
Metrics & Scoring Committee

November 20, 2015

The logo for the Oregon Health Authority is centered at the bottom of the slide. It features the word "Oregon" in a smaller, orange, serif font above the word "Health" in a larger, blue, serif font. Below "Health" is the word "Authority" in a smaller, orange, serif font. The entire logo is set against a light blue, curved background that spans the width of the slide.

Oregon
Health
Authority



Consent agenda

*Approve September minutes

Agenda Overview

- Finalize 2016 benchmarks and tobacco measure
- 2016 work plan and meeting schedule
- Child & Family Wellbeing Workgroup presentation
- Public testimony
- Follow up from October retreat / debrief on joint BH learning session

Finalize 2016 Tobacco Measure

The Committee previously considered a proposal to weight the three components of the tobacco prevalence measure and asked TAG to recommend a way to apply the weighted component concept to the measure while keeping the minimum cessation benefit pass / fail.

Original Proposal	2016		2017		2018	
For meeting minimum cessation benefit requirement	40%	60%	33%	66%	25%	75%
For reporting EHR-based prevalence data (meeting population thresholds, etc)	40%		33%		25%	
For reducing prevalence (meeting benchmark / improvement target)	20%		33%		50%	

TAG Recommendation

- Keep the weighted component approach to the measure.
- The minimum cessation benefit remains pass / fail:
 - If the CCO passes, it is worth [%] toward their total score.
 - If the CCO fails, they cannot meet the measure, regardless of their score on the remaining components.
- Each CCO must meet the minimum cessation benefit requirement AND meet a certain threshold score to meet the total measure and earn quality pool payment.

Example 1: CCO meets threshold score and earns quality pool payment.

Measure components	Component Score	Total Score (running)
CCO met the minimum cessation benefit requirement	40%	40%
CCO submitted EHR-based data.	40%	80%
CCO did not reduce prevalence.	0%	80%
Total Score		80%

Example 2: CCO did not meet cessation benefit requirement, even though they meet threshold score, they do not earn quality pool payment.

Measure components	Component Score	Total Score (running)
CCO did not met the minimum cessation benefit requirement	0%	40%
CCO submitted EHR-based data.	40%	40%
CCO did reduce prevalence.	40%	80%
Total Score		80%

Revised Proposal

Revised Proposal	2016		2017 (A)		2017 (B)		2018	
For meeting minimum cessation benefit requirement*	40%	60%	33%	66%	30%	66%	25%	75%
Pass / Fail – CCO must meet this component to meet the measure.								
For reporting EHR-based prevalence data (meeting population thresholds, etc)								
For reducing prevalence (meeting benchmark / improvement target)	20%		33%		40%		50%	

Finalize 2016 Benchmarks

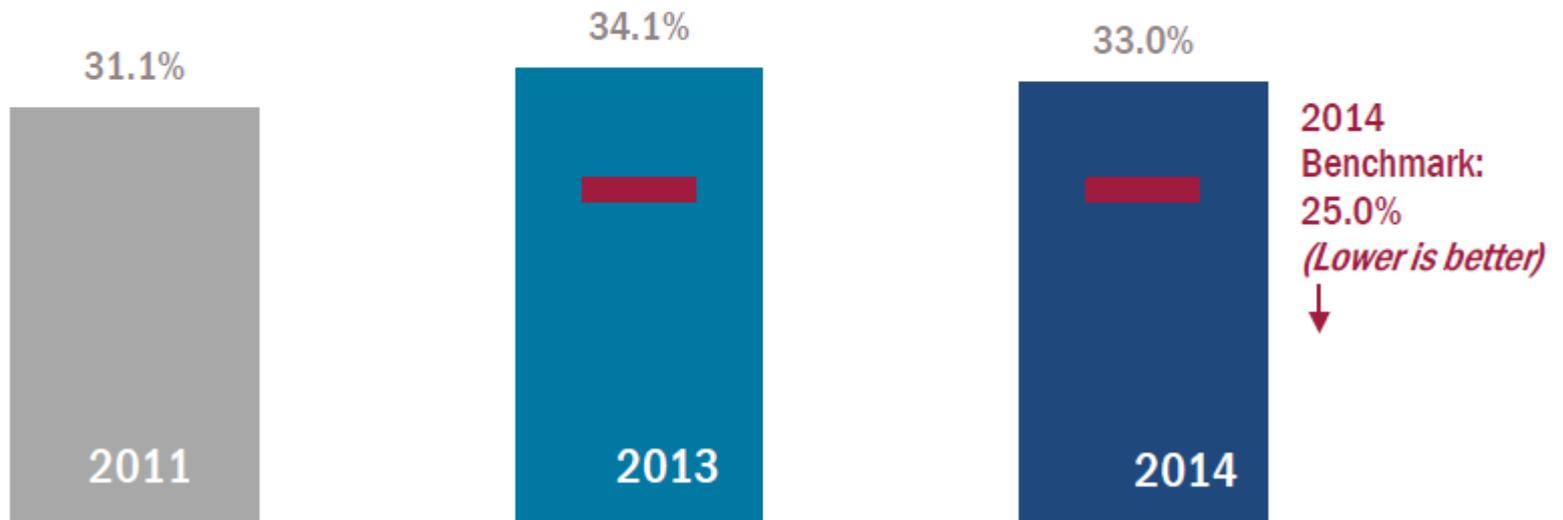
Tobacco Prevalence (Bundle)

Colorectal Cancer Screening

Tobacco Prevalence Data (CAHPS)

