

RECOMMENDED STRATEGIES TO ADDRESS CHILDHOOD OBESITY

BACKGROUND

Obesity rates in Oregon have jumped 140 percent among adults since 1990. In Oregon, the prevalence of obesity among people with low incomes (less than \$15,000) is 29.4 percent, compared to 25.1 percent of people with incomes of \$50,000 or more. In 2012, nearly one-third of Oregon's 6-9 year olds were overweight or obese: 15 percent of children were overweight, 15 percent were obese. Children who are obese are more likely to become obese adults, putting them at greater risk of chronic disease.

EVIDENCE IN SUPPORT OF WEIGHT LOSS

ROUTINE BODY MASS INDEX (BMI) SCREENING AND REFERRAL TO BEHAVIORAL INTERVENTIONS

Coordinated care organizations (CCOs) can ensure access to routine obesity screening, and can assist providers in collecting and monitoring BMI. Obesity screening and counseling are covered preventive services under the Affordable Care Act and have received a Grade B recommendation by the US Preventive Services Task Force.

- <http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/obesity-in-children-and-adolescents-screening?ds=1&s=obesity>
- http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full.pdf+html
- <http://www.aafp.org/afp/2011/0315/p739.html>

COMPREHENSIVE BEHAVIORAL INTERVENTIONS TO REDUCE AND MAINTAIN WEIGHT LOSS

CCOs can provide access to comprehensive behavioral interventions to reduce and maintain weight loss. Behavioral interventions consisting of 26 or more hours of contact time for obese children and adolescents (95th to 97th percentile for age and sex) ages 6 and older have demonstrated short-term weight loss.

The effect of comprehensive behavioral interventions are estimated to be a 13 pound difference for 8-year olds; 17-18 pound difference for 12-year olds; 19 pound difference for 16-year old girls; and 22-23 pounds for 16-year old boys, compared to children and adolescents who did not receive comprehensive behavioral interventions.

- When combined with pharmacotherapy such as sibutramine or orlistat, comprehensive behavioral interventions yield a greater impact on weight for adolescents 12-18 years with adult class II obesity. For adolescents who received sibutramine plus comprehensive behavioral interventions, average weight reduction was 14 pounds at 12 months.
<http://pediatrics.aappublications.org/content/125/2/e396.full.pdf+html>
- Technology-supported multicomponent coaching or counseling interventions to address obesity are recommended by the Community Preventive Services Task Force. Technology-supported interventions may include the use of computers, video conferencing, personal digital assistants, pedometers or computerized telephone system interventions targeting physical activity, nutrition, or weight.
<http://www.thecommunityguide.org/obesity/RRTechnologicalCoaching.html>

OTHER NATIONALLY-RECOMMENDED INTERVENTIONS

TREATMENT FOR OBESITY

Providers can practice family-centered care to diagnose and treat childhood obesity.

- **Standardized care.** Health care providers can adopt standards of practice for prevention, screening, diagnosis, and treatment of overweight and obesity to help children, adolescents, and adults achieve and maintain a healthy weight, avoid obesity-related complications, and help reduce the psychosocial consequences of obesity. http://www.iom.edu/~media/Files/Report%20Files/2012/APOP/APOP_insert.pdf
- **Patient-centered communication.** Motivational interviewing takes into account patient readiness to change, uses non-judgmental questions and reflective listening to uncover the beliefs and values of a parent or patient. http://www.pediatrics.org/cgi/content/full/120/Supplement_4/S164

HEALTHY WEIGHT GAIN DURING PREGNANCY AND BREASTFEEDING

Breastfed children have a reduced risk of obesity later in life and a baby's risk of becoming an overweight child is reduced with each month of breastfeeding.

- **Promotion of weight gain during pregnancy and breastfeeding.** Providers can support healthy weight gain during pregnancy and the initiation and continuation of breastfeeding. http://www.iom.edu/~media/Files/Report%20Files/2012/APOP/APOP_insert.pdf

The US Preventive Services Task Force recommends interventions during pregnancy and after birth to promote and support breastfeeding. <http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/breastfeeding-counseling>

- **Baby-Friendly Hospital Initiative.** The *Baby-Friendly Hospital Initiative* describes ten steps to successful breastfeeding that have been shown to increase breastfeeding rates by providing support to mothers. <http://www.cdc.gov/breastfeeding/pdf/BF-Guide-508.PDF>

NUTRITION STANDARDS

Nutrition standards have demonstrated increased fruit and vegetable consumption and decreased consumption of fats, which support healthy weight.

- **Nutrition standards for all foods and beverages sold or provided through the government and the private sector, including hospitals and clinics.**

The *Dietary Guidelines for Americans* provide specific recommendations for optimizing dietary intake to prevent disease and promote health.

http://www.iom.edu/~media/Files/Report%20Files/2012/APOP/APOP_insert.pdf

- **Consumption of sugary beverages.** Comprehensive strategies can be employed to reduce consumption of sugary beverages. http://www.iom.edu/~media/Files/Report%20Files/2012/APOP/APOP_insert.pdf
- **Nutrition, physical activity and screen time requirements for licensed childcare providers.** State and local childcare and early childhood education regulators can establish requirements for each program to improve its nutrition and physical activity standards while reducing the amount of time children spend in front of televisions and computers. http://www.iom.edu/~media/Files/Report%20Files/2012/APOP/APOP_insert.pdf
http://www.une.edu/sites/default/files/Maine-Harvard-PRC_2011.pdf
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm>

MEASURE FRAMEWORK CROSSWALK

Table 1: CCO 2015 Incentive Measures and Institute of Medicine Core Measures, sorted by Triple Aim Dashboard Domain

Measures (or measure concepts) appearing in both measure sets are highlighted in blue below.

