
2015 CCO INCENTIVE MEASURE SELECTION SURVEY

REPORT TO THE METRICS & SCORING COMMITTEE,
JULY 2014

INTRODUCTION

The Oregon Health Authority fielded this survey to inform the Metrics & Scoring Committee’s selection of the CCO incentive measures for the third measurement year, 2015.

The intent was to collect feedback from a variety of stakeholders, including coordinated care organizations (CCOs), providers, community partners, state programs, and other advocates with an interest in the 2015 CCO incentive measure set. The survey provided a standardized template for receiving feedback on the existing 17 CCO incentive measures, but also provided a venue for respondents to propose new measures.

The survey was open from April 29, 2014 through June 12, 2014. During this period, OHA received over 200 responses from across the state.

This report provides an overview of survey respondents, the results for each survey question, and all new measures proposed through the survey for the Committee’s consideration.

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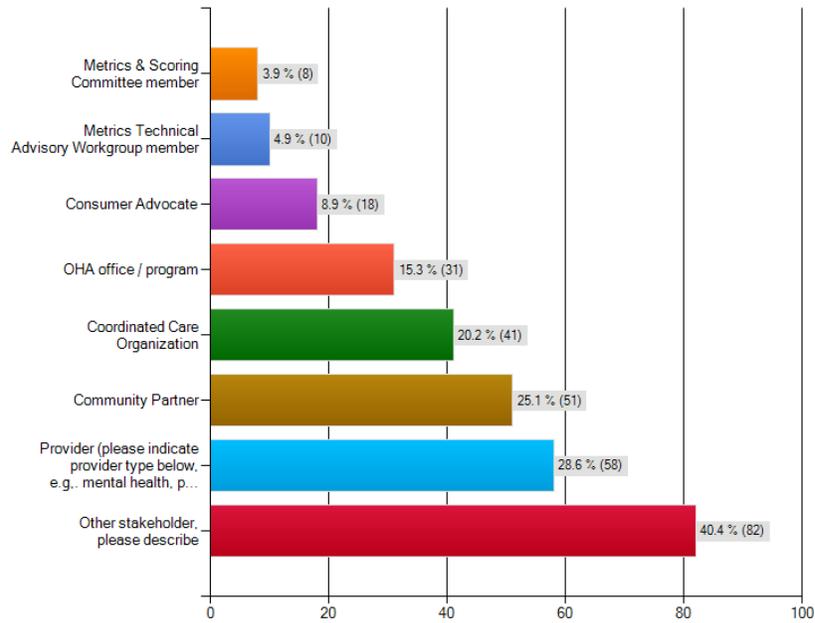
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SURVEY RESPONDENTS

OHA received 207 responses to the survey, including responses from all 16 coordinated care organizations. The survey asked respondents to identify which stakeholder group they identified with (respondents could select multiple options).

Respondents by stakeholder group

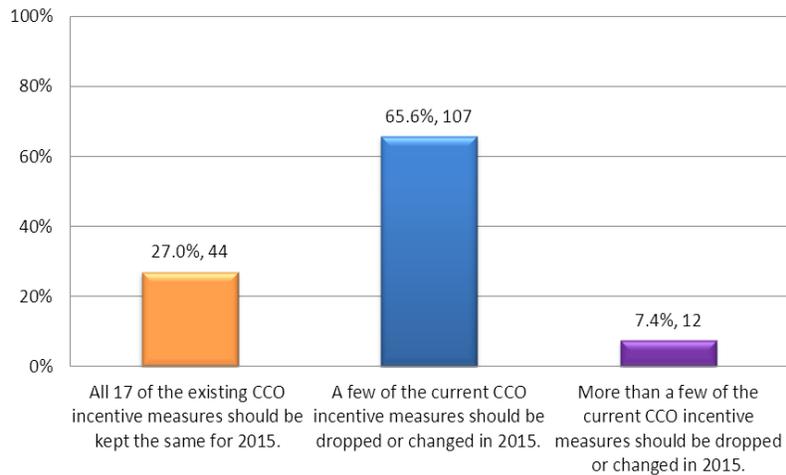
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FEEDBACK ON THE CURRENT CCO INCENTIVE MEASURES

Respondents were asked to provide feedback on the current set of 17 CCO incentive measures, including both overall preference for measure selection and an opportunity to comment on each of the 17 existing metrics.

Question: Please select the statement that most closely describes your preference for 2015:
n=163



The majority of respondents agree that a few changes should be made to the existing measure set, rather than a more comprehensive adoption of new measures.

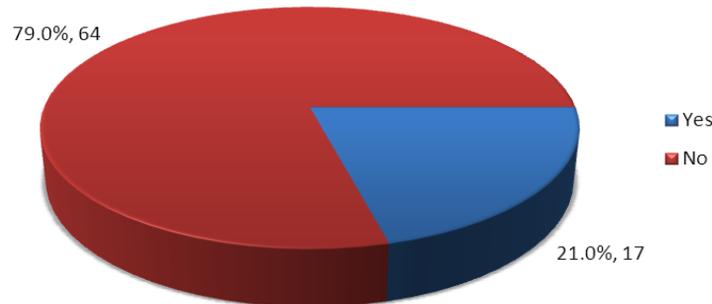
Next, respondents were asked whether each of the current CCO incentive measures should be dropped or modified for 2015. Respondents could provide supporting comments for each measure.

This section provides survey results for each measure, as well as all comments provided. Comments are provided here on a continuum and have been edited slightly for clarity and to protect respondents' privacy.

ADOLESCENT WELL CARE VISITS

Question: Should the Adolescent Well Care Visits measure be dropped or modified for 2015?

n=81



Comments in support of keeping the measure as is:

- This is a key metric for the health of adolescents and the only opportunity we have to assure that developing youth receive comprehensive screening and that youth with special health needs are accessing the care they need.
- This is the only measure that directly applies to the adolescent population: it is imperative to ensure quality of care and access to care for adolescents. In the future, there will need to be measures that reflect the quality of care for this population (e.g., what actually happens in the visit).
- Adolescent well care visits are a critical measure of health care access and the receipt of preventive health services for this population. When adolescents receive high-quality well visits that map to AAP Bright Futures Guidelines, screening, anticipatory guidance and health education are provided that support the healthy adolescent development and the early identification of physical, mental and behavioral health factors that will impact lifelong health and cost to the health care system... The provision of high-quality well visits also support movement in other measures, including: SBIRT, depression screening, and adolescent immunizations.
- Adolescent well visits are an important part of preventive care, which promotes the long-term health of the community. The pediatric community is working diligently to ensure the adolescent well visit provides value to the patient and can help address long-term health challenges through appropriate screenings.
- Adolescents are a vulnerable population at a crucial time. Well visits for HPV, Tdap and meningitis will prevent significant morbidity and mortality. Adolescents are the medium term pay-off for cost savings if we can raise graduate rates, decrease unwanted pregnancy, provide annual mental health and SBIRT screenings and follow up to acute care as needed.

- This is an important metric for a high risk population where well visit rates are low, yet key to preventing costly problems later in life.
- Adolescence is a high-risk age with multiple physical and mental/emotional health risks. Prevention of unintended pregnancy, STDs, cigarette, and alcohol use, as well as lack of self-care around obesity and heart health are only some of the long-term burdens on the healthcare system that can be partially or completely prevented by the continuation of routine office visits and the foundation of a healthy patient-doctor relationship that is forged at this age. In absence of this routine discussion and support of the adolescent and their family, societal burden and financial costs of these future adults could rise significantly.
- There is a lot of discussion about whether or not adolescent well care visits are useful. Although this measure does not target high-utilizers or the chronically ill, when we look at what works over time – preventive visits, trusted relationships with doctors, discussions about life choices, etc – it makes a difference. Although not immediately gratifying, we should see where this measure takes us over the long-term.
- This is an important measure: family advocates work to let families know that under the ACA, adolescent well care visits are covered and encourage families to use them to their best advantage. Families of children with special needs sometimes tell us they “forget” about well-care in the midst of specialty care. We know that unwell youth may grow to be unwell adults and requiring this measure may help reverse that.
- Adolescent well care visits drive many other improvements: immunizations; obesity, mental health and substance use screenings; and management of chronic diseases.
- Measures should be kept the same or with as few changes made as possible for at least three years to see if there is any measureable improvement over time.

Comments in support of modifying the measure:

- Consider changing the recommended frequency [of the adolescent well child visit] to every two years. Not enough evidence to support annual visits.
- Consider aligning the age range for the adolescent well visit and SBIRT measures (12+)
- Consider adding requirements to what should occur during the adolescent well care visit, such as discussion about drug and alcohol use, and sexual activity, or rolling depression screenings as part of the metric.
- Consider adding a risk assessment for alcohol / drug use, sexual activity / contraceptive planning, and safety (e.g., violence, helmets, and seatbelts). A risk assessment will make this measure more meaningful for providers and more relevant for outcomes.
- Consider allowing visits at School Based Health Centers and visits with Behavioral Health Providers within a patient-centered primary care home to count towards the metric.

- Consider counting the member's adolescent well child visit regardless of which CCO they were enrolled in when it occurred. This would promote care coordination and reduce duplication of efforts.
- Consider transitioning all measures to another mechanism of obtaining data that is not dependent on encounter data.
- Consider modifying to include teens' access to their own visit notes / medical records, with option for privacy from parent or guardian access.
- Consider modifying the benchmark and improvement targets: it is not realistic to expect the Medicaid rate to be above the commercial rate. If a CCO matches or exceeds the commercial adolescent well visit rate that should be success.
- Consider modifying to include the ACES screening tool. This will assist in diagnosis root causes of long-term health outcomes and collection of statewide data related to youth outcomes. It will also inform patient treatment plans and identify referral needs.

Comments in support of dropping the measure

- Too much energy is being expended trying to meet a guideline... there are other issues people regard as more pressing, such as holding up the primary care providers so they don't sink under the pressure of all the unanticipated enrollees and increasing access to mental health services directly in primary care.
- There is no evidence that adolescent well care visits are useful in improving care or outcomes. We should focus on something that matters (e.g. legislation that bars non-immunized children from public exposure to prevent diseases like measles).
- Replace with a measure of females age 13 years who have received 3 doses of HPV vaccine.

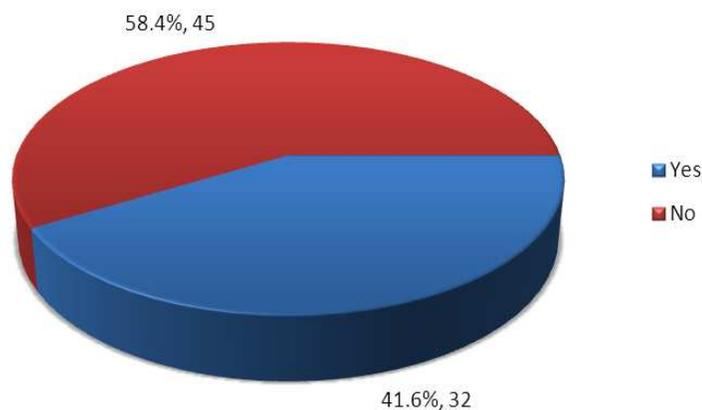
Other comments

- Payor policies and payment schedules create difficulties for this measure: practices are creating different workflows for Medicaid patients to meet the measure.
- If this measure is adopted for 2015, significant effort should be made to bring commercial payers on board as well. Many insurers will not reimburse for annual adolescent well care visits, will only cover every x number of years.
- This inconsistency in coverage makes it difficult for primary care practices to reach out to patients. Accidentally bringing in an adolescent whose insurance does not cover the visit can result in either the patient being billed or the primary care practice having to provide the service without reimbursement. This leads to different standards of care within the community.
- If annual visits are truly important to adolescent health, they should be encouraged and covered for all adolescents, regardless of payor. Request for OHA to reach out to private insurers to begin work to align coverage policies in support of this metric in Oregon.

- Consider options for adult preventive health care measurements which are not represented in the current incentive measure set – consider as an alternate to adolescent well care visits, or as an additional metric.
- It would be helpful to understand the outcome related to this output: this particular metric feels like counting widgets.

ALCOHOL AND DRUG MISUSE (SBIRT)

Question: Should the Alcohol and Drug Misuse (SBIRT) measure be dropped or modified for 2015?
n=77



Comments in support of keeping the measure as is:

- There is less support for SBIRT screening than others, but now that we are doing it, don't change horses in mid-stream.
- The measure should not be dropped. We should take the time, learn the model, invest in prevention, and measure over the long-term.
- The measure needs more time to become well-integrated.
- In support of the changes already made to the measure, including: v79.1 as a standalone mechanism to identify SBIRT services and G0442 and G0443.

Comments in support of modifying the measure:

- This measure will need ongoing modification.
- There are significant issues with the current codes and measurement, but the measure should continue to be modified and improved.
- Consider modifying to capture both screenings and screenings that result in referral and treatment.
- Consider lowering the age range of this measure to include adolescents (12+ instead of 18+):
 - The adolescent years comprise a critical period in the life span and provide opportunities to positively influence future health behaviors and health outcomes.

- Research shows a strong relationship between age of first use of alcohol and risk for lifetime dependence. It is also well-documented that many providers do not routinely screen for alcohol and substance use among adolescents. SBIRT has been shown to be effective with adolescents, and the evidence base continues to grow. SBIRT can be delivered within the context of a high quality adolescent well visit, and inclusion of younger adolescents in this measure would enhance the focus on early identification and prevention.
- If the measure is lowered to include children, collection of this information should reach beyond claims data as screening may take place but not be billed due to privacy and confidentiality issues for adolescents.
- This measure should follow national AAP recommendations and be lowered to age 12.
- The top three killers of teens and young adults are all influenced by alcohol misuse and cannabinoid use (plus others). SBIRT process can be a lifesaver. Injuries; riding with altered drivers; suicide; and homicides – all are associated with screening, therapy and prevention efforts. Unwanted pregnancy, rapes, non-fatal accidents, fights, and ED visits are all related to alcohol misuse. Finding adult substance abuse is way too late – need to focus on adolescents.
- Consider ways to count SBIRT in:
 - hospital settings;
 - mental health settings; and
 - obstetric care settings. Screenings during prenatal and postpartum care can identify babies or mothers at risk for complications. This period represents a key opportunity for health care providers to educate and support families.
- Currently what is captured / reported by the CCOs is only a small portion of the SBIRT process. Focusing on only reporting the percent of patients that have received a brief intervention neglects other parts of the SBIRT process that are just as vital to patient care - for example, percentage of patients screened. The downside is that this data cannot be found via claims but only via reports developed within each health center. This requires additional work. But in order to implement SBIRT and do it well - which is the end goal - we need to track more than just brief interventions. I worry about suggesting this, as I know clinic have more than enough to measure right now, but I also know that "what gets measured is what gets done".
- SBIRT should be a clinical quality measure, with data coming from providers' clinical records, and options for reporting.
 - Ideally SBIRT will become a clinical EHR measure like depression screening, but this may be difficult to implement by 2015.