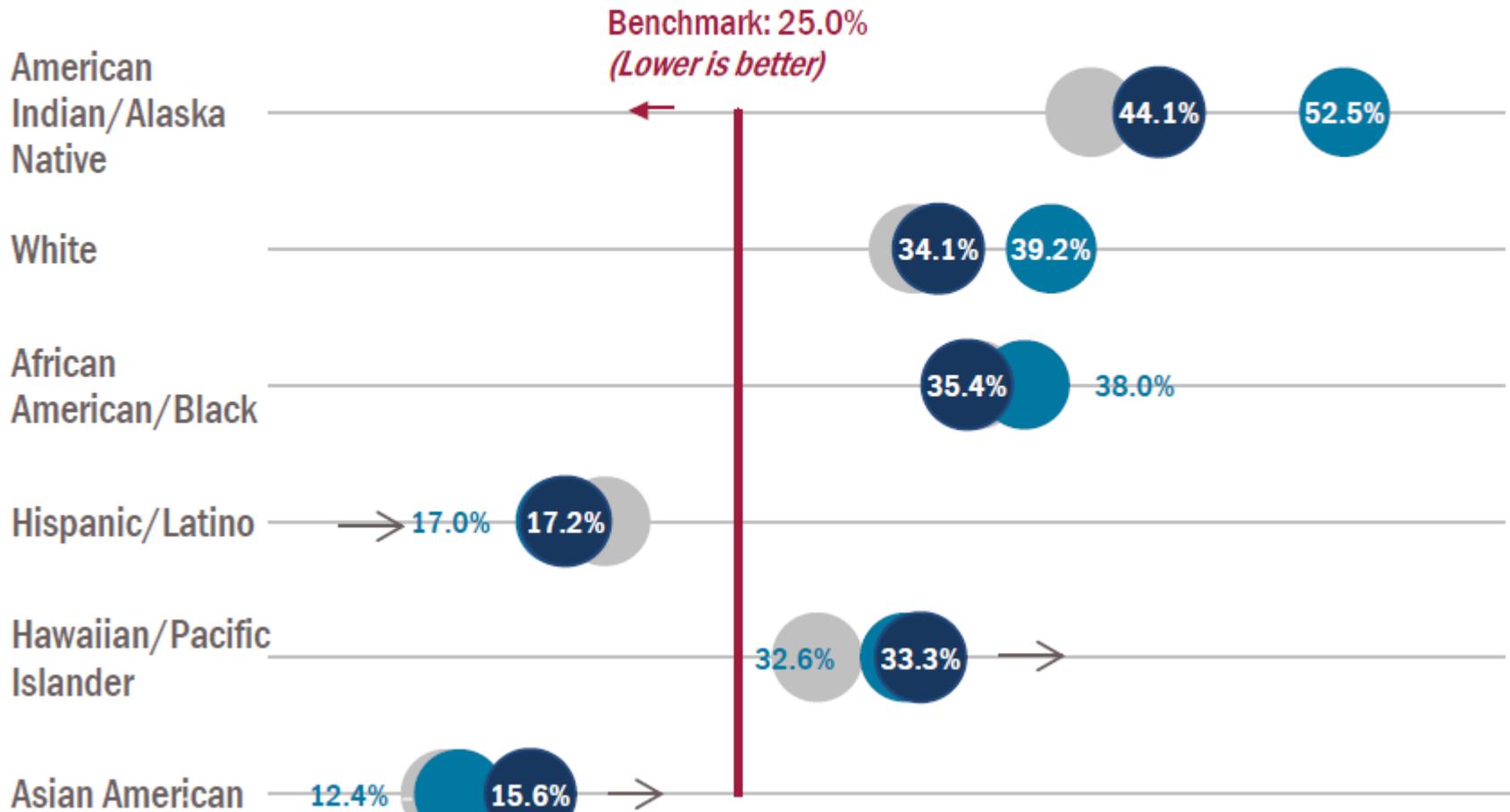
Statewide, tobacco use prevalence decreased slightly between 2013 and 2014.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark source: Oregon's 1115 demonstration waiver goals



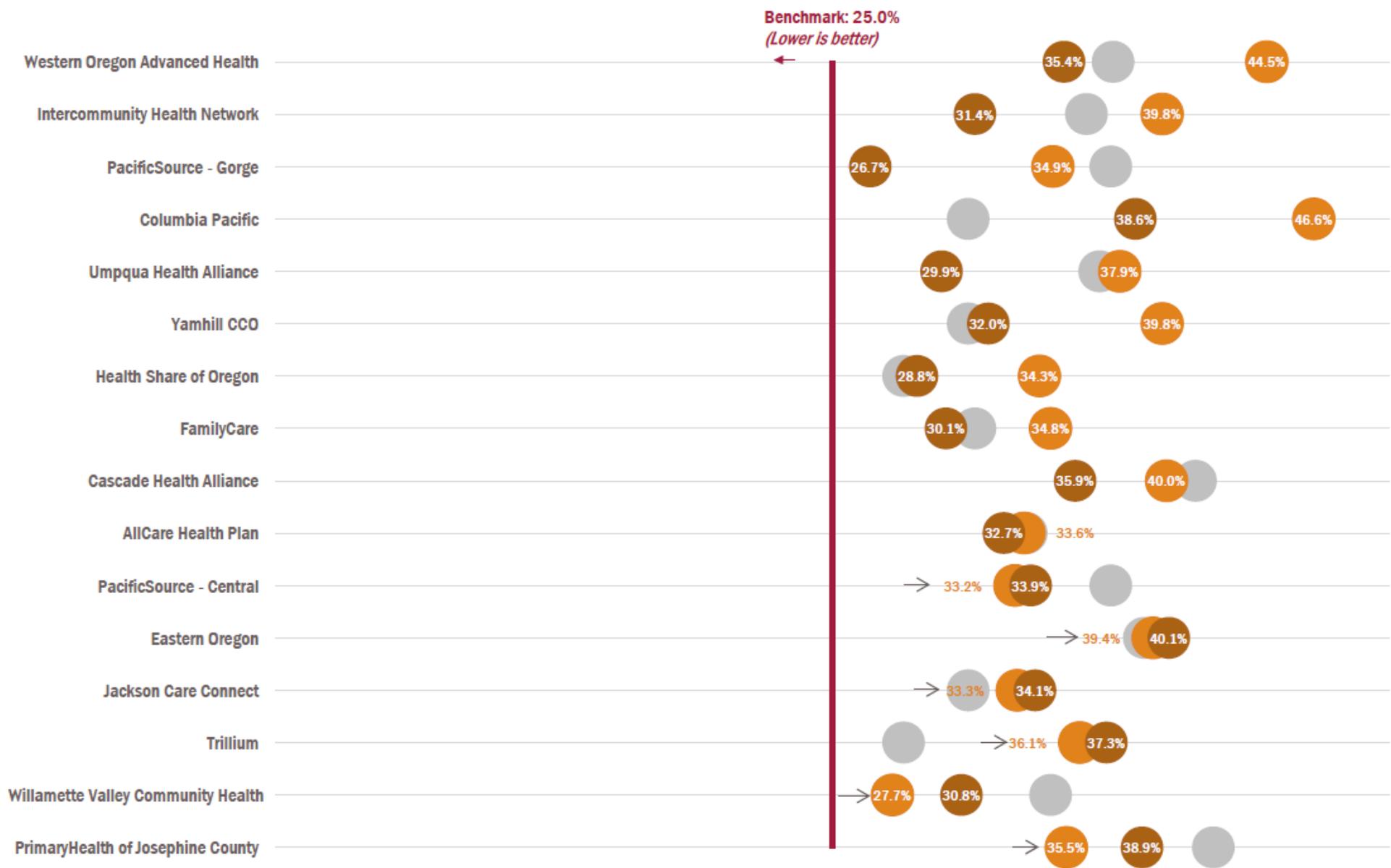
Tobacco use prevalence improved most for American Indian/Alaska Native members between 2013 and 2014.