Triple Aim Dashboard Domain	2015 CCO Incentive Measures	IOM Core Measures
Fostering Healthy Beginnings	<ul style="list-style-type: none"> Prenatal care Adolescent well-care visits Dental sealants for children Developmental screening Assessments for children in DHS custody 	<ul style="list-style-type: none"> Maternal mortality Infant mortality
Promoting Health Living and Disease Prevention	<ul style="list-style-type: none"> Colorectal cancer screening Effective contraceptive use 	<ul style="list-style-type: none"> Colorectal cancer screening Influenza immunization Breast cancer screening Healthy eating patterns Activity levels Alcohol dependence / misuse Tobacco use Drug dependence / illicit use Contraceptive use

Triple Aim Dashboard Domain	2015 CCO Incentive Measures	IOM Core Measures
Supporting Individuals with Chronic Conditions	<ul style="list-style-type: none"> • Depression screening and follow-up • Hypertension control • Diabetes HbA1c control (subset of composite) • Follow up after hospitalization for mental illness • Alcohol or other substance misuse (SBIRT) 	<ul style="list-style-type: none"> • Depression • Hypertension control • Diabetes control composite • Multiple chronic conditions
Maintaining Choice, Dignity, and Independence at the End of Life		<ul style="list-style-type: none"> • End-of-life/advanced care planning
Extending and Maintaining the Coordinated Care Model	<ul style="list-style-type: none"> • Ambulatory care: emergency department utilization • PCPCH enrollment • EHR adoption 	<ul style="list-style-type: none"> • Medication reconciliation • Unnecessary care composite • Wrong-site surgery • Pressure ulcers • Cardiovascular risk reduction • Heart attack therapy protocol • Stroke therapy protocol
Ensuring Access to Care	<ul style="list-style-type: none"> • CAHPS: access to care composite • CAHPS: satisfaction with care composite 	<ul style="list-style-type: none"> • Care access • Patient experience • Usual source of care • Delay of needed care • Shared decision making • Involvement in health initiatives

Triple Aim Dashboard Domain	2015 CCO Incentive Measures	IOM Core Measures
Building Healthy and Safe Communities		<ul style="list-style-type: none"> • Childhood poverty rate • Availability of healthy food • Walkability • Violence and injury mortality • Air quality index • Childhood asthma • Drinking water quality index • Community health benefit agenda
Improving Affordability and Sustainability of Coverage		<ul style="list-style-type: none"> • Healthcare related bankruptcies • Population spending burden • Total cost of care • Health care spending growth

Table 2: Institute of Medicine Domains and Measures, aligned with CCO 2015 Incentive Measures and Triple Aim Dashboard Domains

IOM Core Measures	2015 CCO Incentive Measures	Triple Aim Dashboard Domains (listed more than once)
Life expectancy <ul style="list-style-type: none"> • Infant mortality • Maternal mortality • Violence and injury mortality 		<ul style="list-style-type: none"> • Fostering healthy beginnings • Building healthy and safe communities
Well-being <ul style="list-style-type: none"> • Multiple chronic conditions • Depression 	<ul style="list-style-type: none"> • Depression screening and follow-up • Follow up after hospitalization for mental illness* 	<ul style="list-style-type: none"> • Promoting healthy living and disease prevention • Supporting individuals with chronic conditions
Overweight and obesity <ul style="list-style-type: none"> • Activity levels • Healthy eating patterns 		<ul style="list-style-type: none"> • Promoting healthy living and disease prevention
Addictive behavior <ul style="list-style-type: none"> • Tobacco use • Drug dependence / illicit use • Alcohol dependence / misuse 	<ul style="list-style-type: none"> • Alcohol or other substance misuse (SBIRT) 	<ul style="list-style-type: none"> • Promoting healthy living and disease prevention
Unintended pregnancy <ul style="list-style-type: none"> • Contraceptive use 	<ul style="list-style-type: none"> • Effective contraceptive use 	<ul style="list-style-type: none"> • Promoting healthy living and disease prevention
Healthy communities <ul style="list-style-type: none"> • Childhood poverty rate • Childhood asthma • Air quality index • Drinking water quality index 		<ul style="list-style-type: none"> • Building healthy and safe communities

IOM Core Measures	2015 CCO Incentive Measures	Triple Aim Dashboard Domains (listed more than once)
Preventive services <ul style="list-style-type: none"> • Influenza immunization • Colorectal cancer screening • Breast cancer screening 	<ul style="list-style-type: none"> • Adolescent well-care visits • Colorectal cancer screening • Dental sealants for children • Developmental screening* • Prenatal care* 	<ul style="list-style-type: none"> • Fostering healthy beginnings • Promoting healthy living and disease prevention
Care access <ul style="list-style-type: none"> • Usual source of care • Delay of needed care 	<ul style="list-style-type: none"> • Ambulatory care: emergency department utilization* • CAHPS: access to care composite • Assessments for children in DHS custody* • PCPCH enrollment* 	<ul style="list-style-type: none"> • Ensuring access to care • Extending and maintaining the coordinated care model
Patient safety <ul style="list-style-type: none"> • Wrong-site surgery • Pressure ulcers • Medication reconciliation 	<ul style="list-style-type: none"> • EHR adoption* 	<ul style="list-style-type: none"> • Extending and maintaining the coordinated care model
Evidence-based care <ul style="list-style-type: none"> • Cardiovascular risk reduction • Hypertension control • Diabetes control composite • Heart attack therapy protocol • Stroke therapy protocol • Unnecessary care composite 	<ul style="list-style-type: none"> • Hypertension control • Diabetes HbA1c control (subset of composite) 	<ul style="list-style-type: none"> • Supporting individuals with chronic conditions • Extending and maintaining the coordinated care model
Care match with patient goals <ul style="list-style-type: none"> • Patient experience • Shared decision making • End-of-life/advanced care planning 	<ul style="list-style-type: none"> • CAHPS: satisfaction with care composite* 	<ul style="list-style-type: none"> • Maintaining choice, dignity, and independence at the end of life • Ensuring access to care

IOM Core Measures	2015 CCO Incentive Measures	Triple Aim Dashboard Domains (listed more than once)
Personal spending burden <ul style="list-style-type: none"> • Healthcare related bankruptcies 		<ul style="list-style-type: none"> • Improving affordability and sustainability of coverage
Population spending burden <ul style="list-style-type: none"> • Total cost of care • Health care spending growth 		<ul style="list-style-type: none"> • Improving affordability and sustainability of coverage
Individual engagement <ul style="list-style-type: none"> • Involvement in health initiatives 		<ul style="list-style-type: none"> • Maintaining choice, dignity, and independence at the end of life • Extending and maintaining the coordinated care model
Community engagement <ul style="list-style-type: none"> • Availability of healthy food • Walkability • Community health benefit agenda 		<ul style="list-style-type: none"> • Building healthy and safe communities

*indicates best fit; measure could align with multiple domains.

