

CCO Metrics & Scoring Committee
c/o Sarah Bartelmann
Oregon Health Authority
Portland Oregon

To the Members of the Metrics & Scoring Committee:

We the undersigned organizations urge you to adopt patient food insecurity screening and assistance as the first social determinant of health performance measure for Coordinated Care Organizations. Diet-related disease affects the health status of an ever expanding segment of Americans and is driving up the cost of care. Healthy food is the least expensive and invasive type of prevention and treatment, with no negative side effects. Health care providers are a uniquely influential voice and source of information for older Oregonians. There are resources in every community which can help improve the diet of low income patients. Among adults 60 years of age and older, 60% of those eligible for SNAP benefits (food stamps), do not receive them. Many do not know about local food pantries or could benefit from education about shopping and preparing healthy food on a budget.

The two validated food insecurity screening questions are being widely used across the U.S. and provide several advantages. They are a quick way to give important information to providers and identify patients who may be adversely affected by social determinants beyond food insecurity (such as unstable housing or dangerous environments). Our partner, the Oregon Food Bank, prepares a simple one page local resource handout for every Oregon county that can be incorporated into the electronic health record system and provided to patients that screen positive as part of their after visit summary. A brief review of the resources with patients will increase the likelihood that they will access resources that are new for them. Two standard ICD codes for performance of the screen and the results, are already being used by dozens of clinics and hospital departments across the state who have found patient food insecurity screening and patient assistance relatively simple to incorporate into their workflow. Lessons learned from the almost two hundred clinics already implementing will further simplify and inform the state-wide adoption of this new performance measure.

We urge your action now, to start this important effort to reduce costs and improve the health and nutrition of Oregonians at all ages.

Sincerely,

ELDERS IN ACTION
OLDER OREGONIANS HUNGER COALITION
CHILDHOOD HUNGER COALITION
Katie McClure, OREGON'S HEALTHIEST STATE



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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

CCO Metrics and Scoring Committee
Food Security Screening
May 15, 2015

Thank you for this opportunity to testify before you today.

My name is Elaine Friesen-Strang. I'm a member of the Older Oregon Hunger Coalition, the Exec Council of AARP Oregon and the EIA Commission. More personally, I am 61 years old; the relationship I have with my health care providers is the closest link I have to good health. The trusting partnership I have with my provider influences the very basics of my care: my blood sugar, weight and heart health, my ability to move, the ease in my aging process. I'm lucky-- I have access to good produce and protein, but many people my age do not. Many live on incomes that have declined or remained flat, while the cost of food has risen 60% in the last 20 years.

Nationally, only 60% of people 60 years of age and older who qualify for SNAP benefits receive them, In Oregon that figure is 42%. People don't know they qualify, they are embarrassed to admit they need help. To make matters worse, the enrollment process is complex. Older adults try to get by. They don't want to be a bother. They don't understand the impact that inadequate nutrition has on their health or where to get help. Clinics throughout Oregon that are already screening find that most older adults aren't aware of resources in their community.

A predictable point of contact and influence for most older adults in terms of their health outcomes is their care provider. If a provider says, "a better diet will help you feel better and here's how you can attain that", I believe older adults will take it seriously. How great to hear the answer isn't another medication prescription—it's just the food you put on your plate. And if a clinic follows-up-- helps you access new resources—whether it be SNAP benefits, locating convenient free produce, or connecting to a group meal program—good health becomes more likely to happen.

Until we incorporate our understanding of the power of social determinants of health into the everyday delivery of care, we are not going to make the change we all seek in our health care system.

I worked for 35 years for non-profits in social services. Now I am volunteering to improve the quality of life for people who are vulnerable because of their age and lack of supports. I know that working with community partners such as the Oregon Food Bank, this is a simple, first step the state can take in improving the health of older adults, as well as improving the system that serves us all.

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2012 Oregon SNAP Participation by County:

Use this chart to see how many people are getting SNAP in your county and how many federal dollars are coming into your local economy.

