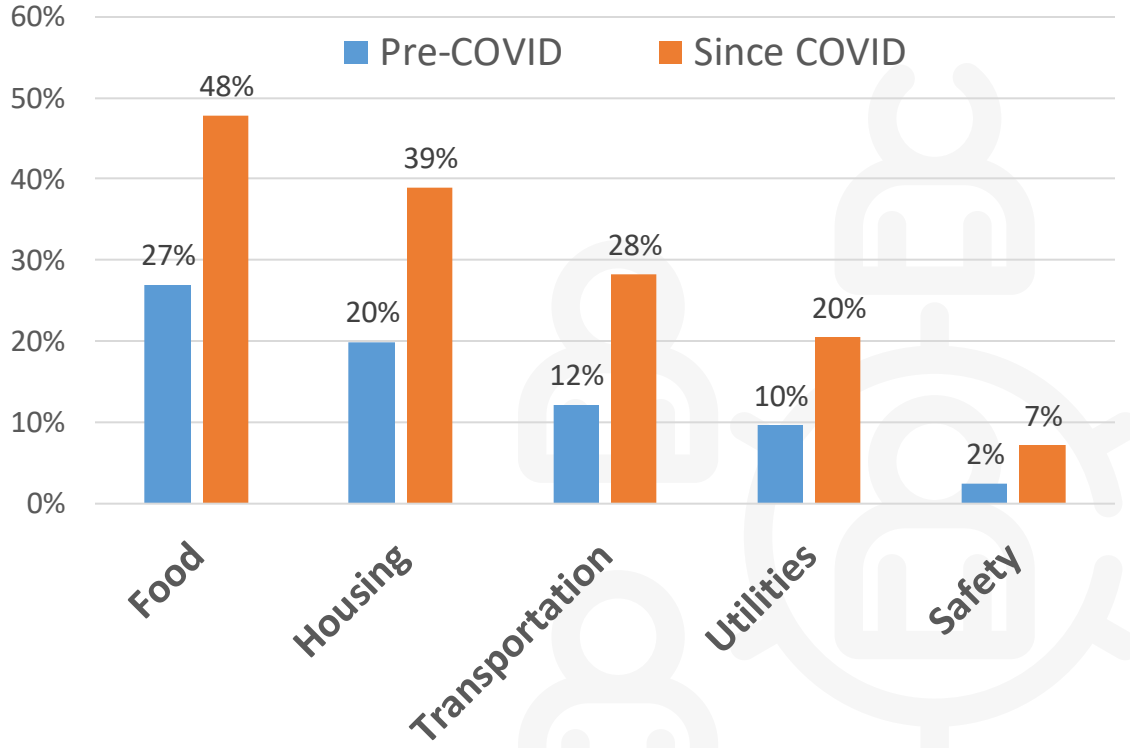
- Care managers & coordinators
- Clinic staff
- Medical assistants
- Patient navigators
- Patients screen themselves

Image courtesy of aafp.org

Accountable Health Communities (AHC) Study

AHC is a national CMS study of whether screening for social needs, provision of community resource information, and help from a patient navigator to access resources improves health and reduces the cost of care for Medicaid and Medicare beneficiaries.

- 12,000 patients screened across 15 counties in Oregon
- Medicaid members reporting at least one social need:
  - rose during COVID-19 from 48% to 70%
- Substantial increase in social need across all races and ethnicities
- Disparities for non-White members exacerbated by the pandemic



*Pre-COVID 12/10/18 – 3/22/20 vs. Since COVID 3/23/20 – 8/20/20. 3/22/20 was the start of the "stay at home" order in Oregon.