METRICS & SCORING COMMITTEE: MEASURE RETIREMENT CHECKLIST

The Metrics & Scoring Committee's measure retirement checklist was developed in 2015 for the Committee's use when retiring CCO incentive measures. Not all of these criteria must be met before a measure could be retired. Note retired CCO incentive measures may continue as monitoring measures.

NO ADDITIONAL OPPORTUNITY FOR MEANINGFUL PERFORMANCE IMPROVEMENT (“TOPPED OUT”)

For example, the statewide rate and all (or most) CCO rates exceed the highest possible benchmark; there is not a higher benchmark that could be adopted; or performance has not yet met the benchmark, but there is clear rationale (e.g., underlying differences in data sources) and no reasonable expectations for further meaningful improvement.

MEASURE NO LONGER ADDS MEANINGFUL VALUE

For example, the measure set already contains measures that focus on the population or domain of interest (e.g., relative importance); a more appropriate or relevant measure exists to address the population or domain that the original measure was intended to address; the measure is redundant or duplicative; the measure is less transformational than other measures in the set, given the need for parsimonious measure selection; there is evidence of unanticipated or unintended consequences of implementing the measure; there is evidence that the measure undermines quality improvement activities or underlying manipulation to 'meet' a measure.

SUPPORTING CLINICAL GUIDELINES OR EVIDENCE-BASE HAVE CHANGED

For example, the measure was based on a clinical guideline which has since changed (e.g., the process of care has been shown to be irrelevant or harmful); review of literature suggests that the measure no longer predicts anything important to the patient (e.g., no longer scientifically acceptable); the measure may be slated for retirement or modification due to change in clinical guidelines, but there is a lag between the measurement year and the retirement or modification date.

MEASURE HAS BEEN RETIRED / PENDING RETIREMENT BY MEASURE STEWARD

For example, the measure steward (e.g., NCQA, CMS) has recently retired or announced plans to retire the measure from its active set(s); the measure has lost endorsement; or does not have an active measure steward.

MEASURE CANNOT BE MEASURED

For example, the state, CCOs, or providers no longer have the capacity to maintain or report on the measures; the available data cannot be used for the intended purpose of the measure; data for the measure is no longer available or will cease to be available for the measurement year; or low prevalence of a condition or small denominators lead to low reliability and high variation for the measure.



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May 8, 2015

TO: Oregon Health Authority Metrics and Scoring Committee
FROM: PacificSource Community Solutions
RE: 2016 CCO Tobacco Prevalence Incentive Measure

Testimony in Support of Utilizing Meaningful Use Electronic Health Record Data to Measure Tobacco Prevalence

In 2015, the Oregon Health Authority (OHA) Metrics and Scoring Committee (MSC) is considering including the rate of tobacco use among adult members as a Coordinated Care Organization (CCO) incentive measure for 2016. The Metrics Technical Advisory Group (TAG) has expressed methodological concerns regarding the use of Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data for measurement of tobacco prevalence. In response, the MSC has asked TAG to explore other measurement alternatives including the use of Meaningful Use Electronic Health Record (EHR) data.

Due to the dynamic nature of Medicaid enrollment and the inconsistent results that can be generated from small sample size surveys, it is PacificSource Community Solutions' belief that using tobacco prevalence as an incentive measure does not accurately reflect the efforts of the CCO to reduce tobacco use among its members. However, PacificSource Community Solutions applauds all efforts to prevent tobacco use amongst the CCO population and will support the best available measurement of tobacco prevalence. Therefore, PacificSource Community Solutions is submitting the following as written testimony in support of utilizing Meaningful Use Electronic Health Record data rather than CAHPS survey data to measure tobacco prevalence in Oregon's Medicaid population.

Upon reviewing the options presented by OHA, PacificSource Community Solutions believes that using CAHPS data to measure tobacco prevalence presents significant challenges:

- CAHPS does not include children in their assessment of tobacco prevalence and this is a demographic with high membership in CCOs and significant tobacco addiction. Any tobacco cessation measure should evaluate the prevalence and support improvement efforts in this population.
 - Smoking and smokeless tobacco use are initiated and established primarily during adolescence. Nearly 9 out of 10 smokers first tried cigarettes by age 18, and 99% first tried cigarettes by age 26.^{1 2 3 4}

- 1 in 5 high school students who are current e-cigarette users are not conventional cigarette smokers and are potentially becoming addicted to nicotine through e-cigarettes.⁴
- In 2014, a total of 24.6% of high school students reported current use of a tobacco product, including 12.7% who reported current use of ≥ 2 tobacco products. Among all high school students, e-cigarettes (13.4%) were the most common tobacco products used, followed by hookahs (9.4%), cigarettes (9.2%), cigars (8.2%), smokeless tobacco (5.5%), snus (1.9%), pipes (1.5%), bidis (0.9%), and dissolvables (0.6%).⁵
- In 2014, e-cigarettes were the most commonly used tobacco product among middle (3.9%) and high (13.4%) school students. From 2011 to 2014, statistically significant nonlinear increases were observed among high school students for current e-cigarette (1.5% to 13.4%) and hookah (4.1% to 9.4%) use.⁵
- The small population sampled by CAHPS means that the margin of error is great.
 - For Central Oregon, PacificSource Community Solutions had approximately 60,000 members and the 2014 CAHPS sample size was 900 adults with a 37.1% response rate. 446 adults were non-responsive to mail or phone.
 - For Columbia Gorge, PacificSource Community Solutions had approximately 12,000 members and the 2014 CAHPS sample size was 900 adults with a 40.8% response rate. 400 adults were non-responsive to mail or phone.
 - The CAHPS margin of error = 4.8 - 6.0, 95% level of confidence. It's difficult to determine if CCOs are making meaningful reductions in tobacco use when the margin of error is greater than the expected percentage decline in prevalence.
- Currently, there is a significant delay in receiving CAHPS data results. Due to the time-intensive process of administering the assessment, results are often not available until months after the measurement year has ended. The CCOs ability to create current year cessation strategies based on previous year's results would be negatively impacted.
- CAHPS Information is not available by clinic, by location, or by provider. CCOs would have difficulty identifying, monitoring and supporting settings in need of performance improvement.

