

Oregon CCO Metrics and Scoring Committee

AGENDA

May 15, 2015

9:00 am – 1:00 pm

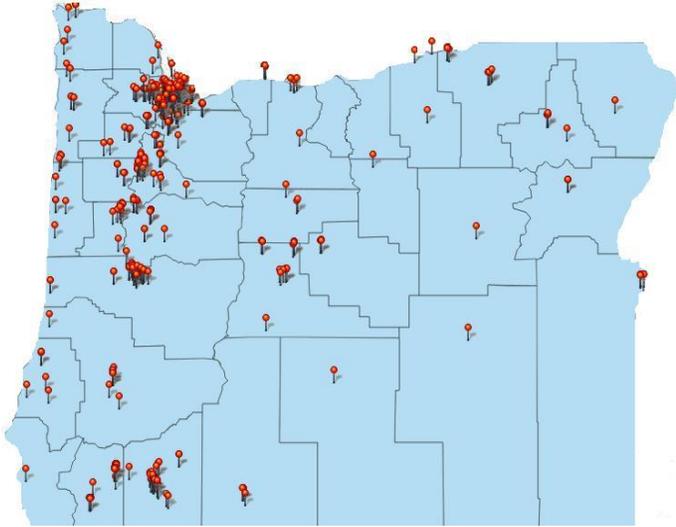
**Wilsonville Training Center
29353 SW Town Center Loop E
Wilsonville, OR**

Conference Line: Dial: 1-888-808-6929; Committee Code: 275-474; Public Listen Only Code: 915-042

#	Time	Item	Presenter	Action Item
1	9:00 am – 9:10 am	Welcome and consent agenda	Maggie Bennington-Davis	x
2	9:10 am – 9:20 am	Updates <ul style="list-style-type: none"> • Legislative updates • CY 2014 close out / validation 	Lori Coyner Sarah Bartelmann	
3	9:20 am – 9:30 am	Public Testimony* <i>*Measure-specific public testimony will be held at 11:30 – 12:45 as part of the 2016 On-Deck Measures Status Update agenda item.</i>	Maggie Bennington-Davis	
4	9:30 am – 9:50 am	Patient-Centered Primary Care Home (PCPCH) Program Update	Nicole Merrithew	
5	9:50 am – 10:10 am	Adolescent Well Care Visits and Confidentiality Update	Dana Hargunani	
6	10:10 am – 10:40 am	Metrics Deeper Dive: Emergency Department Utilization and Developmental Screening	Sarah Bartelmann	
7	10:40 am – 10:55 am	BREAK		
8	10:55 am – 11:25 am	2016 Measure Selection – Framework <ul style="list-style-type: none"> • Draft measure retirement checklist • Measure selection criteria - revisit • Measurement framework options 	Lori Coyner	X
9	11:25 am – 12:45 pm	2016 On-Deck Measures – Status Updates	Sarah Bartelmann	
10	12:45 pm – 12:55 pm	Measure Retirement – OHA recommendation for 2016	Lori Coyner	
11	12:55 pm	Wrap up / Adjourn	Maggie Bennington-Davis	

Patient-Centered Primary Care Home Program

Patient-Centered Primary Care Homes (PCPCHs) are health care clinics that have been recognized by the Oregon Health Authority for their commitment to providing high quality, patient-centered care. At its heart, this model of care fosters strong relationships with patients and their families to better treat the whole person. Primary care homes reduce costs and improve care by catching problems early, focusing on prevention, wellness and management of chronic conditions.



Map of Recognized PCPCHs (as of October 2014)

PCPCH Program Facts

- More than 540 clinics across Oregon have been recognized by the Oregon Health Authority as primary care homes. There are recognized PCPCHs in 34 out of 36 counties in Oregon.
- Through our partnership with Quality Corporation, the Patient-Centered Primary Care Institute is advancing practice transformation state-wide through technical assistance opportunities and resources.
- Over 85 PCPCHs have received on-site verification visits. The site visits create an opportunity to collaborate with clinics and identify needs, barriers and areas of improvement.

Key Attributes for PCPCH recognition

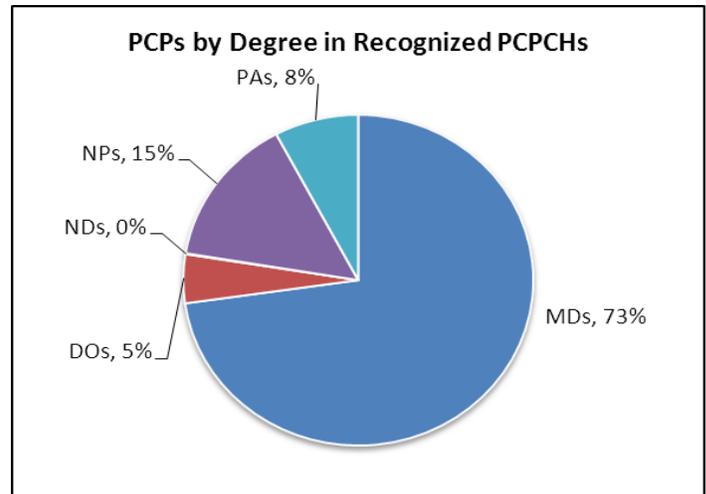
- **Accessible:** Care is available when patients need it.
- **Accountable:** Clinics take responsibility for the population and community they serve and provide quality, evidence-based care.
- **Comprehensive:** Patients get the care, information and services they need to stay healthy.
- **Continuity:** Providers know their patients and work with them to improve their health over time.
- **Coordinated:** Care is integrated and clinics help patients navigate the health care system to get the care they need in a safe and timely way.
- **Patient & Family Centered:** Individuals and families are the most important part of a patient's health care. Care should draw on a patient's strengths to set goals and communication should be culturally competent and understandable for all.



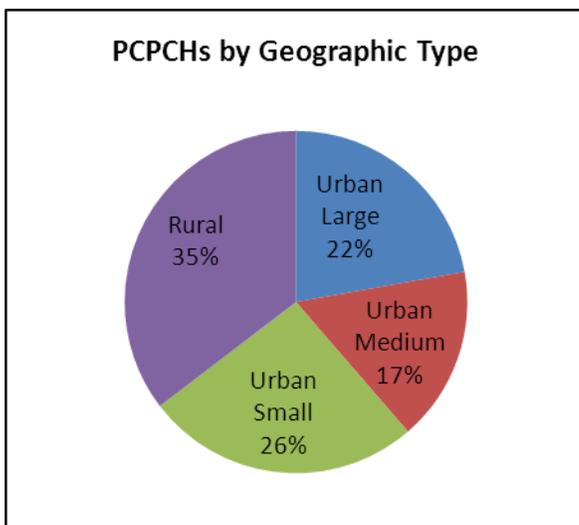
Patient-Centered Primary Care Home Program

Characteristics of PCPCHs

- Over 2,500 primary care providers serve patients at PCPCHs
- Average number of providers = 5.1 FTEs
- Average number of other clinic staff = 9.4 FTEs
- The majority of practices serve adult and pediatric populations
- Less than 20% of practices offer complementary and alternative medicine
- Over 80% of PCPCHs surveyed initiated a new service or program directly related to the implementation of the PCPCH model



Source: Oregon Health Care Quality Corporation Provider Directory (Jan 2013)



Source: PCPCH Supplemental Survey (June 2013)

PCPCHs and CCOs

PCPCHs are at the heart of Oregon's health system transformation efforts. Coordinated Care Organizations (CCOs) are required to include PCPCHs in their networks of care to the extent possible. Expanding the availability of primary care homes will provide better access to care now and strengthen the primary care networks as CCOs emerge. Over 500,000 CCO members (over 75% of the total CCO population) already receive care at a primary care home. This number is expected to grow over time.

PCPCHs and the Triple Aim

Oregon implemented the PCPCH program as part of the state's strategy to achieve the Triple Aim of improving the individual experience of care, improving population health management and decreasing the cost of care.

- Significantly lower rates for specialty office visits, radiology, and emergency department use as well as lower total expenditures were demonstrated by PCPCH patients as compared to those seeking care in non-recognized clinics.
- 85% of practices surveyed report that PCPCH implementation is helping them improve individual experience of care.
- 82% of practices report that PCPCH implementation is helping them improve population health management.
- 85% of practices report that PCPCH implementation is helping them increase the quality of care provided.

Metrics Deeper Dive Report

Developmental Screening & Emergency Department Utilization

Presented to the Metrics & Scoring Committee

May 15, 2015

Introduction

In their March 2015 meeting, the Metrics & Scoring Committee expressed interest in learning more about what was “under the hood” driving coordinated care organization (CCO) performance on the incentive metrics. The Committee is interested in additional context, or case studies, from CCOs and clinics / practices to help determine where improvements in performance are due to improved coding practices, random variation, or specific interventions put in place by the CCO or practice.

The first two incentive metrics identified for a ‘deeper dive’ are developmental screening and emergency department (ED) utilization.

This report provides a summary of the survey OHA developed and fielded with CCOs in April and early May to learn more about their work on these two metrics.

About the survey

OHA designed this deeper dive survey to collect information on interventions and practices put in place by CCOs and practices across the state to affect developmental screening and emergency department utilization. The survey asked respondents about whether specific best and promising practices for these metrics had been implemented, and if yes, when implementation began, the scope of the implementation, and additional details. Respondents could also provide additional information on other interventions or improvement activities.

Best and promising practices for developmental screening include:

- Policy or clinical guideline changes (e.g., requirement to use validated screening tool for developmental surveillance)
- Provider education
- Provider / office staff training
- Alternate payment methodologies
- Improving access to care
- Identification of children missing developmental screenings, with or without tailored outreach to them or their provider
- Improving health information technology to support developmental screening
- Working with local Early Learning Hub to improve developmental screening

Best and promising practices for emergency department (ED) utilization include:

- Patient education
- ED navigators
- Increasing non-ED capacity / expanding access to primary care
- Alternate payment methodologies
- Financial incentives for patients
- Pre-hospital diversion programs
- Intensive case management
- Identification of high utilizers, with or without tailored outreach to them or their providers

The full survey tool is available in the Appendix.

Response

The deeper dive survey was open between April 7 and May 7 2015. OHA received responses from 13 of the 16 CCOs:

- AllCare
- Columbia Pacific
- FamilyCare
- Health Share of Oregon
- Intercommunity Health Network
- Jackson Care Connect
- PacificSource – Central Oregon
- PacificSource - Gorge
- PrimaryHealth of Josephine County
- Trillium
- Umpqua Health Alliance
- Western Oregon Advanced Health
- Willamette Valley Community Health

Surveys were completed by medical directors and/or quality improvement staff.

Key points

- Each CCO had multiple interventions for each metric; there was no “silver bullet” approach.
- Interventions varied considerably by CCO. The only intervention that all respondent CCOs have implemented is identifying high utilizers for emergency department utilization.
- Organizations that existed pre-CCO were more likely to have had programs up and running prior to 2012, but even these previously existing entities added new interventions once they became CCOs (e.g., use of patient navigators and alternate payment methodologies).
- CCOs did not roll out interventions wholesale across their provider network or member population – almost all interventions described were tailored, or begun as pilots or for a subset of providers, practices or members, with plans to scale.

For more information

State and CCO performance on these measures is available in Oregon’s Health System Transformation Reports, online at www.oregon.gov/oha/metrics/.

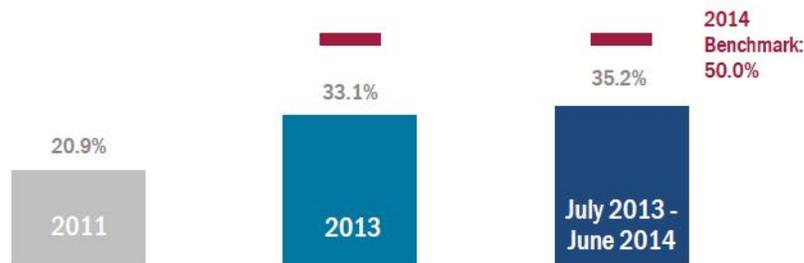
Please contact us at metrics.questions@state.or.us.

Developmental screening

As of June 2014, developmental screening rates have increased across the state and for a majority of CCOs, with several exceeding the benchmark of 50 percent.

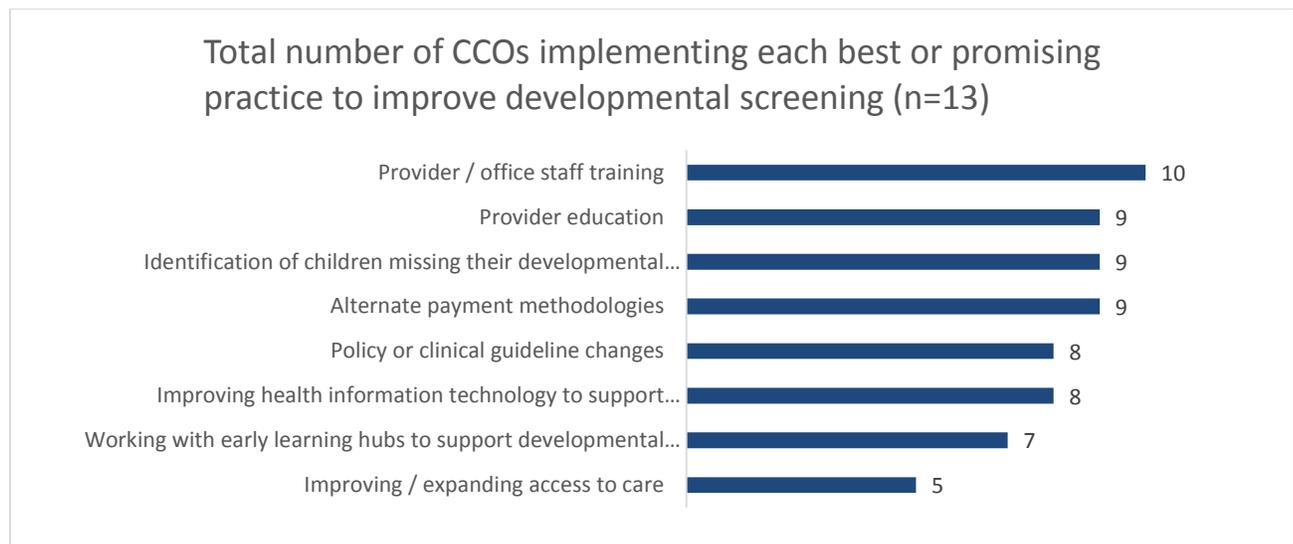
Statewide, developmental screening continues to increase.

Data source: Administrative (billing) claims
2014 benchmark source: Metrics and Scoring Committee consensus



From Oregon's Health System Transformation 2014 Mid-Year Report, published January 2015.