OHA committee* conversations: Key Takeaways

- Center racial equity
- Ensure patient centered approach
- Concerns about screening without follow up
- Data sharing across organizations will be crucial to the success of this effort
- Avoid overburdening providers and members
- Ensure some structure AND some flexibility

**Medicaid Advisory Committee, Health Equity Committee, Public Health Advisory Board, Community Advisory Council Coordinators.*

Measure concepts

MEASURE CONCEPTS	1	2	3	4
	Rate of social needs screening in the total member population -- any data source	**Rate of social needs screening in children 0-21* -- any data source**	**Rate of social needs screening by any Medicaid billing provider -- Z-codes**	**Rate of social needs screening for members with a primary care visit --Electronic Health Records (EHRs)**
Denominator	Total CCO membership	Total CCO members ages 0-21	Total CCO membership	CCO members with a primary care visit
Numerator	CCO members screened	CCO members ages 0-21 screened~	CCO members screened	CCO members screened

Other measure concepts & designs we ruled out

CONCEPT	REASONS FOR EXCLUSION
All CCO members using data only from Community Information Exchange (CIE) systems	• Not all CCOs/communities have CIEs; CIE landscape is rapidly evolving
All CCO members using CCO case management data only	• Does not align with vision for future system of integrated social and medical care • Barriers to data sharing and thus risk of rescreening
Screening of members with a behavioral health visit	• Likely not feasible given problems with data sources (e.g. EHR limitations and state behavioral health data collection source)
Screening & referral of CCO intensive care coordination members	• CCOs already required to screen this population • Doesn't include all members • Open rules create uncertainty about who would be screened
Reporting only whether screen was done (not outcome of screen)	• Doesn't align with statewide goals for tracking and improving social needs
Specifying one tool to use statewide	• Doesn't align with local/partner use of multiple tools • Limited evidence-based tools, particularly culturally responsive
Screening at the household level only	• No standard definition of what constitutes a "household" • Limited to no ability to record/match this data in EHR, other medical data systems

Measure Concepts:
Early feedback from the Workgroup

- There is value in moving forward, despite imperfections & unknowns
- Strong interest in screening the full CCO population (vs. a subpopulation like children or primary care patients only) to ensure equitable approach
- Workgroup seems most interested in Measure Concept 1: *Rate of social needs screening in the full population, using any data source*, despite inherent complexity
- Measure Concept 3, using z-codes, may also be of interest.
- Interest in choosing a measure that moves the system towards the desired future state of:
  - Tracking rate of social needs statewide
  - Ensuring screening outcome is available for action at the point of care
  - Tracking referrals & receipt of services

Measure 1: Rate of Social Needs Screening in the Full Population, using any Data Source

Potential Glide Path	Year 1	Year 2	Year 3	Year 4	Year 5+
Structural measure: • CCOs submit plan to implement screening in an equitable and trauma-informed way (e.g., REALD, workflows to avoid rescreening) • CCOs conduct environmental scan and create data collection/sharing plan (e.g., assess available data systems & population covered)					
Reporting (SAMPLE) • CCO reports data on **sample list** of members (provided by OHA) • OHA to calculate rates based on CCO's member-level data submission: (a) screening rate; (b) of those screened, % with need					

Outcome/Performance (SAMPLE)
• CCO reports data on **sample list** of members (provided by OHA)
• OHA to calculate rates (a) screening rate; (b) of those screened, % with need; (c) of those with a need, % with a referral made
  ○ Benchmark / to meet measure:
  ▪ Report (a), (b), (c)
  ▪ Meet target on (a) - % screened*					