As an alternative to the use of CAHPS, PacificSource Community Solutions recommends utilizing Meaningful Use EHR data to measure tobacco prevalence within the Oregon Medicaid population.

- Currently, greater than 50% of providers in Oregon use an EHR and this percentage continues to grow each year. In addition, more than 75% of

PacificSource Community Solutions members had at least one provider visit in 2014.

- Data can be analyzed by CCOs within two months of capture⁶. The proposed tobacco prevalence measure will then become actionable as providers can react to data findings and change strategies in a timely manner.
- The Centers for Medicare and Medicaid Services (CMS) Meaningful Use Core Measure 9 requires that smoking statuses for patients 13 years and older be recorded as structured data.⁶ This will ensure that the high risk population of adolescents would be included in any measure of prevalence.
 - 90% of adult smokers start before the age of 18^{1 2 3 4}, so it is imperative that providers have the ability to identify, intervene and report adolescent tobacco use.
- Meaningful Use data will allow for more specificity – CCO, encounter location, member age, provider, smoking status details (type of use, amount of use), etc. Detailed data will allow for targeted efforts to decrease tobacco prevalence.
- The American Dental Association continues to urge its members to become fully informed about tobacco cessation intervention techniques to effectively educate their patients to overcome their addiction to tobacco.⁷
 - In future years, use of data from Dental EHRs could be explored as an additional source of information for tobacco prevalence.
- Meaningful Use EHR data will capture non-enrolled as well as enrolled members while CAHPS currently only captures those enrolled at the time of the survey.

For CCOs to successfully leverage EHR Meaningful Use reporting to measure tobacco prevalence, PacificSource Community Solutions recommends a phased-in approach modeled after OHA's Technology Plan Quality Improvement Measures (QIM) strategy. This includes considering the use of the following for implementation:

- Year 1 (2016) should establish a baseline and focus on infrastructure development and defining requirements.
 - Focus on the necessary clinic-level infrastructure to build, enhance and/or validate tobacco prevalence reporting from EHRs.
 - Invested effort by OHA early in 2015 to create shared definitions, technical specifications, and data submission standards and requirements to ensure readiness on or before January 2016.
 - Require a minimum threshold of participating providers/clinics to submit data in first year, with expectation the percent will increase over time.

- Allow for aggregate submission and map a timeline that will eventually lead to member-level reporting by Year Four (4).

The goal of the Oregon Health Authority's outcomes and quality measures is to use "quality health metrics to show how well Coordinated Care Organizations (CCOs) are improving care, making quality care accessible, eliminating health disparities, and curbing the rising cost of health care."⁸ With this in mind, PacificSource Community Solutions believes that the evidence given in this document creates a strong argument for using Meaningful Use EHR data, rather than CAHPS survey data. Use of Meaningful Use data will encourage a community approach to tobacco prevalence, cessation, and prevention and will allow providers greater control in determining the outcome of the tobacco prevalence measure.

Thank you for your attention to this important issue and your commitment to the health of all Oregon residents.

Best regards,



Alison Little, MD, MPH
Medical Director, Medicaid Programs
PacificSource Community Solutions

¹ U.S. Department of Health and Human Services. Preventing Tobacco Use Among Young People: A Report of the Surgeon General(http://www.cdc.gov/tobacco/data_statistics/sgr/1994/index.htm). Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Office on Smoking and Health, 1994 [accessed 2015 Apr 20].

² U.S. Department of Health and Human Services. Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General(http://www.cdc.gov/tobacco/data_statistics/sgr/2012/index.htm). Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Office on Smoking and Health, 2012 [accessed 2015 Apr 20].

³ Campaign for Tobacco-Free Kids. The Path to Smoking Addiction Starts at Very Young Ages [PDF-164.63 KB]. Washington: Campaign for Tobacco-Free Kids, 2009 [accessed 2015 Apr 20].

⁴ Centers for Disease Control and Prevention. Electronic Cigarette Use Among Middle and High School Students — United States, 2011–2012. *Morb Mortal Wkly Rep* 2013; 62:729-30.

⁵ Centers for Disease Control and Prevention. Tobacco Use Among Middle and High School Students — United States, 2011–2014. *Morbidity and Mortality Weekly Report* 2015;64(14):381-385[accessed 2015 May 8].

⁶ Centers for Medicare and Medicaid Services. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/9_Record_Smoking_Status.pdf. Washington: Centers for Medicare and Medicaid Services, 2014 [accessed 2014 Apr 21].

⁷ American Dental Association. Summary of Policy and Recommendations Regarding Tobacco(<http://www.ada.org/en/about-the-ada/ada-positions-policies-and-statements/summary-of-policy-and-recommendations-regarding-to>). Chicago: American Dental Association, 2015 [accessed 21 April 2015].

⁸ Oregon Health Authority. Technical Specifications and Guidance Documents for CCO Incentive Measures-Overview(<http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>)



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JACQUELYN O. GROSHONG, MD

ROBERT L. DANNENHOFFER, MD

To: Metrics and Scoring Committee

Date May 14, 2015

Re: New Equity metric

Achieving health equity and reducing disparities is a major goal of health care transformation. It has been repeatedly noted that people of color, Native Americans, those whose preferred language is not English and those in frontier areas may be eligible for Medicaid but may not receive the same services or get the same quality care as others.

Our goal should be to improve the overall health of those who are served by the CCO's and to reduce the disparities in care. Each of our current metrics measure performance by race and ethnicity, but none of the measures is specially designed to measure health equity or to reduce disparity and none of the incentives rewards the reduction of disparity. Unfortunately, there are no widely used incentive measures that address equity or decrease disparity. At the same time, the Metrics and Scoring committee is faced with many possible measures and has tried to limit the number of measures, so as not to overwhelm those who need to accomplish them.

Let me suggest a novel "meta-measure" that would both measure and incentivize the reduction of health disparities, while not adding to the a new work process to the CCO's. Meta measures use already collected data, looked at in a new way to incentivize behavior.

In general, this measure would incentivize CCO's to attain the same performance for the historically underserved populations as they do for their overall population.