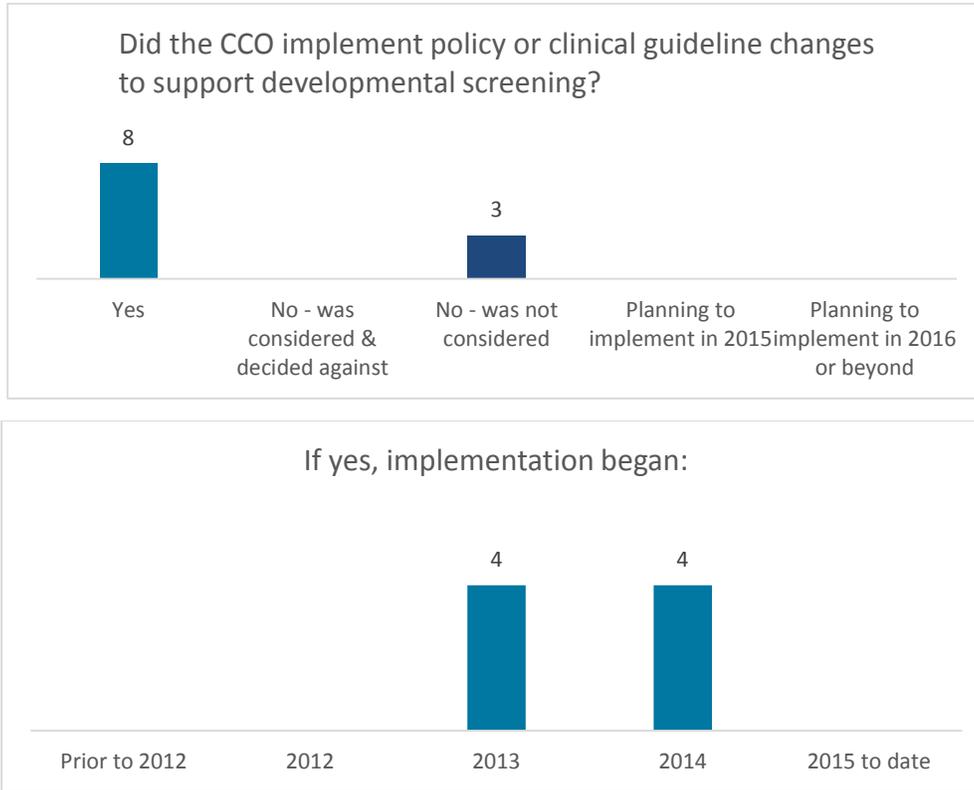
While some of the initial gains seen in 2013 are likely due to changes in provider billing and improved documentation of services, CCOs have implemented a number of best and promising practices for improving developmental screening rates.



This section summarizes what has been implemented for each of the best or promising practices identified, and highlights specific examples across CCOs.

Policy or clinical guideline changes

This practice could include a requirement that specific or all health supervision visits before age 5 include developmental surveillance, or a requirement to use validated screening tools for developmental surveillance.

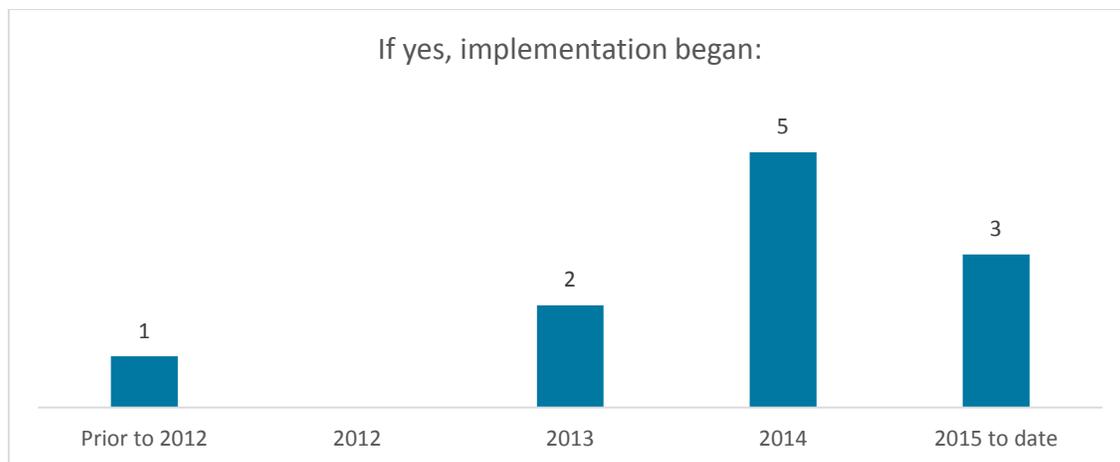
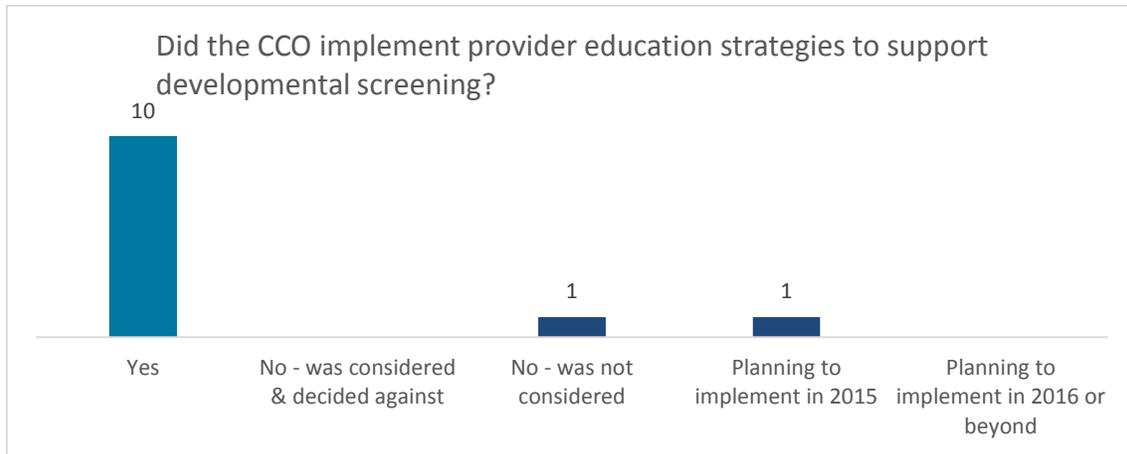


CCO Example

Intercommunity Health Network recommended that the Ages & Stages Questionnaire (ASQ) be the developmental screening tool adopted by CCO providers.

Provider education

This practice could include education focusing on systematic and consistent use of standardized screening tools rather than informal checklists or developmental milestone lists, or a provider campaign on the importance of developmental surveillance and early intervention.

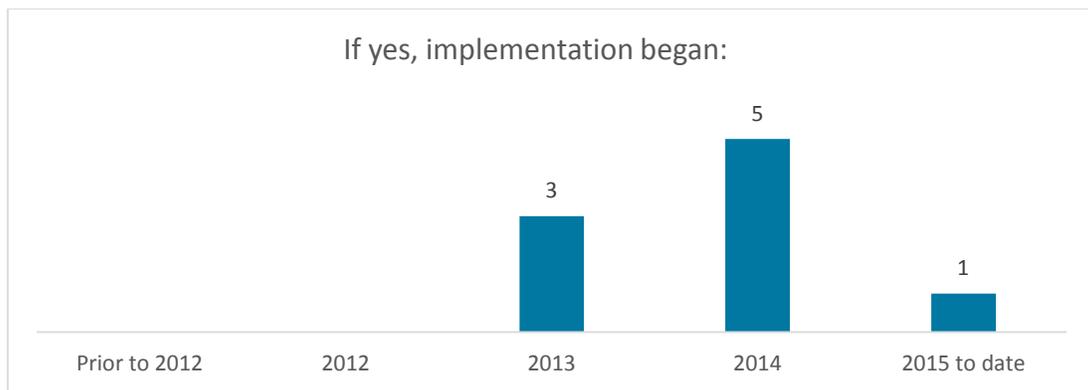
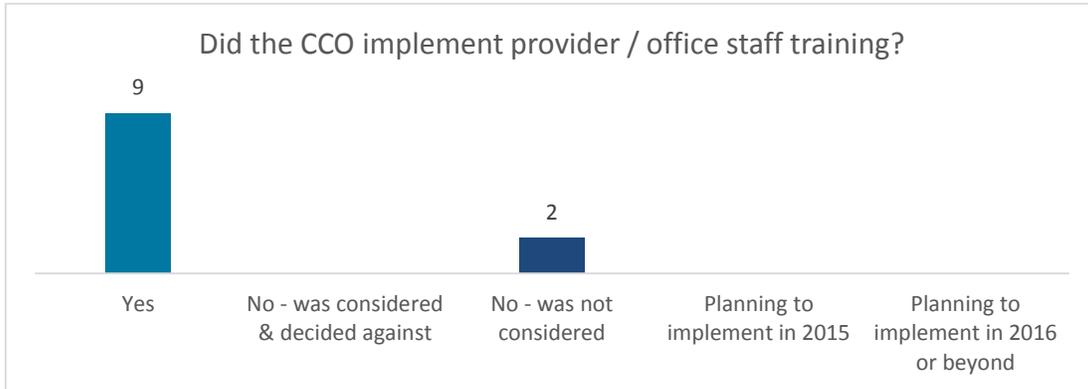


CCO Example

Provider education at several CCOs focused primarily on the incentive measure and technical specifications for appropriate coding. The appropriate screenings were already occurring, but were not being documented. Several CCOs also provided practice coaching to pediatric clinics.

Provider / office staff training

This practice could include clinic detailing or quality visits, continuing education opportunities, group trainings, focusing on workflow or processes to embed developmental screening into visits, and/or identifying champions.



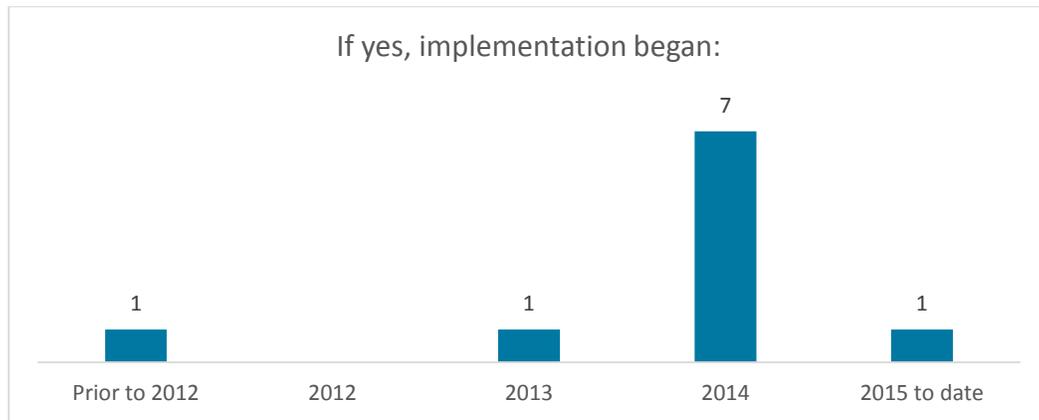
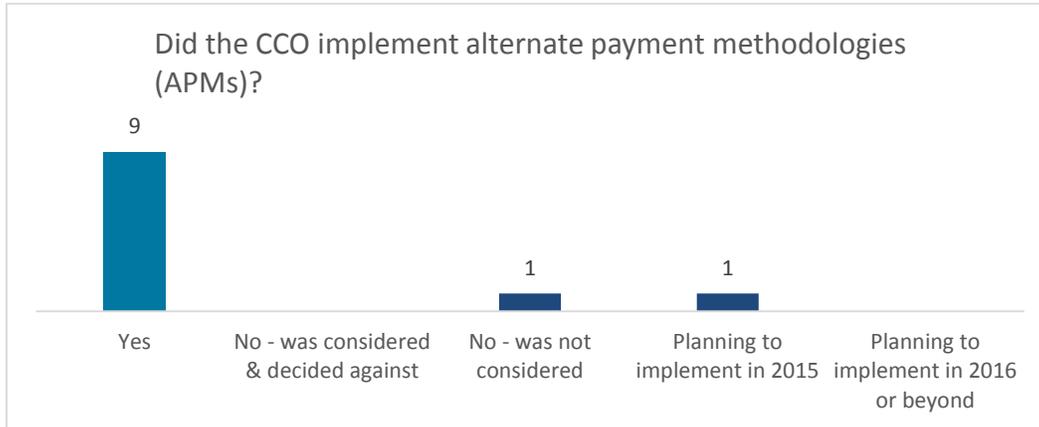
CCO Example

Prior to 2012, FamilyCare partnered with the Oregon Pediatric Society to provide START training for pediatric clinics. Additional EHR system review and coaching for pediatric clinics for best practices / flow for developmental screening were also provided.

Prior to the selection of the incentive measures, several other communities held trainings and had early adopters of the Ages & Stages Questionnaire (ASQ) for developmental screening.

Alternate payment methodologies

This practice could include capitation or sub-capitation, or incentivizing providers for increasing developmental screening rates (either provision of screening or coding for screenings already being provided).



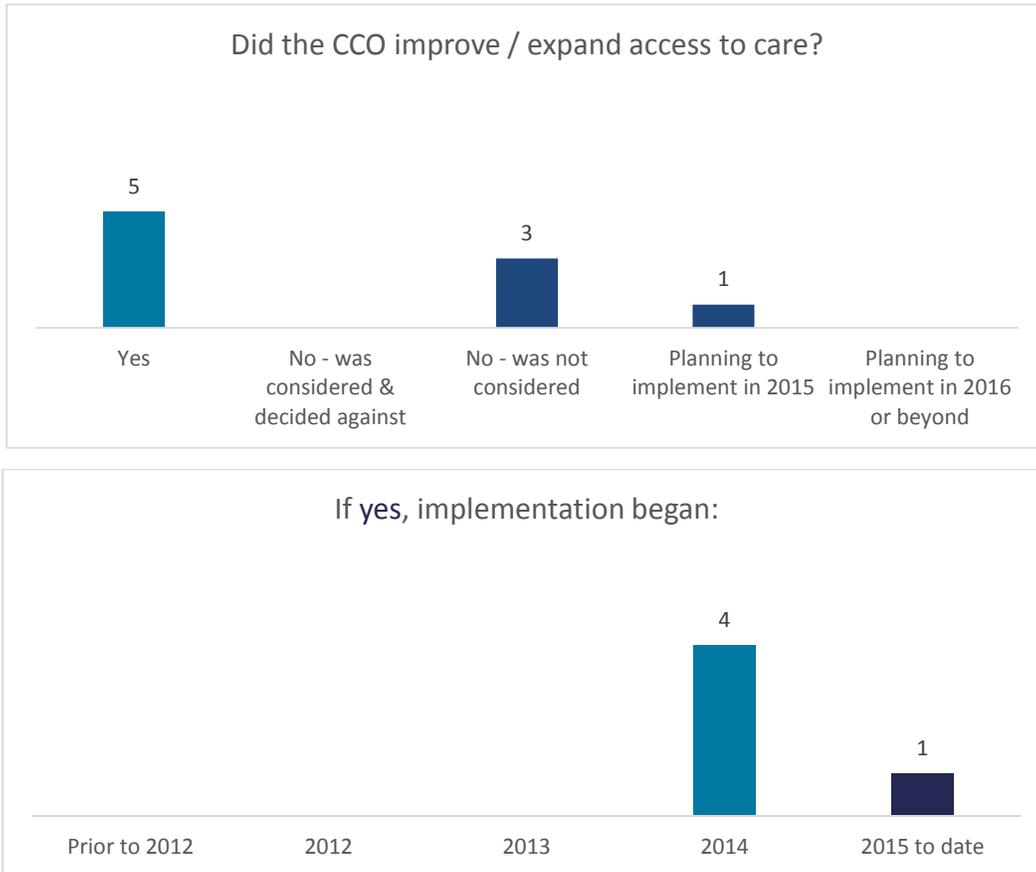
CCO Example

Willamette Valley Community Health distributes quality pool payments to network providers based on incentive measure performance. This process provides increasing levels of compensation to clinics based on their ability to meet performance thresholds ranging from improvements over their own baseline to meeting more rigorous statewide benchmarks. WVCH also funded the Marion County Early Learning Hug to incentivize documentation of developmental screening within the early learning system.