Gray dots represent 2011. Data missing for 9.2% of respondents. Each race category excludes Hispanic/Latino.



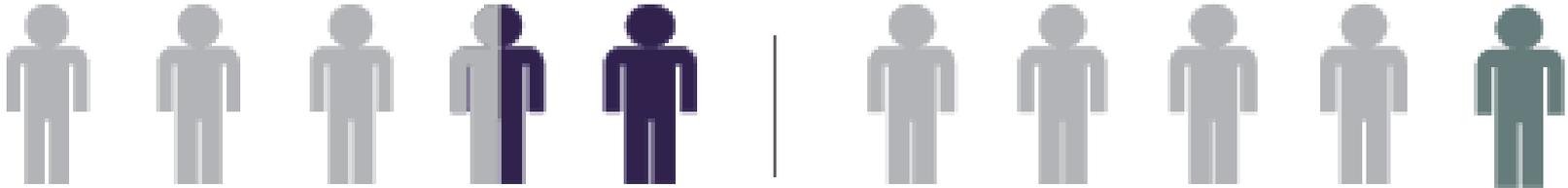
Tobacco use prevalence improved in 10 of 16 CCOs between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



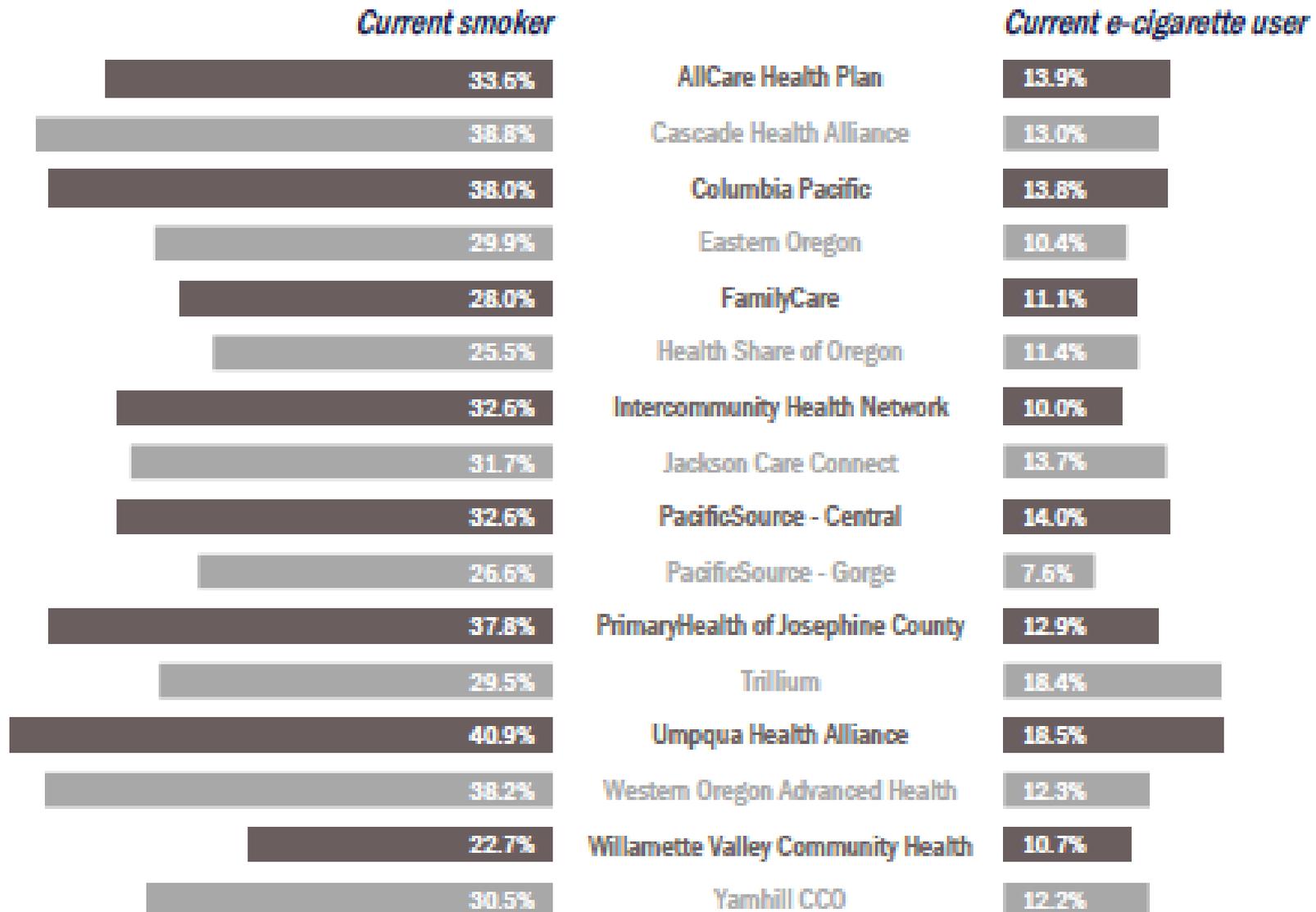
Tobacco Prevalence Data (MBRFSS)

Statewide in 2014, a greater proportion of adult **Medicaid members** used tobacco products than the general population.