- Please support the work of the SBIRT workgroup in identifying methods to more accurately measure performance on this measure. Accepting the diagnosis code v79.1 is a good start; incorporation of EHR data will further move this along. Reliance on the CPT / HCPCS codes only significantly undercounts the adoption of SBIRT due to the multiple barriers to billing.
- Reporting SBIRT as a clinical quality measure from an EHR will allow for capture of multiple workflows (e.g., brief screenings separate from full screenings, etc).
- Consider transitioning all measures to another mechanism of obtaining data that is not dependent on encounter data.
- Just because this measure is low across the state doesn't mean we should drop it. There needs to be a better way to get at what this metric measures. There is a lot of this work that reaches outside of Medicaid and that the current methodology doesn't account for the working realities of physical practices.
- Benchmarks should be revised to reflect the broader population so that pre-screening is also included in the numerator.
- If SBIRT does not move to a clinical quality measure for 2015, we recommend:
 - (a) Revising the state benchmark (since it was based on a prevalence rate that is not representative of the statewide prevalence) and factoring-in the sensitivity of pre-screening questioning so that those who may be positive for alcohol or drug misuse but are not identified in the pre-screening process are accounted for. And also factoring-in the low sensitivity of the full SBIRT tools (18-24% in some cases) since we know many providers don't want to bill for negative screens because they don't spend the full time reviewing it, doing brief intervention and referring.
 - (b) Counting the member's SBIRT regardless of what CCO they were in when it occurred to promote care coordination and reduce duplication of efforts.
- This measure should be modified slightly to adjust for the barriers to success as identified in 2013 and 2014. Some minor changes in the specifications could help capture more of the activity being done. The benchmark is unrealistic for the methods we are using. With a reasonable benchmark, we could see some good practice changes.
- Consider changing the measure title:
 - The metric measures completion of the AUDIT or DAST tools, not performance on the SBIRT process. The measure name and process are misleading. Recommend measuring the full SBIRT process, not AUDIT or DAST screening rates. Alternately change the name of the measure to be more honest.
 - Take SBIRT out of the measure title, since it creates confusion among providers that believe we are tracking the number of brief screenings conducted when we are actually measuring the triggered AUDIT or DAST. Many providers are opting to start with AUDIT/DAST and are skipping the brief screening all-together. The "sell" for

SBIRT was that it is brief, but OHA is not rewarding the brief screening so it feels like bait and switch.

- The Metrics & Scoring Committee selected SBIRT as the incentive measure, but only positive results on the AUDIT or DAST are showing up in the numerator, which are dependent on many other factors besides performance of the screening.
- The measure should follow HEDIS or another national standard; the numerator and denominator do not make sense.
- Need to separate the services from the billing codes to capture the true use of the measure.

Comments in support of dropping the measure

- This measure seems out of reach: SBIRT is performed far more than it is recorded in claims data due to billing challenges and clinicians are spending a lot of time and stress trying to figure out how to bump up a number for data collection when the program is already well used.
- This is still a measure that a lot of clinics find cumbersome. There have been so many changes to the measure already that the physicians are no longer taking it seriously. Also, the CMS equivalent measure has a 10% requirement which most physicians find unreasonable and have rejected working on this measure. If they are not going to work on SBIRT for CMS, they will not work on it for the State.
- The measure should be dropped: the literature does not support the efficacy or effectiveness of interventions based upon this screening. We should be choosing measures that have good literature behind them.
- The SBIRT measure as it currently stands does not measure any follow-up from the screenings which are already happening, which is really what we're concerned about. Every single new (and practically every returning) patient in every single primary care practice is asked about alcohol and drug use and they have been for years. It is just not documented in the claims or the EMR and this is adding cost and burden to the practices for a "we already do this" measure.

Other comments

- Treatment options must include more than 12-step programs.
- Significant effort should be made to bring commercial payers on board if this measure is to continue. Currently there are commercial payers that do not pay for SBIRT service codes. This causes issues for primary care clinics who seek to screen, but have to be cautious as to which patients they perform SBIRT with. Performing SBIRT on a patient whose insurance does not cover the service can result in either the patient being billed or the primary care clinic having to provide the service without reimbursement. CCO metrics should be designed in ways that seek to elevate quality in standards of practice across all patient populations within our community. A CCO metric that requires special treatment/services for CCO patients that is not necessarily available to patients with other insurance increases

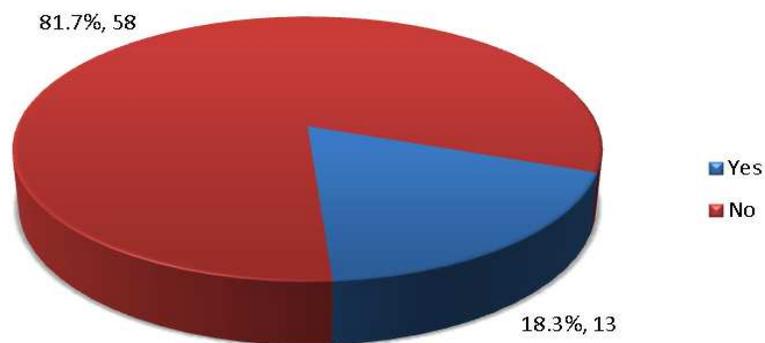
administrative burden on practices who have to try to figure out which patients should receive what care.

- One of the problems with SBIRT is that, in many cases, the act of providing a brief intervention requires additional resources / FTE. SBIRT, compared to the other CCO measures, is a much more complex process to implement within a primary care setting. It bothers me that such a complex measure has been selected, but - to my knowledge - no clear pathway has been set to provide the funding for the additional positions that are often required to provide the brief interventions - rather, it's just been left up to the clinics to find the implementation costs in hope that there will be, financially, a "trickle down" effect from the CCO to the clinic if the targets are met.
- Do we have the capacity within the state of Oregon to provide timely access to substance abuse services via our mental health programs? Do we have enough resources? Just something to ponder.

AMBULATORY CARE: OUTPATIENT & EMERGENCY DEPARTMENT UTILIZATION

Question: Should the Ambulatory Care: Outpatient and Emergency Department Utilization measure be dropped or modified for 2015?

n=71



Comments in support of keeping the measure as is:

- ED utilization measure should stay as is.
- The incentive measure should continue to be based on ED Utilization only. With the innovative work around community health workers and alternative care models, the use of ambulatory care in the measure would be misrepresentations of the actual services that are provided.
- More measures need to go this direction - force collaboration and discussion across the care continuum. If hypertension is reduced (the cause), what is the change (the effect) – of that population, is there a reduction in medication, is there a reduction in hospitalization?
- Measures should be kept the same or with as few changes made as possible for at least three years to see if there is any measureable improvement over time.

Comments in support of modifying the measure:

- Create a sub-measure for access to urgent care after hours.
- Consider including ED visits primarily related to mental health and substance abuse concerns.
- The measure should be stratified by age: pediatrics has very different reasons to have young children seen in the ED (e.g., parent worry, child abuse, fever in unimmunized children, etc). The measure should be more sophisticated to take into account appropriate ED use in children.

- An ACES screening tool should be added as a way to determine causation of regular ED visits and potential alternatives.

Comments in support of dropping the measure

- Outpatient utilization measure should be scrapped until you can come up with one that measures the good care people are getting through multiple types of contact (email, phone, in person, with RN OR MA, with CHW). Outpatient utilization measure measures "old way" i.e. only face-to-face encounters while OHA (among many) is trying to drive "new way" PCPCH team-based, evidence-based care delivered via many mechanisms.
- The measure should be dropped until CCOs can get cooperation from the hospitals on reducing ED visits. This is a high priority revenue stream for hospitals and they have no incentive to reduce these visits.
- The measure should be dropped because the measurement is inaccurate and based off billing data, which is six months too late to be meaningful. Data mining is only as good as the garbage that is entered at the input end. If it were more timely, it might help.

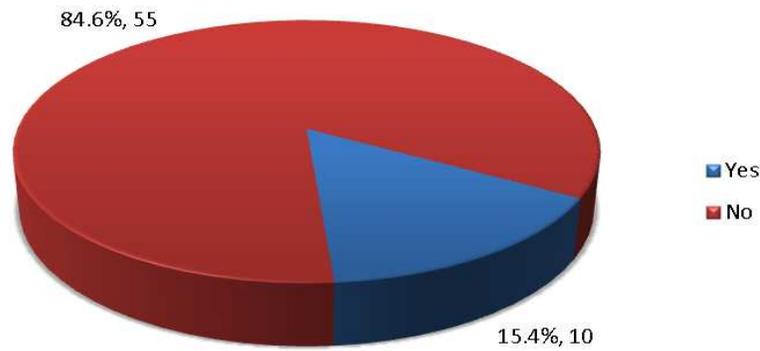
Other comments

- Utilization of ER and non-primary care facilities for non-emergent health problems is driven in part by primary care access, however, is also encouraged by lack of routine primary care visits, lack of anticipatory guidance and misunderstandings in the community regarding the value of using the same PCP provider for as many concerns as possible as part of an ongoing plan of care.
- Concerning Ambulatory Care... ambulances are paid by the ER, when taking people to the ER; when an ambulance arrives at a scene and does not transport, they do not receive pay. However, they are medically trained and qualified to provide a wide variety of emergency services at location, and intervene in situations to prevent transportation to the ER; allowing the person safety and remedy until the able to reach their primary care provider (the same day or next day)... Ambulances should be able to bill the CCO directly for providing services, perhaps even functioning as a mobile medical unit, at reduced fees for multiple usages... Paying the ambulance alone is much more affordable than paying both the ambulance as well as the ER visit. Many ER visits are unnecessary after receiving needed medication or emergency care from the paramedic onsite, but are nevertheless transported to the ER, so that the paramedic can bill for payment. Establish alternative payment methods for Ambulances.
- We should anticipate an increase in ED utilization given the dramatic expansion of Medicaid. Our own experience with the Oregon Health Insurance Experiment showed that those who are newly insured are much more likely to visit the ER. That, coupled with the dramatic increase in demand for PCP access is likely to increase utilization in 2014 vs. 2013. We do not yet have adequate claims run-out to predict. I think 2015 benchmarks should take this into consideration. I do think that it is important to continue NOT to push CCOs to have office utilization above benchmarks. Measuring it as a balancing measure is still reasonable.

- The system is set up to generate financial windfalls for CCOs that meet benchmarks. I'm concerned that measures like this will encourage organizations to try to meet them by less than desirable means for the patient.
- We should move away from measures of overall ED utilization and focus on ambulatory sensitive conditions: i.e., those that can be effectively moved back into the clinic setting. This creates a clear path to action, rather than leaping to the erroneous conclusion that high ED rates reflect lack of access to primary care: a clearly disprovable conclusion. In addition, we need to add some measures that create incentives for hospitals and ED physicians to participate in the reduction in ED utilization: both entities are, and will continue to be, incentivized to continue a high level of through-put in EDs, while be able to effectively blame the problem on primary care physicians (e.g., primary care lacks access or primary care needs to educate their patients). There will be no effective movement in ED rates without aligning the incentives of hospitals and ED physicians to this goal.
- There is a lot of work to be done to ensure that clinics receive timely data that they can use to outreach to patients. In an ideal world, the hospital would alert the clinic or the CCO the day of the ED visit, via electronic lists, which would then be sent to the clinic to start patient outreach.

CAHPS COMPOSITE: ACCESS TO CARE

Question: Should the CAHPS Composite: Access to Care measure be dropped or modified for 2015?
n=65



Comments in support of keeping the measure as is:

- The survey information is an integral part of the triple aim. It must be administered the same way over the years for comparability.
- Measures should be kept the same or with as few changes made as possible for at least three years to see if there is any measureable improvement over time.
- This the only patient experience of care data that relates to practice-based care. Given the triple aim, it is imperative that this data source be maintained.
- Do not drop the NOTION of access to care as a quality metric, even if changes are made to which measure is selected or modifications made to this measure.

Comments in support of modifying or dropping the measure:

- The AMH mental health surveys should be included in the incentive measures as well. They have been administered annually for years and offer a strong baseline to improve upon.
- More measures focused on the CAHPS and/or composite measures within the CAHPS should be considered. Secondly, the PCPCH standards related to the CAHPS should be improved to require standardized administration.
- In terms of access to care, there are the realities of appointment access along with the customer satisfaction with those experiences. While CAHPS is great at measuring customer satisfaction, the delay in getting the information inhibits rapid response and change. I would suggest third-next available appointment as a measure for access. It can apply to multiple providers - mental health, PCP, dental - in a standard way.

- The intention of this measure is not exactly clear. If it is intended to measure actual *access* to care, then it should be dropped and an alternative measurement should be adopted. But, if this measure is actually to observe customer satisfaction or customer opinion, then it should be kept.
- The timing of the survey should be taken in to consideration, since sentiment of access may change depending on the time of year (if it is flu season, it could be harder to get an appointment than the middle of summer). We would request that OHA field a mid-year interim CAHPS survey.
- If surveys are currently conducted once per year, then surveys should be done more frequently (at least quarterly), with feedback made available to CCOs.
- You are asking people to rate something for which they have no standard or experience receiving. Also, the return rate of the survey is so poor that you can make no valid statistical conclusions based on it. If you can get the return rate to 60 or 65%, then maybe.
- The CAHPS is one of the worst push poll surveys in use. It does not accurately develop or assess consumer attitudes or satisfaction. We need a neutral assessment tool to use for consumer satisfaction.
- We ought to look at Dana Safran's studies and align our patient satisfaction measures to what she learned, particularly related to the loyalty domain.

The “loyalty domain” includes questions about provider listening, provider preparation for the visit, willingness to recommend the provider to a family member or friend, etc. Providers who do well in this domain find that their patients are more willing to accept and act upon their advice (often referred to as “compliance”). Patients tend to have better quality scores as a result.

- Many people struggling in the community to re-integrate or to improve their professional changes of working and contributing have issues and overwhelming obstacles because of dental decay and/or need for prosthesis; Dental care with limited cosmetic services should be available as needed, on exceptional basis for those members on Medicaid or OHP who are actively engaged in training, job certification or job seeking programs. It would be inappropriate to blanket cover the entire population of Medicaid; but counter-productive to prohibit the advancement, mental health and over-all wellbeing of individuals who take action to improve their lives and become self-sustaining and independent.

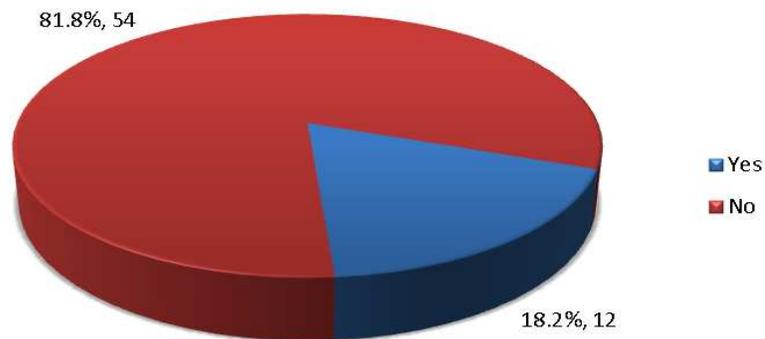
Other comments

- It would be very valuable to have CAHPS data at the practice level.

CAHPS COMPOSITE: SATISFACTION WITH CARE

Question: Should the CAHPS Composite: Satisfaction with Care measure be dropped or modified for 2015?

n=66



Comments in support of keeping the measure as is:

- CAHPS [measure] should only be dropped if it is replaced with policy that ensures the same end.
- Measures should be kept the same or with as few changes made as possible for at least three years to see if there is any measureable improvement over time.