In 2013, PacificSource increased the allowed amounts for developmental screenings in the IPA contract.

Improving access to care

This practice could include an emphasis on children receiving the recommended number of preventive care visits, thus increasing the number of opportunities for timely developmental screening, or improving connections to community resources for referral and follow up (providers may be unwilling to screen if there are no resources when problems are identified).

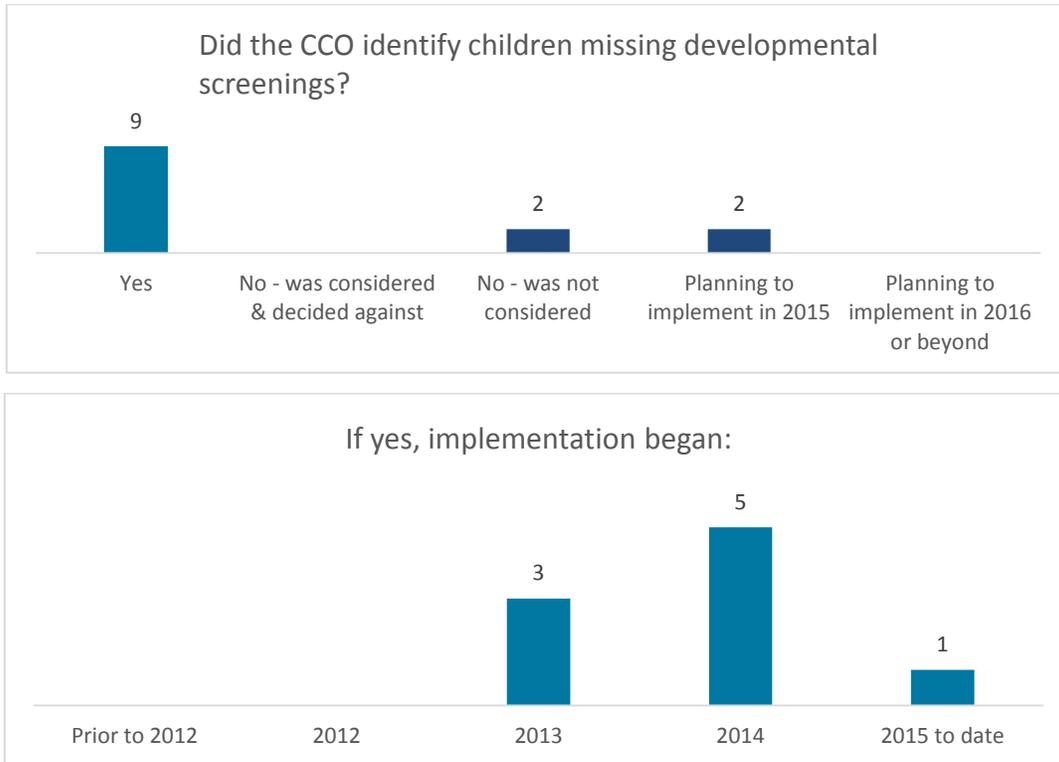


CCO Example

Willamette Valley Community Health is sponsoring a series of learning collaboratives to address physical and mental health integration. A major component of this work will be to improve referral networks for providers who identify a developmental delay.

Intercommunity Health Network sends mailings to members advocating for well child check-ups and developmental screening. The Ages & Stages Questionnaire is also mailed out to families in advance of their well child appointments.

Identification of children missing developmental screenings with or without tailored outreach to them or their provider

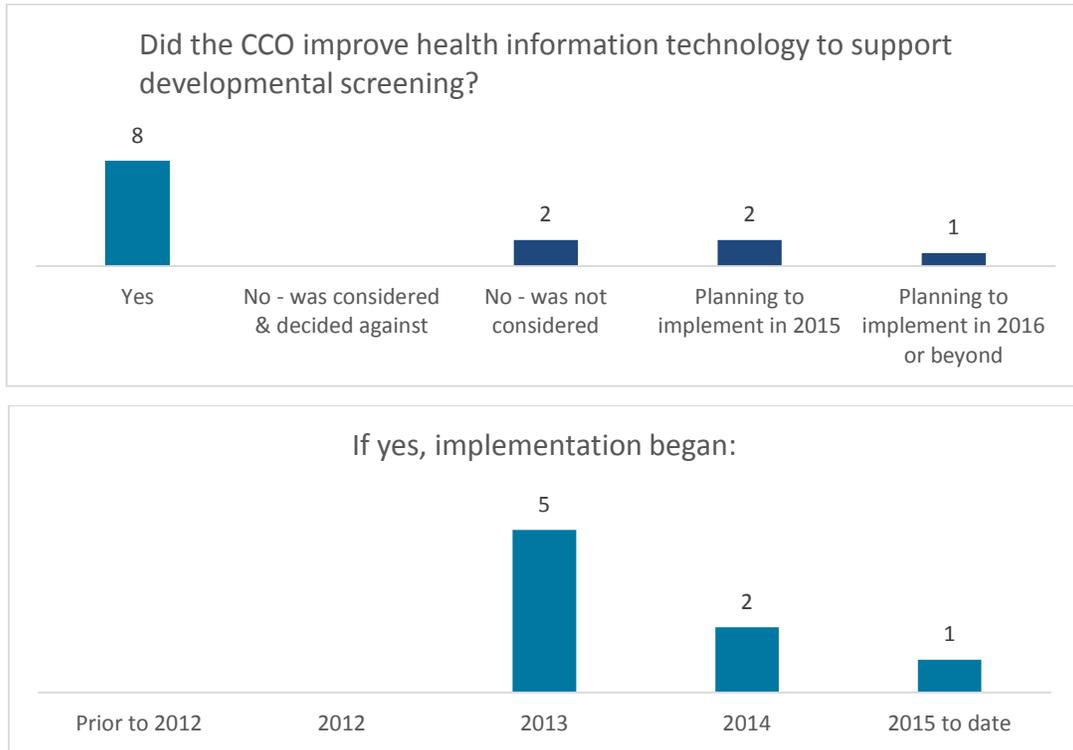


CCO Example

A number of CCOs generated lists for providers, letting them know which children needed developmental screenings; several CCOs also reported provider-specific screening rates.

Improving health information technology to support developmental screening

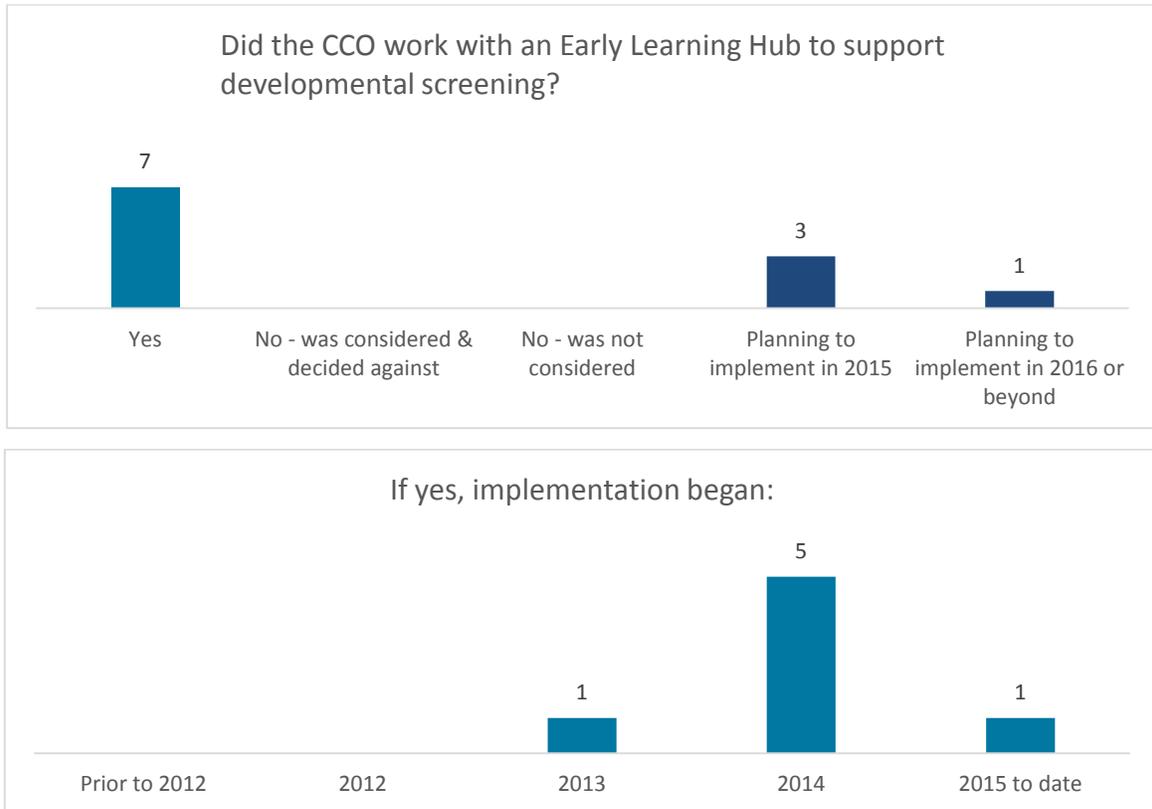
This practice could include modifying electronic health records to prompt for developmental screening, capture developmental screening and results, and/or generate encounters for developmental screening; or the creation or modification of the system to collect developmental screenings from other organizations and transfer to providers' office.



CCO Example

Willamette Valley Community Health and the local Early Learning Hub have developed a system to grant select early learning providers with restricted access to the WVCH case management system for the purpose of documenting developmental screenings conducted at their organization. This enables early learning providers to share screening outcomes with PCPs and significantly enhances community across systems.

Working with local Early Learning Hub to support developmental screening



CCO Example

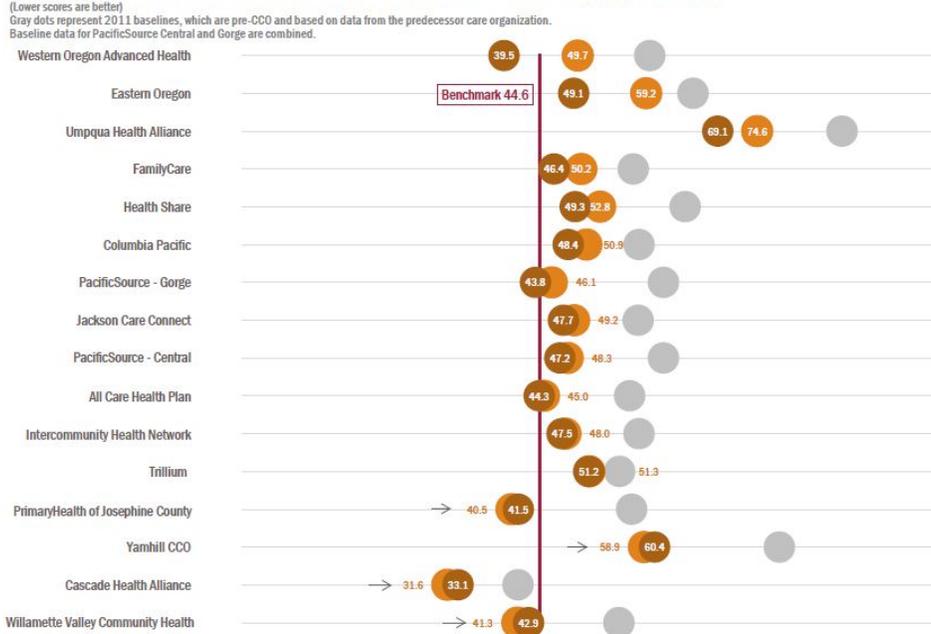
Intercommunity Health Network is collaborating with the Early Learning Hub regarding ideas and strategies to incentivize developmental screening.

AllCare has approved two Community Health Workers to work within the local Head Start and Early Head Start school programs in two counties. The CCO also hired a health and education integration coordinator to assist in the local Hub application.

Emergency Department utilization

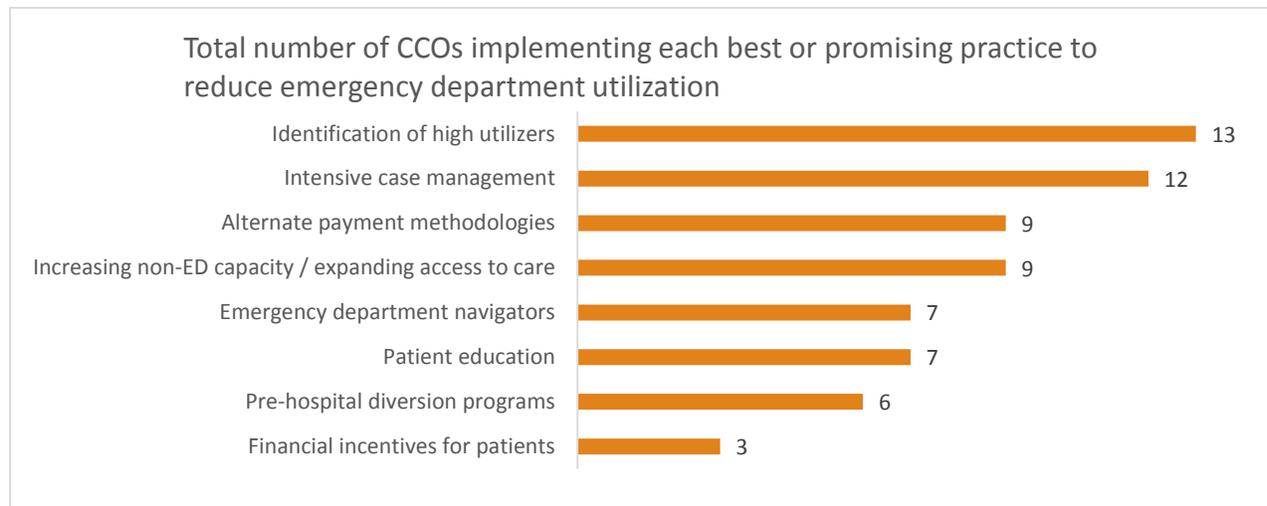
As of June 2014, emergency department utilization rates have declined across the state and for the majority of CCOs, with several exceeding the benchmark of 44.6 / 1,000 member months (lower rates are better).

