

Oregon Metrics & Scoring Committee
Minutes
December 13, 2013
1:00 – 4:00 PM

ITEM

Welcome

Committee members present: Maggie Bennington-Davis, Robert Dannenhoffer, Phil Greenhill, Bob Joondeph, David Labby, Jeff Luck.

Not attending: Gloria Coronado, R.J. Gillespie, Jeanine Rodriguez.

OHA Staff: Lori Coyner, Sarah Bartelmann, Ari Ettinger.

Consultants: Michael Bailit, Bailit Health Purchasing.

Consent Agenda

The Committee approved the November 25, 2013 meeting minutes. The Committee also agreed to schedule additional phone meetings in 2014 as needed, beginning with a meeting in January.

Updates

Lori Coyner provided an update on the quality pool methodology webinar OHA hosted Thursday, December 12, 2013.

- Webinar slides are available online here:
[www.oregon.gov/oha/CCODData/Quality%20Pool%20Webinar%20\(Dec%202013\).pdf](http://www.oregon.gov/oha/CCODData/Quality%20Pool%20Webinar%20(Dec%202013).pdf)
- The updated quality pool methodology is available online here:
www.oregon.gov/oha/CCODData/ReferenceInstructions.pdf

OHA will schedule a repeat of this webinar in January for Committee members, Innovator Agents, and any CCOs who were unable to attend on the 12th.

Committee members shared thoughts on CCO Summit held December 5, 2013. A video of the panel interview with CCO CEOs discussing reflections on their first year and moving forward is available online here: <http://transformationcenter.org/cco-summit/>

2014 Benchmarks and Improvement Targets

Lori Coyner provided a summary of the Committee's November 25th decisions to adopt existing measures and specifications for a majority of measures and noted changes for 2014 for the remaining measures. The Committee adopted the following benchmarks and improvement targets for 2014:

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Measure	2013 Benchmark	2014 Benchmark	2014 Improvement Target
Adolescent well care visits	53.2% <i>2011 National Medicaid 75th percentile (admin data only)</i>	57.6% <i>2013 National Medicaid 75th percentile (admin data only)</i>	Minnesota method ¹ with 3 percentage point floor.
Alcohol and drug misuse (SBIRT)	13% <i>Committee consensus.</i>	13% unless CCOs demonstrate higher performance in 2013. Review in Q1 2014.	Minnesota method with 3 percentage point floor.
Ambulatory care: emergency dept. utilization	44.4/1,000 member months <i>2011 National Medicaid 90th percentile</i>	44.6/1,000 member months <i>2013 National Medicaid 90th percentile</i>	Minnesota method
CAHPS: Access to Care	87% <i>Average of the 2012 National Medicaid 75th percentiles for adult and child rates.</i>	88% <i>Average of the 2013 National Medicaid 75th percentiles for adult and child rates.</i>	Minnesota method with 2 percentage point floor.
CAHPS: Satisfaction with Care	84% <i>Average of the 2012 National Medicaid 75th percentiles for adult and child rates.</i>	89% <i>Average of the 2013 National Medicaid 75th percentiles for adult and child rates.</i>	Minnesota method with 2 percentage point floor.
Colorectal cancer screening	n/a – improvement target only	TBD by Committee in January 2014	n/a – benchmark only.
Developmental screening	50% <i>Committee consensus.</i>	50% <i>Committee consensus.</i>	Minnesota method.
Early elective delivery	5% or below <i>Committee consensus.</i>	5% or below <i>Committee consensus</i>	Minnesota method with 1 percentage point floor.

¹ Additional information about the Improvement Target methodology is available online at:
<http://www.oregon.gov/oha/CCODData/Improvement%20Targets%20--%20Revised%20September%202013.pdf>

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Electronic Health Record Adoption	49.2% <i>Federal benchmark for EHR adoption by 2014.</i>	72% <i>Committee consensus, based on highest performing CCO in July 2013.</i>	Minnesota method with 3 percentage point floor.
Follow up after hospitalization for mental illness	68% <i>2012 National Medicaid 90th percentile</i>	68.8% <i>2013 National Medicaid 90th percentile.</i>	Minnesota method with 3 percentage point floor.
Follow up for children prescribed ADHD medication (initiation rate)	51% <i>2012 National Medicaid 90th percentile</i>	51% <i>2013 National Medicaid 90th percentile</i>	Minnesota method.
Mental and physical health assessments for children in DHS custody	90% <i>Committee consensus.</i>	90% <i>Committee consensus.</i>	Minnesota method with 3 percentage point floor.
Patient Centered Primary Care Home (PCPCH) enrollment	Goal: 100% of members enrolled in Tier 3 PCPCH	Goal: 100% of members enrolled in Tier 3 PCPCH	n/a
Timeliness of prenatal care	69.4% <i>2012 National Medicaid 75th percentile, admin data only.</i>	90% <i>2013 National Medicaid 75th percentile</i>	Minnesota method.

The three clinical measures (depression screening, diabetes control, and hypertension control) will remain “pay for reporting” in 2014. CCOs will be required to submit an updated technology plan and expanded proof of concept data to “meet” these three measures. OHA will provide updated guidance in 2014. However, to qualify for the challenge pool on depression screening and diabetes control, the CCO will need to meet a benchmark. The Committee will establish benchmarks for these two measures in their next meeting.

Dental Metrics Workgroup Recommendation

Dr. Patrice Korjenek and Dr. Eli Schwarz presented the Dental Quality Metrics Workgroup recommendation of outcome and quality measures and benchmarks. They reviewed workgroup membership, charge, domains and criteria used.

Recommended CCO incentive measures include:

- Sealants on permanent molars for children age 6-9 and 10-14.
- Members age 2-21 receiving any dental service.

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Recommended measures for performance monitoring include:

- Patient experience with access to dental care (two questions from the CAHPS dental survey).
- Topical fluoride intensity.
- Comprehensive exam rate.

The Committee discussed the lack of standardized measures for dental outcomes. The Committee was particularly interested in measures such as “improved oral health”, “school absenteeism due to dental pain”, “retaining teeth as long as possible” or “not having new cavities from one visit to the next.”

The Committee also addressed whether dental measures should be pediatric or adult (or both), and whether dental metrics should be determined based on dental as a line of CCO business, or based on how oral health affects members’ lives and health outcomes.

The Committee was very interested in whether or not the recommended dental metrics aligned with other metrics, with priority populations, and with the quality improvement focus areas for CCOs. The Committee highlighted the importance of measures that would “force” cooperation between dental and medical, to further integration and drive performance improvement.

The Committee did not make a decision about the recommended dental metrics in their December meeting, and have requested additional information for consideration at their next meeting, including:

- Exact methodology and specifications (including codes) for each of the recommended measures;
- Baseline data at the Dental Care Organization level for the recommended measures;
- Opportunities for dental metrics to align with current CCO measures, populations of interest, and other quality improvement efforts.

Measurement Framework

David Labby introduced the concept of a measurement framework that would help the Committee determine which domains, outcomes, and populations are represented in selected measures, and where there are gaps. This framework would help guide the Committee’s future metric decisions: “given where we are trying to go as a state, what are we trying to measure, and will these measures tell us if we are getting there.”

In January, the Committee will review the seven quality improvement focus areas and the criteria used to select the initial 17 CCO incentive measures, and continue developing a framework. Staff will provide the Committee with a brief overview of the various groups working on measure alignment.

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Public Testimony

No public testimony was provided.

Next Meeting

January 31, 2014 from 1:00 – 3:00 pm – by phone.