Comments in support of modifying or dropping the measure:

- If surveys are currently conducted once per year, then surveys should be done more frequently (at least quarterly), with feedback made available to CCOs.
- This measure is a bit superficial. Good manners and polite, respectful treatment of patients are good practices for medical workers to use, but they don't substitute for helping the patient get well quickly and effectively.
- There is some emerging evidence that this specific measure may be negatively correlated with high quality, effective care. The effect size is small, but it raises a number of issues.
- Care satisfaction is an important part of any practice. However, the various issues which drive patient dissatisfaction are often in direct competition with what is best for their healthcare. Patients are frustrated by long wait times, poor bedside manner and inefficient responses when contacting their provider. These measures seem well defined and actionable on the part of the provider/health system. However, frustration with not being prescribed higher doses of narcotics than are appropriate, being encouraged to vaccinate

children when medically indicated, etc are measures which also impact patient satisfaction and are not and should not be actionable by the provider.

- You are asking people to rate something for which they have no standard or experience receiving. Also, the return rate of the survey is so poor that you can make no valid statistical conclusions based on it. If you can get the return rate to 60 or 65%, then maybe.
- The CAHPS is one of the worst push poll surveys in use. It does not accurately develop or assess consumer attitudes or satisfaction. We need a neutral assessment tool to use for consumer satisfaction.
- This [measure] should be included, but there definitely is nuance needed and too high of rates of satisfaction actually may result in increased cost.
- Add question(s) on “were my treatment preferences and goals discussed, considered, and respected”

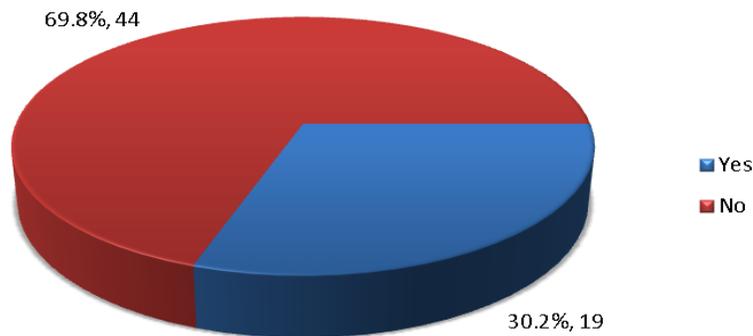
Other comments

- The CAHPS survey should be measured at the provider level, because satisfaction with the provider will lead to a satisfied health care consumer. If it is surveyed at the provider level, assistance should be given by the State or CCO to assist community providers with the cost of administering the survey.

COLORECTAL CANCER SCREENING

Question: Should the Colorectal Cancer Screening measure be dropped or modified for 2015?

n=63



Comments in support of keeping the measure as is:

- Measures should be kept the same or with as few changes made as possible for at least three years to see if there is any measureable improvement over time.

Comments in support of modifying or dropping the measure:

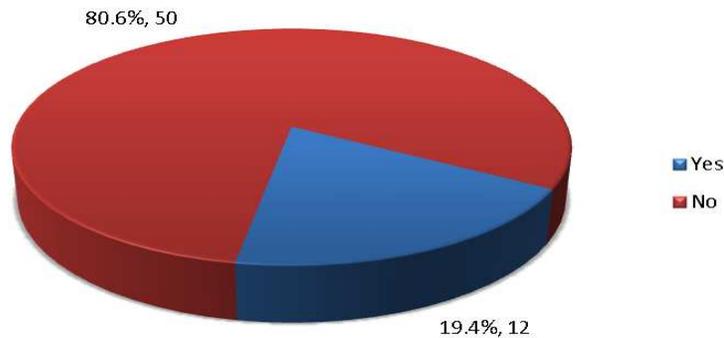
- Need to transition to chart-sampling process given long window of time needed to evaluate appropriate screening.
- As EHR adoption increases and medical records become truly digital, providing an EHR report on previously performed colonoscopies should meet the requirement rather than visually inspecting records.
- This needs to be correlated with high risk groups, not just the general public. Testing the feces of every patient who shows up for any health issue is a waste of resources. Most people have a much higher risk of having cardiac disease, HTN, or diabetes, than they do colon cancer.
- You have to include retrospective data including colonoscopy screening back to 2004. If you don't the data gathered is meaningless. Also numerous folks get screened by FOBT and are probably improperly billed and coded to count.
- This is a very difficult measure to track and should be in line with national reporting standards.
- Modified from 2013; it should follow HEDIS specs.

- This measure does not identify members who have had a colorectal cancer screening in previous years. The measure should allow for submission of evidence for prior screening tests if they remain relevant for subsequent years.
- As has been discussed many times at M & S committee, this measure is very tricky with respect to look back periods and various methods for screening. I recommend either dropping the measure or modifying it to reflect some form of chart sampling/ review.
- This is too complicated to measure accurately in this highly transient OHP population. The number of years necessary for an appropriate look-back for this metric (according to HEDIS) makes data difficult to accurately obtain in this population.
- There are many barriers to using encounter data as a means of measuring outcomes. All measures should be transitioned to another mechanism of obtaining data that is not dependent on encounter data.
- We were under the impression that the rules stated the look back period was 3 years. What we have since found out is that the state look back period is now one year. This is not reasonable or best practice. I would recommend that we stick with the HEIDIS measure and do the look back up to 10 years.
- I'm of mixed feeling about this. From a resource utilization standpoint, we ought to be focusing on increasing FIT as the screening of choice and to be reserving colonoscopy for those who fail screening. Unfortunately, we will not be able to convince the medical industry to change its highly profitable focus on colonoscopy, and, therefore, we will be unlikely to change the measure.
- The measure should be modified to include a longer look-back period and alternative screening techniques.
- This is a difficult metric to track because it requires looking into the past (up to ten years) and many provider offices do not have a means of doing that except through paper chart reviews.
- Incredibly difficult to implement and measure.
- [The measure] needs to be up to date with variety of [screening] methods based on evidence.
- A plan with more fluctuating population would have less opportunity to provide colorectal cancer screening to its beneficiaries, even though the total member month could be relatively big. And the age range overlap with Medicare, so it is hard to say this is about Medicaid.
- This measure does not accurately measure the need for colorectal cancer screenings and promotes over screening. This measure should be modified to better account for members with a full colonoscopy that do not need a test each year.

CONTROLLING HYPERTENSION

Question: Should the Controlling Hypertension measure be dropped or modified for 2015?

n=62



Comments in support of keeping the measure as is:

- Measures should be kept the same or with as few changes made as possible for at least three years to see if there is any measureable improvement over time.

Comments in support of modifying the measure:

- This measure should reflect the JNC 8: 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eighth Joint National Committee. Flexibility for those older than 80 or 85.
- Perhaps specifically call out people with serious mental illness and HTN?

Comments in support of dropping the measure

- The last BP of the year is a poor indicator of controlling hypertension.
- Very time-consuming for practices to measure.
- This measure is highly susceptible to inaccuracies based on the skill of the medical assistant and the condition of the office equipment. We would like to see a measure that aligns with existing state/federal efforts such as HEDIS, 5-Star, etc. (for example, Treatment of Blood Cholesterol based on ACC/AHA guidelines).
- This metric is not clinically relevant. There are many things that can influence a patient's blood pressure on a given visit date. Having worked with this metric, and its HEDIS version, for several years, I have found measurements to be greatly influenced by the level of skill of the Medical Assistant (MA) who takes the pressure as well as by the condition of the office equipment. Additionally, is not unusual for physicians to re-take a patient's blood pressure if the pressure recorded by the MA is high, then document this in the written note, rather

than in a discreet field in the EMR.

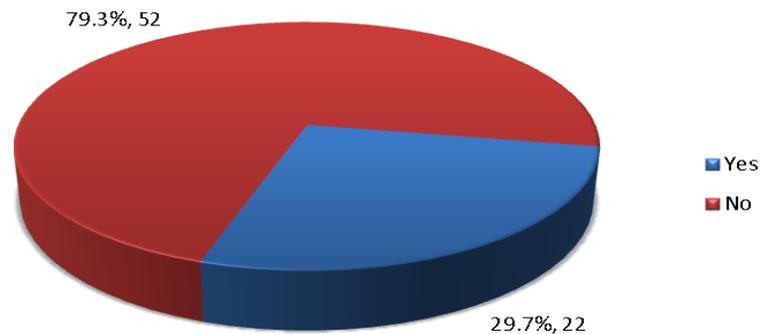
In place of this metric, I would propose a metric related to the new Nov 2013 ACC/AHA guidelines on the treatment of blood cholesterol, such as: Individuals ages 21-75 with clinical atherosclerotic cardiovascular disease* will be prescribed a high intensity statin. Measurement period is January 2015 through December 2015, with at least one prescription meeting the statin intensity requirement in this time period. *Clinical ASCVD includes acute coronary syndromes, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin. This is much easier to measure through administrative data and is more clinically relevant than the HTN measure (and less dependent on the skill of the medical assistant and the condition of the office equipment).

Other comments

- It is not clear how we envision all practices reporting MU measures. There will be significant overlap of members and data accuracy will be a challenge. I am in support of MU measures. I just anticipate some big hurdles in 2015.

DEPRESSION SCREENING AND FOLLOW UP PLAN

Question: Should the Depression Screening & Follow Up Plan measure be dropped or modified for 2015?
n=74



Comments in support of keeping the measure as is:

- I would modify all the measures, but if we do that, we might not get any compliance with depression screening and follow-up.
- Measures should be kept the same or with as few changes made as possible for at least three years to see if there is any measureable improvement over time.

Comments in support of modifying the measure:

- Modify so that PHQ-9 positives are routinely given a bipolar screening test (e.g. MDQ, or, better, "MoodCheck", a composite bipolar screener the components of which have been validated and the whole of which is designed specifically for screening in primary care.
- Please ensure that the [specifications for the CCO incentive measure] depression screening with follow-up plan align with the upcoming UDS 2014 depression screening and follow-up plan requirements for FQHCs. I THINK it will (the reporting specifications should be delivered later this year) but just something to keep on the radar as a state.
- Expand measure to include screening in obstetric care settings; and change screening age to include adolescents. Screenings during prenatal and postpartum care can identify babies or mothers at risk for complications. And this period represents a key opportunity for health care providers to educate and support families. The adolescent years comprise a critical period in the life span and provide opportunities to positively influence future health behaviors and health outcomes.
- Adolescents need to be added. School shootings, and related morbidity mortality is huge measure should start at 12 as national guidelines suggest.

- Does it include depression or psychosocial dysfunction screening in adolescents? If no, then it should include adolescents 12 years and above.
- Let's start depression screening measure at age 15.
- Recommend dropping the age for inclusion in the denominator to 12. Approximately 1 in 4 youth in Oregon report having a depressive episode in the last year, and suicide is the 2nd leading cause of death among Oregon youth. It is well documented that many providers do not routinely screen for depression. Depression screening and necessary follow-up can be delivered within the context of a high-quality adolescent well visit.
- The Depression screening and follow up measure should be modified to include adolescents (ages 12+). If the measure does include children, collection of this information should reach beyond just claims data as screening may take place but not be billed due to privacy and confidentiality issues for adolescents.
- Expanded to include adolescents. Most adult mental health disorders begin in childhood. Having early treatment and skills can decrease adult burden of disease.
- This should be extended to age 12 to include adolescents. The prevalence data on Adolescent Depression, coupled with the high suicide rate in that age group, supports this.
- Consider dropping the follow up portion of the depression screening measure.
- We should keep depression screening, drop the follow-up plan piece. Alternately, measuring the rate of re-screening patients 6 months or more after their initial positive screen might be a worthwhile measure. But accurate measurement of a follow-up plan would require reading the text of a progress note. All the reportable elements we can use to measure whether a documented follow-up plan exists push clinicians away from best practices. e.g. It is a best practice for our primary care providers to manage many depressed patients without medication; we expect our providers to treat most depression without referring to a specialist; we expect our providers to screen patients who present with a complaint of depression with a full mood questionnaire. Following all of those best practices reduces our score on the measure because those are precisely the data elements we can detect; reversing those practices takes us away from the triple aim; it is a measure that incentivizes precisely the opposite practices we want to emphasize.
- It may be more reasonable to start by measuring the depression screening; that will give providers an opportunity to build the infrastructure to successfully record and report the follow-up plan. The majority of our providers still struggle with having the functionality in their EHR to track this, but they have upgrades planned for later this year. It remains to be seen if the upgrades will have the functionality to track the follow-up plan appropriately. I would strongly consider changing the metric to measure just the screening for now.
- I am worried about universal screening and its impact. Is it going to pick up a huge set of patients that are transitionally depressed and would normally cycle through without any intervention? And if so, will this lead to increased use of SSRI's when they may not be necessary? Can it be changed to measure only if the patient is in for a physical or well care? No clinic is going to introduce this into a work flow when the patient comes in for a cold.

- Modify to include more interaction with Mental Health providers.

Comments in support of dropping the measure

- Potential to move this to a performance metric [rather than an incentive metric].
- Should consider replacing this measure with a more effective one if such is available.
- Consider dropping this measure. It is a USPSTF B recommendation only when all supports are in place - perhaps add it back later when behavioral health and primary care integration is more robust.

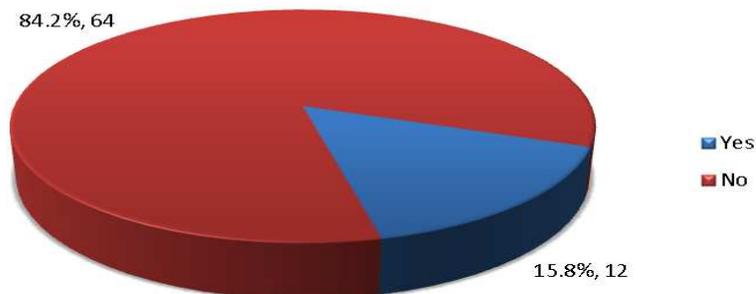
Other comments

- It is not clear how we envision all practices reporting MU measures. There will be significant overlap of members and data accuracy will be a challenge. I am in support of MU measures. I just anticipate some big hurdles in 2015.
- While the measure makes some sense, I suspect you've discovered that it is near impossible to effectively measure at the level of a CCO or health plan. Accordingly, for this (and related measures that need data from provider records) we ought to be focusing efforts on how we can get at those measures (and how we will achieve the level of trust throughout the system, provider to CCO to state, to believe the data furnished by providers). Getting the data can be relatively easy, but getting folks to believe data that comes from someone with a financial interest in that data is going to be a bigger problem.
- Concerned about unintended consequences of incentivizing depression screening. Because the CCOs have significant dollars attached to each metric, they are spending money to meet them. When you incent depression screening in our current medical model, you will see an increase in the "diagnosis" of depression and an increase in prescription treatment. Having read *The Anatomy of an Epidemic*, I am concerned about what we are creating (along the lines of opioid incentive to treat all pain?)
- Similar to the SBIRT measure, this is strictly an EMR issue and we're requiring providers to incur cost to add to/alter their EMRs. Unlike SBIRT, however, depression screenings are not as integrated into normal clinic practices as drug/alcohol screening are, and we do need improvement in primary care screening and treatment for depression. Due to variants among EMRs, there is no simple way to collect this data. Primary care physicians/NPs/PAs/MAs need training and education and the state should adopt some standard form for this screening instead of leaving it up to practices.