Emergency department utilization continued to decline for many CCOs between 2013 & June 2014.



Data from Oregon's Health System Transformation 2014 Mid-Year Report, published January 2015.

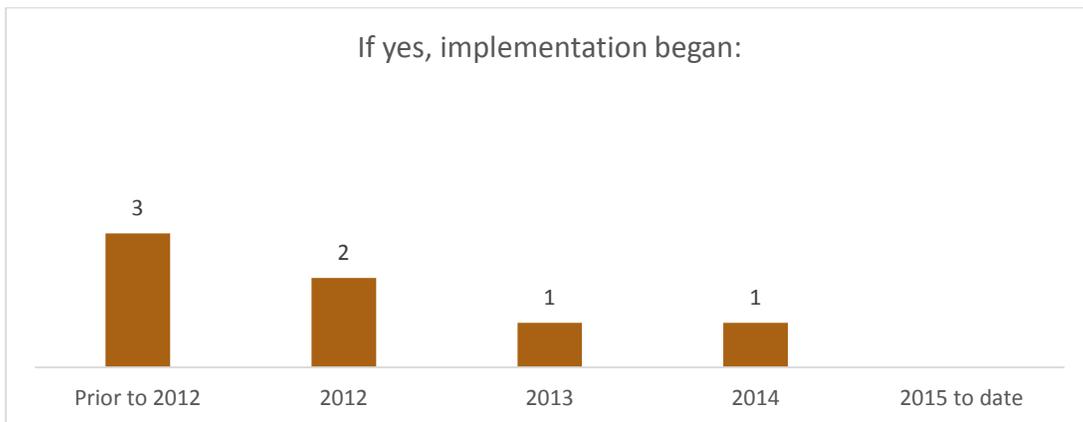
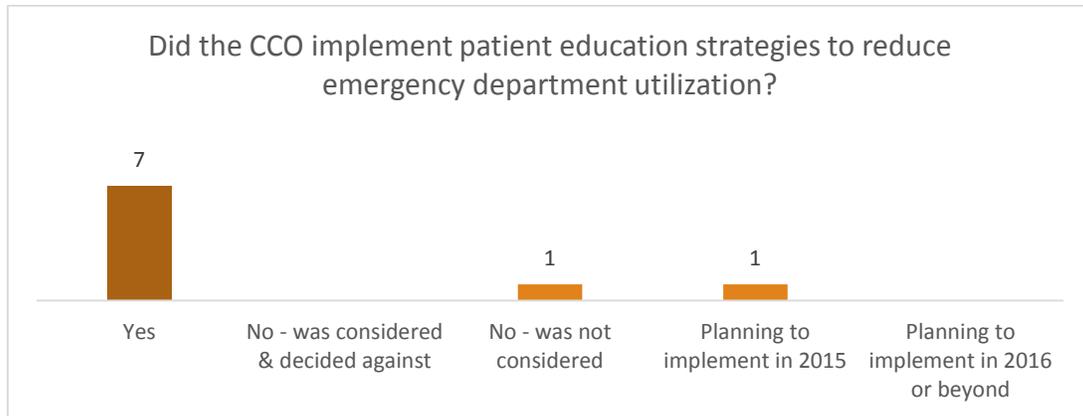
While some of the improvement seen may be due to national trends, CCOs have implemented a number of best and promising practices for reducing emergency department utilization rates.



This section summarizes what has been implemented for each of the best or promising practices identified, and highlights specific examples from survey respondents.

Patient education

This practice could include patient education campaigns, or brochures, discharge instructions, or other materials focusing on receiving appropriate care in appropriate settings, or where to receive care for non-emergent needs.

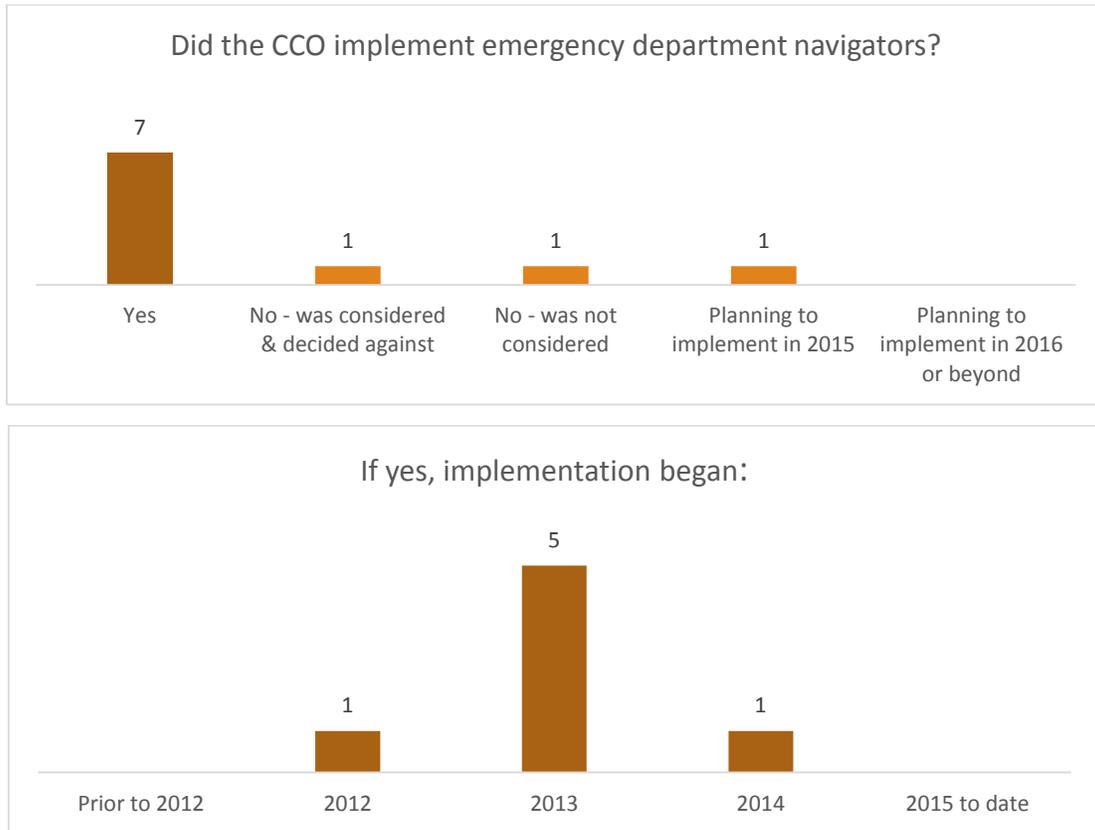


CCO Examples

Health Share participated in a CMMI grant focused on creating a more intentional system of care around high utilizers of ED and inpatient services, which included providing patient information highlighting alternatives to ED utilization and ED guides within select EDs to provide patient education when members enter the ED who could be served elsewhere.

Western Oregon Advanced Health provides all members with education on how to appropriately access care and the nurse triage line. Members with repeated non-emergent visits to the ED receive personalized information identifying their PCP and offering assistance with scheduling or transportation. After-hours and urgent care available in two large clinics has been advertised to the local community.

Emergency Department navigators



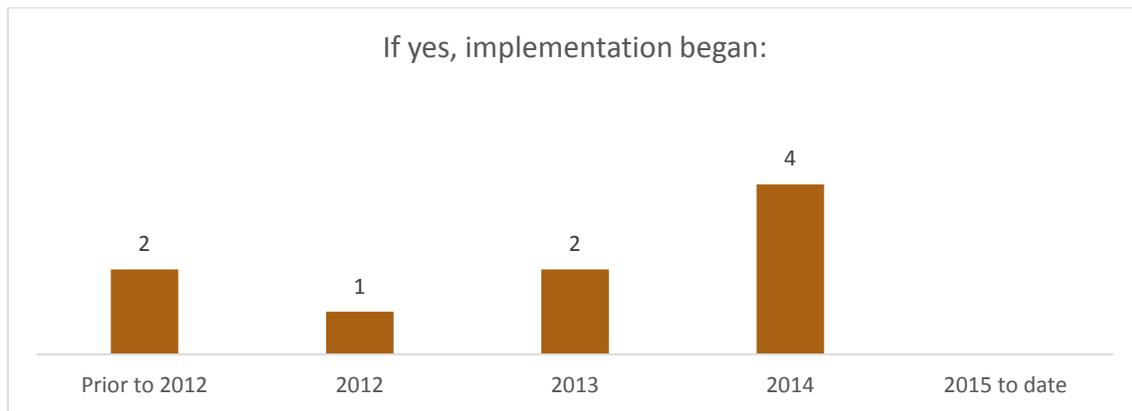
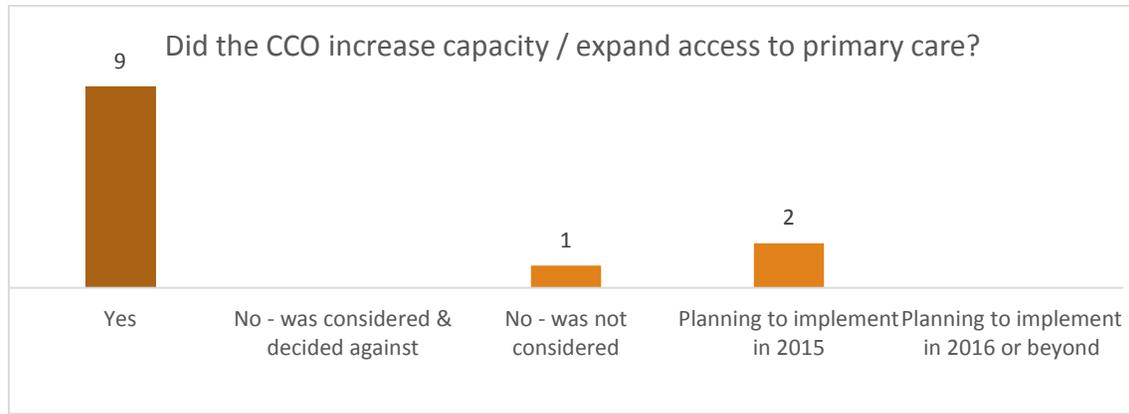
CCO Example

One pilot project at a Jackson Care Connect hospital focused on an ED guide connecting with low-acuity patients and referring them to appropriate levels of care in the community. The program now includes referrals to a PCPCH for patients who do not have a PCP, dental, and drug/alcohol referrals, as well as more intensive management for patients that have had 3+ ED visits in the last 6 months. This program is expanding to a second hospital in 2015.

FamilyCare coordination staff follow up with members seen in the ED to discuss and provide education on proper use, clinic after-hours or advice line, the importance of PCP/provider establishment, and potential barriers that need to be addressed.

Increasing non-ED capacity / expanding access to primary care

This practice could include creating new clinics, creating alternative primary care sites, expanding hours of care or provider availability at existing clinics, and/or improving access by reducing wait time for primary care visits.



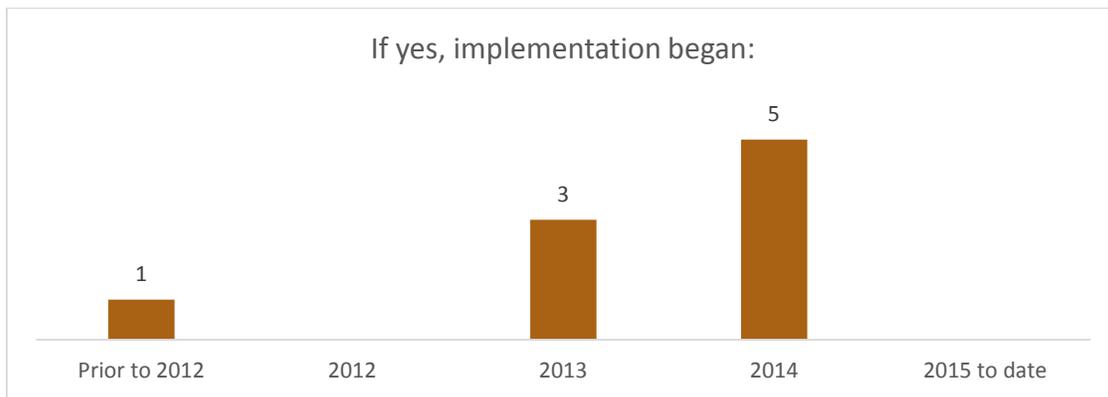
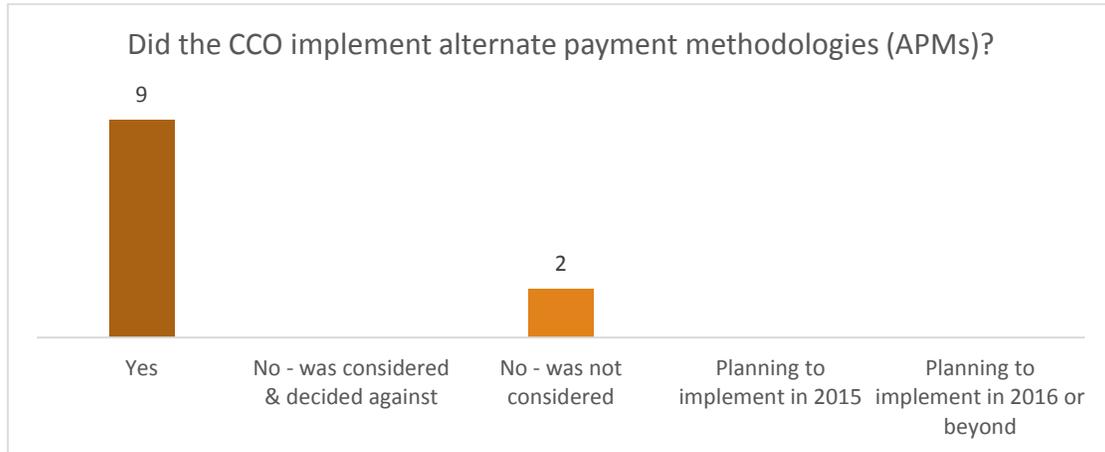
CCO Example

PrimaryHealth's FQHC opened a walk-in clinic in 2013 and expanded hours to include Saturdays in 2014. A second clinic expanded access and hours for the acute care department, and a local hospital opened an urgent care facility (there are no other urgent care facilities in the county that accept PrimaryHealth).