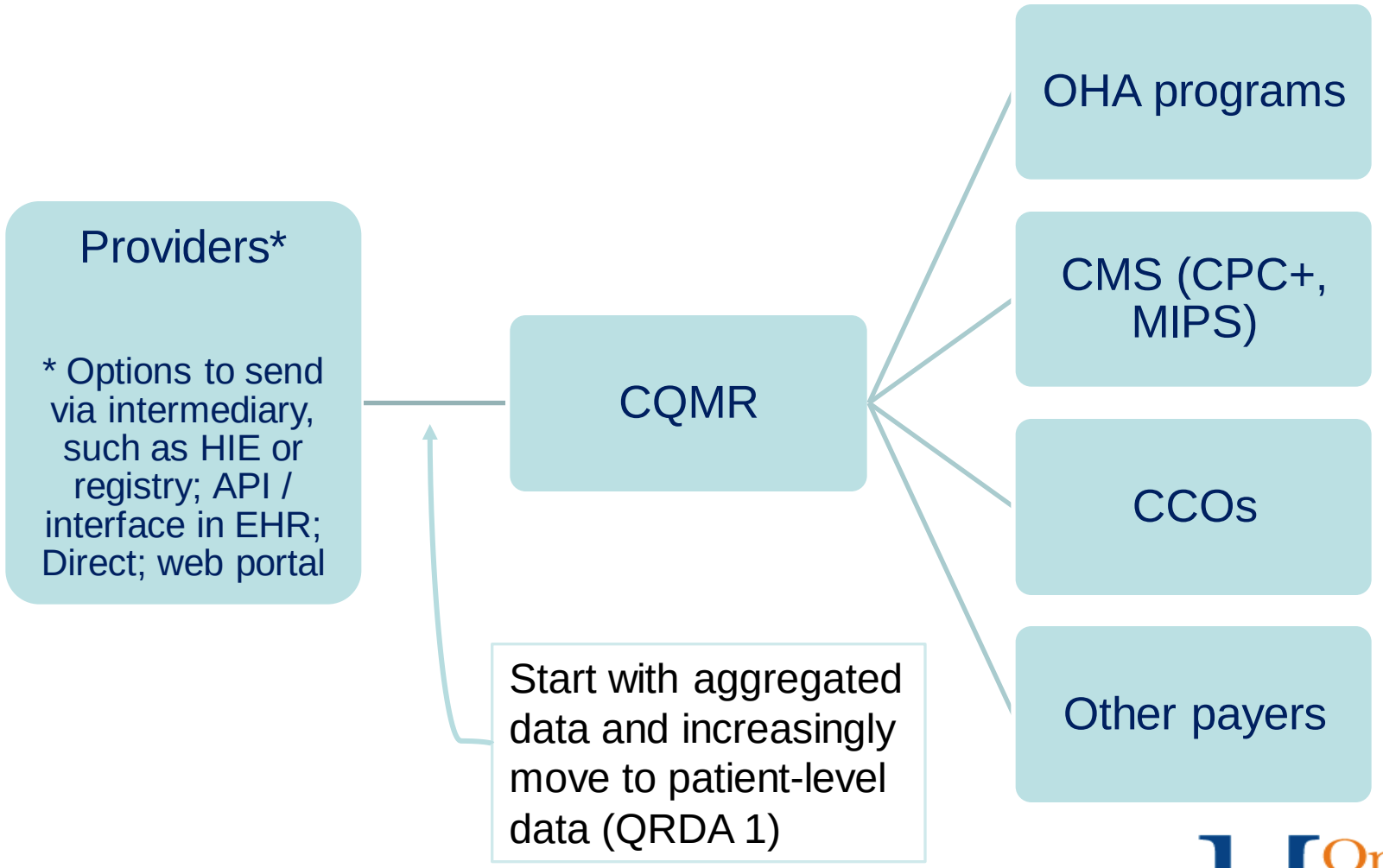
Goal: Outcome/Performance (FULL POPULATION) Logistical elements (e.g. data submission/system to capture data) still to be determined					

Note: Metrics & Scoring to determine whether pay-for-performance begins in year 3 or 4.