We already collect 34 measures across the entire CCO population, and in most cases, can break down that data by race, ethnicity, preferred language and zip code. To be suitable for this meta measure, the measure would need to have large denominators and would need to be able to be measured on an individual basis. About 20 or 25 of those measures would be suitable for this "meta-measure", including colorectal cancer screening, developmental screening, the dental measures and ED usage. (Some small denominator measures, like the foster care measure or survey measures that sample a population would likely not be suitable). I would use a statistical definition for "same performance", i.e. overlapping confidence intervals would be defined as "the same"

For each of those 25 measures, we could measure the performance for the CCO overall, and for the various groups for whom we want to reduce disparity- thus we would have up to 100 measures per CCO for performance in the potentially underserved groups. A CCO would get credit if the performance on a measure for a historically disadvantaged group was similar to the CCO overall. Thus, if a CCO was perfectly equitable (i.e., the performance for each group on every measure was similar) then the CCO would get 100% of this incentive. If 90% of the historically disadvantaged groups were similar to the CCO overall, the CCO would 90% of the incentive. This would be a continuously reinforcing measure, largely under the control of the CCO, without the need to add another process for the CCO.

This incentive would be exactly in keeping with the goals of transformation, is quite feasible, clearly transformative and much of the background work has been done by the CCO's- now it is time for them to pay attention to and fix health disparities.

Sincerely,

Robert Dannenhoffer, MD

Tobacco Prevalence using EHRs: Updated Survey Results

To learn more about electronic health record (EHR) functionality and how tobacco use status is collected and reported out of EHRs, OHA fielded a survey to collect additional information from CCOs and clinics to provide context for tobacco prevalence measure development.

The survey was initially fielded between the March 26th and April 23rd Metrics Technical Advisory Workgroup (TAG) meetings. OHA received 29 valid responses representing at least 28 practices, 10 EHR platforms, and 9 CCOs. At the April 23rd TAG meeting, OHA agreed to re-open the survey to allow additional CCOs and clinics time to respond. Between April 23rd and May 21st, OHA received an additional 15 valid responses, bringing the total to 44 valid responses, representing at least 12 CCOs

This revised report summarizes the survey results, including respondents, data collection, data reporting from Meaningful Use, data reporting from custom query, and resources needed to be able to report on tobacco prevalence from EHRs.

Respondents

OHA received 44 valid responses, representing at least 12 CCOs and 16 EHR platforms (see table below). Some responses are applicable to large groups of providers all on the same EHR or for all providers the CCO provides direct EHR support for.

OHA also received additional partially completed responses and responses for providers without EHRs. These responses are not included in this summary.

Represented CCOs	Represented EHRs	
<ul style="list-style-type: none"> ▪ AllCare ▪ Cascade Health Alliance ▪ ColumbiaPacific ▪ Eastern Oregon ▪ FamilyCare ▪ Health Share ▪ Jackson Care Connect ▪ PacificSource – Central ▪ PacificSource – Gorge ▪ Trillium ▪ WVCH ▪ Yamhill 	<ul style="list-style-type: none"> ▪ AllScripts Touchworks EHR ▪ Centricity ▪ Cerner-Anasazi ▪ CGM WebEHR ▪ ChiroTouch ▪ CPS12 ▪ CrystalPM ▪ eClinicalWorks ▪ Epic¹ ▪ Greenway 	<ul style="list-style-type: none"> • Mac-Practice ▪ Med3000 ▪ Meditec ▪ Mosaiq/Elekta ▪ NextGen ▪ Pro-filer

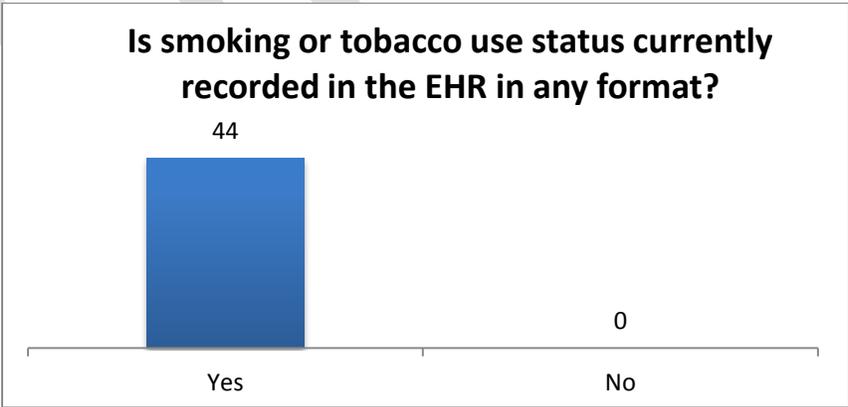
The majority of EHRs represented in the responses are 2014 certified (40/44); information provided in this summary may be less relevant to those 2011 certified EHRs.

Data Collection

Respondents were asked a series of questions about if smoking / tobacco use status is recorded in the EHR, and if yes, how it was recorded. The survey did not differentiate between cigarette smoking and other tobacco products; for the purposes of the survey and likely for an EHR-based prevalence measure, smoking and tobacco use will be used interchangeably.

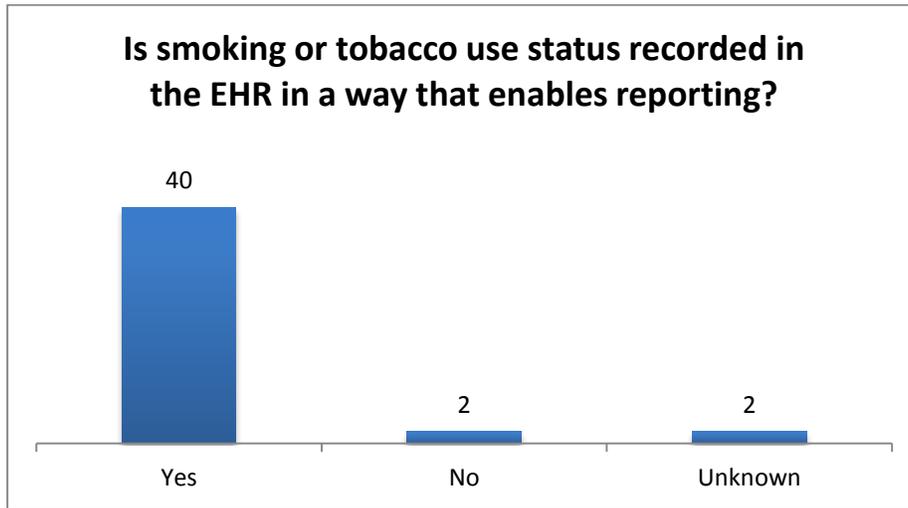
Is smoking or tobacco use status currently recorded in the EHR in any format?