FamilyCare has increased PCP reimbursement rates to facilitate provider access for members: this allows more time with a provider to mitigate downstream health system utilization.

Alternate payment methodologies

This practice could include capitation or subcapitation, or financial incentives for providers.



CCO Example

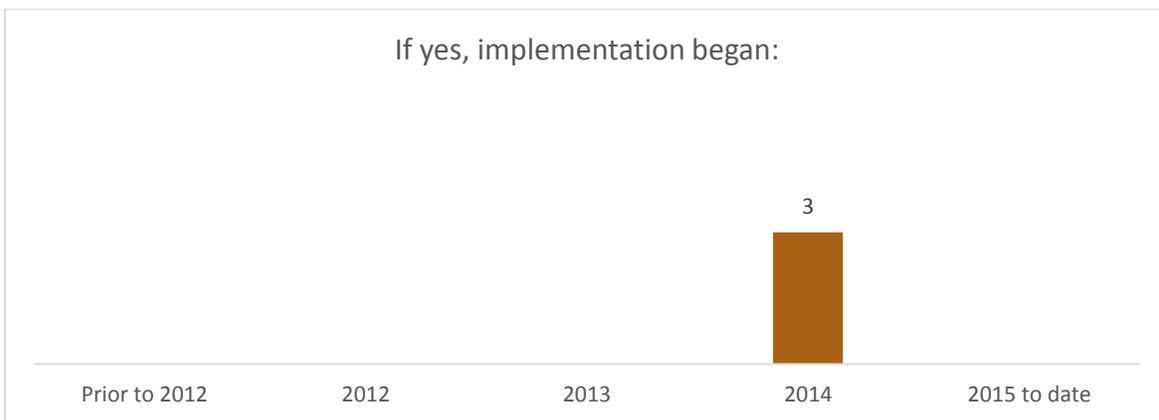
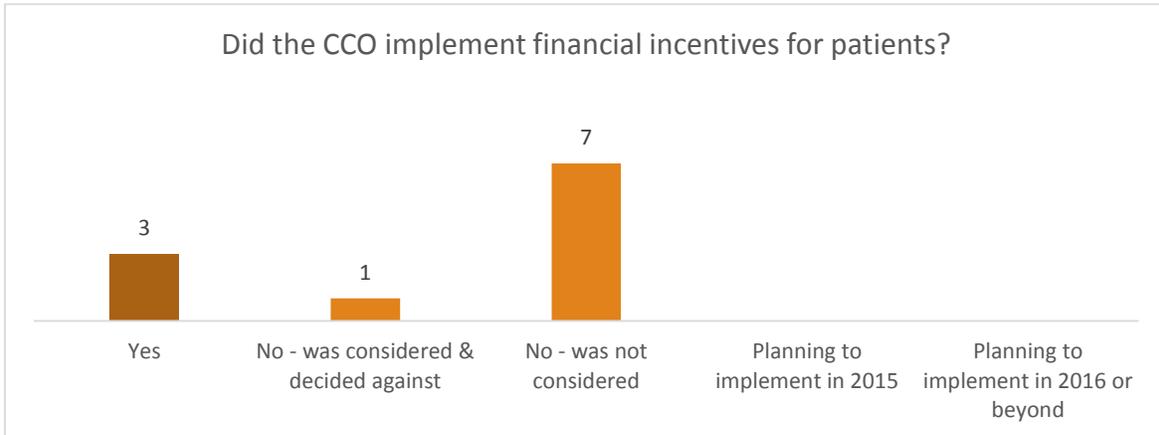
AllCare developed alternate payment methodologies for primary care and pediatric practices in Josephine County in 2014. The focus areas included: access, utilization (decreased ED, increased PCP visits, high generic Rx rate and increased preventive service), and quality measures.

PrimaryHealth provides a payment to PCP clinics based on whether they meet the CCO target for ED utilization. This payment was adjusted based on member months.

Western Oregon Advanced Health used their 2013 quality pool payment to support the after-hours / urgent care availability in local communities, as earmarked by their CAP.

Financial incentives for patients

This practice could include incenting the use of certain sites of care.



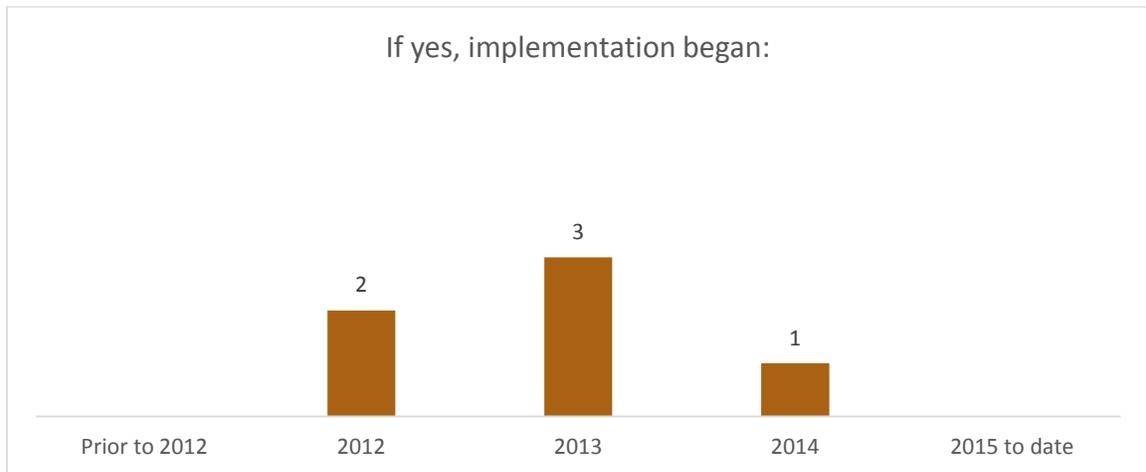
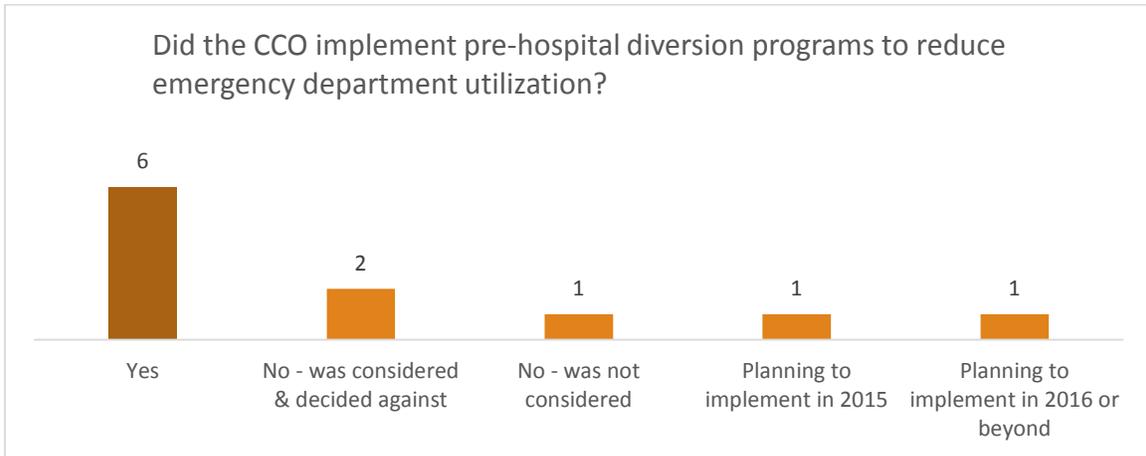
CCO Example

While not an incentive program for patients, one CCO made the deliberate choice not to implement any visit co-pays for members, as this would have required a co-pay for a primary care visit, but not for an emergency department visit.

AllCare developed an incentive program for pregnant members with multiple high risk factors including inadequate or no housing, domestic violence, inadequate nutrition or living in food deserts, mental health and A&D issues. If scheduled appointments were kept with providers, women were given vouchers to trade for baby items, diapers, etc. This program contributed to pregnant members avoiding unnecessary emergency department utilization and less than optimum birth outcomes.

Pre-hospital diversion programs

This practice could include emergency medical services diversion, staff embedded in the ED to divert, or ambulatory clinic on site at the ED.

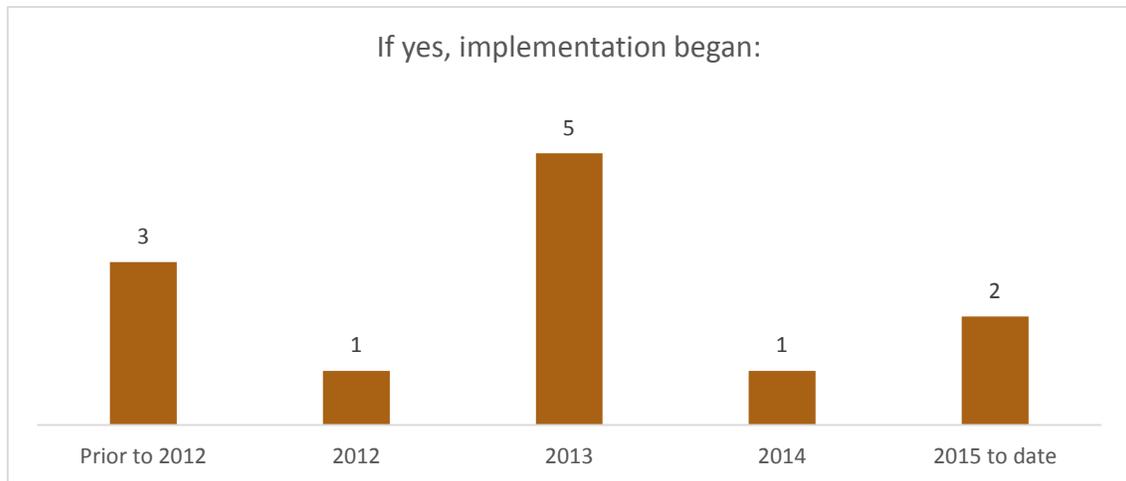
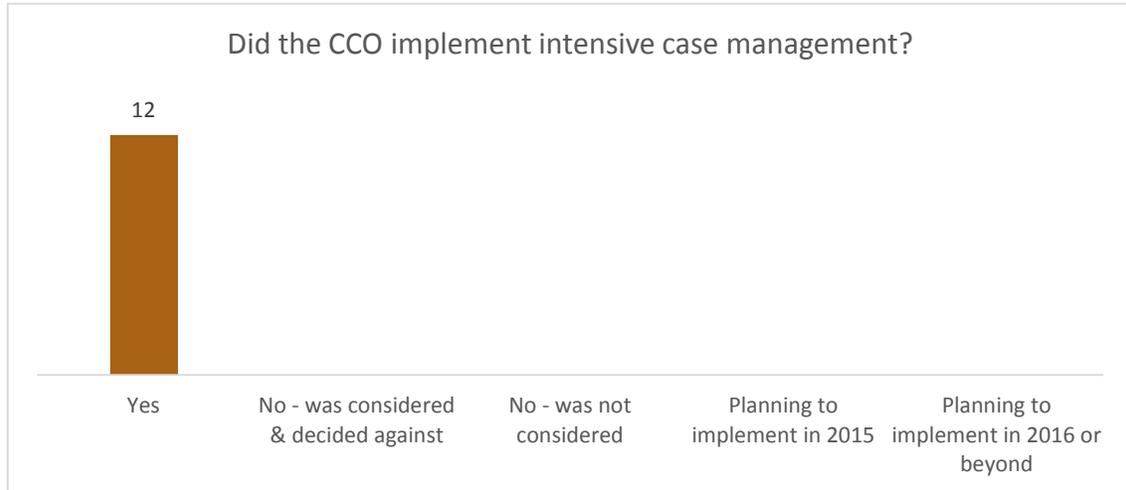


CCO Example

PacificSource's hospital system began an emergency room diversion project for high utilizers in 2012.

Intensive case management

This practice could include case management or care coordination provided by traditional health workers, community health workers, nurse case managers, etc. with a focus on high utilizers or reducing emergency department utilization.

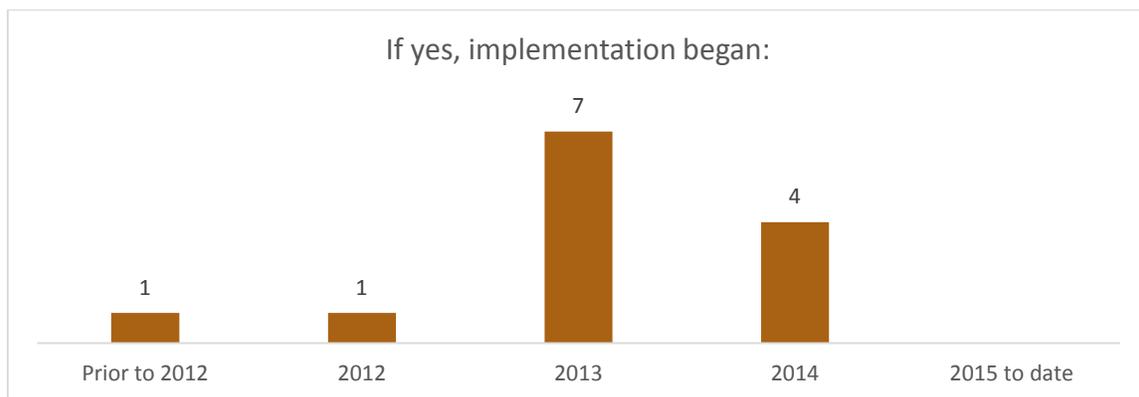
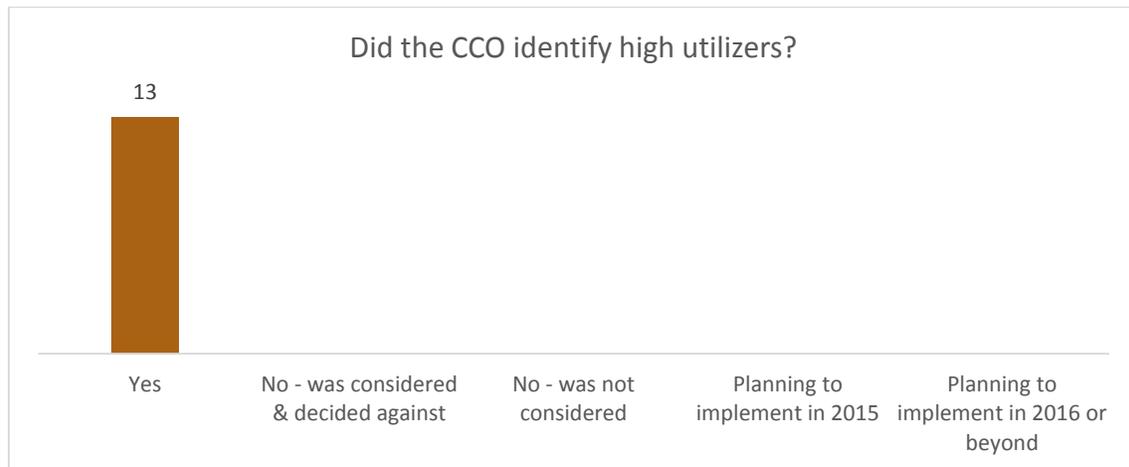


CCO Example

As part of its CCMI grant, Health Share's Health Resilience Program was developed to work with most frequent utilizers of intensive services, or those who are at highest risk for inappropriate utilization. The program has spread to numerous primary care clinics.