DEVELOPMENTAL SCREENING

Question: Should the Developmental Screening measure be dropped or modified for 2015?

n=76



Comments in support of keeping the measure as is:

- This measure contributes to the ultimate outcome of kindergarten readiness. Till we have kindergarten readiness measures, keep this measure. Identifies children needing special services.
- This measure has greatly influenced family medicine to start screening. Early identification and follow up, treatment via IEP is huge. Finding these kids early prepares them for kindergarten; look at Heckman equation. We need to invest more at much younger ages to get ROI about 88 dollars. Early brain development, cumulative adverse child events leads to significant alteration in physiology and adult disease. Soon kindergarten readiness (combining education and health care reform will payoff in long run.)
- Although developmental screening is a process measure - kindergarten readiness is the target. This includes that screens are done, that kids get into necessary services when they fail a screen, and also includes family risk assessments and all the social determinants of health work that impacts early childhood development. I think eventually (when the committee is ready) that Kindergarten Readiness should replace or augment this particular measure.
- Imperative measure that is a flag of Bright Futures recommended care. Relates to health and education system goals of early identification. Future measures should relate to FOLLOW-UP based on use of standardized screening tools. There are methods, learnings and tools to be considered based on the ABCD III project.
- Routinized developmental screening in Pediatric practices is critical to the earliest possible identification of children with delays, which with early treatment may be reversed or at least resolved to the extent possible. This lowers societal and medical burden for these patients as they age.

- This particular outcome is more complex than simply developmental screening - Creating a best practice will be important - for example the screening should occur more often for younger children.
- This is a critical measure and we are finally making headway.
- We need to measure developmental screenings.
- Prevention provides the long-term cost savings - we have to keep this in the mix or we'll pay for it 20 years from now.

Comments in support of modifying the measure:

- Add CPT Code 96111 [developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report].
- Count the member's screen regardless of what CCO they were in when it occurred (to promote care coordination and reduce duplication of efforts). So if a member is assigned to a different CCO for 45 days or less and receives the screening service during that time, the member should still count in the numerator if they are kept in the denominator. This better aligns with the intentions of the Triple Aim and will discourage wasteful duplication by providers who are concerned services will not get counted.
- There needs to be work done to coordinate the different program requirements for these screens or allow local communities to determine when screens are done for social service programs such as Head Start, Public Health home visiting, Healthy Families etc. Currently we all require these in our programs at the same ages. While we don't duplicate in these programs it makes it hard not to duplicate with primary care providers if they are also doing the screens.
- I think that it should be modified to have more of an effort should be made to engage the community childcare partners and parents that are doing the screenings so that the full screening and recommendations can be completed. Currently, in our area a very small percentage [of screenings] end up being reviewed by the PCP and recommendations being made, as well there is no real system for checking on follow up.
- I think that ASQs provided by community partners should be counted as "completed" developmental screens.
- Include provision for county health visiting nurses to be able to document the screen.
- There are many barriers to using encounter data as a means of measuring outcomes. I believe all measures should be transitioned to another mechanism of obtaining data that is not dependent on encounter data.
- I think that we need to reconsider the appropriate ages for this screening to align this measure with those ages. By appropriate, I mean not only what the literature says (efficacy)

but also how practical it is to accomplish and follow up those measures (effectiveness). We cannot let a desire for perfect keep us from getting this work done.

- This should follow a standard that is recognized as being reliable and valid to the needs of the population.
- I think that we should be using the ACES tool to assess stable and attached families rather than the ASQ.

Comments in support of dropping the measure

- There is a question as to whether reacting to a positive ASQ makes any difference in outcomes, so I am not sure the measure is worth the effort.

Other comments

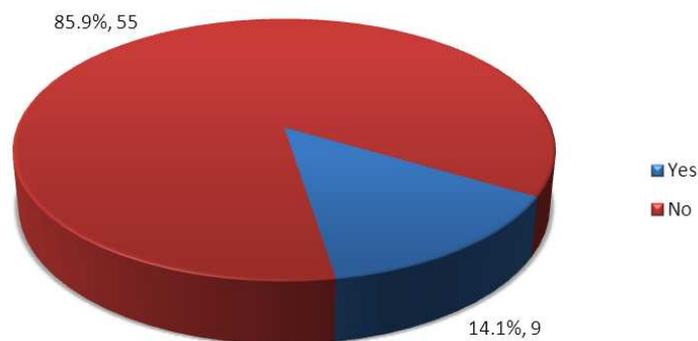
- [Regarding the statewide 2013 benchmark] It's unreasonable to only expect 50% of Oregonian children to be assessed for developmental landmarks, when they finally get in to see a licensed health care provider. With such a large number of children living in poverty, few ever make it in to see a health care provider for any form of health care services, especially not on any sort of a regular or predictable basis. If only half of them are screened for developmental landmarks, that means that half of them (probably the poorest and/or the least well-cared for half) may go for years with vision, hearing, growth, attention, social, emotional, or other serious delays/disabilities that are never caught, thus leaving them unnecessarily lagging behind their peers in school, home, and community pursuits. The longer these types of developmental delays are permitted to be overlooked/ ignored/ disregarded, the more severe the consequences will be for the child, teacher, parents, school, and community.

With much more readily available health insurance coverage for children, in Oregon, there's no excuse for ignoring the developmental milestones they have/have not achieved, at each visit. Giving licensed health care providers permission to ignore the development of half our children is the most overt form of medical neglect/abuse I've heard proposed as public policy, in quite some time. It's essentially saying that as long as 50% of our kids are developing OK, it doesn't matter what happens to the rest of them.

Diabetes: HbA1c Poor Control

Question: Should the Diabetes: HbA1c Poor Control measure be dropped or modified for 2015?

n=64



Comments in support of keeping the measure as is:

- Keep the measure, use HEDIS specifications only.
- Measures should be kept the same or with as few changes made as possible for at least three years to see if there is any measureable improvement over time.
- The measure is driving some more adult focused improvement.

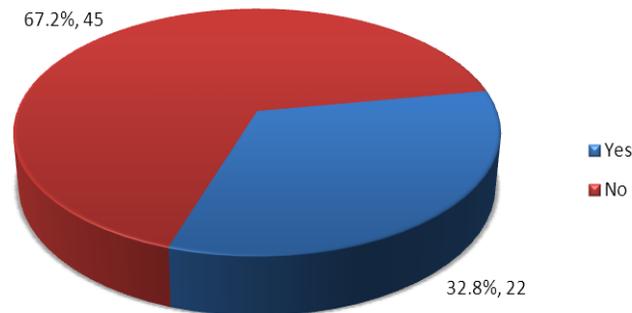
Comments in support of modifying the measure:

- Follow guidelines for elderly / very elderly diabetics.
- This measure applies to all ages; in some very elderly patients, [A1c] control is not as important.
- Should be HbA1c <8.
- Perhaps modified to specifically call out people with serious mental illness and diabetes?
- Should seek a measure which indicates the number of diabetes patients who have their disease under control.
- Just noting that, from a QI perspective, I have found that this measure can be confusing to the staff on the ground within our centers - specifically, that we want this measure to decrease, not increase. Is there any reason we are focusing on poor control and not % controlled, which is what most health centers tracked prior to this?
- Add "and follow-up plan."

EARLY ELECTIVE DELIVERY

Question: Should the Early Elective Delivery measure be dropped or modified for 2015?

n=67



Comments in support of keeping the measure as is:

- This is a national priority: late preterm delivery has medical, educational, societal costs.
- Imperative and this has generated significant and important work in this area.

Comments in support of modifying the measure:

- Exclude providers who offer [elective delivery].

Comments in support of dropping the measure

- [CCPs] have no ability to track, trend or make adjustments throughout the year.
- [CCOs] do not have a way of monitoring our progress on this measure due to the data coming from the hospital association. That is a barrier to making improvements.
- Too cumbersome for reporting.
- This measure is influenced more by hospital policy and reporting; less CCO impact.
- Too easy a metric.
- This makes no sense to keep.
- This should be dropped, there are already many national measures of this, hospitals track it very closely, and the practice norms have changed to the point that measuring is a waste of time and resources because rates are so incredibly low.

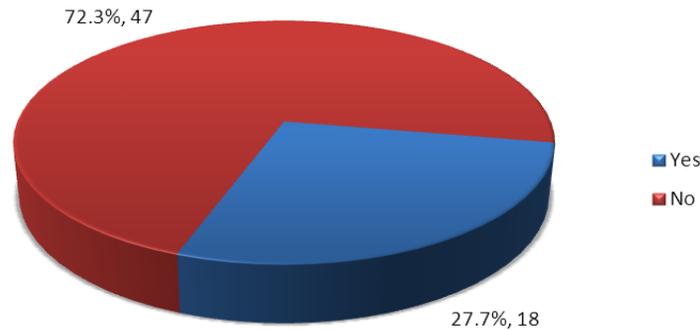
- [This] has been standard of care for many years and that [hospitals] are very compliant with this measure.
- The statewide performance of the measure has largely improved in the past two years, which from what I understand; hospitals already make it a policy to refuse early elective delivery. Besides, it is not a measure that CCOs can easily interfere in.
- Not meaningful at this point at the CCO level and the rate has significantly improved overall. It could stay as one of the 33 measures, but not be an incentive measure.
- Move to monitoring status. We really have this under control as a state.
- [This measure] is passé: I think our data are ok for this.
- I don't think this is a huge issue in Oregon, is it?
- CMS guidelines have rules regarding this. Most hospitals already have a policy in place around this measure.
- The rate has dropped significantly. There is less room for improvement from now on. Any factors in data collection process could potentially have bigger impact than the real quality improvement.

Other comments

- This is another issue of aligned incentives. While hospitals might find it convenient to participate in this measure, the actual work is done by providers. And, of all the distribution methodologies I've seen from CCOs, the bulk of the incentive goes to hospitals, and it's simply not practical or ethical to reward the hospital for work that must be done by providers. By the way, this is actually an issue behind all of these measures: the bulk of the work will be done by primary care, but the smallest portion of the reward is always for primary care. This will not create a sustainable enterprise.
- There should be less than 1% of mothers electively inducing deliveries. This is not a procedure invented for MD, midwife, and/or parental convenience. It should only happen if it's clear that the fetus is in serious distress and cannot wait for a more natural birthing process. This topic needs to be fully discussed with the pregnant woman at the first prenatal visit and underscored during all follow-up visits, so that the expectations around delivery procedures are clear from the start. Neither parenting nor birthing are "convenience" experiences and all parties involved with them need to be accepting of those facts. Those who don't want to be "inconvenienced", need to have nothing to do with pregnancies, nor pregnant women/children.

ELECTRONIC HEALTH RECORD (EHR) ADOPTION

Question: Should the Electronic Health Record Adoption measure be dropped or modified for 2015?
n=65



Comments in support of keeping the measure as is:

- Uncertain [whether to drop or modify the measure]; probably not; EHR utilization and quality continues to need incentive to improve.

Comments in support of modifying the measure:

- As the amount of incentive payment from the Medicaid, Medicare, or Medicare Advantage EHR Incentive Program declines, newer potential adoptees may not choose to enroll in the program but may make the decision to use EHR. There needs to be a way to include clinics and providers who are using electronic health records but not participating in the EHR Incentive Program.
- Should include access to vital providers of Mental Health Treatment, i.e., crisis workers should be able to use and share information when a Mental Health individual is in the ED Room.
- Require Open Notes.
- EHR adoption is a major investment and a planning stage or process stage should be granted as yes for 1 year.
- I'm not convinced that EHR use in and of itself contributes to good patient care. Would trade this for more specific indicators of what EHR's are supposed to accomplish (medication safety, timely screening etc).

Comments in support of dropping the measure

- Recommend dropping this measure. For areas where providers have been on EHR for a while, the incentive or return on investment to participate in Medicare, Medicaid, or

Medicare Advantage EHR incentive payment programs, and therefore not reflect the true EHR adoption and utilization in a region.

- By 2015, any practice that has not yet adopted an EHR either voluntarily, or as a result of pressures put on them in the preceding years is unlikely to do so.
- EHR seem to be widely used now. Perhaps this measure is not as important as it was.
- Drop this measure as I don't think it is a major influence on provider decisions to adopt an EHR at this time.
- This measure has a challenging calculation that is not modifiable during the year. With all of the emphasis on data exchange with the 3 clinical measures, this should be taken out of the Incentive Measures. It could stay as one of the 33 measures.
- Most CCO's have little impact on this measure. In our area, this is going to be driven more by the hospitals and meaningful use than by the CCO's.
- This should just be part of the PCPCH measure.
- Oregon already has a high adoption rate for EHR adoption. Will be difficult to document improvement for those that have not yet implemented. The CMS meaningful use program already incentivizes adoption.

Other comments

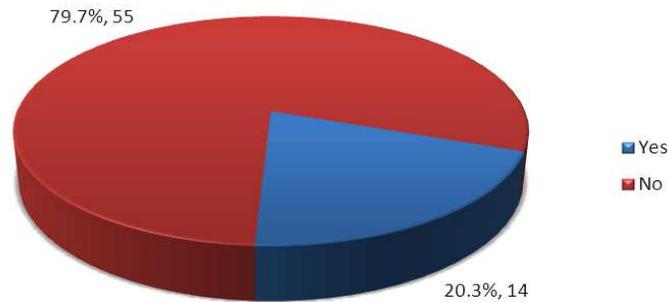
- There is not a good mineable EMR that is user friendly in existence. The data gathered is incomplete, and inaccurate. So we need to stop pretending that information that is incomplete and inaccurate is of any value. And none of the 600 vendors that sell "MU compliant" products meet the standards as defines, so there is no control over any of the vendors, data quality or other requirements. 15 years of EMR adoption and research have shown exactly zero outcomes based support for its use.
- Having an EMR is not helpful, despite what some of the "data wonks" seem to think. Having data and reporting it might or might not reflect real performance or be able to effect performance improvement. We have to deal with the "garbage in/garbage out" issue and we have to deal the discipline with which all of this data is analyzed and turned into information. My experience so far, however, is that the data is assumed to be correct if in the EMR and that anyone can pull that data and turn it into a report for driving improvement. Neither is correct, and that reality is leading us to expend resources on things that might not be important and upon improvement efforts that are unlikely to succeed.
- The initial expectations of the EHR are not to be found in simply having an EHR (i.e., it is still possible to have providers and staff enter incomplete or inaccurate data, key information might still appear in unstructured portions of the EHR, key components of the EHR neither improve care or capture better data, etc...) Essentially the quality of EHR data is only as good as the discipline and detail of the structure that uses the EHR. Accordingly, efficiencies and improved quality is to be found in thoughtfully modifying clinical work flows and creating structures within the clinic to produce desired results. There are low hanging fruit

(e.g. using registries to manage chronic disease and preventive services) that are amenable to clinic workflow redesign which will support effectiveness and efficiency beyond just “adopting” an EHR.

FOLLOW UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Question: Should the Follow Up after Hospitalization for Mental Illness measure be dropped or modified for 2015?

n=69



Comments in support of keeping the measure as is:

- More measures should be like this one.
- Measures should be kept the same or with as few changes made as possible for at least three years to see if there is any measureable improvement over time.

Comments in support of modifying the measure:

- Currently stays for which claims were denied are included in the measure. That doesn't make sense to me. It's also extremely difficult to respond to out of state hospitalizations which we don't know about until a claim shows up. And for some out of state hospital stays, the follow-up cannot be face to face if the individual doesn't immediately return to the local community. So I'd suggest that out of state stays be excluded.
- It is an important measure, but there need to be legal changes to the way mental health information is permitted to be transmitted in order for us to get actionable data. As a primary care organization, we are unable to get notification when one of our patients has been hospitalized due to mental illness.
- There are many barriers to using encounter data as a means of measuring outcomes. I believe all measures should be transitioned to another mechanism of obtaining data that is not dependent on encounter data. If we continue to use encounter data, we should be able to count services provided on the same day as discharge. This is best practice and is what many in our region are doing when members are discharged.
- There needs to be a way to not punish certified mental health professionals (CMHPs) that make contact with the individuals on the day of discharge.