All respondents indicated that smoking or tobacco use status is currently being recorded in the EHR somehow.



¹ Multiple installations of Epic are reflected in the survey responses, including a response from OCHIN on behalf of CCOs that may be using the current OCHIN reporting solution for the three existing clinical measures. Apart from this list, all Epic responses are treated individually in the summary.

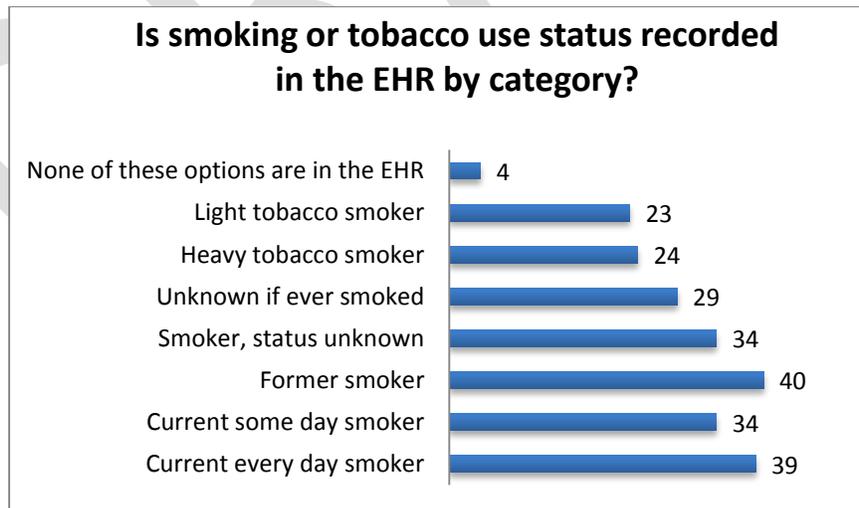
Is smoking or tobacco use status currently recorded in the EHR in a way that enables reporting (i.e., as structured data)?



The majority of respondents indicated that smoking or tobacco use status was being recorded in the EHR in a way that enables reporting, i.e., as structured data. See Appendix A for a more detailed description of how smoking or tobacco use status is recorded in these EHRs.

Is smoking or tobacco use status recorded in the EHR using any of the following categories? Please select all options that are available.

These categories align with Meaningful Use standards required for EHRs in 2014. Specifically, Standards Criteria §170.207(h).



Of those respondents who indicated none of these responses are in the EHR, smoking or tobacco use status is recorded as:

- Free text narrative.

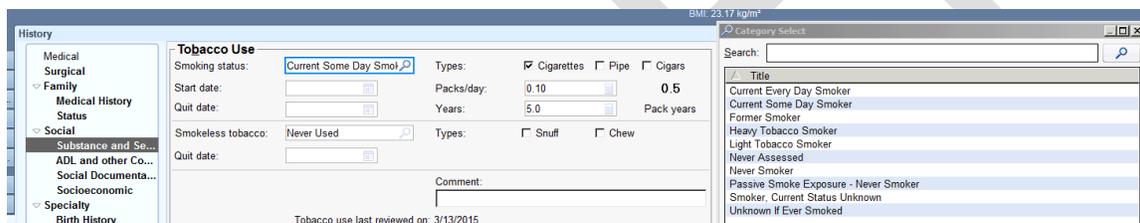
- Yes or no check boxes, with narrative.
- Tobacco use status: yes, never, not asked, quit, or passive.
- Tobacco use status: yes, no, unknown

Of those respondents who indicated at least one of the standards criteria categories above, many noted additional information is captured, as either structured data or in chart notes, including, but not limited to: type of tobacco, amount / level of addiction, exposure to secondhand smoke, intent to quit, and dates (e.g., start date, quit date).

Where tobacco use status is recorded in the EHR also varies. Tobacco use information may be recorded in multiple places within the same EHR. Responses included:

- In the patient’s social history
- In a structured risk factors form
- In the vitals section and/or in social history

Screenshot of tobacco use section in OCHIN Epic



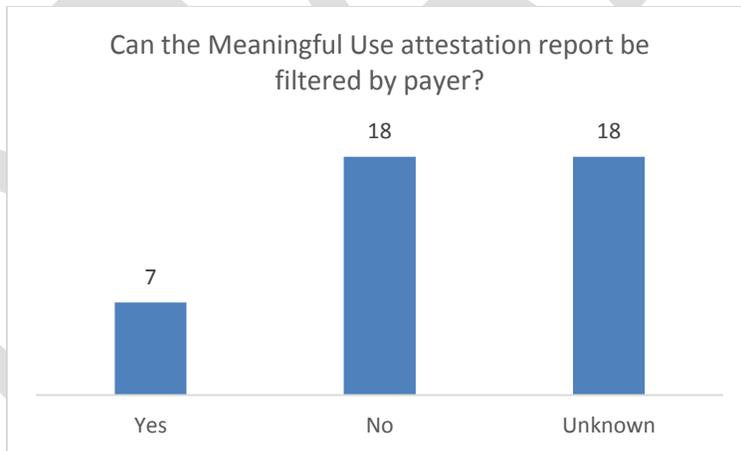
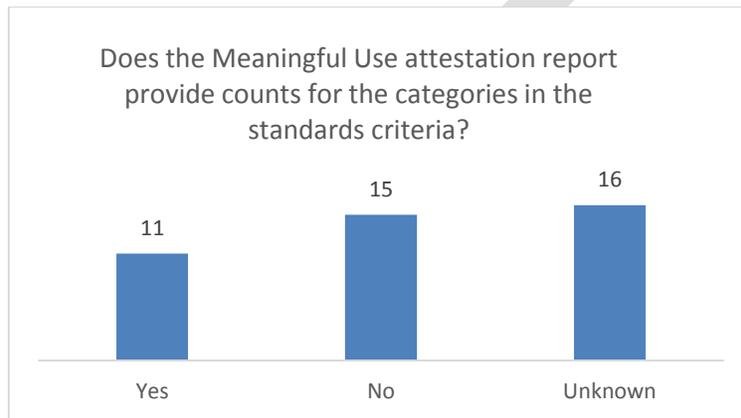
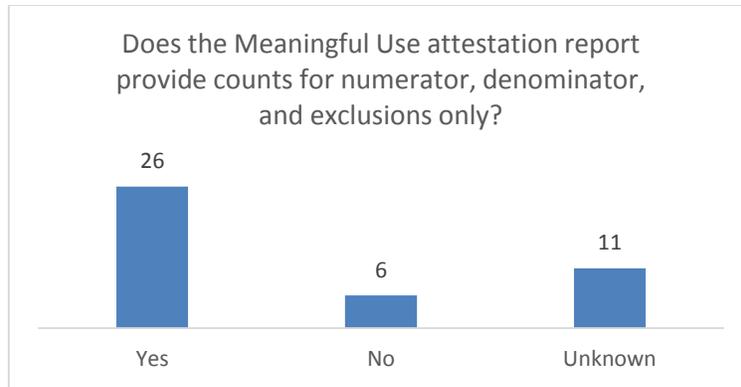
Data Reporting from Meaningful Use