County	Total Population	Average Monthly SNAP Participants	Participation Rate		Annual Value of SNAP Benefits	Eligible People Not Participating	Annual Value of Increasing Participation*
			All Eligible	Eligible 65+			
Baker**	15,611	3,551	71%	35%	\$5,206,220	1,432	\$2,098,981
Benton	81,776	10,089	39%	30%	\$16,869,963	15,937	\$26,648,488
Clackamas	381,562	49,733	80%	34%	\$80,527,200	12,759	\$20,658,912
Clatsop	36,250	7,632	76%	46%	\$12,111,661	2,345	\$3,722,280
Columbia	48,743	9,449	79%	35%	\$15,128,973	2,559	\$4,097,772
Coos	61,348	16,593	87%	39%	\$26,565,838	2,575	\$4,122,644
Crook	20,602	4,994	70%	35%	\$7,629,042	2,149	\$3,282,902
Curry	22,219	4,362	77%	41%	\$6,785,489	1,298	\$2,018,821
Deschutes	161,035	32,502	75%	32%	\$52,753,250	11,120	\$18,047,891
Douglas	105,852	27,574	84%	37%	\$43,947,979	5,294	\$8,437,680
Gilliam	1,889	266	61%	25%	\$366,270	169	\$232,705
Grant	7,281	1,259	56%	23%	\$1,741,109	1,004	\$1,388,462
Harney	7,215	1,472	68%	41%	\$2,082,419	701	\$992,566
Hood River	22,236	3,416	68%	51%	\$4,962,177	1,573	\$2,284,453
Jackson	204,278	49,931	81%	39%	\$81,092,511	11,757	\$19,093,823
Jefferson	20,701	6,843	99%	97%	\$10,882,424	69	\$109,195
Josephine	82,097	24,218	80%	40%	\$39,524,418	6,027	\$9,836,394
Klamath	65,048	17,603	84%	32%	\$27,743,095	3,230	\$5,091,398
Lake	7,467	1,529	68%	41%	\$2,346,429	717	\$1,100,320
Lane	347,917	77,274	65%	38%	\$128,438,160	42,355	\$70,399,032
Lincoln	45,470	10,847	84%	46%	\$17,663,587	2,088	\$3,400,487
Linn	116,696	28,552	80%	35%	\$45,338,910	6,977	\$11,079,398
Malheur	27,932	8,310	80%	39%	\$12,554,717	2,116	\$3,197,477
Marion	312,710	78,577	79%	54%	\$124,769,859	21,132	\$33,554,479
Morrow	11,117	2,386	76%	57%	\$3,585,963	773	\$1,161,093
Multnomah	745,334	156,165	78%	62%	\$267,851,916	44,515	\$76,352,209
Polk	74,687	11,800	60%	36%	\$18,341,848	7,765	\$12,069,654
Sherman	1,846	329	58%	25%	\$502,650	238	\$363,181
Tillamook	24,428	4,829	70%	29%	\$7,691,980	2,049	\$3,263,228
Umatilla	71,637	16,279	73%	56%	\$24,147,326	6,142	\$9,111,028
Union	25,143	5,341	64%	32%	\$8,116,818	2,965	\$4,505,178
Wallowa	6,876	1,038	58%	29%	\$1,518,422	738	\$1,078,946
Wasco	24,732	5,320	65%	40%	\$8,072,697	2,894	\$4,390,840
Washington	541,898	66,454	63%	43%	\$106,431,413	39,016	\$62,487,043
Wheeler	1,259	243	88%	40%	\$347,170	35	\$49,596
Yamhill	94,981	19,753	71%	30%	\$31,292,825	7,890	\$12,498,833
Statewide	3,826,398	766,527	73%	42%	\$1,244,951,432	276,648	\$449,316,440

*People not participating times the average annual benefit.

**Information presented in each row is an independent calculation and not derived from data in rows above or below it.

That's more than **\$1 billion** coming into Oregon's economy each year!

Every \$1 of SNAP benefits generates **\$1.70** in local economic activity.



-Center on Budget and Policy Priorities, State-by-State Fact Sheet

To learn how you can help connect more Oregonians to SNAP, contact Katie Furia, SNAP Outreach Manager, Partners for a Hunger-Free Oregon (katie@oregonhunger.org). For more information on the report's methodology, visit oregonhunger.org/snap-participation.



Partners for a Hunger-Free Oregon
Ending hunger before it begins.