- Follow up should be allowed on day of discharge. This system has been built into many mental health organizations already. There are different codes for mental health follow up verses codes for discharge from the hospital. This should be an easy data collection piece.
- MUST include same-day visit/discharge as "counting".
- Not sure how to measure, but this should be more focused on the on-going integration between mental and physical health providers, NOT just following hospitalization.
- Ensure this measure also includes ranges for the type of follow up (sub-metrics).

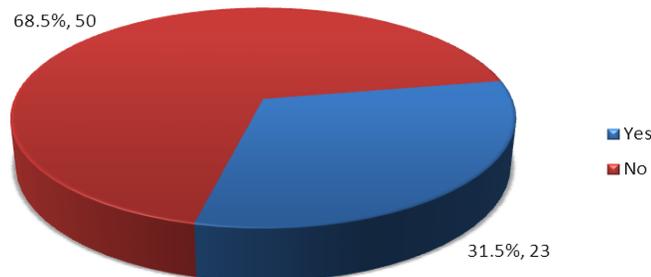
Comments in support of dropping the measure

- The denominator is too low for small CCOs.
- Clarity around what qualifies as a visit would be helpful. Access to mental health care in general remains a big problem, so perhaps something that looks at access in general would be more helpful. This is a very small portion of the population, and a measure that looked at access, wait times, etc. would be more meaningful.
- Better to get at core needs for Mental Illness than this difficult measure.
- From a primary care perspective, mental health services [seem to be] less directed by patient need and informed literature, and more directed by political decisions or partially informed entities, such as Regional Support Networks. To attempt to intervene in this problem at the level of primary care or the mental health provider is unlikely to gain much traction, and these providers certainly can do nothing to significantly change the behavior of legislators, regulators, or RSNs. In other words, the measure is focused on the wrong thing.
- The mental health system in Oregon is pathetic, poorly organized, and generally ineffective. As such, an enormous number of mental ill individuals end up inappropriately incarcerated in jails or prisons, rather than receiving the mental health care they deserve and require. Permitting a third of those who have been discharged from mental health hospital units to be flung out into the streets to, again, be ignored, overlooked, and/or thrown back into the criminal justice system, rather than receive appropriate follow-up care following hospitalization is irresponsible and neglectful of vulnerable individuals. The fact that few Oregon politicians care a fig about those who suffer from mental health issues has been flagrantly apparent for more than 25 years. Setting such a low standard for follow-up care and services, following hospitalization, reflects the continuing abandonment of this population, within Oregon's health care system. This vulnerable population requires special monitoring and careful follow-through, to prevent unnecessary readmissions, homelessness, medication noncompliance, exploitation by others, self-harm/suicide, criminal incarceration, or malnutrition. It is the responsibility of the admitting hospital to ensure that all of their inpatients are fully stabilized before discharging them back into the community. This standard is exceptionally important amongst those suffering from severe mental illnesses, as too often they have no community advocates/guardians looking out for their best interests, so are at great risk, upon discharge.

FOLLOW UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATIONS

Question: Should the Follow Up Care for Children Prescribed ADHD Medications measure be dropped or modified for 2015?

n=73



Comments in support of keeping the measure as is:

- This is very important to keep. Knowing that foster children on ADHD meds are frequently under the care of multiple providers, medication management is critical. Some of these meds result in weight gain as well, which might be cause enough for follow up care.

Comments in support of modifying the measure:

- Consider adapting to reflect follow-up care provided by phone or email instead of in-person.
- Allow for follow up via telephone, with an RNCC or behavioral health provider in primary care would be much more meaningful.
- Needs to be more flexible to allow phone follow-up or patient portal follow-up occur. Many primary care centers are working to expand their non-encounter based care to improve access and provide flexibility for families. If measure only includes encounter follow-up should be replaced by another childhood mental health measure.
- This measure does not measure the appropriate action, and is outside of the standard practice. Follow up care with children who have been prescribed ADHD medications does not always involve an office visit, and often is a phone call. The best time to come into the office is after 30 days, once the refill has been made. This measure may inadvertently drive an increase in office visits that are not necessarily. The concept to measure ADHD is important, but the definition may need to be modified.
- [...] some of the children on specific ADHD medications could be causing rates to be reduced because the standard of care for review of the child on these medication is not in the 30 day window, but in a 45-60 day window. If we keep the measure as it is, we are asking physicians to make the child come back for follow-up for no good reason. I agree that the

efficacy of some of these drugs is within 30 days, but the ones that are over that should be eliminated from the measure.

- Move to a HEDIS measurement time period.
- There are many barriers to using encounter data as a means of measuring outcomes. I believe all measures should be transitioned to another mechanism of obtaining data that is not dependent on encounter data.
- This measure is narrowly focused on only one type of medication prescribed for behavioral purposes. This measure should be expanded to include all psychotropic medication as defined in ORS 418.517(1)(b) and to comport with the review procedures for children in foster care found in the Child Welfare procedure manual, chapter IV, Section 21, page 16, which require external, annual review of necessity.
- The real measure should be the validity of ADHD diagnosis in children and the overuse of medication for children under the age of 6.
- Add ACES Screening. Collecting data on the number of children diagnosed with ADHD and their correlating ACES Score will put Oregon on the forefront of Trauma Informed Care.

Comments in support of dropping the measure

- Identify another measure that is focused on pediatric health. Do not reduce the number of metrics assuring health of children.
- Difficult to measure, even though the concept is admirable. Perhaps something simpler such as all children on stimulants getting 2-4 visits per year would be better.
- Small denominators - I think it should be replaced with a more robust pediatric measure.
- It is too difficult to identify the index prescription for ADHD medication, at least in our rural small population. Again, in order to get actionable data needed to move this measure, we need to know whether the patient was previously prescribed the medication in order to follow-up with a provider, and we do not have a reliable source at this time. An appropriate measure might be the ongoing follow up care for patients who receive an ADHD prescription, regardless of whether or not it is the first or a dosage change.
- Apparently this measure has not been successfully implemented with adequate results to determine significance.
- [This measure has a] small denominator. Children are followed up at appropriate initiation intervals, but is often 31-39 days. Not meaningful. The continuation phase would be worth doing, but because the initiation part of the measure affects the continuation part, it would not be a good measure.
- The impact of this metric affects such a small population that the statistics on it can be all over the map based on just 2 or 3 patients.

- For many complicated reasons (one of them including a frequently low "n" in the denominator for the CCOs), this measure should be dropped.
- Drop it entirely. ADHD has become medications (and social issues) in search of a disease. We have so much non-differential misclassification going on that any analysis of the data is going to be useless.
- [This measure] doesn't follow a standard. What was the purpose of this measure anyway? How does this reflect improving health in this population?
- With the lack of accuracy in diagnosis of ADHD in far too many children, it is irresponsible to only monitor half of those receiving prescription medications for this disorder. Again, that sets a low standard for pediatric health care providers to meet; permitting them to disregard half of the patients they are prescribing serious medications to, while only tracking those who are most appealing and/or most "successful", in their private assessments. The risks involved in misdiagnosing and/or mistreating young children who may or may not have ADHD are too great to allow half of the "problematic kids" who have that label slapped on them, to just struggle through their lives without follow-up or ongoing assessment. I have, personally, witnessed children who were inappropriately diagnosed with ADHD become addicted to the methamphetamines they were prescribed, only later to end up in substance abuse centers for related treatment, within a few years of being misdiagnosed. Their psychiatrists were no more interested in tracking the genuine signs and symptoms of the misdiagnosed children, than they were in educating the parents in how to raise their children in nurturing/supportive, rather than punitive, ways. So long as psychiatrists are solely responsible for "pushing pills", rather than providing ongoing, interpersonal psychotherapy, these episodes of misdiagnoses will continue. Assessing anyone's behavior for a mere 10 - 15 minutes, once or twice a month, is insufficient to effectively gain any degree of insight into either their issues or their relationships. The children of Oregon deserve higher quality mental health services, especially if they're going to be stamped with the label of ADHD, than they are receiving, at present. The standards must be raised and the prescribing health care provider be held fully accountable for providing thorough, ongoing mental health assessments and therapy, while prescribing potentially addictive medications to their clients.

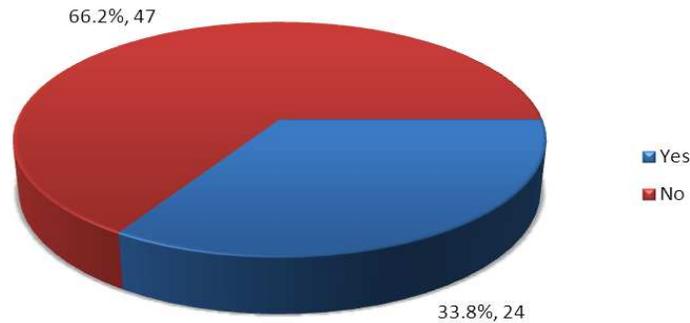
Other comments:

- Concerned about unintended consequences of incentivizing this measure. Because the CCOs have significant dollars attached to each metric, they are spending money to meet them. I already have a physician billing for weekly follow up visits after ADHD medication and he is now incented to prescribe more ADHD medications. In a time when we could be enhancing behavioral health, mental health, and trauma-informed care, we are unintentionally incenting prescription solutions on the physical health side.

MENTAL & PHYSICAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Question: Should the Mental and Physical Health Assessments for Children in DHS Custody measure be dropped or modified for 2015?

n=71



Comments in support of keeping the measure as is:

- [Keep the measure as is, but] more interaction should be enacted.
- This is a small subset of the population, but an important measure to track the quality of children in DHS custody.
- This measure is forcing important and valuable conversations across the community about how to better coordinate care for this important and vulnerable population.

Comments in support of modifying the measure:

- Clarify and make consistent data elements required for numerator, e.g. be consistent with either within 60 days of the DHS/OHA notification date custody date or within 30 days prior to the DHS/OHA notification date.
- Tighten ability to prescribe psychoactives without a consult.
- Children who are in ITS level of care during the year don't need yet more assessments. They should be excluded. I challenge the clinical utility of asking clinicians who are treating children to code for a MH Assessment just to meet the metric. I would exclude children who are receiving mental health services before placement that continue following placement, and only counting children in the metric once per year.
- The process for notification needs to be further refined, and the time from entry into foster care until notification also needs to be decreased. I think that a time frame that includes the entire year will help ameliorate the very small numbers we had to work with.

- The concept here is a good one. Much more need for collaboration. However, the CCOs need access to ORKids and DHS also needs to have accountability for making improving this measure at the CCO level.
- The impact of this metric affects such a small population that the statistics on it can be all over the map based on just 2 or 3 patients. It needs to be consistent with DHS metric.
- The denominators are so low- we need to do something.
- Capture of this data is horrible and results in very small numbers-- we end up chasing a few changes rather than creating system changes. Also this needs to be consistent with DHS metrics.
- This particular metric needs to be modified to meet DHS standards - DHS has shorter time frames than OHA and it would be extremely helpful to align the metrics.
- There are many barriers to using encounter data as a means of measuring outcomes. I believe all measures should be transitioned to another mechanism of obtaining data that is not dependent on encounter data.
- Please add ACES Screening! We have to find out what happened in order to have any hope of providing adequate treatment.

Comments in support of dropping the measure

- Coordination of this measure is nearly impossible, as the infrastructure to get the information is almost impossible to manage.
- This measure is more of an issue around communications between the social services agencies and the medical community. Apparently the social services agencies don't even communicate with each other. I don't know how making this a measure would fill the gap - the health plans can't make the social services groups talk to each other or to the providers. This is definitely an internal issue.
- Very hard to track these, and to know when children need to be seen.
- It is particularly difficult to count which days children were under DHS custody. Manual process is hard to replicate or validate.
- The DHS database is a huge barrier. We get conflicting and incomplete info on kids all the time. Until the notification systems are improved, this metric should be dropped.
- This needs to be managed with DHS. They are the ones with control over this.
- I realize that the time of notification for this measure to start is the day the CCO gets notification by the State, but we have seen the State not send these timely. In some cases, we still have a problem working with DHS. I would prefer to see the State do more mandating with DHS than with the CCOs on this measure.

- The issue around this one is coordination with DHS as well as eligibility issues around CCO assignment once child has been taken into care.
- This population is so small and so transient and they already receive many more services than our general Medicaid population does, that improving this measure is too costly and has minimal benefit.
- This doesn't seem to be the right venue for this issue. As CCOs broaden their scope of membership, this measure will not be useful.
- This seems to have low impact. Looking at psychotropic meds in foster care? Asthma has more prevalence. Kindergarten readiness would be far better and system changing measure. Kids who can't read by 3rd grade have pretty low graduation rates. Early literacy promotion, ACES would have more population health [affect]. Also screening and responding to food security given our rates of poverty and hunger would affect at least 30 percent of families.

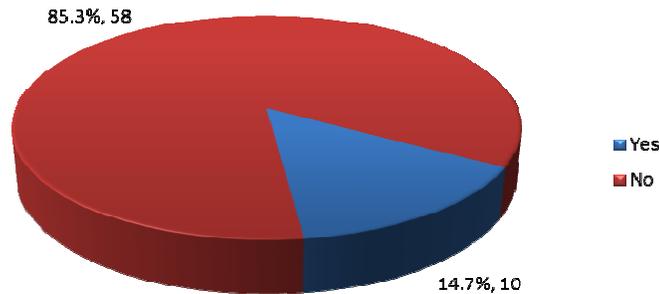
Other comments

- [Why did we] choose such a highly focused measure (and, therefore, of limited applicability to the bulk of patient need) when there are so many other things of more clinical importance and/or impact to larger populations of patients?
- We do not currently have a reliable data source to identify when a child is in DHS custody, so it is difficult to know how to get this data or move it at the clinic level.
- I think that the metric itself is fine, but the lack of cohesive system and standard practice for gathering, sharing and tracking the information varies hugely across the state... I believe that a tighter collaboration between the CCO's, DHS central office and OHA central office would result in one standard process and system across the state.

PATIENT CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT

Question: Should the PCPCH Enrollment measure be dropped or modified for 2015?

n=68



Comments in support of keeping the measure as is:

- [The measure should be kept as is.] That said, requirements should be made that a portion of the incentive received should [go] back to the practice that submitted for PCPCH.
- DO NOT DROP!!!!

Comments in support of modifying the measure:

- I'm not sure that the benchmark of 100% of providers attesting at a tier 3 level is realistic.
- I know that in a very rural area there may be some issues to becoming a PCPCH, but that does not mean that the people being served does not call it their primary care provider, and receive the same sort of services as a clinic with PCPCH status.
- There should be a measure of how effectively is the PCPCH being implemented. Signing people up is easy but actually getting staff to make it happen is not so easy but is at the heart of what the CCO is all about.
- This metric also needs alignment for reporting purposes for the Early Learning Division - age breakdown of 0-6 population.
- Increase value of tier 3 medical home.
- Should also reward for clinics achieving high tier, rather than any tier (if not already in the measure).
- Include behavioral health home.
- This should follow the PCMH.

- Ongoing financial support of care management for ACA diagnosis and including better assessment of children at higher risk would be great improvements.

Comments in support of dropping the measure

- By 2015, any practices that have not yet sought recognition as PCPCHs either voluntarily, or as a result of pressures put on them in the preceding years, is unlikely to do so.
- There is no real value in the PCPCH. Most of the ongoing studies fail to demonstrate any real value in them.
- Move [from CCO incentive measure] to monitoring status.