All EHRs used for Meaningful Use provide an attestation report that includes (at minimum) counts for the numerator, denominator and exclusions for the measures. Some EHRs may provide additional reports to support meaningful use.

Note the Meaningful Use measure is *not* a prevalence measure, but rather a measure of how many patients who had an office visit have their smoking status recorded as structured data.

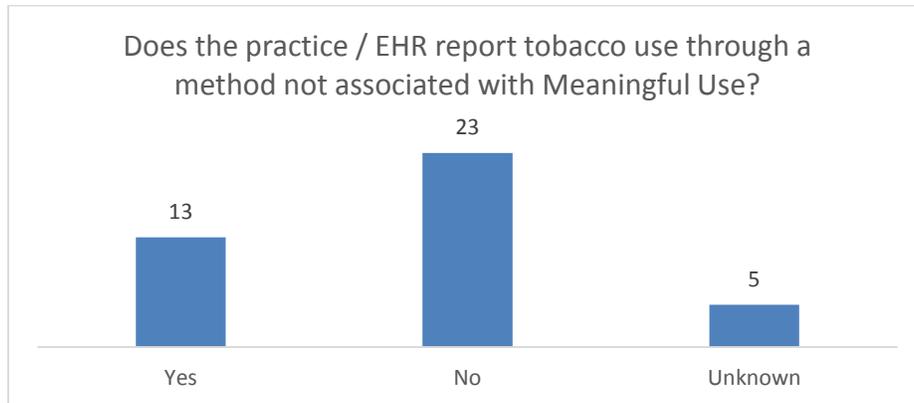
The attestation report is likely only useful for a prevalence measure if the information in the Meaningful Use measure numerator (those patients with smoking status recorded as structured data) can be accessed to determine how many of those patients actually are smokers / tobacco users.

This series of questions asked about what the Meaningful Use attestation report looks like and what level of granularity is available within that report to determine if it can be used as a starting place for a prevalence measure.



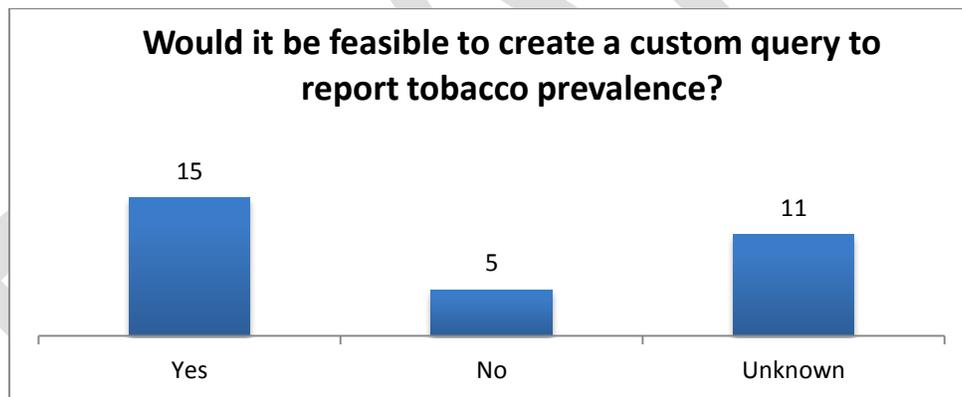
Data Reporting from Custom Query

Respondents were also asked about any reporting of tobacco prevalence outside of the Meaningful Use reports.



Examples of these other options include UDS reports, internal quality improvement or performance reporting, PQRS reports, and a customized datamart for clinical quality measurement.

If not currently reporting tobacco prevalence through any method, would it be feasible to create a custom query to report this data?



Comments included:

- It may be possible to create a custom query, but unsure that the custom reports will provide all of the details needed.
- It is feasible, but unclear how much work or resources it would take.
- Custom reporting is very expensive and time consuming for IT personnel. Also it requires at-minimum that the data are structured, and even then reports can be unreliable.
- Reporting on tobacco use status is relatively easy, especially compared to the depression screening and FU metric that we built last year. The customization is for CCO members only.

What resources would be needed to develop a custom query to report tobacco prevalence from this EHR?