Identification of high utilizers, with or without specific outreach to them or their provider

This practice could include tracking ED visits to reduce “ED shopping,” or encouraging participation in Oregon’s Prescription Drug Monitoring Program (PDMP) and using PDMP data to help track high utilizers.



CCO Example

PrimaryHealth implemented a new software program that can be used to identify high utilizers based on utilization of specific services or by total costs.

Trillium provides a ‘hot spotter’ list to all practices monthly, with complex case management for high utilizers of the emergency department.

Many CCOs have implemented EDIE (Emergency Department Information Exchange) or are in the process of rolling out additional tools, such as PreManage, to help identify and coordinate care for high utilizers.

Appendix: Metrics Deeper Dive Survey Tool

In their March 2015 meeting, the Metrics & Scoring Committee expressed interest in learning more about what was “under the hood” driving CCO performance on the incentive metrics. The Committee is interested in additional context, or case studies, from CCOs and practices to help determine where improvements in performance are due to improved coding practices, random variation, or specific interventions put in place by the CCO or practice.

The first two measures identified for a deeper dive are emergency department (ED) utilization and developmental screening.

This survey is intended to collect information on interventions and practices put in place across the state to affect ED utilization and developmental screening. Information collected through this process will be shared with the Metrics & Scoring Committee at their May meeting, and may inform future measure selection and/or benchmark setting. OHA will likely compile the results into a summary report for the Committee.

The survey can be completed in the document below and emailed to metrics.questions@state.or.us or completed online at: <https://www.surveymonkey.com/s/MetricsDive/>

Please contact us with any questions about the request / process at: metrics.questions@state.or.us

Contact Information

Please provide the relevant contact information for the individual completing the survey for any follow-up questions.

Note OHA intends to only share survey results in aggregate, but may wish to highlight specific programs or innovations by individual CCOs or practices. If there is sensitivity to any information provided (e.g., practice requests to not be identified by name), please indicate in the open-ended comment boxes below each section.

CCO	Click here to enter text.
Practice (if applicable)	Click here to enter text.
Contact person	Click here to enter text.
Contact email	Click here to enter text.

Emergency Department Utilization

As of June 2014, emergency department utilization rates have declined across the state and for the majority of CCOs, with several exceeding the benchmark of 44.6 / 1,000 member months (lower rates of ED utilization are better). There are a number of best practices and recommended programs that have been identified for reducing ED utilization.

Please indicate in the table below which (if any) of the following best practices and programs the CCO or practice has implemented specifically to address ED utilization. If there are efforts the CCO or practice has implemented not specifically to address ED utilization, but believes resulted in reduced ED utilization, please note those in the open-ended comment boxes below.

Please indicate in the table below when implementation began, or if the CCO or practice is planning to implement in the future. Note that some CCOs or practices may have implemented something years ago and consider it already in place, that is, there was not a new or renewed focus on it. If this is the case, please select “Yes” in the first column, and “prior to 2012” in the second column.

CCO implementation can refer to implementation across the whole CCO or contracted provider network, or for a subset or pilot of sites or practices. Please indicate in the table below what the scope of the implementation was. For any subsets or pilot projects, please provide additional details in the open-ended comment boxes below.

Note some of these interventions may overlap (e.g., the CCO implemented ED navigators with a focus on patient education). In that case, please select the categories you feel are most representative of the intent and work, and provide any clarifying details in the open-ended comment boxes below.

Best practices and programs	Did the CCO or practice implement?	If yes, when did implementation begin?	If yes, what was the scope of the implementation?
<p>Patient education</p> <p><i>Including, but not limited to: patient education campaigns; brochures, discharge instructions, or other materials focusing on receiving appropriate care in appropriate settings / where to receive care for non-emergent needs.</i></p>	<p>-Yes</p> <p>-No – was considered & decided against</p> <p>-No – was not considered</p> <p>-Planning to implement in 2015</p> <p>-Planning to implement in 2016 or beyond</p>	<p>-Prior to 2012</p> <p>-2012</p> <p>-2013</p> <p>-2014</p> <p>-2015 to date</p>	<p>-All practices</p> <p>-All providers</p> <p>-All members</p> <p>-Subset of practices</p> <p>-Subset of providers</p> <p>-Subset of members</p> <p>-Pilot</p>
Emergency Department navigators	Choose an item.	Choose an item.	Choose an item.
<p>Increasing non-Emergency Department capacity / Expanding access to primary care</p> <p><i>Including, but not limited to: creating new clinics; creating alternative primary care sites; expanding hours of care or provider availability at existing clinics; improving access by reducing wait time for primary care visits.</i></p>	Choose an item.	Choose an item.	Choose an item.

Best practices and programs	Did the CCO or practice implement?	If yes, when did implementation begin?	If yes, what was the scope of the implementation?
<p>Alternate payment methodologies</p> <p><i>Including, but not limited to: capitation or sub-capitation; financial incentives for providers.</i></p>	Choose an item.	Choose an item.	Choose an item.
<p>Financial incentives for patients</p> <p><i>Including, but not limited to incenting the use of certain sites of care.</i></p>	Choose an item.	Choose an item.	Choose an item.
<p>Pre-hospital diversion programs</p> <p><i>Including, but not limited to: emergency medical services diversion; staff embedded in the ED to divert; ambulatory clinic on site at the ED.</i></p>	Choose an item.	Choose an item.	Choose an item.
<p>Intensive case management</p> <p><i>Including, but not limited to: case management or care coordination provided by traditional health workers, community health workers, nurse case managers, etc...with a focus on high utilizers, or reducing ED use;</i></p>	Choose an item.	Choose an item.	Choose an item.
<p>Identification of high utilizers, with or without specific outreach to the individual or their provider.</p> <p><i>Including, but not limited to: tracking ED visits to reduce “ED shopping”; encouraging participation in Oregon’s Prescription Drug Monitoring Program and using PDMP data to help track high utilizers.</i></p>	Choose an item.	Choose an item.	Choose an item.
Other (describe below)			

For any best practices or programs the CCO or practice implemented identified above, please provide a brief description of the program or approach, or any clarifying information on the implementation. If any information has already been written up in support or describing the program or approach that can be shared, please include it as an attachment.

Patient Education

[Click here to enter text.](#)

Emergency Department Navigators

[Click here to enter text.](#)

Increasing non-Emergency Department capacity / Expanding access to primary care

[Click here to enter text.](#)

Alternate payment methodologies

[Click here to enter text.](#)

Financial incentives for patients

[Click here to enter text.](#)

Pre-hospital diversion programs

[Click here to enter text.](#)

Intensive case management

[Click here to enter text.](#)

Identification of high utilizers

[Click here to enter text.](#)

Did the CCO or practice implement any additional programs or quality improvement activities to address ED utilization? If yes, please describe:

[Click here to enter text.](#)

Please provide addition details on the scope of the implementation as indicated in the table above, such as selection criteria for pilot projects, or inclusion criteria for subsets of practices, providers, or members.

[Click here to enter text.](#)

Did the CCO change any billing or coding practices or policies, or work with providers to change any billing or coding practices in support of this measure? If yes, please describe:

[Click here to enter text.](#)

Did the CCO conduct any evaluation or assessment of the program or quality improvement activities? If so, please briefly describe any results, including whether the program was successful, any particular challenges, and any implications for future implementation.

[Click here to enter text.](#)

Are there any other local initiatives of which you are aware that may have had an impact on ED utilization for your CCO or practice (including any initiatives that you were not involved in)? If yes, please describe.

[Click here to enter text.](#)

Developmental Screening

As of June 2014, developmental screening rates have increased across the state and for the majority of CCOs, with several exceeding the benchmark of 50%. While some of the improvement may be due to changes in provider billing and documentation for services, there are also a number of best practices and recommended approaches that have been identified for improving developmental screening rates.

Please indicate in the table below which (if any) of the following best practices and programs the CCO or practice has implemented specifically to address developmental screening. If there are efforts the CCO or practice has implemented not specifically to address developmental screening, but believes resulted in increased developmental screening, please note those in the open-ended comment boxes below.

Please indicate in the table below when implementation began, or if the CCO or practice is planning to implement in the future. Note that some CCOs or practices may have implemented something years ago and consider it already in place, that is, there was not a new or renewed focus on it. If this is the case, please select “Yes” in the first column, and “prior to 2012” in the second column.

CCO implementation can refer to implementation across the whole CCO or contracted provider network, or for a subset or pilot of sites or practices. Please indicate in the table below what the scope of the implementation was. For any subsets or pilot projects, please provide additional details in the open-ended comment boxes below.

Note some of these interventions may overlap (e.g., the CCO implemented a policy change with a focus on provider education). In that case, please select the categories you feel are most representative of the intent and work, and provide any clarifying details in the open-ended comment boxes below.

Best practices and programs	Did the CCO or practice implement?	If yes, when did implementation begin?	If yes, what was the scope of the implementation?
Policy or clinical guideline changes <ul style="list-style-type: none"> • Specific / All health supervision visits before age 5 include developmental surveillance; • Requirement to use validated screening tool for developmental surveillance; • Other (please describe below). 	-Yes -No – was considered & decided against -No – was not considered -Planning to implement in 2015 -Planning to implement in 2016 or beyond	-Prior to 2012 -2012 -2013 -2014 -2015 to date	-All practices -All providers -All members -Subset of practices -Subset of providers -Subset of members -Pilot
Provider education <ul style="list-style-type: none"> • Systematic and consistent use of standardized screening tool rather than informal checklists or developmental milestone lists; • Importance of developmental surveillance and early intervention campaign; 	Choose an item.	Choose an item.	Choose an item.

Best practices and programs	Did the CCO or practice implement?	If yes, when did implementation begin?	If yes, what was the scope of the implementation?
<p>Provider / Office Staff training</p> <p><i>Including, but not limited to clinic detailing or quality visits; continuing education opportunities; group trainings; focusing on workflow / processes to embed developmental screening into visits; and identifying champions.</i></p>	Choose an item.	Choose an item.	Choose an item.
<p>Alternate payment methodologies</p> <p><i>Including, but not limited to: capitation or sub-capitation; incentivizing providers for increasing developmental screening rates (either provision of screening or coding for screenings).</i></p>	Choose an item.	Choose an item.	Choose an item.
<p>Improving access to care</p> <ul style="list-style-type: none"> • Emphasis on receiving the recommended number of preventive care visits, increasing the number of opportunities for timely developmental screening; • Improving connections to community resources for referral and follow up (providers may be unwilling to screen if there are no resources when problems are identified). 	Choose an item.	Choose an item.	Choose an item.
<p>Identification of children missing developmental screenings, with or without tailored outreach to them or their provider.</p>	Choose an item.	Choose an item.	Choose an item.
<p>Improving Health IT:</p> <ul style="list-style-type: none"> • Modifying electronic health records to prompt for developmental screening, capture developmental screening and results, and/or generate encounters for developmental screening; 	Choose an item.	Choose an item.	Choose an item.

Best practices and programs	Did the CCO or practice implement?	If yes, when did implementation begin?	If yes, what was the scope of the implementation?
<ul style="list-style-type: none"> Creation of, modification of system to collect developmental screenings from other organizations and transfer to providers' office. 			
Working with local Early Learning Hub to identify and implement strategies for improving developmental screening.	Choose an item.	Choose an item.	Choose an item.
Other (describe below)			

For any best practices or programs the CCO or practice implemented indicated above, please provide a brief description of the program or approach. If any information has already been written up in support or describing the program or approach that can be shared, please include it as an attachment.

Policy or clinical guidelines changes

[Click here to enter text.](#)

Provider education

[Click here to enter text.](#)

Provider training

[Click here to enter text.](#)

Alternate payment methodologies

[Click here to enter text.](#)

Improving access to care

[Click here to enter text.](#)

Identification of children missing developmental screenings

[Click here to enter text.](#)

Improving health IT

[Click here to enter text.](#)

Did the CCO or practice implement any additional programs or quality improvement activities to address developmental screening? If yes, please describe:

[Click here to enter text.](#)

Please provide addition details on the scope of the implementation as indicated in the table above, such as selection criteria for pilot projects, or inclusion criteria for subset of practices, providers, or members.

[Click here to enter text.](#)

Did the CCO change any billing or coding practices or policies, or work with providers to change any billing or coding practices in support of this measure? If yes, please describe:

[Click here to enter text.](#)

Did the CCO conduct any evaluation or assessment activities of the program or quality improvement activities? If so, please briefly describe any results, including whether the program was successful, any particular challenges, and any implications for future implementation.

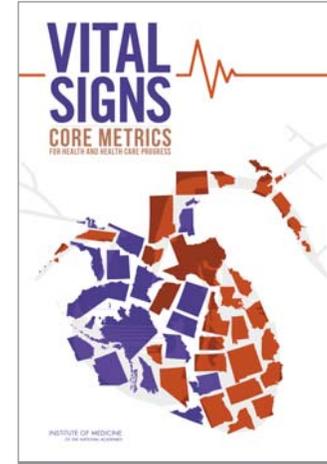
[Click here to enter text.](#)

Are there any other local initiatives of which you are aware that may have had an impact on ED utilization for your CCO or practice (including any initiatives that you were not involved in)? If yes, please describe.

[Click here to enter text.](#)

Vital Signs

Core Metrics for Health and Health Care Progress



Thousands of measures are in use today to assess health and health care in the United States. Although many of these measures provide useful information, their sheer number, as well as their lack of focus, consistency, and organization, limits their overall effectiveness in improving performance of the health system. To achieve better health at lower cost, all stakeholders—including health professionals, payers, policy makers, and members of the public—must be alert to which measures matter most. What are the core measures that will yield the clearest understanding and focus on better health and well-being for Americans?