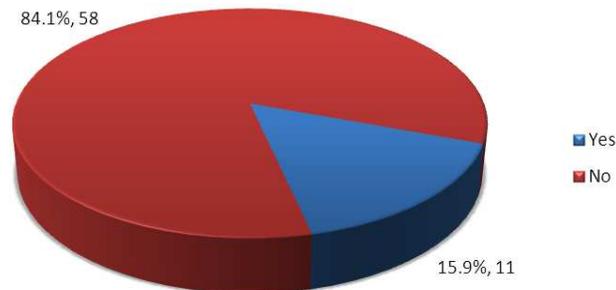
Other comments

- I would suggest that, rather than having its own state-specific criteria, the state ought to accept recognition by NCQA or TJC.

TIMELINESS OF PRENATAL CARE

Question: Should the Timeliness of Prenatal Care measure be dropped or modified for 2015?

n=69



Comments in support of keeping the measure as is:

- Measures should be kept the same or with as few changes made as possible for at least three years to see if there is any measureable improvement over time.

Comments in support of modifying the measure:

- HEDIS only specifications.
- Expand definition to include adequacy of prenatal care. In addition to the timing of prenatal care initiation, the adequacy of prenatal care is important in promoting healthy outcomes for women and their infants. Adequacy of prenatal care can be measured using the Kessner Index: adequacy is defined as whether a woman (1) had her first prenatal care visit during the first trimester of pregnancy and (2) had 5 or more prenatal care visits. This measure is transparent and easy to understand.
- It should be modified to reflect the actual DUE date, not the DELIVERY date--they are not the same. Using the current methods, we will find that every early preterm delivery did not have prenatal care more than 175 days prior to delivery. I think the measure should be kept and refined.
- Global billing codes that include prenatal care should be sufficient evidence of appropriate prenatal care regardless of the initial date of service.
- There are many barriers to using encounter data as a means of measuring outcomes. I believe all measures should be transitioned to another mechanism of obtaining data that is not dependent on encounter data.
- We should use as good data as possible.

Comments in support of dropping the measure

- This is a bad way to measure 'access'. The measure is impacted by pre-conception readiness, which is more actionable.
- The clinical practice norm is to NOT see women in their first trimester. When pregnant women call an OB/GYN and say they think they're pregnant, the first thing the staff does is ask them how far along they think they are and then they schedule them to come in the SECOND trimester. Providers no longer want to see women in the first trimester and although the literature recommends the first visit be within 6-8 weeks of conception and the second occur within 10-12 weeks, this is simply not the practice norm. In addition, with delays in Medicaid enrollment, retro-active enrollment, and administrative problems with the data provided by OHP, health plans and providers are often not even aware of having pregnant members until well after the window for the measurement.

Other comments

- I am not sure. This is an important measure, but the claims calculation is very problematic. Will be interesting to see how the hybrid approach works this year.
- There is a HCPCS code for a risk assessment in pregnancy, H1000. It is currently part of the specifications for inclusion in the numerator. It is one of those elements of prenatal care that makes EARLY care more meaningful, much like the adolescent well visit. Screening women for their health behaviors, substance use, mental health needs, food and housing, family violence early in their pregnancy and connecting them to resources can impact the health of the whole family. There are currently efforts to establish a universal family well-being assessment that would be a standard tool that everyone would use and could be aggregated by practice or community or CCO.

This is also an important opportunity for maternity care to connect to early childhood care. The early childhood providers in the Early Learning Hubs would use the same family well-being assessment as a way to coordinate services, partner in a meaningful way with CCOs, and meet the metrics they need to meet. Dana Hargunani has mentioned that this type of family well-being assessment could be included in the aggregated database she is working on with U of O. All providers could use this database to document developmental screening and well-being assessments and both would go a long way toward improving coordination and collaboration between our systems.

Because prenatal care billing is so weird and complex, we could "re-sell" this metric as getting that H1000 code in before the first trimester is over, then we wouldn't have to worry about the crazy OB billing practices. This code is already included in the specifications, but not many providers use it. If they did, it would make tracking so much easier.

PROPOSED NEW MEASURES

Survey respondents were also given the option to propose new measures for the Metrics & Scoring Committee’s consideration. Respondents were asked to provide as much information about the proposed measures as possible, including the rationale for proposing the measure, a description of the measure, the measure source (e.g., NQF), and a sense of how well the proposed measure aligns with Committee measure selection criteria.

More than 40 respondents proposed new measures; however as there was duplication in the measures being proposed, each proposed new measure is presented only once in the following pages. Rationale and additional information provided across multiple respondents has been consolidated where possible; responses have been edited slightly for clarity.

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Increasing oral health coverage for young and middle-aged adults

Measure description:

Oral Health for Working Adults, exceptional circumstances; provide services for an adult entering or actively preparing to enter the work force, to leave state dependency, to be able to receive coverage for dental prosthesis/bridges/crowns, regardless of whether a previous denture had been provided within the past 10 years.

Rationale:

Oral Health and the state of an individual's teeth affect general health, total well-being, as well as mental health and social acceptance. Missing teeth, especially visibly in the front or sides, or gingivitis or other serious problems, both cosmetic and/or from infection, stigmatize the individual and limits capacity to interact in a dignified and unbiased way. Extended program(s) or exceptional dental requests should be applicable to individuals who are actively engaged in a work training program, job certification program, or who are actively seeking work through a verifiable state/DHS job-search or training program, or Oregon Worksource programs. This will limit the amount of requests for extended dental care, limit costs to occasional services, and enable the individual to have the physical presentation necessary to advance their work/profession. Many OHP consumers are under educated, and job opportunities are often limited to customer service, retail, restaurant, sales, etcetera... positions which require a presentable physical aspect and interaction with others. A company will not hire someone with teeth that give the impression of negative lifestyle or past. Not providing adequate dental care is prohibiting the individual and incapacitating them from moving forward to a self-sustaining and independent life.

Measure source:

None provided.

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	X		
<i>Has state, regional, or national level data available:</i>	X		
<i>Is feasible to collect / has existing data source:</i>			X
<i>Presents an opportunity for quality improvement:</i>	X		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	X		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	X		
<i>Comments:</i>			
Well-being and mental health of patients is greatly attributed to their stigma or lack of stigma in			

society; working increases self-worth, not working increases poor health habits; as one is at home more often, would tend to become more obese, develop greater physical problems etcetera, ad infinitum.

FOOD INSECURITY & HUNGER

Measure description:

We propose the USDA's 2 question set on food insecurity, capturing referral to appropriate services.

- ❖ "Within the past 12 months we worried whether our food would run out before we got money to buy more," and
- ❖ "Within the past 12 months the food we bought just didn't last and we didn't have money to get more."

This is also adaptable to use as a 30 day indicator. The numerator would be all adults who signaled food insecurity and provided with or referred to an appropriate service; the denominator, all adults >18.

Rationale:

- ❖ Screening and referral for food insecurity/hunger would allow health systems to better understand, manage, and address current CCO quality incentive metrics such as hypertension control, diabetes control, and obesity rates. Screening and referral in the general population creates opportunities to reduce the rates of patients developing hypertension, diabetes, or obesity in the first place. With a rate of 17% of food insecurity in the general population using related questions in the (2010 OR BRFSS metric "Oregon adults living in food insecure households), we expect higher rates of food insecurity due to income and other factors in the OHP population. This factor is upstream to other health outcome metrics and is facilitated by the CCO focus on prevention.
- ❖ Social determinants of health; hungry children don't learn; high rates of poverty and food insecurity for children in Oregon.

Measure source:

USDA and OHA's Public Health Division, which has used the long-form of this question set in the statewide BRFSS survey to capture food insecurity from 2000-2010, and will in the 2014 BRFSS oversample for the Medicaid population. Oregon Food Bank has been promoting this two question screening, which will be performed at Kaiser Permanente departments in Oregon.

[http://www.ers.usda.gov/datafiles/Food Security in the United States/Food Security Survey Modules/short2012.pdf](http://www.ers.usda.gov/datafiles/Food%20Security%20in%20the%20United%20States/Food%20Security%20Survey%20Modules/short2012.pdf)

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee.</i>	Yes	No	Unsure
<i>This measure:</i>			
<i>Is evidence-based:</i>	X		
<i>Has state, regional, or national level data available:</i>	X		
<i>Is feasible to collect / has existing data source:</i>	X		

<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>			x
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			
The Oregon Food Bank is joining the Oregon Primary Care Association in proposing this measure.			

PATIENTS RECEIVING LANGUAGE SERVICES SUPPORTED BY QUALIFIED LANGUAGE SERVICES PROVIDERS

Measure description:

Numerator: The number of limited English-proficient (LEP) patients with documentation they received the initial assessment and discharge instructions supported by trained and assessed interpreters, or from bilingual providers and bilingual workers/employees assessed for language proficiency.

Denominator: Total number of patients that stated a preference to receive their spoken health care in a language other than English.

Rationale:

Patient understanding of services, prescriptions and self-management requirements for their health is essential for patient compliance and improved health outcomes. Patient communication in appropriate and culturally specific methods and health literacy are necessary components to reduce disparities in health outcomes. This measure provides one proxy for increased cultural competency in healthcare, culturally and linguistically appropriate services (CLAS) in healthcare, and the commitment of health providers to providing language support for their patients.

Measure source:

NQF Measure L2,

<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=70142>

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>	x		
<i>Is feasible to collect / has existing data source:</i>			x
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			

HOMELESSNESS SCREENING

Measure description:

This is designed as a metric, validated for adults (but expandable to adolescents) to track the rate of individuals in CCOs who respond positively to a screening for housing instability or homelessness over the last year and were referred to appropriate services.

We propose the VA homelessness screening tool, a two question set with optional follow-up and referral for positive screens. It's presently used as an ongoing, universal screen for veterans who receive health care through the Veterans Health Administration. 1: In the past 2 months, have you been living in stable housing that you own, rent, or stay in as part of a household? ("No" response indicates positive for homelessness.) 2 : Are you worried or concerned that in the next 2 months you may NOT have stable housing that you own, rent, or stay in as part of a household? ("Yes" response indicates positive for risk.)

Rationale:

Individuals with housing insecurity have a higher cost of care, higher risk of morbidity, and greater difficulty managing chronic diseases. Ensuring that individuals receive additional resources for housing and that their housing needs are tracked can decrease the cost of healthcare and improve outcomes.

Measure source:

VA, <http://www.endveteranhomelessness.org/research/ii-homelessness-risk-assessment>

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>	x		
<i>Is feasible to collect / has existing data source:</i>			x
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>			x
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			
While this does not reflect services or care that the CCO holds, decreasing rates in housing insecurity or homelessness will decrease costs of care and improve quality of life.			

RATE OF OHP MEMBERS RECEIVING CARE FROM MENTAL HEALTH CLINICIAN FOR MENTAL HEALTH OR BEHAVIOR CHANGE RELATED TO PHYSICAL HEALTH CONDITION

Measure description:

None provided.

Rationale:

High burden of illness in OHP population with historic low rates of uptake of services and limited venues of services. In some regions, there's a large gap between funding provided to community mental health agencies and value of services billed.

Measure source:

None provided.

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>			x
<i>Has state, regional, or national level data available:</i>	X		
<i>Is feasible to collect / has existing data source:</i>	X		
<i>Presents an opportunity for quality improvement:</i>	X		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	X		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	X		
<i>Comments:</i>			

PLAN ALL-CAUSE READMISSION RATE

Measure description:

For Medicaid enrollees age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission

Rationale:

Readmissions are impacted by multiple health care efforts and initiatives.

Measure source:

NCQA/HEDIS

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	X		
<i>Has state, regional, or national level data available:</i>	X		
<i>Is feasible to collect / has existing data source:</i>	X		
<i>Presents an opportunity for quality improvement:</i>	X		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	X		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>			x
<i>Comments:</i>			
<p>A potential deviation from HEDIS that would be worth considering is excluding members who are admitted for complications due to pregnancy and are subsequently admitted later for the actual delivery. Given the high proportion of pregnant mothers on OHP for most plans, admissions where a pregnant mother gets treatment and then is admitted later to actually deliver the baby will falsely inflate the readmission rate.</p>			

TIMELY INVESTIGATION OF MALPRACTICE LAWSUITS

Measure description:

Any licensed health care practitioner malpractice lawsuit that is either settled out of court or that a jury/judge finds the practitioner to be "guilty" of, will automatically trigger a full, thorough investigation of the injury and all related events, by the relevant Oregon State Practitioner Licensing Board, within six months of the closure of the court case. The licensed health care practitioner in question shall have his/her license suspended until the relevant Oregon State Licensing Board has fully completed their investigation of the matter.

Rationale:

[Experience with malpractice, resulting in permanent disability. Personal details redacted.]

Since aging physicians are not required to remove themselves from practice, whether they continue to be either safe or competent to practice according to current, modern standards or not, I believe it must be the Oregon Medical Board's responsibility to either thoroughly test elderly physicians (both on theoretical and "hands-on" matters), or mandate they retire by a specific age (as pilots, air traffic controllers, police officers, firefighters, teachers, and other professionals are required to do). Elderly doctors jeopardize the health and safety of thousands of unsuspecting patients, every single day. Yet, this society treats them as though they are "gods", not mere mortals who can get sick, age, make poor judgments, grow incompetent, or literally die, while cutting open a naive patient...How many more people are going to have to lose major things because of [this doctor and his peers] - refusing to quit because being an MD is their entire reason for living and they couldn't care less what happens to anyone but themselves!

Measure source:

None provided.

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>			x
<i>Is feasible to collect / has existing data source:</i>			x
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			

TOBACCO PREVALENCE (SMOKING CESSATION)

Measure description:

Prevalence of tobacco use among OHP population.

Proportion of enrolled adults with tobacco use history documented in problem list.

Numerator: current smokers

Denominator: CCO enrollees

Rationale:

- Smoking directly affects health and indirectly affects financial well-being, including hunger. [A metric beyond “advice to quit” is needed.]
- Bring OHP [tobacco use] rate by age group and gender in line with rest of Oregon population.
- Tobacco use is the leading cause of preventable illness in our state, and a major driver of medical care costs. Medicaid enrollees have a much higher prevalence of tobacco use than do other Oregonians. Decreasing the prevalence of tobacco use would further the triple aim of: improving health, improving care (measuring tobacco use and offering cessation services is an evidence-based practice), and decreasing health care costs.

Measure source:

Data available in medical record, <http://www.uspreventiveservicestaskforce.org/uspsttopics.htm>

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	X		
<i>Has state, regional, or national level data available:</i>	X		
<i>Is feasible to collect / has existing data source:</i>	X		
<i>Presents an opportunity for quality improvement:</i>	X		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	X		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	X		
<i>Comments:</i>			

ANNUAL FLU VACCINE

Measure description:

All individuals age 6 months to 64 years receive annual flu shot.

Rationale:

None provided.

Measure source:

Healthy People 2020.

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	X		
<i>Has state, regional, or national level data available:</i>	X		
<i>Is feasible to collect / has existing data source:</i>	X		
<i>Presents an opportunity for quality improvement:</i>	X		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	X		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>			
<i>Comments:</i>			

HIV SCREENING

Measure description:

Individuals age 15-65 years with a documentation of at least one HIV screening.

Rationale:

Established leading cause of morbidity and mortality for which screening leads to reduction in morbidity, mortality, and secondary transmission.

Measure source:

Healthy People 2020.