1.5 in 5 Medicaid members used tobacco products | compared with 1 in 5 people in the general population.

Cigarette smoking and e-cigarette use by CCO in 2014:



Tobacco Prevalence Benchmark

2016 Benchmark & Target Option(s)

25%	Goal established in 1115 demonstration waiver for Medicaid adult tobacco prevalence.
15%	Goal established in Oregon's State Health Improvement Plan (general population)
Other %	TBD by Committee

Staff recommendation

Benchmark: 25%

No improvement target for 2016 (due to lack of EHR-based 2015 data)

Finalize 2016 Benchmarks

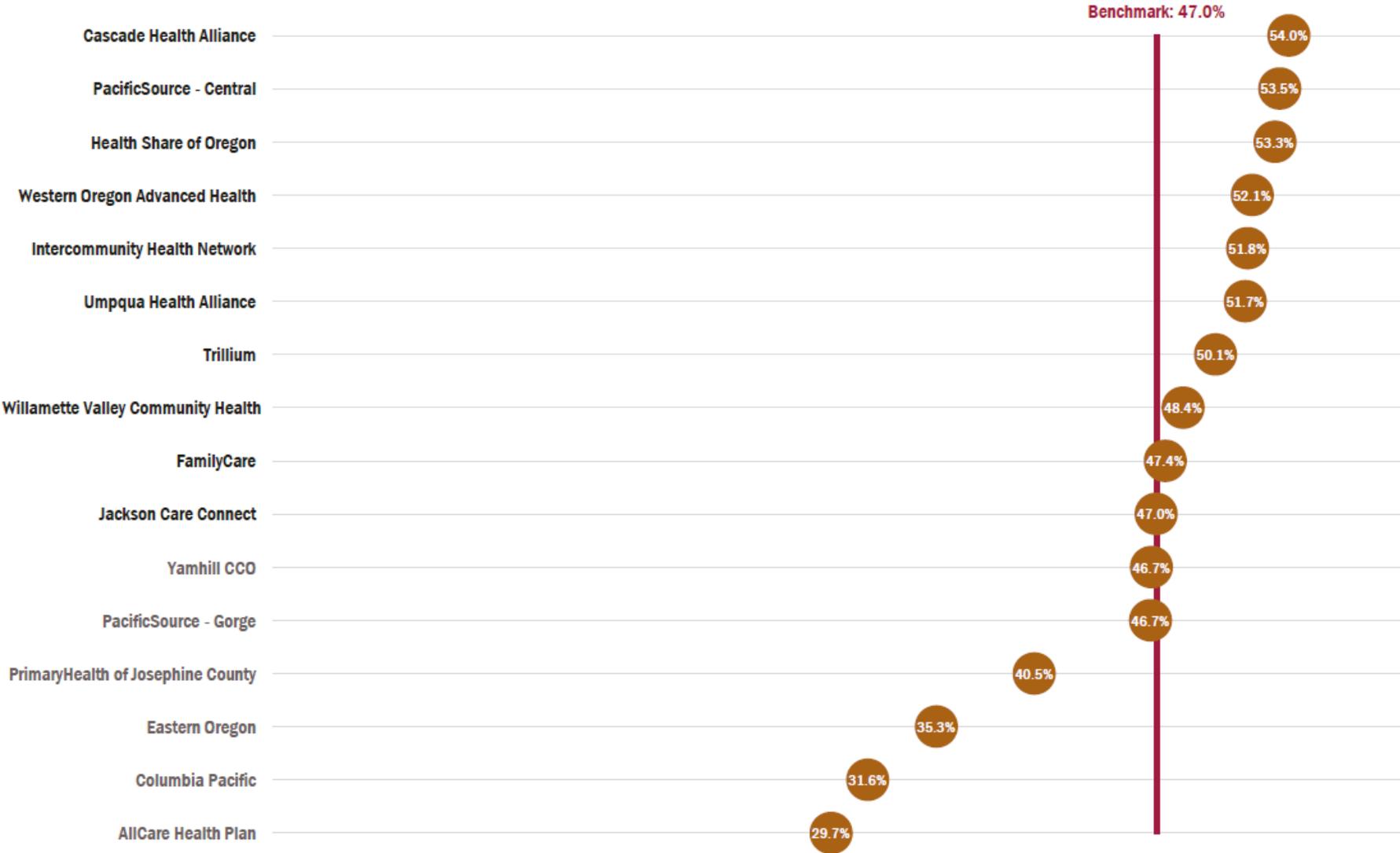
Colorectal Cancer Screening

Committee initially selected benchmark at September meeting (47%) but after hearing concerns about increased CCO denominators due to Expansion population, agreed to revisit at future meeting.

Ten of 16 CCOs met the benchmark for colorectal cancer screening in 2014.

Bolded names met benchmark. This measure does not have an improvement target for 2014.

2014 data are not comparable to earlier years due to changed methodology.