Discussion

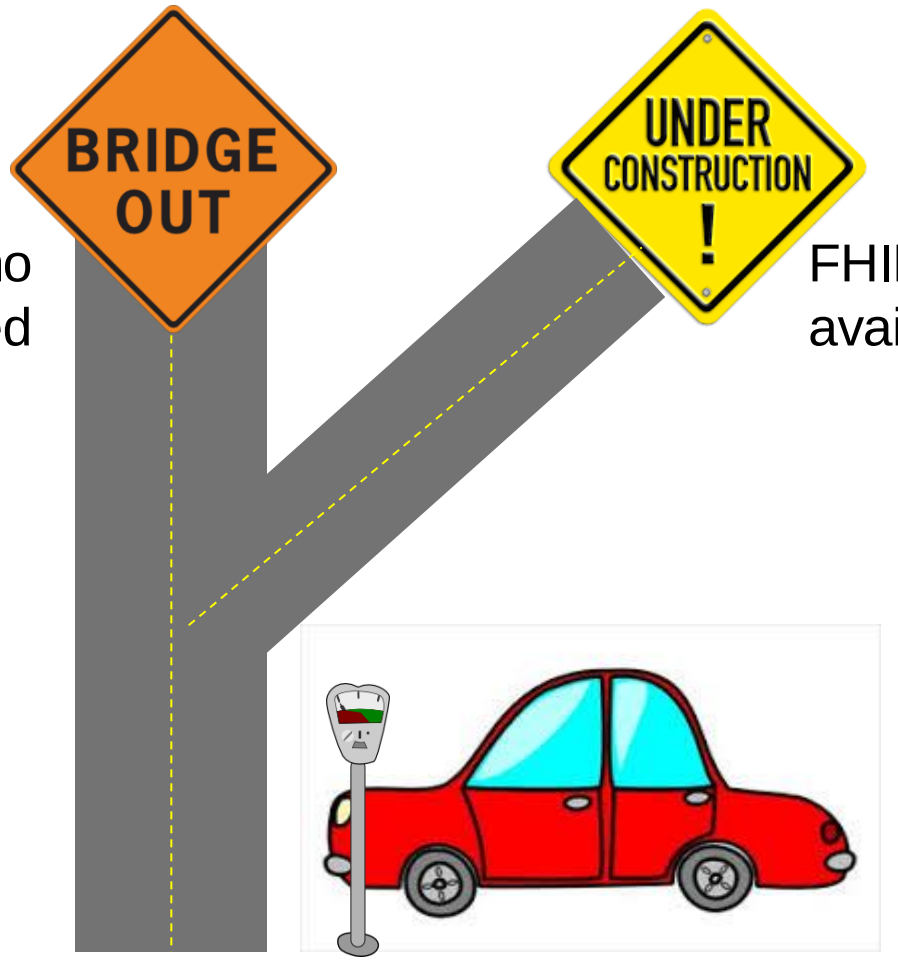
CLINICAL QUALITY METRICS REGISTRY (CQMR) SERVICE SUSPENSION

Refresher: Where we set out to go with CQMR



Where we are now

QRDA 1: no longer supported



FHIR: not yet available

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Evolving National Standards

- Fast Healthcare Interoperability Resources (FHIR – pronounced fire) has applications in multiple aspects of interoperability/ data exchange
  - E.g., patients downloading data into apps of their choosing
- FHIR is expected to support future quality reporting, but timing is unclear
- CMS has set a roadmap for moving to FHIR-based electronic clinical quality measures (eCQMs), but no timeline published
  - Delays in requirement for certified health IT/ EHR vendors to make available new FHIR API functionality (Bulk FHIR APIs) because of COVID
  - Current vendor deadline for new API functionality: 12/31/22 (ONC Interim Final Rule published 11/4/20)

What's Next

- For 2020, revert to former data collection method (Excel templates)
- Monitor national landscape and look for new opportunities
- Ongoing work with stakeholders as landscape becomes more clear

Oregon Health Authority

Metrics & Scoring Committee Agendas: Selecting 2022 CCO Incentive Measures

Dec. 2020 – Jan. 2021	Feb. – April 2021	May 2021	June 2021	July 2021
HIATUS – NO MEETINGS	Detailed discussion national measurement changes / context Equity Impact Assessment – updates Review measure selection criteria Other topics?	Equity Impact Assessment – presentation, discussion, & next steps Begin selecting 2022 incentive measure set	Finalize *penultimate* 2022 measure set (provides one month for public review before finalization) *OHA finalizes 2020 benchmark reopening criteria document	**Finalize 2022 measure set**