Select responses included:

- A different EHR system.
- Time.
- We currently have registry reporting that allows us to pull patients by at least some of the smoking status categories as well as a custom reporting tool. Would likely need to work with EHR vendor to work out any issues with accessing data to be able to use the custom reporting tool. Needs further testing.
- The functionality that we currently have to use for custom queries in our EHR allows us to include specifics in the request, but the output report does not provide us with details. We would have to run reports by each tobacco status category separately. We don't really have other options for this type of custom report that I am aware of so it would probably require more technology and resources on the vendor's end to build functionality.
- Data is reportable through a Cognos reporting tool, EBO.
- All resources are currently in place, minimal additional work would be involved.
- A report writer that understands writing reports in SQL and Crystal Reports. Would likely take a qualified report writer 2 hours to create and validate these reports if they have a solid understanding of the database the data is being pulled from.
- Would need resources to get the information into structured data and built into the process flow; would need IT personnel with expertise to write a report probably using Crystal Reports; and would need some kind of analysis to verify report accurate and a way to send the information securely.
- Would need money to fund an analyst and to have access to a person who knows eCW and can work with us to develop the report. We can pay the vendor to write reports for us, but they arrive not meeting the criteria that we need given that developing these types of reports is usually an iterative process.
- It depends on if the report would need to match the more detailed categories from the Meaningful Use standards criteria. If it did need to match, this would need to be built into the EHR (estimated 35-45 hours for the system build, report build, creation of training materials,

and training of staff on workflow changes, would use in-house IT and EHR team).

- The biggest thing is having very clear specifications of how the metric is to be defined. Assuming this is a simple measure of tobacco use within the CCO population that doesn't require a lot of discussion, it shouldn't take long to develop. Would only require time from the developer. If adding a new metric, this seems like a reasonable one to add.
- Prevalence results could easily be added to the current depression, diabetes, and hypertension by MOB file that is uploaded monthly. If we have to report a breakout by the level of smoking / not smoking from the MU standards criteria, that is much more complicated and would require a request for resources and would delay reporting by several months.

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Appendix A: Description of how smoking status is recorded in EHRs

EHR	Practice	Description
AllScripts Touchworks	St. Charles	Smoking status is recorded in the patient's social history.
AllScripts Touchworks	Treasure Valley Pediatrics	
Centricity	Physicians Medical Center	Data are recorded in a risk factors form.
Cerner-Anasazi	Mid-Columbia Center for Living	
CGM WebEHR	Gifford Medical	Data are recorded in the patient's social history.
Chiro Touch	A Family Healing Center	Smoking status is recorded as free text narrative.
CPS 12	HDH Family Care	Data are recorded by the provider on the CCC form.
CrystalPM	Central Oregon EyeCare	
eClinical Works	St. Charles Family Care Redmond	In addition to the structured categories, smoking status is also recorded in the social history in the progress notes.
eClinical Works	Deschutes Rim Clinic	Smoking status is recorded as structured data.
eClinical Works	Columbia Gorge Family Medicine	Smoking status is recorded through a structured eForm that Medical Assistant completes with patient, space for additional text comments.
eClinical Works	Springfield Family Physicians	Smoking status is recorded as structured data at every visit, under social history. The questions include how soon after waking do you smoke and how many cigarettes per day do you smoke.
eClinical Works	McKenzie Family Practice	Smoking status is recorded under social history in the body of the chart note, also lists current smoker as a diagnosis.
Epic	Mosaic Medical	Smoking status is confirmed with the patient at each visit, then recorded / updated in the "social history" section of Epic. All discrete fields indicate frequency, amount, and type of tobacco used. There is also a section for free text comments. Smoking status is encounter-based, to enable tracking of status over time (i.e., the data are not overwritten each time).
Epic	Columbia Gorge ENT & Allergy	Smoking status is recorded with radio buttons with space for text.
Epic	Deschutes County Public Health	Smoking status is recorded in the vitals section and documents the frequency, type, and whether or not the client is wanting to quit.
Epic	Crook County Health	
Epic	La Pine CHC	Smoking status is recorded as part of the vitals section. Additional details may be provided using the social history activity.
Epic	OHSU Primary Care Clinics	Tobacco use, including smoking and smokeless, is captured in a patient's social history. Tobacco use

EHR	Practice	Description
		types, amounts, start date, quit date, and longevity of usage are captured. Tobacco use reviewed and counseling given are also recorded in the EHR.
Epic	Legacy Medical Group	Smoking status is recorded as structured data, with drop downs for category.
Epic	Legacy	In addition to the categories above, EHR also includes never assessed, never smoker, passive smoke exposure – never smoker.
Epic	Adventist Health Medical Group	Smoking status is documented for each patient in the social history section of Epic. Data should be discrete, but have not attempted to pull data outside of the MU reports.
Epic	Providence	Tobacco use status: yes, never, not asked, quit or passive. Other fields indicate type of use and amount. Can probably create categories from MU standards criteria via a combination of existing fields.
Epic	Kaiser Permanente NW	
Epic	PeaceHealth	
Epic	Virginia Garcia McMinville	Smoking status is recorded as yes/no, and how much via check boxes with additional narrative.
Epic	Cascades East Family Medicine	
GE Centricity	Central City Concern – Old Town Clinic	Smoking status is recorded via radio button selection on vital signs form; choices are never smoker, current every day smoker, former smoker.
Greenway	21 providers in AllCare’s network	Smoking status is recorded as structured data.
MacPractice		
Med3000		Data are recorded in the patient’s social history.
Meditech		Data include smoking status, packs per day, smoking history with packs per day, chewing tobacco use, quit status, counseling received /given, and secondhand smoke exposure.
Mosaiq/Elekta	St. Charles Cancer Center	Smoking status is recorded in either Vital Signs or patient assessment tabs.
NextGen	Mid Columbia Outpatient Clinics	
NextGen	Multiple practices	In addition to the standards criteria, tobacco use can also be recorded in several other ways. The initial question is “have you ever used tobacco” with options to record no/never, yes, and unknown. Tobacco use other than smoking options include chewing, smokless, and snuff. Tobacco types include cigarette, cigarillo, cigar, and pipe. For each option, structured data fields are: daily use yes/no, usage quantity #/units, years used, age started, and age stopped. There is also a pick list for current tobacco use status separate from the smoking status categories, with 36 choices.

EHR	Practice	Description
OCHIN Epic	One Community Health	Smoking status is recorded with a pick list of 10 options, start date, quit date, tobacco type, and packs per day.
OCHIN Epic	CareOregon	Smoking/tobacco use, intent to quit, and follow up are all recorded. Tobacco use can be collected in the substance section of history and intent to quit and counseling given is documented in vitals and health history. Follow up plans and referrals can also be tracked.
Pro-Filer	Deschutes County Behavioral Health	Smoking status is collected in the MOTS data form. The statement is "tobacco use" and the response options are "yes" "no" or "unknown".

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