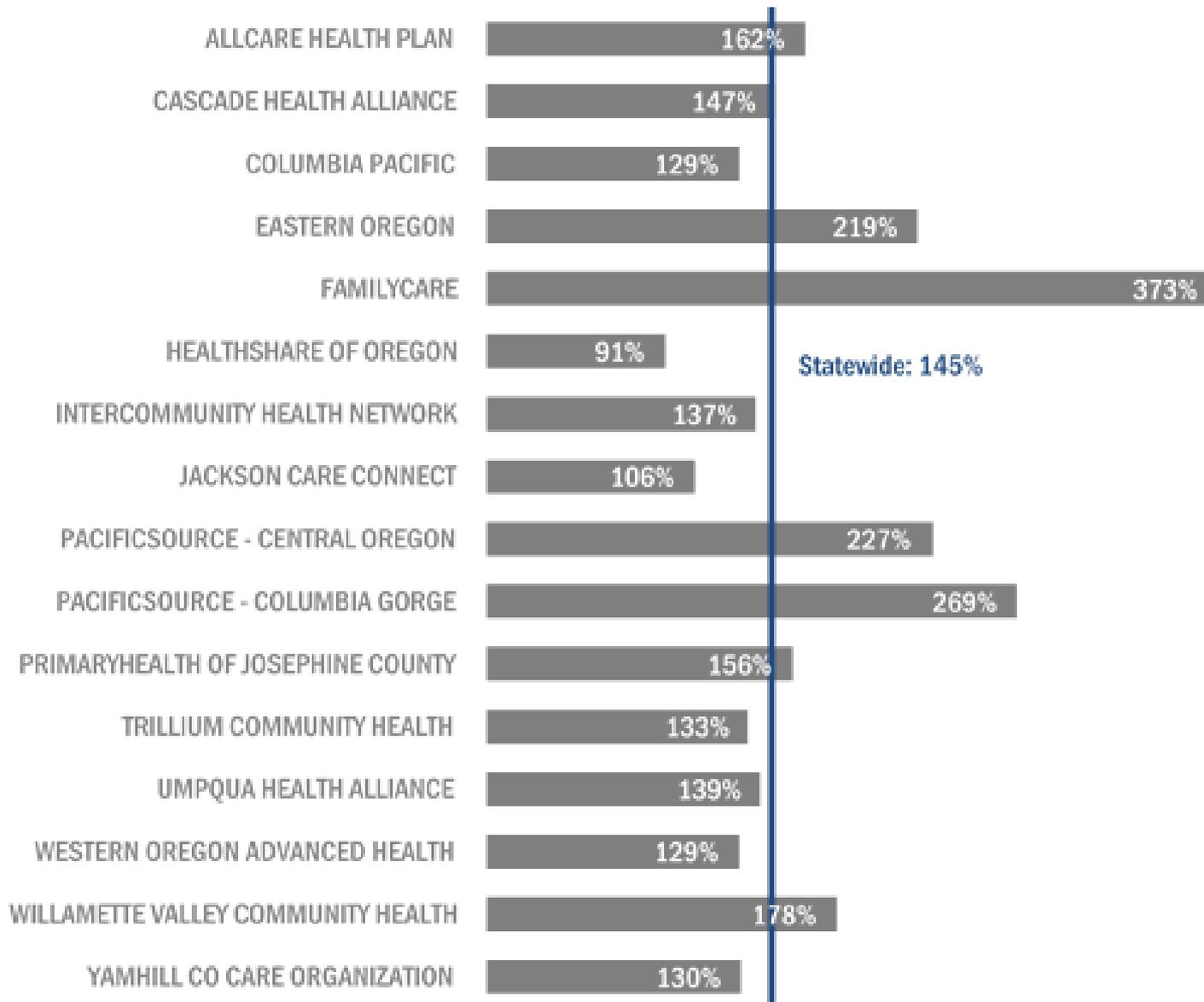


CCO enrollment ages 50-75

CCO	December 2013	August 2015
ALLCARE HEALTH PLAN	3,817	10,005
CASCADE HEALTH ALLIANCE	1,350	3,328
COLUMBIA PACIFIC	2,410	5,508
EASTERN OREGON	2,221	7,084
FAMILYCARE	3,890	18,393
HEALTHSHARE OF OREGON	22,389	42,734
INTERCOMMUNITY HEALTH NETWORK	4,530	10,721
JACKSON CARE CONNECT	2,788	5,745
PACIFICSOURCE - CENTRAL OREGON	2,626	8,586
PACIFICSOURCE - GORGE	531	1,962
PRIMARYHEALTH OF JOSEPHINE COUNTY	1,075	2,750
TRILLIUM COMMUNITY HEALTH	7,871	18,317
UMPQUA HEALTH ALLIANCE	2,100	5,020
WESTERN OREGON ADVANCED HEALTH	2,189	5,003
WILLAMETTE VALLEY COMMUNITY HEALTH	5,329	14,833
YAMHILL CO CARE ORGANIZATION	1,687	3,873
Statewide	66,803	163,862

Percent increase in enrollment ages 50-75 between December 2013 and August 2015.

Compared with overall statewide.



Colorectal Cancer Screening

Current (2014) Performance	2014 Benchmark & Target	2015 Benchmark & Target
State: 46.2%	47.0% <i>Committee consensus</i>	47.0% <i>Committee consensus</i>
High CCO: 54.0%	N/A	MN method with 3 percentage point floor
Low CCO: 29.7%		

Colorectal Cancer Screening (2)

2016 Benchmark & Target Option(s) – previously presented

47.0%	Committee consensus, consistency with previous years.
54.0%	Highest performing CCO in 2014.
52% and 58%	Results for two Medicaid ACOs, 2014
58% or 66%	2015 national Commercial 50 th or 75 th percentile.



2016 WORK PLAN & MEETING SCHEDULE

Month	Meeting Topics
Jan - Feb	<p data-bbox="411 154 1302 201">At least one meeting. Agenda items include:</p> <ul data-bbox="411 277 1827 1296" style="list-style-type: none"><li data-bbox="411 277 1827 439">● Develop framework and mechanics for incentive program under the new waiver (2018 – 22), including core / menu set measures and criteria for menu selection. <li data-bbox="411 519 1827 1176">● Presentations on additional measurement work (e.g., home visiting measures) and priority areas identified at the retreat:<ul data-bbox="510 705 1547 1176" style="list-style-type: none"><li data-bbox="510 705 884 743">○ Behavioral health<li data-bbox="510 758 890 796">○ Care coordination<li data-bbox="510 811 1547 849">○ Demographics of Medicaid population post-Expansion<li data-bbox="510 863 683 902">○ Equity<li data-bbox="510 916 1354 955">○ Maternal & Child Health Title V priority areas<li data-bbox="510 969 1190 1008">○ Obstacles to health for Oregonians<li data-bbox="510 1022 1547 1061">○ Opioid performance improvement projects / measures<li data-bbox="510 1075 1321 1113">○ Public Health Modernization priority areas<li data-bbox="510 1128 1045 1166">○ Workforce / quadruple aim <li data-bbox="411 1253 1315 1296">● Presentation on CY 2015 mid-year report.