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Next Meeting: 19 February

SLIDES HEREAFTER FOR REFERENCE ONLY

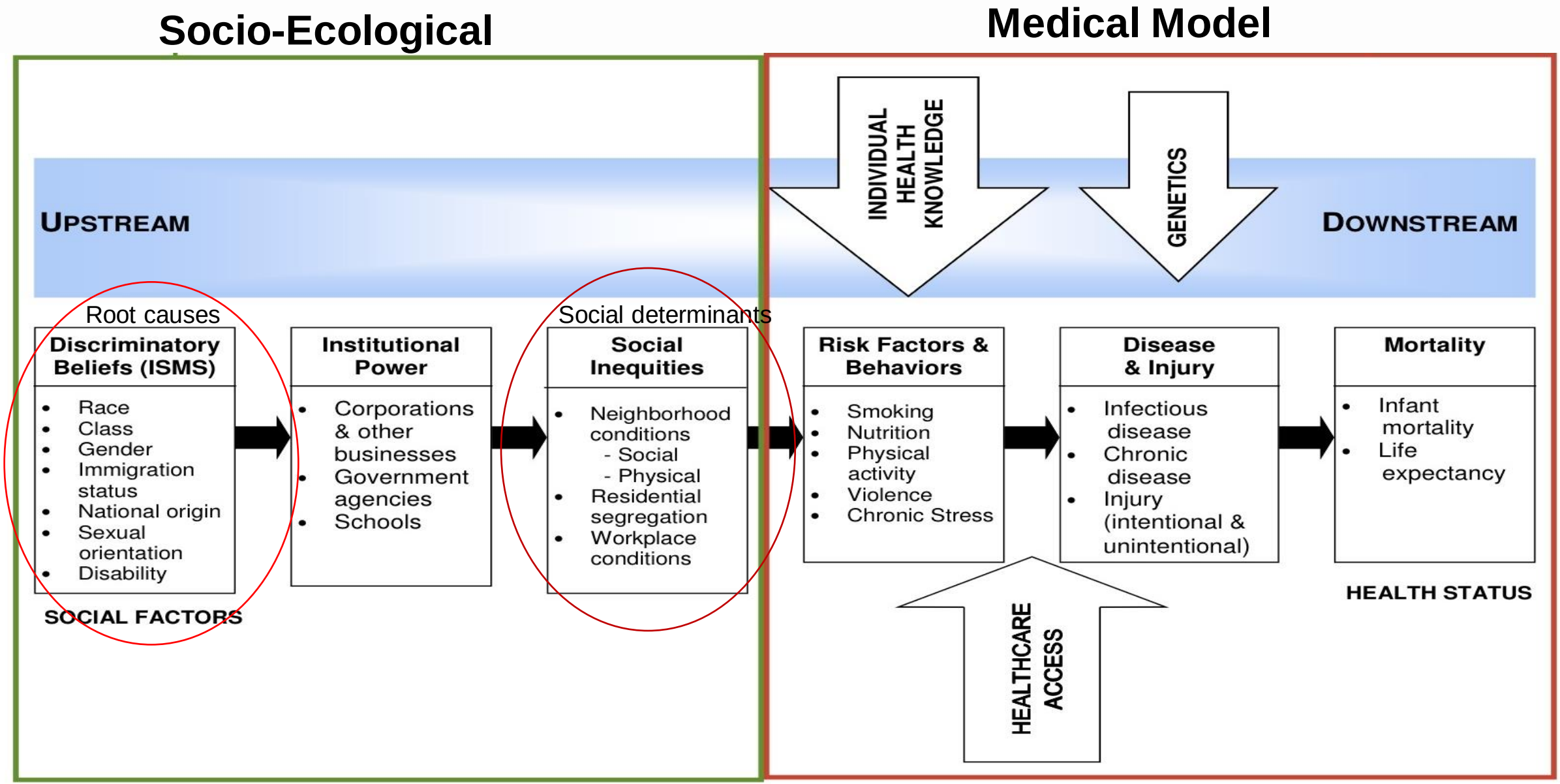
Preventive Dental Measure – Level Set

- For conversation today, differentiate ‘dental’ from ‘oral health’ as below, from American Dental Association’s Dental Quality Alliance:

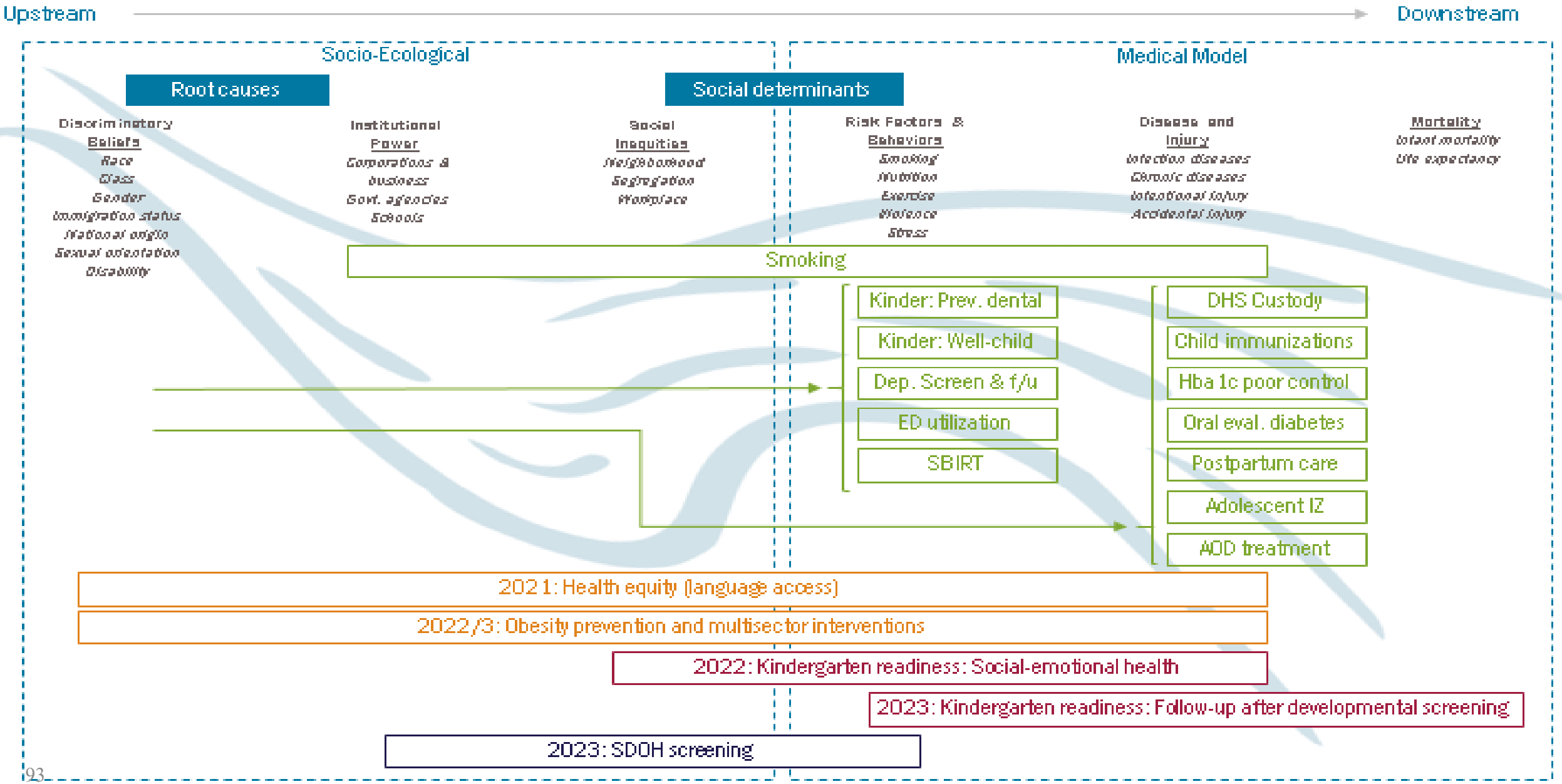
‘For the purpose of measurement, based on definitions from the Centers for Medicare & Medicaid Services:

- “**Dental**” services refer to services provided by or under the supervision of a dentist.
- “**Oral health**” services refer to services provided by other personnel e.g. pediatricians.’

A Framework for Health Equity



For discussion, DRAFT: CCO Incentive Measures Over a Framework of Health Equity



Incentive Measure Retirement History