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	X		
<i>Has state, regional, or national level data available:</i>	X		
<i>Is feasible to collect / has existing data source:</i>	X		
<i>Presents an opportunity for quality improvement:</i>	X		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			

HEPATITIS C TESTING

Measure description:

One recorded Hepatitis C test for individuals born 1945-65, or anyone with an Hepatitis C Ab+ result with a recorded Hepatitis C RNA test.

Rationale:

Hepatitis C is a growing concern in our community.

Measure source:

None provided.

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>			
<i>Has state, regional, or national level data available:</i>			
<i>Is feasible to collect / has existing data source:</i>			
<i>Presents an opportunity for quality improvement:</i>			
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>			
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>			
<i>Comments:</i>			

OBESITY PREVALENCE

Measure description:

Reduce the obesity rate among adults age 18 and older.

Rationale:

Obesity contributes significantly to chronic disease.

Measure source:

HealthyPeople 2020.

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	X		
<i>Has state, regional, or national level data available:</i>	X		
<i>Is feasible to collect / has existing data source:</i>	X		
<i>Presents an opportunity for quality improvement:</i>	X		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>			
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>			
<i>Comments:</i>			

CHILDHOOD IMMUNIZATIONS

Measure description:

- ❖ Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV).
- ❖ Percent of children fully immunized by age 3 (UDS measure / NQF 0038).
Denominator: patients turning 3 in the measurement period.
Numerator: those in the denominator who have documentation of all UDS recommended vaccines.

Rationale:

This is a major area of focus for our population and throughout the state. Having a high vaccination rate is one of the interventions that saves the most years of life in a population. Oregon has pockets of vaccine hesitancy and resistance which are becoming a public health risk.

None provided.

Measure source:

Healthy People 2020 <http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx>

UDS 2013 <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting/2013udsreport.pdf>

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	X		
<i>Has state, regional, or national level data available:</i>	X		
<i>Is feasible to collect / has existing data source:</i>	X		
<i>Presents an opportunity for quality improvement:</i>	X		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			

PRICE TRANSPARENCY

Measure description:

Providers make available costs of top 20 office visits codes for which they bill OHP/patient. 30% of OHP providers had cost sheets posted in waiting room and available for patients. Measure is self-reported from each provider office each quarter that they are/are not in compliance

Rationale:

Currently, providers have NO idea what costs are and have no stake in containing them.

Measure source:

None provided.

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>			x
<i>Has state, regional, or national level data available:</i>	X		
<i>Is feasible to collect / has existing data source:</i>	X		
<i>Presents an opportunity for quality improvement:</i>	X		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	X		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	X		
<i>Comments:</i>			

FOLLOW UP AFTER ED VISIT FOR BEHAVIORAL HEALTH CONDITIONS

Measure description:

Follow-up after emergency department use for mental illness or AOD

Rationale:

This measure is under development with NCQA as part of a project to identify measures that address disparities in the prevalence and outcomes of physical health and chronic conditions among individuals with serious mental illnesses and/or alcohol and other drug use disorders (AOD). Include follow-up for any behavioral health visit rather than tying it to diagnosis.

Measure source:

In development with NCQA

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>			X
<i>Has state, regional, or national level data available:</i>			X
<i>Is feasible to collect / has existing data source:</i>			X
<i>Presents an opportunity for quality improvement:</i>	X		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	X		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	X		
<i>Comments:</i>			

HIGH INTENSITY STATINS FOR ADULTS WITH CLINICAL ASCVD

Measure description:

Individuals ages 21-75 with clinical atherosclerotic cardiovascular disease* will be prescribed a high intensity statin. Measurement period is January 2015 through December 2015, with at least one prescription meeting the statin intensity requirement in this time period. *Clinical ASCVD includes acute coronary syndromes, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin.

Denominator: Individuals ages 21-75 with a clinical atherosclerotic cardiovascular disease diagnosis in 2014.

Numerator: Individuals ages 21-75 with a clinical atherosclerotic cardiovascular disease diagnosis in 2014 with at least one prescription filled for a high intensity statin during the measurement period (Jan 2015-Dec 2015). Include some sort of continuous eligibility criteria.

Rationale:

This metric comes from the new Nov 2013 ACC/AHA guidelines of the treatment of blood cholesterol. It is evidence-based and can be measured through administrative (claims) data. "Women and men with clinical ASCVD are at increased risk for recurrent ASCVD and ASCVD death. An extensive body of evidence demonstrates that high-intensity statin therapy reduces ASCVD events more than moderate-intensity statin therapy in individuals with clinical ASCVD."

Measure source:

2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines.

<http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a>

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	X		
<i>Has state, regional, or national level data available:</i>	X		
<i>Is feasible to collect / has existing data source:</i>	X		
<i>Presents an opportunity for quality improvement:</i>	X		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	X		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			

ANY ORAL EXAM FOR ADULTS

Measure description:

The denominator would be the number of OHP patients 21-65.

The numerator would be the number of OHP patients 21-65 that received one or more of the following services during the measurement period; CDT Codes D0120, D0140, D0150, D0160, D0170, D0180.

Rationale:

It is my understanding that currently "Any Dental Service for Adult Members" is being considered as a measure. "Any Oral Exam for Adult Members" assures that a DENTST is looking at the patient's mouth if even for a problem focused exam.

The use of "any dental service" does not provide this assurance.

Measure source:

None provided.

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>			x
<i>Has state, regional, or national level data available:</i>			x
<i>Is feasible to collect / has existing data source:</i>	x		
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			

CESAREAN RATE FOR LOW-RISK WOMEN

Measure description:

This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section.

Rationale:

In the absence of medical indications, cesarean sections can pose avoidable risks, including longer maternal recovery, neonatal respiratory problems, and potentially severe complications in subsequent pregnancies.

Nationally, the Maternal and Child Health Bureau is developing a performance measure around cesarean rate for low-risk women, and this measure would align with that change.

Measure source:

NQF, <https://manual.jointcommission.org/releases/TJC2013A/MIF0167.html>

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>	x		
<i>Is feasible to collect / has existing data source:</i>	x		
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			

PREVALENCE OF CHILDHOOD OBESITY

Measure description:

Proposed numerator: CCO enrollees 2 > 18 years of age classified as overweight or obese as determined by BMI-for-age-and-sex percentile, based on height and weight.

Proposed denominator: CCO enrollees 2 > 18 years of age CDC Growth Charts are used to determine the corresponding BMI-for-age and sex percentile. For children and adolescents (aged 2—19 years): Overweight is defined as a BMI at or above the 85th percentile and lower than the 95th percentile for children of the same age and sex. Obesity is defined as a BMI at or above the 95th percentile for children of the same age and sex.

Rationale:

We support the adult obesity measure proposed by the Oregon Public Health Division and further recommend expansion to include a measure of childhood obesity.

From CDC: Health risks now Childhood obesity can have a harmful effect on the body in a variety of ways. Obese children are more likely to have:

High blood pressure and high cholesterol, which are risk factors for cardiovascular disease (CVD). In one study, 70% of obese children had at least one CVD risk factor, and 39% had two or more. Increased risk of impaired glucose tolerance, insulin resistance and type 2 diabetes. Breathing problems, such as sleep apnea, and asthma. Joint problems and musculoskeletal discomfort. Fatty liver disease, gallstones, and gastro-esophageal reflux (i.e., heartburn). Obese children and adolescents have a greater risk of social and psychological problems, such as discrimination and poor self-esteem, which can continue into adulthood. Health risks later. Obese children are more likely to become obese adults. Adult obesity is associated with a number of serious health conditions including heart disease, diabetes, and some cancers. If children are overweight, obesity in adulthood is likely to be more severe. Additionally, obese and overweight children have increased medical costs as compared to healthy weight peers (there is some research with costs available). Health care providers routinely collect weight and height on children and youth (US Preventive Services Task Force recommendations)

Measure source:

<http://www.cdc.gov/obesity/childhood/basics.html>

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>	x		

<i>Is feasible to collect / has existing data source:</i>	x		
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			

TOBACCO USE DURING PREGNANCY

Measure description:

The measure would describe the number of pregnant women (both adult and adolescent) who smoke at the time of birth. The measure would also be stratified by race and ethnicity.

Numerator: CCO enrollees of women who report smoking cigarettes every day, some days, or not at all at the time of birth of their baby.

Denominator: CCO enrollees of women who have given birth.

Rationale:

We support the measure for tobacco provided by the Oregon Tobacco Program; and we would like to add a measure specific to pregnancy, as the effect is so great on the unborn child. Much is known about tobacco use during pregnancy as a primary cause of poor birth outcomes. Diseases and conditions causally related to tobacco use in pregnancy include, but are not limited to: Sudden Infant Death Syndrome, Birth Defects, Adult Onset Diabetes, Decreased IQ, ectopic pregnancies, other birth and delivery problems, brain damage during gestation, low birth weight, growth retardation, overweight obesity in childhood, abnormal blood pressure in infants & children, risks resulting in neonatal intensive care, infant death from perinatal disorders, cancer-causing agents in infants' blood, carcinogenic genetic mutations, childhood leukemia, colic, childhood asthma, childhood respiratory disorders, childhood eye problems, mental retardation, Attention Deficit & Hyperactivity Disorder in childhood, learning & developmental problems, behavioral problems, smoking in adolescence, spontaneous abortion, Placenta Previa, Placental Abruption, impaired neurodevelopment, disruptions to fetal cardiovascular functioning, and impaired immune system.

Measure source:

Vital Statistics Birth Records.

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee.</i>	Yes	No	Unsure
<i>This measure:</i>			
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>	x		
<i>Is feasible to collect / has existing data source:</i>	x		
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change</i>	x		

<i>care delivery in a desired manner):</i>			
<i>Comments:</i>			

BREAST CANCER SCREENING

Measure description:

Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.

Numerator Statement: One or more mammograms during the measurement year or the year prior to the measurement year.

Denominator Statement: Women 42–69 years of age as of Dec 31 of the measurement year (note: this denominator statement captures women age 40-69 years).

Denominator Exclusions: Women who had a bilateral mastectomy or for whom there is evidence of two unilateral mastectomies. Look for evidence of a bilateral mastectomy as far back as possible in the member’s history through Dec 31 of the measurement year.

Rationale:

Breast cancer is one of the most common types of cancers, accounting for a quarter of all the new cancer diagnoses in American women. Breast cancer is the second top cause of cancer deaths in women (after lung cancer) with nearly 40,000 estimated deaths in 2010.

Measure source:

NQF 0031: Breast Cancer Screening,

http://www.qualityforum.org/Measure_Evaluation_Form/Cancer_Project/0031.aspx

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>	x		
<i>Is feasible to collect / has existing data source:</i>	x		
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>			x
<i>Comments:</i>			

CERVICAL CANCER SCREENING

Measure description:

Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.

Numerator Statement: One or more Pap tests during the measurement year (one calendar year) or the two years prior to the measurement year.

Denominator Statement: Women 24-64 years of age. For commercial plans, this includes the measurement year and the two years prior to the measurement year. For Medicaid plans, this includes the measurement year.

Denominator Optional Exclusion: Women who had a hysterectomy with no residual cervix.

Rationale:

Cervical cancer is nearly 100 percent preventable, yet it is the second most common cancer among women worldwide. In the United States, about 12,000 women are diagnosed with cervical cancer each year, resulting in more than 4,000 deaths. For women in whom pre-cancerous lesions have been detected through Pap tests, the likelihood of survival is nearly 100 percent with appropriate evaluation, treatment and follow-up. For women under 50 years old, cervical cancer is diagnosed in the early stage 62 percent of the time. In 2008, the prevalence of recent Pap test use was lowest among older women, women with no health insurance and recent immigrants.

Measure source:

NQF #: 0032: Cervical Cancer Screening,

<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=68262>

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>	x		
<i>Is feasible to collect / has existing data source:</i>	x		
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>			x
<i>Comments:</i>			

GENETIC COUNSELING FOR BREAST / OVARIAN CANCER

Measure description:

Percentage of women with a family history of breast and/or ovarian cancer who are referred for genetic counseling due to increased risk for potentially harmful BRCA mutations.

Numerator Statement: Number of women aged 18 years and older who were referred for genetic counseling due to increased risk for potentially harmful BRCA mutations, met the USPSTF criteria, based on first-degree relatives only, for BRCA1/2 genetic counseling referral, and who do not have a personal history of breast or ovarian cancer.

Denominator Statement: Number of women aged 18 years and older who met the USPSTF criteria, based on first-degree relatives only, for BRCA1/2 genetic counseling referral, and who do not have a personal history of breast or ovarian cancer.

Denominator Exclusions: Women who have a personal history of cancer.

Rationale:

This is one of the HealthyPeople 2020 Genomics Objectives. “Women with certain high-risk family health history patterns for breast and ovarian cancer could benefit from receiving genetic counseling to learn about genetic testing for BRCA1/2. For women with BRCA1/2 mutations, surgery could potentially reduce the risk of breast and ovarian cancer by 85 percent or more (US Preventive Services Task Force.” Genetic risk assessment and BRCA mutation testing for breast and ovarian cancer susceptibility: Recommendation statement. Ann Intern Med. 2005 Sep 6;143(5):355-61.)

Measure source:

Similar to HP2020 G-1 objective,

<http://www.healthypeople.gov/2020/topicsobjectives2020/ObjectivesList.aspx?topicId=15>

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>			x
<i>Is feasible to collect / has existing data source:</i>	x		
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		

EFFECTIVE CONTRACEPTIVE USE

Measure description:

Effective contraception use among women who are at risk of unintended pregnancy.

- ❖ Denominator includes: women age 18-44, not currently pregnant, have not had a hysterectomy, not currently abstinent, not trying to get pregnant or “don’t care if get pregnant, and excludes those without known contraceptive use status (those who ended the survey early or who refused/didn’t know their contraceptive use status). Numerator includes: those in the denominator who use IUD, implant, female sterilization, vasectomy, or pill, patch, ring or shot IF used “every time you have sex”. Data is currently collected annually from the Behavioral Risk Factor Surveillance System (BRFSS), but could eventually be collected from clinical records.
- ❖ Denominator: women at risk of unintended pregnancy. Inclusion: women age 15-50. Exclusion: women who are currently pregnant, trying to get pregnant, or wouldn’t mind getting pregnant, have had a hysterectomy, or are abstinent.

Numerator: women using an effective method of contraception. Inclusion: women who use male or female sterilization, IUDs or implants (highest tier of effectiveness) AND women who use pills, injectables, patches or ring for contraception and report that they are satisfied with that method. Exclusion: all other methods and abstinence.

Rationale:

- ❖ The proposed metric is currently included in the 1115 Demonstration Core Performance Measure set. Inclusion of this measure will encourage CCOs to deliver high quality family planning services. If clinicians are required to report the proportion of women in their practices who are using effective contraception, then they will have to screen women for their pregnancy intentions and document this in the medical record. The proportion of those at risk of unintended pregnancy but who are not using effective contraception will be a quality deficiency of the clinic. After screening, clinicians will need to ensure that women have access to all forms of contraception services, whether or not they provide contraception themselves. This will hold primary care providers accountable for whether their patients have access to contraception in the same way we are holding them accountable for blood sugar control in diabetics. Doing so prioritizes contraception as a necessary preventive service that is part of high-quality primary care.

We are aware that the Public Health Division has recommended adding the measure ‘Pregnancy among girls ages 15-17’ to the Incentive Measure set. We believe that a measure focused on the provision of effective contraception represents a more proximal measure that will lead to the more distal outcome of a reduction in teen pregnancy rates. Furthermore, the Centers for Disease Control and Prevention just released an MMWR “Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs” that outlines how to provide quality family planning services within all care settings including primary care. Elevation of the proposed metric

to the Incentive Measure set aligns well with the recommendations outlined in the MMWR.