Month	Meeting Topics
March – April	<p data-bbox="421 215 1309 265">At least one meeting. Agenda items include:</p> <ul data-bbox="421 337 1798 568" style="list-style-type: none"> <li data-bbox="421 337 1798 444">• Reviewing draft measurement strategy language and framework for incentive program for new waiver. <li data-bbox="421 522 1340 568">• Additional presentations on priority areas.
May – June	<p data-bbox="469 636 1083 686">Begin 2017 measure selection:</p> <ul data-bbox="421 758 1846 1203" style="list-style-type: none"> <li data-bbox="421 758 1846 918">• Presentations previously requested on alternate access and patient experience measures, development of the food insecurity screening measure, and the health equity index (“meta-measure”). <li data-bbox="421 986 1705 1089">• Results from stakeholder survey or other public input vehicle (suggested measures in priority areas) <li data-bbox="421 1158 1329 1203">• Additional presentations on priority areas.

Month	Meeting Topics
July – Sept	<p>At least two meetings needed. Agenda items include:</p> <ul style="list-style-type: none"> • Presentation on CY 2015 / quality pool distribution. • Continue selection of 2017 measures. • Benchmark setting for 2017 • Finalize 2017 measure and benchmark selection: <u>must be complete by Sept 30.</u> • Begin work on recommendation for new Health Plan Quality Metrics Committee
Oct – Dec	<p>At least one meeting. Potential agenda items include:</p> <ul style="list-style-type: none"> • “Annual” Committee retreat? • Continued work on recommendation for the new Health Plan Quality Metrics Committee? • Additional presentations on priority areas / status updates on other measurement work.

Meeting Date / Time / Location

Committee meetings were originally scheduled on the third Friday of the month, to follow the CCO CEO meetings that are held the third Thursday. Given changes in Committee membership:

- Are third Fridays still the most convenient time?

Committee meetings were originally scheduled in Wilsonville to make it easier for members to attend without dealing with Portland traffic and parking limitations.

- Is Wilsonville still the preferred location?

CHILD & FAMILY WELLBEING WORKGROUP PRESENTATION



Public Testimony



**DEBRIEF FROM OCTOBER
RETREAT & JOINT
BEHAVIORAL HEALTH
LEARNING SESSION**

Committee Vision:

Continue to lead on and expand influence of incentive measures to improve the health of Oregonians, through HST and cross-system collaboration

Are you satisfied with the Committee's vision?

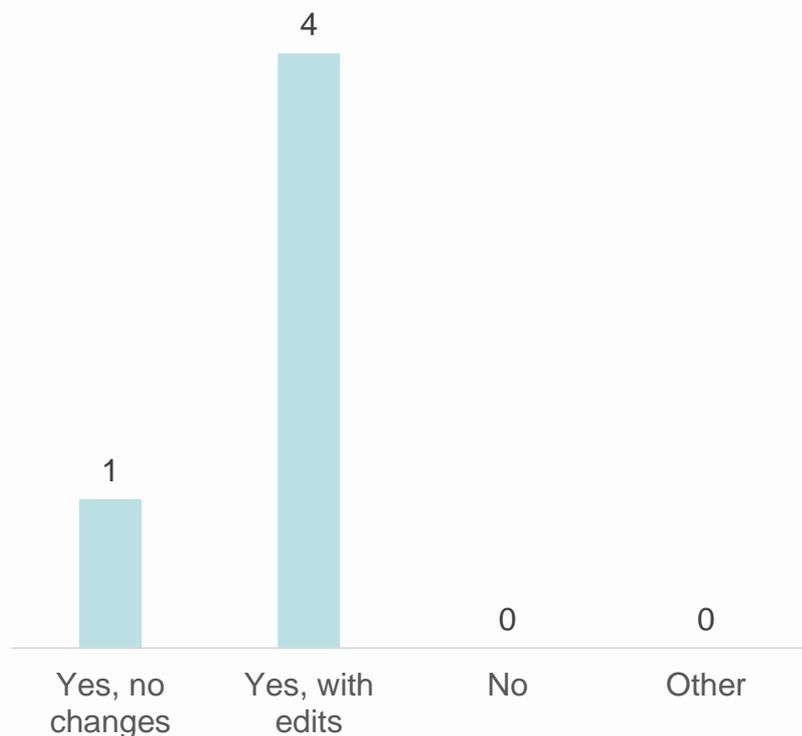


N=5

Potential areas of focus for future measurement

- Behavioral health
- Care coordination
- Collaboration outside the health system (e.g., shared accountability, cross-systems)
- Equity
- Health care workforce (“quadruple aim”)
- Integration within the health system (e.g., physical, behavioral, and oral health)
- Measures that support simplification, not complexity
- Population health / community health
- Vulnerable populations

Do you agree with the areas of focus for metrics as identified at the retreat?



- There are qualitative differences between the topics; might be valuable to group or prioritize them.
- Recommend prioritizing the list:
 - Vulnerable populations and equity should be at the top to provide overarching guidance to the rest of the work.
- Concern with getting into workforce metrics – important, but messy and complicated to measure. May be a distraction from patient-centered work.
- Add “moving upstream / prevention”

List of potential new / revised measure selection criteria as identified at the retreat

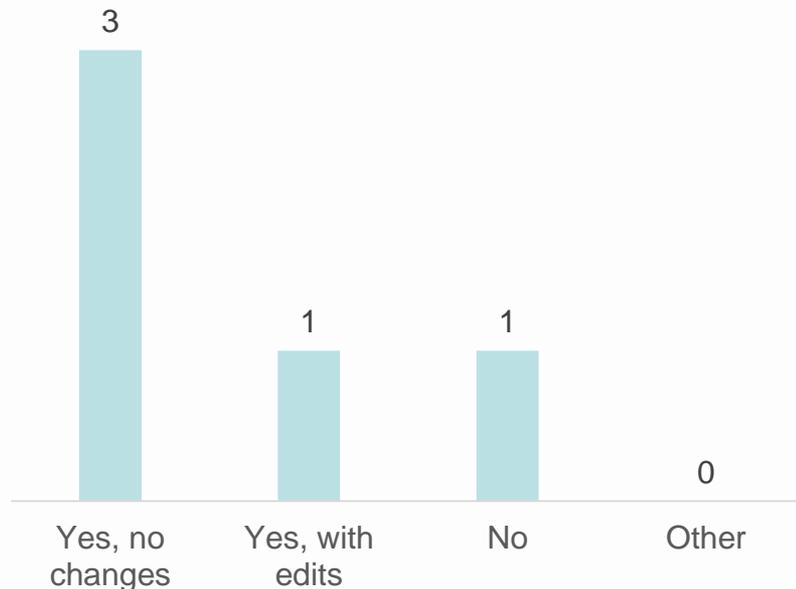
Where possible, the Committee should consider measures that are:

- Age-agnostic, or applicable to everyone
- Multi-generational, or two-household
- Bundled (i.e., multiple concerns / services in single measure)
- Collaborative across multiple systems (i.e., outside the health care system, “synergistic”)
- Aligned with public health modernization and state health improvement plan priorities
- High impact, or have broad opportunity to improve health

The Committee should consider:

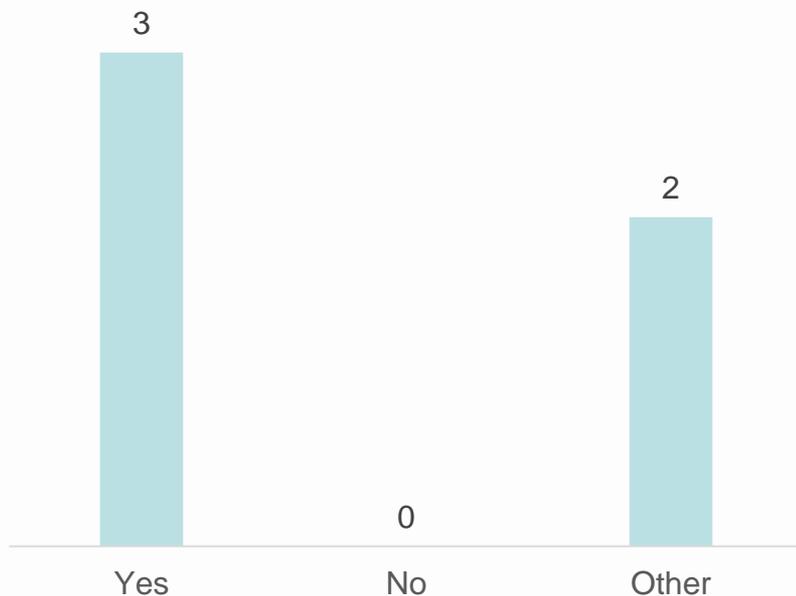
- Readiness of the system to adopt or improve on a measure
- Sustainability (i.e., not retiring a measure too soon if that puts progress at risk)
- Balancing the measure set between process and outcome measures
- Balancing the measure set between upstream and downstream measures.

Do you agree with the list of potential new / revised measure selection criteria?



- Concerns with “readiness of the system” as concept – organizations do not like change. Don’t let this criteria delay implementation of measures that would benefit all Oregonian’s health.
- Ok with readiness = “can this actually be measured”, but not with readiness = “health plans / providers tell us they are ready”. Don’t stand in the way of true innovation.
- Need more information on age-agnostic / applicable to everyone criteria to understand the intent.

Do you think you will be changing your approach to the tasks of the Committee as a result of the discussion at the retreat?

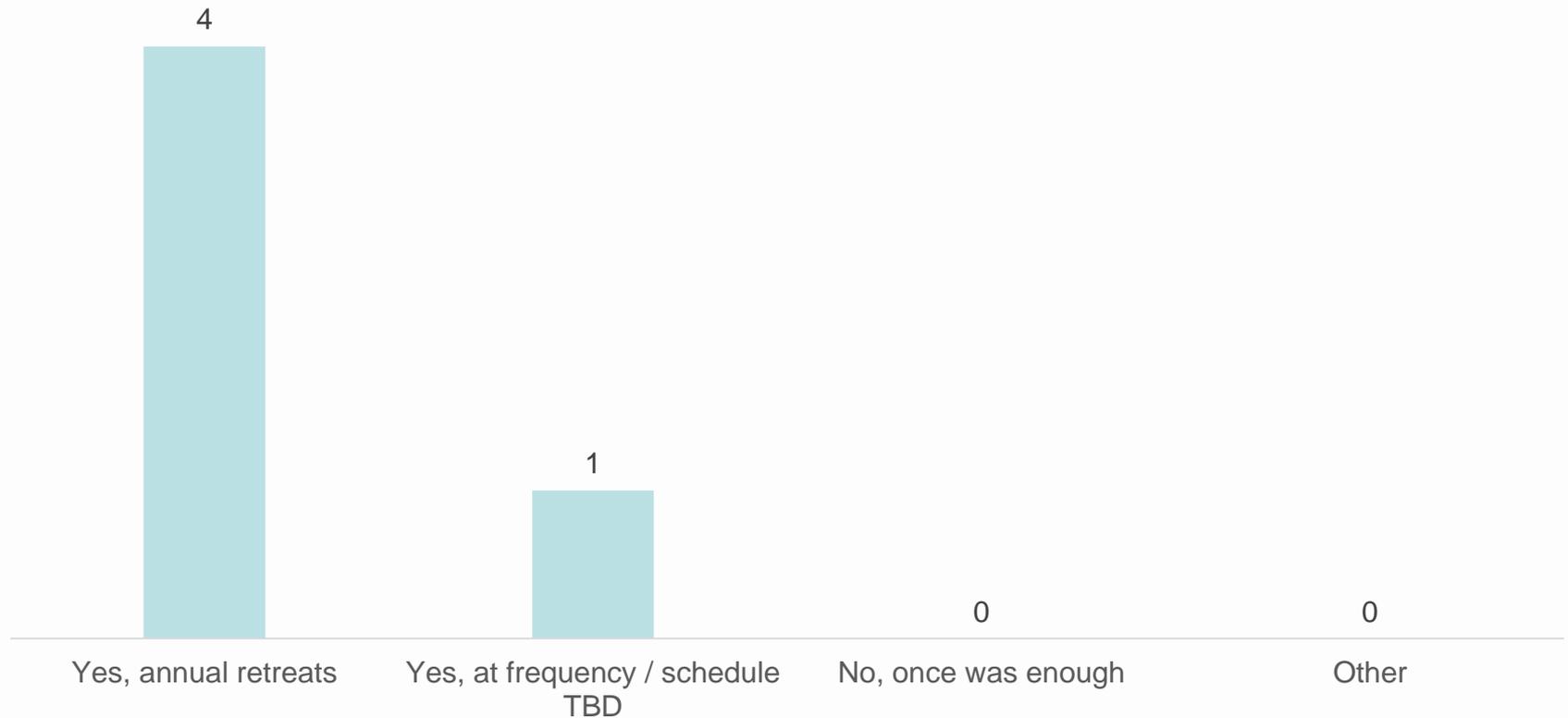


- Now have more defined and clear understanding of the group’s thinking and direction.
- Not a changed approach, but more confident in knowing there is clear agreement about where we want to go.
- Approach doesn’t change, but nice to have focus and signposts to guide work.
- Would like us to be more strategic rather than reactive to pressure from interest groups who want specific (single condition) metrics.
- Take more “core ideas” approach rather than individual topics that come up. Be more aware of guiding principles. Be bold about measures.