With support from the Blue Shield of California Foundation, the California Healthcare Foundation, and the Robert Wood Johnson Foundation, the Institute of Medicine (IOM) convened a committee to identify core measures for health and health care. In *Vital Signs: Core Metrics for Health and Health Care Progress*, the committee uses a four-domain framework—healthy people, care quality, lower cost, and engaged people—to propose a streamlined set of 15 standardized measures, with recommendations for their application at every level and across sectors. Ultimately, the committee concludes that this streamlined set of measures could provide consistent benchmarks for health progress across the nation and improve system performance in the highest-priority areas.

A streamlined set of measures could provide consistent benchmarks for health progress across the nation and improve system performance in the highest-priority areas.

The Measurement Landscape

Health measurements are requested or required by many organizations for many purposes, including efforts to track population, community, and individual health; assessments of health care quality and patient experience; transparency monitoring; public reporting and benchmarking; system or professional performance requirements; and funder reporting. Many of these measures are very similar, with only slight variations in terminology and methodology. However, their differences are often significant enough to prevent direct comparisons across states, institutions, and individuals. In addition, many measures focus on narrow or technical aspects of health care processes, rather than on overall health system perfor-

mance and health outcomes. According to the committee, the growing number of clinical measures, even those that provide valuable information, draws attention to narrow, specific elements and away from system capacity and effectiveness.

The necessity to collect, analyze, and store data for such a large number of measures also imposes a significant burden on providers, organizations, and the health care system as a whole. Preliminary research commissioned by the committee finds that the growth in measurement and reporting activities results in considerable expense and requires substantial time commitments—without a matching return on investment. The establishment of a core set of measures could improve efficiency and ensure a focus on the most important health outcomes.

The Core Measure Set

To select a core measure set, the committee first considers each candidate measure’s importance for health, likelihood to contribute to progress, understandability, technical integrity, potential to have broader system impact, and utility at multiple levels. Next, in considering how the measures should

operate as a set, the committee selects 15 measures that together have systemic reach, are outcomes-oriented, are meaningful at the personal level, are representative of concerns facing the U.S. health system, and have use at many levels. The core measures proposed by the committee are as follows:

- 1. Life expectancy:** Life expectancy is a validated, readily available, and easily understandable measure for a critical health concept. Because life expectancy depends on a full range of individual and community influences on health—from cancer to homicide—it represents an inclusive, high-level measure for health.
- 2. Well-being:** Well-being captures the subjective dimensions of health related to quality of life. Furthermore, levels of well-being often predict utilization of and satisfaction with health care. Self-reported well-being is a reliable indicator.
- 3. Overweight and obesity:** More than two-thirds of Americans are overweight or obese, a fact that has causes and consequences that extend beyond the health system—including socioeconomic, cultural, political, and lifestyle factors.

BOX Core Measure Set with Related Priority Measures

 <p>1. Life expectancy Infant mortality Maternal mortality Violence and injury mortality</p>	 <p>7. Preventive services Influenza immunization Colorectal cancer screening Breast cancer screening</p>	 <p>11. Care match with patient goals Patient experience Shared decision making End-of-life/advanced care planning</p>
 <p>2. Well-being Multiple chronic conditions Depression</p>	 <p>8. Care access Usual source of care Delay of needed care</p>	 <p>12. Personal spending burden Health care-related bankruptcies</p>
 <p>3. Overweight and obesity Activity levels Healthy eating patterns</p>	 <p>9. Patient safety Wrong-site surgery Pressure ulcers Medication reconciliation</p>	 <p>13. Population spending burden Total cost of care Health care spending growth</p>
 <p>4. Addictive behavior Tobacco use Drug dependence/illicit use Alcohol dependence/misuse</p>	 <p>10. Evidence-based care Cardiovascular risk reduction Hypertension control Diabetes control composite Heart attack therapy protocol Stroke therapy protocol Unnecessary care composite</p>	 <p>14. Individual engagement Involvement in health initiatives</p>
 <p>5. Unintended pregnancy Contraceptive use</p>		 <p>15. Community engagement Availability of healthy food Walkability Community health benefit agenda</p>
 <p>6. Healthy communities Childhood poverty rate Childhood asthma Air quality index Drinking water quality index</p>		

The necessity to collect, analyze, and store data for such a large number of measures imposes a significant burden on providers, organizations, and the health care system as a whole.

4. Addictive behavior: Addiction, including to nicotine, alcohol, and other drugs, is prevalent in the United States, representing a complex challenge for the health system, communities, and families. Every year, substance abuse and addiction cost the country more than \$500 billion.

5. Unintended pregnancy: Unintended pregnancy, a significant challenge for both individual and community health, is a measure that aggregates a variety of social, behavioral, cultural, and health factors—particularly women’s knowledge about and access to tools for family planning.

6. Healthy communities: Individual health is a function of a wide range of socioeconomic and community factors, from infrastructure to social connections. Community health includes critical elements of health that fall outside the care system, such as housing, employment, and environmental factors.

7. Preventive services: Preventive services (for example, screening for hearing loss or counseling for tobacco cessation) present a valuable opportunity for both improving health and reducing costs.

8. Care access: A person’s ability to access care when needed is a critical precondition for a high-quality health system. Factors that could hamper access to care include lack of health insurance, clinician shortages, lack of transportation, cultural and linguistic barriers, and physical limitations.

9. Patient safety: Avoiding harm is among the principal responsibilities of the health care system, yet adverse outcomes are common. Ensuring patient safety will require a culture that prioritizes and assesses safety through a reliable index of organizational results.

10. Evidence-based care: Ensuring that patients receive care supported by scientific evidence for appropriateness and effectiveness is a central challenge for the health care system. Currently, an estimated one-third of U.S. health care expenditures

do not contribute to improving health. Aggregating carefully selected and standardized clinical measures can provide a reliable composite index of system performance.

11. Care match with patient goals: Systematically assessing each patient’s individual goals and perspectives ensures that the health care system is focusing on the aspects of care that matter most to patients.

12. Personal spending burden: Care that is too expensive can limit access to care, lead people to avoid care, or prevent them from spending money in other areas of value to them—with far-reaching economic impacts.

13. Population spending burden: Health care spending consumes a large portion of the U.S. gross domestic product, dwarfing the health care spending of other nations. This burden can be measured at national, state, local, and institutional levels.

14. Individual engagement: Given the effects of personal choices on health, as well as the increasing use of personal health devices, it is critical for individuals to be aware of their options and responsibilities in caring for their own health and that of their families and communities.

15. Community engagement: Across the United States, communities have and utilize different levels of resources to support efforts to maintain and improve individual and family health—for example, addiction treatment programs, emergency medical facilities, and opportunities for social engagement.

The committee recognizes that these 15 measures will not be sufficient to meet every interest for each organization, nor are there established methods for measurement in each area. To begin to accommodate these challenges, the committee identifies 39 additional priority measures that can act as surrogates while refinement is under way (see Box).



Committee on Core Metrics for Better Health at Lower Cost

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Robert Wood Johnson Foundation

Refinement of the measures and methodology will require leadership from stakeholders across sectors.

Implementation of the Core Measures

Successful implementation of the core measures will depend on their relevance, reliability, and utility to stakeholders. Implementation challenges include multiple competing priorities for stakeholders, the sizable degree of change proposed, and the slow pace of change overall in the health system. Progress can be accelerated by ensuring that the core measurement set is applied by, and adds value to, existing measurement activities. The committee stresses that leadership will be required at nearly every level of the health system. CEOs of health care organizations, payers and employers, standards organizations, and public health agencies will have important roles in the uptake, use, and maintenance of the core measures as practical tools. The committee recommends that the Secretary of the Department of Health and Human Services, with support from the Executive Office of the President, lead the effort to refine, standardize, and implement core measures throughout the nation.

Conclusion

The set of core measures proposed by the committee is a tool for enhancing the efficiency and effectiveness of measurement. Ultimately, widespread application of a limited set of standardized measures could not only reduce the burden of unnecessary measurement but also align the incentives and actions of multiple organizations at multiple levels. *Vital Signs* lays the groundwork for the adoption of core measures that, if systematically applied, could yield better health at lower cost for all Americans. 



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PROPOSED MEASURE RETIREMENT CRITERIA

This document outlines proposed criteria for the Metrics & Scoring Committee to use when retiring CCO incentive measures. Retiring may refer to removing the measure from the CCO incentive set, but leaving it as a monitoring measure in other measure sets.

Not all of these criteria must be met before a measure could be retired; this document is not a comprehensive checklist, but rather a compilation of scenarios or potential criteria that could prompt a more comprehensive discussion of whether a measure should be retired or not.

These considerations for measure retirement are based on criteria used by CMS, NCQA, NQF, The Joint Commission, and AHRQ.

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

- The statewide rate and all CCO rates exceed the highest possible benchmark.
- The statewide rate and most CCO rates exceed the highest possible benchmark.
- There is not a higher benchmark that could be adopted (e.g., benchmark is already 90th percentile, early elective deliveries are already below 2%, etc...).
- State and/or CCO performance has not met the benchmark but there is clear rationale for not meeting the benchmark (e.g., underlying data source differences) and no reasonable expectations for further meaningful improvement.

SUPPORTING CLINICAL GUIDELINES OR EVIDENCE-BASE HAVE CHANGED

- The measure was monitoring performance 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 relevant to the measure suggests that a measure is no longer scientifically acceptable (e.g., the outcome of the measure no longer predicts anything important to the patient).
- The measure may be slated for retirement in the future (see above) due to change in clinical guidelines, but there is a lag between measurement year and proposed retirement date.

- The measure may be slated for modification to adhere to the new / revised clinical guideline, but there is a lag between measurement year and proposed modification date.

MEASURE HAS BEEN RETIRED / PENDING RETIREMENT BY MEASURE STEWARD

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

MEASURE CANNOT BE MEASURED

- OHA / CCOs / providers no longer have 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.
- Low prevalence of a condition, or small denominators lead to low reliability and high variation for the measure.

MEASURE NO LONGER ADDS VALUE

- The measure closely aligns with another measure, resulting in redundancy across the measure set and/or duplication of effort.
- A more appropriate or more relevant measure exists to address the population, domain, etc that the original measure was intended to address.
- There is evidence of unanticipated / undesirable consequences of implementing the measure, or underlying manipulation to 'meet' a measure.
- There is evidence that the measure undermines quality improvement activities.

**Buying Value
Measure Selection Criteria Worksheet
February 13, 2014**

The priority performance goals of the program being measured are:

1. _____
2. _____
3. _____
4. _____
5. _____

I. Technical Measure Criterion (tests that each measure should meet)				
Potential criterion	Description	Include	Consider	Exclude
1. Evidence-based and scientifically acceptable	The measure will produce consistent (reliable) and credible (valid) results. The measure has been endorsed by the NQF or by another national body with a rigorous method for review and endorsement of measures (e.g., NCQA).			
2. Has a relevant benchmark	State, regional or national level performance data are available for the same measure.			
3. Not greatly influenced by patient case mix	Providers serving more complex or ill patients will not be disadvantaged by comparative measurement.			
II. Program-Specific Measure Criterion (tests that each measure should meet)				
Potential criterion	Description	Include	Consider	Exclude
4. Consistent with the goals of the program	The measure corresponds to a program performance priority.			
5. Useable and relevant	The intended users (consumers, purchasers, providers, and/or policy makers) can understand the results of the measure and are likely to find them useful for quality improvement and decision-making.			

Potential criterion	Description	Include	Consider	Exclude
6. Feasible to collect	The measure can be implemented and data can be collected without undue burden.			
7. Aligned with other measure sets	The measure aligns with a measure that providers in the program are otherwise required to report and/or for which they are held accountable.			
8. Promotes increased value	Improving this measure will translate into significant changes in outcomes relative to costs, with consideration for efficiency.			
9. Present an opportunity for quality improvement	There is a gap between baseline performance and best-practice performance.			
10. Transformative potential	Improving this measure will fundamentally change care delivery in a desired manner.			
11. Sufficient denominator size	In order to ensure that the measure is not prone to the effects of random variation, the measure should have a sufficient denominator in the context of the program.			
III. Potential Measure Set Criteria (tests that the overall measure set should meet)				
Potential criterion	Description	Include	Consider	Exclude
12. Representative of the array of services provided by the program				
13. Representative of the diversity of patients served by the program				
14. Not unreasonably burdensome to payers or providers				

Metrics Principles, Domains and Example CCO Accountability Metrics

OHPB Stakeholder Workgroup on Outcomes, Quality, and Efficiency Metrics

Potential CCO Performance Measures

At a minimum, any selected performance measure selected should meet standard scientific criteria for reliability and face validity. Potential measures should also be evaluated against the principles below, with the goal of establishing a set of CCO performance measures that reasonably balances the various criteria. OHA should re-examine selected measures on a regular basis to ensure that they continue to meet criteria.

Principle	Selection criteria	Change criteria
Transformative potential	<ul style="list-style-type: none"> ○ Measure would help drive system change 	<ul style="list-style-type: none"> ○ Measure reinforces the status quo rather than prompting change
Consumer engagement	<ul style="list-style-type: none"> ○ Measure successfully communicates to consumers what is expected of CCOs 	<ul style="list-style-type: none"> ○ Measure is not understandable or not meaningful to consumers
Relevance	<ul style="list-style-type: none"> ○ Condition or practice being measured has a significant impact on issues of concern or focus* ○ Measure aligns with evidence-based or promising practices 	<ul style="list-style-type: none"> ○ Lack of currency - measure no longer addresses issues of concern or focus*
Consistency with existing state and national quality measures, with room for innovation when needed	<ul style="list-style-type: none"> ○ Measure is nationally validated (e.g. NQF endorsed) ○ Measure is a required reporting element in other health care quality or purchasing initiative(s) ○ National or other benchmarks exist for performance on this measure 	<ul style="list-style-type: none"> ○ Measure loses national endorsement ○ Measure is unique to OHA when similar standard measures are available
Attainability	<ul style="list-style-type: none"> ○ It is reasonable to expect improved performance on this measure (can move the meter) 	<ul style="list-style-type: none"> ○ CCO or entity performance is “topped out” ○ Measure is too ambitious
Accuracy	<ul style="list-style-type: none"> ○ Changes in CCO performance will be visible in the measure ○ Measure usefully distinguishes between different levels of CCO performance 	<ul style="list-style-type: none"> ○ Measure is not sensitive enough to capture improved performance ○ Measure is not sensitive enough to reflect variation between CCOs
Feasibility of measurement	<ul style="list-style-type: none"> ○ Measure allows CCOs and OHA to capitalize on existing data flows (e.g. state All Payer All Claims reporting program or other established quality reporting systems) ○ Data collection for measure will be supported by upcoming HIT and HIE developments 	<ul style="list-style-type: none"> ○ Burden of data collection and reporting outweighs the measure’s value

Reasonable accountability	<ul style="list-style-type: none"> ○ CCO has some degree of control over the health practice or outcome captured in the measure 	<ul style="list-style-type: none"> ○ Measure reflects an area of practice or a health outcome over which CCO has little influence
Range/diversity of measures	<ul style="list-style-type: none"> ○ Collectively, the set of CCO performance measures covers the range of topics, health services, operations and outcomes, and populations of interest 	<ul style="list-style-type: none"> ○ There is a surplus of measures for a given service area or topic ○ Measure is duplicative ○ Measure is too specialized

* These issues include, but are not limited to: health status, health disparities, health care costs and cost-effectiveness, access, quality of care, delivery system functioning, prevention, patient experience/engagement, and social determinants of health.