- ❖ Almost half of pregnancies in Oregon are unintended and more than 1/3 of all births are the result of unintended pregnancies. Unintended pregnancies are more likely to be associated with lack of prenatal care, ambiguous feelings about parenting, and abuse and neglect of children. Women living in poverty or dealing with mental health issues or addictions are 5-6 times more likely to have an unintended pregnancy. We have highly effective contraception methods that are grossly underutilized and this type of metric would help providers meet the needs of their patients. This metric is already a demonstration metric with BRFSS survey data as the data source. The specifications have already been worked out and it could be translated to a clinical metric. There is no single measure that stands to save as much money in the Medicaid system as preventing 10,000 unintended births a year.

Measure source:

Although this specific measure has not been endorsed by a national source, the CDC has proposed that NQF adopt the following measure which reads “Proportion of female users at risk of unintended pregnancy who adopt or continue use of the most effective methods or moderately effective methods of contraception”.

Proposed CDC/OPA metrics to be submitted to NQF:

- 1) Proportion of female users at risk of unintended pregnancy who adopt or continue use of the most effective (i.e., male or female sterilization, implants, intrauterine devices or systems) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA approved methods of contraception.
 - 1a) Proportion of female users at risk of unintended pregnancy who adopt or continue use of an FDA approved, long-acting reversible method of contraception (i.e., implants, intrauterine devices or systems).

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>	x		
<i>Is feasible to collect / has existing data source:</i>			x
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change</i>	x		

<i>care delivery in a desired manner):</i>			
<i>Comments:</i> We have evidence about addressing unintended pregnancy, and proactive counseling about contraception, lowering rates of unintended pregnancy by getting women to the best methods.			

CHLAMYDIA SCREENING

Measure description:

Proportion of young women aged 15-65 continuously enrolled for calendar year with at least one chlamydia test.

Rationale:

Established leading cause for morbidity and mortality for which screening leads to reduction in morbidity, mortality, and secondary transmission.

Measure source:

None provided.

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>	x		
<i>Is feasible to collect / has existing data source:</i>	x		
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			

HPV VACCINATION

Measure description:

Proportion of adolescents aged 13 years and enrolled for at least one year with 3 doses of HPV vaccine.

Rationale:

Established leading cause of morbidity and mortality for which vaccines lead to reductions in morbidity, mortality and secondary transmission.

Measure source:

None provided.

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>	x		
<i>Is feasible to collect / has existing data source:</i>	x		
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			

KINDERGARTEN READINESS

Measure description:

Early Development Instrument (EDI) or Oregon Kindergarten Assessment (KA)

Rationale:

- We know more and more about the relationship between children's educational outcomes and their health outcomes later in life. Getting more kids ready for Kindergarten is a key indicator of later educational outcomes. A focus on Kindergarten Readiness is a good opportunity to have a shared measure with early education providers. Pediatric providers are well-positioned to impact measures of Kindergarten readiness.

For a child to be ready to learn in Kindergarten, specific processes must be in place: 1. Family risk factors must be identified and addressed 2. Developmental, relational, and social-emotional delays must be identified and treated 3. Appropriate preventive services, including immunizations, nutrition counseling, vision and hearing screening must be completed 4. Chronic diseases must be diagnosed, managed, and controlled, including mental health disturbances 5. Coordination of care is conducted between the health care system, home visiting, Early Intervention / Early Childhood Special Education and other early childhood community resources.

- Requires collaboration between early education and health system. Potential for great reduction in education expenses and improved academic trajectory for child into employable successful adult. Could also contribute to reduction in high school drop-out rate and rates of substance abuse.
- It aligns with the work that state agencies from health and early childhood education are measuring. Strong predictor of high school graduation. Important key pediatrics prevention measure as it looks at quality of well child care prior to age 5, which we know is critical in school readiness.

Measure source:

EDI: Offord Centre for Child Studies KA: Oregon Department of Education

http://www.offordcentre.com/readiness/EDI_viewonly.html

<http://www.ode.state.or.us/search/page/?=3908>

See also OR Pediatric Improvement Program Kindergarten Readiness brief.

<http://www.oregon-pip.org/resources/Issue%20Brief%20-%20Kindergarten%20Readiness%20Accountability%20Final.pdf>

<p><i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee.</i></p> <p><i>This measure:</i></p>	Yes	No	Unsure
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<i>Is evidence-based:</i>	X		
<i>Has state, regional, or national level data available:</i>	X		
<i>Is feasible to collect / has existing data source:</i>	X		X
<i>Presents an opportunity for quality improvement:</i>	X		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	X		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	X		
<i>Comments:</i>			
<ul style="list-style-type: none"> • Primary care homes within CCOs should be required to document clinical processes for referral and coordination of care between primary care and community-based systems. The role of Home Visiting Nursing programs in family risk assessment and referral should be integrated into CCO structures. • Recommend a workgroup to look at how Kindergarten Readiness would be measured in the context of guidelines for well child care and developmental screening. Look at Bright Futures goals for the 5 year old well child visit – has a great list of areas to consider in child and family wellbeing to assure kindergarten readiness. 			

ASSESSMENT AND MANAGEMENT OF CHRONIC PAIN

Measure description:

- ❖ Percentage of patients diagnosed with chronic pain with referral to physical rehabilitation and/or behavioral management therapy.

This measure is used to assess the percentage of patients age 16 years and older diagnosed with chronic pain with referral to physical rehabilitation and/or behavioral management therapy. Need access to referral data to make this measure work. A proxy could be billings for physical rehab / behavioral management therapy within 30 days after claim with one of these diagnoses (as primary or secondary).

- ❖ Percentage of patients diagnosed with chronic pain with documentation of receiving education regarding their diagnosis of chronic pain, medications, importance of physical activity, and/or any interventional procedures in the medical record; referral to pain specialty or integrated medicine / alternative care provider.

Consider adding an additional component of assessment of “function” to determine how chronic pain is limiting independence and driving up costs for supportive care and equipment.

Inclusions: Number of patients 16 years and older diagnosed with chronic pain. Chronic pain is defined as: Persistent pain Either continuous or recurrent Of sufficient duration and intensity to adversely affect a patient’s well-being, level of function, and quality of life

Include the following International Classification of Diseases, Ninth Revision (ICD-9) diagnoses: Chronic pain: 338.xx Cervical and lumbar pain: 720.x, 721.x, 722.x, 723.x, 724.x, 847.x, Headache: 307.8x, 784.0, Other disorders of soft tissues: 729.x, Myalgia and myositis, unspecified fibro myositis, not otherwise specified (NOS): 729.1

Note: Other diagnoses that are related to chronic pain include low back pain, neck pain and fibromyalgia. Please refer to the Implementation Recommendations in the original measure documentation for suggestions on identifying other ICD-9 codes.

Rationale:

- ❖ In the current medical system, the path of least resistance can be to prescribe opioids for chronic pain, resulting in many potential harms and public health issues. The Health Evidence Review Commission has removed some of the restrictions on physical rehab (effective October 2014) so new treatment options are available. This measure would encourage CCOs and providers to “crowd out” inappropriate opioid use by using effective treatments.
- ❖ Recent changes in the prescribing of opioids for the management of chronic pain. In an effort to treat those with chronic pain the use of prescription opioids increased

dramatically. With new guidelines to decrease the use of opioids and prevent over prescribing the pendulum is at risk for swinging too far the other way resulting in no management of chronic pain. There are very few services/treatment recommendations that have not been included in a traditional health plan. Education to the patient in the medical setting is about all there is at this time and empowers the patient to be part of their treatment plan. A chronic pain patient has potential to require significant resources by way of emergency room visits, adaptive equipment, supportive services, etc. depending upon the functional limitations caused by chronic pain.

Measure source:

NQMC, <http://www.qualitymeasures.ahrq.gov/content.aspx?id=36641#Section593>

<http://www.qualitymeasures.ahrq.gov/content.aspx?id=36640>

ICSI Institute for Clinical Systems Improvement

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		x
<i>Has state, regional, or national level data available:</i>			x
<i>Is feasible to collect / has existing data source:</i>			x
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			

ACES SCREENING

Measure description:

- ❖ Use of the ACES (Adverse Childhood Experiences) screening tool.

Numerator: Number of people that have an ACES screening in their health record.

Denominator: Number of people seen by primary care provider.

- ❖ Number/ percentage of patients completing the ACES questionnaire. A follow up measure would be connected to identified needs.

Rationale:

- This tool is evidence-based and easy to deliver by PCPs. As well, the predictive factors for future negative health and social outcomes are tremendous in identifying and potentially engaging people in their health care. If root childhood traumas are not identified and assistance is not given to resolve or mitigate the impacts the potential costs to society and the individual are enormous. Trauma, in the way of ACES, is a public health concern.
- There is a direct correlation between ACES score and health outcomes. We want to use this screening tool to identify children at highest risk and targeting resources.
- Based on Trauma Informed Care research, this is an excellent predictor of future health issues.
- This measure aligns with trauma informed work that is now being recognized nationally as an indicator of health related concerns later in life.
- ACES are linked to long-term health outcomes. Incorporating awareness and/or screening of ACES in primary care is one approach to providing more trauma-informed care and improving relationships between

Measure source:

CDC and Kaiser Permanente, <http://www.cdc.gov/ace/index.html> and <http://www.cestudy.org>

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		x
<i>Has state, regional, or national level data available:</i>	x		x

<i>Is feasible to collect / has existing data source:</i>	X		X
<i>Presents an opportunity for quality improvement:</i>	X		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	X		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	X		
<i>Comments:</i>			

HEALTH CARE PROVIDER WORKFORCE SHORTAGE

Measure description:

This measure would indicate that the CCO is all or partly in a Health Professional Shortage Area (HPSA). It is possible that this could be set as a gradient where there are ranges identified for the “severity” of the HPSA 0-8, 9-13, 14-17, 18+.

Rationale:

Access to health care (as measured by the number and capacity of health care providers in a given area) is a critical metric.

Measure source:

HRSA – Bureau of Clinician Recruitment and Service. <http://hpsafind.hrsa.gov>

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>	x		
<i>Is feasible to collect / has existing data source:</i>	x		
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>			x
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>			x
<i>Comments:</i>			
The presence of a HPSA says something about access to care. If the measure improves, there is more care accessible.			

NON-NARCOTIC TREATMENT OF PAIN

Measure description:

Number of patients with a visit and diagnosis of chronic pain in the past year who had NOT received a prescription for an opioid in the past 6 months. Benchmark 80%

Denominator: patients with a visit (or problem lists) dx of 338.2x in the reporting period.

Numerator: those in the denominator without a fill or refill of an opioid in the past 6 months of the reporting period.

Rationale:

Treatment of chronic pain is becoming a major issue in the state and nation. More adults died of prescription narcotic overdoses in 2012 than care accidents. Many measures of progress on this front are difficult; this measure is simple and straight-forward.

Measure source:

None provided.

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>		x	
<i>Is feasible to collect / has existing data source:</i>	x		
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			
This data can be collect both from claims as well as EHRs.			

BLOOD PRESSURE CONTROL FOR PEOPLE WITH DIABETES (NQF 0061)

Measure description:

Denominator: all patients with a diagnosis of diabetes.

Numerator: those in the denominator whose last blood pressure reading was less than 140/90.

Rationale:

Blood pressure control is a better predictor of mortality in diabetics than any other measures.

Measure source:

NQF 0061 <http://www.qualityforum.org/QPS/0061>

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>	x		
<i>Is feasible to collect / has existing data source:</i>	x		
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			

CARDIOVASCULAR DISEASE MEASURES

Measure description:

(1) The percentage of members 18-75 years of age who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year:

- LDL-C screening
- LDL-C control (<100 mg/dL)

(2) The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year. Use the HEDIS hybrid methodology for this measure.

Rationale:

Since cardiovascular disease is one of the top causes of morbidity and mortality and a high resource condition at the end of life due to poor monitoring in the early stages, we should get in before these members get sick.

Measure source:

NCQA

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	X		
<i>Has state, regional, or national level data available:</i>	X		
<i>Is feasible to collect / has existing data source:</i>	X		
<i>Presents an opportunity for quality improvement:</i>	X		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	X		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	X		
<i>Comments:</i>			
We need to get our cardiovascular conditions into alignment with the triple aim and focus on improving the health of these members before CHF and COPD.			

ANNUAL DENTAL VISIT

Measure description:

Proposed measure from the dental quality metrics workgroup: annual dental visit.

Rationale:

Oral health is an important part of overall health. Regular visits to the dentist provide access to cleaning, early diagnosis and treatment, as well as education on how to prevent problems.

Measure source:

None provided.

<i>Please indicate how this proposed measure aligns with some of the measure selection criteria adopted by the Metrics & Scoring Committee. This measure:</i>	Yes	No	Unsure
<i>Is evidence-based:</i>	x		
<i>Has state, regional, or national level data available:</i>	x		
<i>Is feasible to collect / has existing data source:</i>	x		
<i>Presents an opportunity for quality improvement:</i>	x		
<i>Reflects services and care that the CCO holds or shares responsibility for:</i>	x		
<i>Is transformational (improving this measure will fundamentally change care delivery in a desired manner):</i>	x		
<i>Comments:</i>			

ADDITIONAL SUGGESTIONS

Several survey respondents provided suggestions on general direction for new measures, without recommending specific measures or providing full details. Their feedback is provided here:

- ❖ Not sure about specifics at this time, but we believe that standardized behavioral health quality measures--that align with other measures at state/fed levels--should be considered. We believe this area is lacking focus and attention in the quality performance of CCOs and is a key component of innovation and reform efforts. So we advocate for having some serious and mindful discussions around additional BH measure(s) that examine the quality of the service delivery system to include in the CCO QIMs, beyond the hospitalization and DHS custody measures (since both have very small populations in several CCOs and are reliant on both behavioral health and physical health). [This is] a very important area for CCO work, and should be held to similar standards as the primary care providers.
- ❖ Our Mental Health Advisory Committee (MHAC) met to discuss the current CCO metrics and feel that more focus is needed in behavioral health (mental and chemical dependency). These two proposed metrics are areas they recommended to show access to services and treatment outcomes: (1) Increase in the number of enrollees served in behavioral health (percentage of membership) (2) A measure related to behavioral health treatment outcomes (outpatient).
- ❖ Consider a pharmacy measure – beginning to track and community prescriptions called in or electronically received but not filled. This will help with medication reconciliation; helps providers know when/if people do/do not pick up medication; helps build infrastructure for communication with pharmacy / CCOs / providers. Providers would report to CCO or prescribing entity on prescriptions not filled within 10 days of order. <http://www.npcnow.org/press-release/new-peer-reviewed-study-shows-mixed-results-aco-medication-readiness-achieve-quality>
- ❖ Would like to see a metric around tobacco screening and prevention education; tobacco is a huge burden in our region.
- ❖ Considering the following measures for 2016 or beyond:
 - Quality of adolescent well visits – whether specific aspects of recommended care were provided (not just if they had a well visit).
 - Follow up for children identified at risk based on developmental screening (this could maybe be a step up measure from developmental screening and before kindergarten readiness).
- ❖ Where possible, measures should be stratified by (1) race/ethnicity, (2) special health care needs. And provide incentives for CCOs that have fewer disparities.

- ❖ Metrics should be connected to upstream public health impact, such as: vaccine completion rates, access to walkable neighborhoods, disparities, etc... All current measures are narrowly focused on the health care system, thus CCOs are focusing on health care system narrowly.