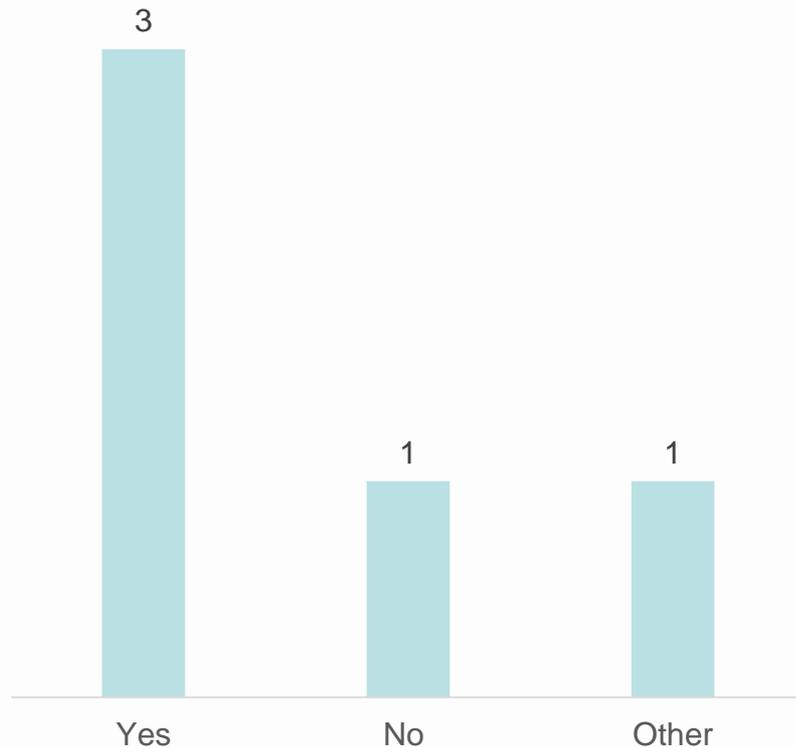
Was there anything not discussed at the retreat that you wished had been?

- How to strategically partner with hospital metrics.
- What are transformative metrics?
 - Do they exist / how are they defined?
 - How do we develop an idea into a metric?

Should the Committee hold additional retreats?

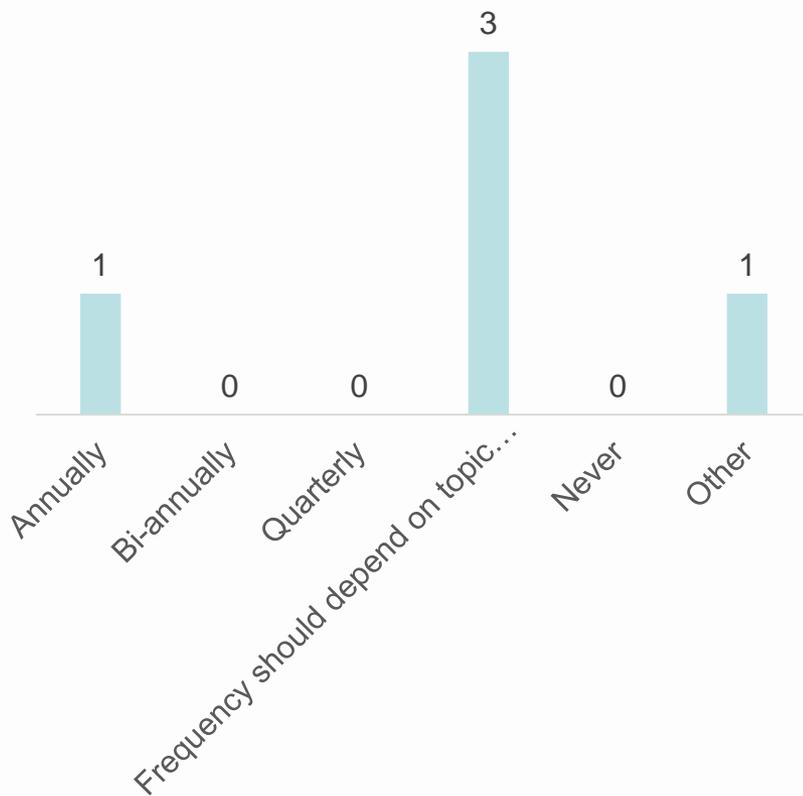


Was the shared learning session with the Hospital Performance Metrics Advisory Committee useful?



- Not a good use of time to sit through presentations / information that could be have distributed in advance.
- Exciting to learn about all the creative work; Perhaps can motivate the group to be less tentative in approach to new measures.
- Good to introduce the committees to each other and think about opportunities to align around a common goal.
- Information was good, but primarily geared for M&S, not hospital committee. No obvious ways to connect over the info.
- Useful, but not much synthesis. More discussion would have been better.

How often should a joint meeting or shared learning session with the Hospital Committee be attempted?



- Maybe discussion instead of learning session? Crosswalk our metrics? Think about metrics for system of care?
- Committees should be merged and funds pooled – stop reflecting historical silos in industry.

Suggestions for improving future learning sessions

- For shared learning session to be valuable, each group needs to have a minimum level of understanding of what the other group is doing, and where they fit into the system.
- Have time after each presentation for questions.
- Presentations from other states that have examples of successful collaboration among hospitals and other sectors around population health.
- Presentations around models for effecting large social change such as collective impact.

Additional discussion



Incentive Measure Crosswalk

Wrap Up!