Domains of Measurement

OHA should assess CCO performance in these domains:

- Accountability for system performance in all service areas for which the CCO is responsible:
 - Adult mental health
 - Children’s mental health
 - Addictions
 - Outpatient physical
 - Inpatient physical
 - Women’s health
 - Dental
 - Prevention
 - End-of-life care
- Accountability for transformation:
 - Care coordination and integration
 - Patient experience and activation
 - Access
 - Equity
 - Efficiency and cost control
 - Community orientation

Status Update: 2016 On-Deck Measures

This document provides a summary of the status of each of the on-deck measures for 2016 identified by the Metrics & Scoring Committee. The Committee selected these on-deck measures in August 2014 to be considered first, when selecting the 2016 incentive measures.

Note this list does not include the tobacco prevalence measure also under discussion for 2016, as it was initially selected for 2015 and not part of the on-deck list. This list also excludes kindergarten readiness and reducing health disparities, as separate proposals are being developed for those metrics.

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Any Dental Service

Measure Description	Percent of members (ages 0-21) receiving any dental services.
Measure Specifications	<p>Yes, measure specifications from CMS for EPSDT reporting exist. This measure can be reported at the state and CCO level, and stratified by race/ethnicity and other variables.</p> <p>NCQA has a similar measure, with a different age range (2-21), which requires at least one dental visit in the measurement year.</p>
Measure Alignment	This measure is not currently in any of OHA's other metric sets, or included in PEBB / OEGB metric sets, or recommended in the HB 2118 set.
QI Focus Area	Improving access to timely and effective care.
Data Source	Claims.
Baseline Data	In FFY 2011, the percent of eligible members (1-20) receiving any dental services was 42.4%, ranging from 21 – 60% across the DCOs. In FFY12, this increased to 45.0% and in FFY13, 44.5%.
Benchmark	No benchmark has been selected, but there is a Healthy People 2020 goal for any dental service: 49.0%.
Recommended By	Dental Quality Metrics Workgroup
Additional Discussion	<p>The Workgroup identified this measure as a measure of access to dental care, and noted its focus on establishing access to address prevention, treatment, or other dental needs, comparable to a primary care visit.</p> <p>The Workgroup recommends that this measure should not be limited to a dental office setting, but be limited to “dental services” as defined by CMS for EPSDT purposes (i.e., services provided by or under the supervision of a dentist as defined by HCPCS / CDT codes D0100 – D9999). This includes dental services provided by an Expanded Practice Permit Dental Hygienist who has a collaborative practice agreement.</p>
References	<p>Dental Quality Metrics Workgroup Recommendation, Dec 2013 http://www.oregon.gov/oha/analytics/DentalMetricsDocuments/Dental%20Metrics%20Recommendation.pdf</p> <p>Dental Quality Metrics Workgroup Presentation to Metrics & Scoring Committee, Feb 2014 http://www.oregon.gov/oha/analytics/MetricsDocs/February%2021,%202014%20Dental%20Materials.pdf</p>

Assessment and Management of Chronic Pain

Measure Description	Percent of patients (age 18 and older) 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.
Measure Specifications	AHRQ and the Institute for Clinical Systems Improvement.
Measure Alignment	This measure is not currently in any of OHA's other metric sets, or included in PEBB / OEBC metric sets, or recommended in the HB 2118 set.
QI Focus Area	<ul style="list-style-type: none"> • Ensuring appropriate care is delivered in appropriate setting • Reducing preventable and unnecessarily costly utilization • Improving primary care for all populations
Data Source	Electronic health record / medical record.
Baseline Data	N/A
Benchmark	N/A
Recommended By	N/A
Additional Discussion	<p>Chronic pain affects at least 50 million adults a year. Prevalence in primary care settings range from 5% to 33% and often imposes upon clinicians the responsibility of managing a substantial disability that can be exacerbated by a patient's distress. Due to its prevalence, the cost of chronic pain is substantial; it has been estimated at \$70 billion per year. Chronic pain has the ability to disable and significantly decrease the quality of life for the individual and his or her support systems; the financial and personal cost to those who are affected by chronic pain is significant (Reid et al., 2002; Olsen & Daumit, 2002).</p> <p>Patient experience is that limited education is done early on and patients do a lot of research on their own. Education is critical and includes setting realistic goals, providing education to patients about their disease state, explaining medications and also any interventional procedures. Well-informed patients will be able to take more responsibility for their care. (AHRQ).</p>
References	<p>AHRQ measure http://www.qualitymeasures.ahrq.gov/content.aspx?id=47738</p> <p>ICSI assessment management measures? https://www.icsi.org/_asset/bw798b/ChronicPain.pdf (pages 54 - 69)</p>

Childhood Immunization Status

Measure Description	Percent of children who received recommended vaccines before their 2 nd birthday.
Measure Specifications	<p>This measure is currently one of OHA's 33 state performance measure; specifications based on the HEDIS measure and modified to incorporate ALERT data have been created and are in use.</p> <p>This measure can be reported at the state and CCO level, as well as stratified by race/ethnicity and other variables.</p>
Measure Alignment	This measure is also a Phase I recommended measure from the Health Plan Quality Metrics Workgroup (HB 2118). This is also one of the Core Children's Health Care Quality Measures for Medicaid and CHIP.
QI Focus Area	<ul style="list-style-type: none"> • Ensuring appropriate care is delivered in appropriate settings. • Improving primary care for all populations.
Data Source	Claims, combined with ALERT immunization registry data.
Baseline Data	In the January 2014 Mid-Year Report, the statewide Medicaid rate was 67.6%, ranging from 57.4 – 77.0% across the CCOs.
Benchmark	OHA is currently using the 2014 National Medicaid 75 th percentile of 82.0% as a benchmark.
Recommended By	N/A
Additional Discussion	N/A
References	<p>2014 Mid-Year Report: http://www.oregon.gov/oha/Metrics/Pages/measure-childhood.aspx</p> <p>Health Plan Quality Metrics Workgroup Recommendation https://www.coveroregon.com/wp-content/uploads/2014/10/HB-2118-Recommendations.pdf</p> <p>Core Children's Health Care Quality Measures for Medicaid and CHIP http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-child-core-set.pdf</p>

Childhood Obesity Prevalence

Measure Description	Percent of children (ages TBD) who are obese, using the CDC BMI-for-age guidelines, 95 th percentile and above.
Measure Specifications	<p>TBD, several options for childhood obesity measures exist, including:</p> <ul style="list-style-type: none"> • NQF 1349: Child (age 10-17) overweight or obesity status based on parental report of BMI. <i>This measure is not designed for health plans, but rather state level monitoring.</i> • NQF 0024: Weight assessment and counseling for nutrition and physical activity for children/adolescents (ages 3-17). <i>This measure reflects patients who had an outpatient visit and had evidence of their BMI percentile was documented in their medical record, as well as received counseling for nutrition and physical activity.</i> <p>OHA does not currently have an obesity prevalence measure at the CCO level.</p>
Measure Alignment	<p>OHA is not currently using a childhood obesity measure as part of its CCO measurement strategy, however NQF 0024 is one of the Core Children’s Health Care Quality Measures for Medicaid and CHIP, and one of the Phase II recommended measures from the Health Plan Quality Metrics Workgroup.</p> <p>Additionally, maintaining or reducing the rate of obesity among 8th and 11th graders is one of the objectives in Oregon’s Healthy Futures plan.</p>
QI Focus Area	<ul style="list-style-type: none"> • Addressing discrete health issues. • Improving primary care for all populations.
Data Source	<p>NQF 1349 uses the National Survey of Children’s Health. NQF 0024 requires EHR or medical record data.</p>
Baseline Data	N/A
Benchmark	<p>NQF 1349 can be compared to other states or national rates. NQF 0024 has Medicaid and Commercial benchmarks available.</p>
Recommended By	N/A
Additional Discussion	<p>Oregon’s State Health Improvement Plan is currently being updated. New statewide targets for childhood obesity prevalence and reducing obesity prevalence among WIC recipients will be incorporated.</p> <p>Oregon is also participating in a Center for Health Care Strategies project on Innovations in Childhood Obesity.</p>

References	<p>Oregon's Healthy Futures plan https://public.health.oregon.gov/About/Documents/oregons-healthy-future.pdf</p> <p>Health Plan Quality Metrics Workgroup Recommendation https://www.coveroregon.com/wp-content/uploads/2014/10/HB-2118-Recommendations.pdf</p> <p>Core Children's Health Care Quality Measures for Medicaid and CHIP http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-child-core-set.pdf</p>
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Fluoride Varnish

Measure Description	Percent of enrolled children (age 1-21) who have received at least one dental service who received at least 2 topical fluoride applications during the measurement year.
Measure Specifications	<p>The Dental Quality Metrics Workgroup recommends adapting the Dental Quality Alliance (DQA) measure “Topical Fluoride Intensity for Children at Elevated Caries Risk”, excluding the qualifier “children who are at elevated risk” as we do not currently have risk assessment data available.</p> <p><i>Note NCQA acknowledges that “elevated risk” correlates with socio-demographic status; it could be assumed that all children on Medicaid are at elevated risk.</i></p>
Measure Alignment	This measure is not currently part of any of OHA’s adopted measure sets, it was recently endorsed by NCQA (NQF 2528).
QI Focus Area	Improving access to timely and effective care.
Data Source	Claims.
Baseline Data	Not currently available, but could be produced with available data.
Benchmark	None identified to date, but comparative data is likely available given NCQA endorsement of DQA measure.
Recommended By	Dental Quality Metrics Workgroup.
Additional Discussion	The Dental Quality Metrics Workgroup recommends additional clarification to determine whether this measure should include fluoride varnish provided in the dental delivery system only, or be expanded to include services provided in the medical system.
References	<p>DQA specifications http://www.ada.org/~media/ADA/Science%20and%20Research/Files/NQF_Dental_DQA_Topical_Fluoride.ashx</p> <p>Dental Quality Metrics Workgroup Recommendation http://www.oregon.gov/oha/analytics/DentalMetricsDocuments/Dental%20Metrics%20Recommendation.pdf</p>

Food Insecurity and Hunger

Measure Description	Percent of patients who screen positive for food insecurity and hunger who received follow up / referral to resources provided by the Oregon Food Bank (or other community programs).
Measure Specifications	<p>Currently, two validated screening questions on food insecurity are used by the US Department of Agriculture and recommended by the Oregon Food Bank for incorporation into EHRs or as part of broader health assessments.</p> <p>Specifications for measuring at the health plan level are not fully developed. A diagnosis code approach to monitor screening (similar to SBIRT) is being used in several states and could be explored in Oregon; utilization of these ICD9 codes in Oregon is currently unknown.</p>
Measure Alignment	This measure is not currently part of any OHA measure sets or any known measure sets.
QI Focus Area	Improving primary care for all populations.
Data Source	Consistent data across the state / CCOs is not currently available, although medical record review may be able to provide needed data. Currently, about 200 practices across Oregon are screening for food insecurity / hunger.
Baseline Data	N/A. Baseline data at the CCO level could be derived from the 2014 Medicaid Behavioral Risk Factor Surveillance System (MBRFSS) survey; however this survey is not replicated annually. Additional state level data is available from the general population BRFSS survey.
Benchmark	N/A
Recommended By	Oregon Food Bank, Oregon Primary Care Association, American Academy of Pediatrics.
Additional Discussion	Currently, about 200 practices across Oregon are screening for food insecurity and hunger, with technical assistance provided by the Oregon Food Bank. Screening needs to be frequent and at the clinic level due to individual's fluctuating income and personal situation. Screening in writing has been shown to produce the most accurate results. No provider time is required but the screen gives valuable information that may relate to a patient's symptoms. Approximately 15 other states are also starting to implement this social determinants of health screening.
References	<p>Public testimony previously provided by the Oregon Food Bank (including the 2 questions) http://www.oregon.gov/oha/analytics/MetricsDocs/August%2022,%202014%20Testimony_Knox.pdf</p> <p>Public testimony previously provided by OPCA and Central City Concern http://www.oregon.gov/oha/analytics/MetricsDocs/July%2018,%202014%20Public%20Testimony.pdf</p>

Homelessness Screening

Measure Description	Percent of patients who screen positive for current or imminent risk of housing instability.
Measure Specifications	<p>Specifications for measuring at the health plan level have not been developed.</p> <p>The VA has developed the two-question Homelessness Screening Clinical Reminder (HSCR) tool which is used to conduct an ongoing, universal screening for current and imminent risk of housing instability.</p>
Measure Alignment	This measure is not currently part of any OHA measure sets or any known measure sets.
QI Focus Area	Improving primary care for all populations.
Data Source	Consistent data across the state / CCOs is not currently available, although medical record review may be able to provide some limited data.
Baseline Data	N/A
Benchmark	N/A
Recommended By	
Additional Discussion	
References	<p>Public testimony previously provided by OPCA and Central City Concern http://www.oregon.gov/oha/analytics/MetricsDocs/July%2018,%202014%20Public%20Testimony.pdf</p> <p>HSCR http://www.endveteranhomelessness.org/research/ii-homelessness-risk-assessment</p>

PQI 92: Prevention Quality Chronic Composite

Measure Description	Rate of admissions per 100,000 member years for the following chronic conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure.
Measure Specifications	Measure specifications have been developed by AHRQ, OHA has implement the PQIs, although has not been reporting to PQI 92 composite.
Measure Alignment	OHA currently uses the Prevention Quality Indicators in its reporting to CMS, PQI #1, 5, 8 and 15 are four of the 33 state performance measures. The PQI 92 composite is also a Phase I recommended measures from the Health Plan Quality Metrics Workgroup.
QI Focus Area	<ul style="list-style-type: none"> • Addressing discrete health issues • Reducing preventable rehospitalizations
Baseline Data	TBD
Benchmark	No comparable benchmarks are available for the PQIs, as AHRQ methodology for reporting differs slightly. OHA uses “10% reduction” from the prior year as the benchmark for all PQIs (lower is better).
Recommended By	Health Plan Quality Metrics Workgroup
Additional Discussion	N/A
References	<p>Health Plan Quality Metrics Workgroup Recommendation https://www.coveroregon.com/wp-content/uploads/2014/10/HB-2118-Recommendations.pdf</p> <p>AHRQ specifications http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%2092%20Prevention%20Quality%20Chronic%20Composite.pdf</p>