Oregon Metrics and Scoring Committee

AGENDA

September 25, 2012
8:30 a.m. to 11:30 a.m.

Wilsonville Training Center
29353 SW Town Center Loop E.
Room 211
Wilsonville, Oregon 97070

Public call-in number (listen only line): Dial: 1-877-455-8688; participant code: 915042

#	Time	Item	Presenter	Action Item
1	8:30	Welcome and agenda review	Bob Dannenhoffer	
2	8:35	Consent agenda: September minutes	Bob Dannenhoffer	X
3	8:45	Review of measures selected during meeting #2: • Follow-up information • Additional proposed measures • Staff recommendations	Michael Bailit	
4	10:00	Review of incentive program framework	Tina Edlund	
5	10:15	Discuss options for year 1 incentive pool	Michael Bailit	
6	10:45	EHR, Meaningful Use, and oral health measures	Michael Bailit	
7	11:00	Next steps and wrap up	Bob Dannenhoffer	
8	11:15	Public testimony	Bob Dannenhoffer	

Next Meeting:

October 10th
8:30 to 11:30 a.m.

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Oregon Metrics and Scoring Committee
Minutes
September 11, 2012
Sheraton Airport Hotel
Cascade Rooms A & B
Portland, OR 97220
8:30 – 11:30 a.m.

Item
Welcome and Agenda Review Committee members present: Robert Gillespie, Maggie Bennington-Davis, Bob Joondeph, David Labby, Robert Dannenhoffer, Jeff Luck, Gloria Coronado, Phil Greenhill, Jeanine Rodriguez (by phone). Consultants present: Michael Bailit (Bailit Health Purchasing). Consultants present (by phone): Kate Bazinsky (Bailit Health Purchasing); Wendy Hill-Petras (Centers for Medicare and Medicaid Services - CMS). OHA Staff: Tina Edlund, Chief of Policy; Carole Romm, Accountability and Quality; Sarah Bartelmann, Project Manager;
Consent Agenda The Committee approved the August 22nd minutes.
Review of CMS requirements for incentive measures Michael Bailit provided an overview of the CMS requirements for incentive measures, the Metrics & Scoring Committee's charge, and the parameters and methodology for incentive measures. Michael's presentation is available in the meeting materials online at: http://cms.oregon.gov/oha/Documents/MetricsScoringCommitteeMaterials120911.pdf
Potential metric domains Michael Bailit presented an incentive measures domain framework, listing domains, categories and populations, as required in statute and in the waiver. Domains not currently included in the framework are health disparities, efficiency, and administrative services. David Labby recommended the new Institute of Medicine (IOM) report *Best Care at Lower Cost: The Path to Continuously Learning Healthcare in America* and encouraged the Committee to focus on cost reduction strategies beyond administrative domains. The IOM report is available online at: http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx Michael reviewed the criteria for selecting incentive measures developed by the Transitional Metrics and Scoring Committee and proposed six criteria for the Committee: 1. Representative of the array of services provided and beneficiaries served by the CCOs 2. Use valid and reliable performance measures 3. Rely on measures from national measure sets whenever possible

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4. Focus on outcomes to the extent possible
5. Exclude measures that would be expected to be heavily influenced by patient case mix
6. Control for the effects of random variation.

The Committee proposed adding transformative potential and measures to address overutilization to the list.

The Committee discussed how many measures should be included in the incentive measures set. Michael recommended a set of 15-20 measures that would be aligned with the reporting requirements and consistent across all CCOs (i.e., plans cannot select their own measures from a list).

Potential metrics for selected incentive metric domains

Michael Bailit introduced a grid of 53 potential measure, organized by domain and category, for the Committee to review as candidates for incentives. The library of potential measures is included in the meeting materials available online at: http://cms.oregon.gov/oha/Documents/MetricsScoringCommitteeMaterials120911.pdf.

Measures marked selected and those designated as potential pending more information will be reviewed on September 25th. Committee members also nominated additional measures for consideration.

Next steps and wrap up

Committee members will review the IOM report and determine if any measures need to be added to the list; they will also submit additional measures for consideration before the next meeting.

Oregon Health Authority staff and Bailit Health Purchasing will pull together baseline data for measures that will be discussed on September 25th and will also prepare additional information on certain measures, as requested.

Public Testimony

No public testimony was provided.

Adjourn

Next Meeting:

September 25th
8:30 – 11:30 a.m.
Clackamas Community College
29353 SW Town Center Loop E
Wilsonville, OR 97070

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Library #	Domain	Category	Measure and Description	Population	Measure Specifications	Recommended/Used By:	Baseline Data	Specifications for Baseline Data
93	Access	Chronic Illness	**% of adults with a chronic disease w/any outpatient visit in past year** (specific chronic diseases could include diabetes, COPD/asthma, coronary artery disease, HTN, schizophrenia)	Adult	n/a	Core Measure: No CMS Suggested Access Measure: Yes NQF Measure: No Exchange Measure: No	No baseline available	n/a
103	Cost	Efficiency	**Potentially avoidable ED visits**	All	TBD - NYU algorithm or MediCal/Washington State/Q-Corp methodology applied to ED visits	Core Measure: Yes CMS Suggested Access Measure: No NQF Measure: No Exchange Measure: No	Age 1-17 19.4% 18+ 12.7%	Measurement year 2010 through 2011 and utilizes the cal-med approach
72	Quality	Behavioral Health Integration	**Screening for Clinical Depression and Follow-up Plan** (% of members patients aged 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented)	Adult	NUMERATOR: Patients whose screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented. DENOMINATOR: All patients 18 years and older.	Core Measure: Yes CMS Suggested Access Measure: No NQF Measure: 0418 Exchange Measure: Medication Management for depression	No baseline available	n/a
43	Quality	Care Coordination	**Medication reconcilliation post-discharge** (% patients 65+ discharged from acute or non-acute inpatient facility who had discharge meds reonciled with current med list in the medical record within 30 days)	Adult	NUMERATOR: Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse, as documented through administrative or medical record review on or within 30 days of discharge. DENOMINATOR: All discharges from an in-patient setting for health plan members who are 66 years and older as of December 31 of the measurement year.	Core Measure: Yes CMS Suggested Access Measure: No NQF Measure: 0554 Exchange Measure: No	No baseline available	n/a
28	Quality	Chemical Dependency	**Alcohol misuse - screening, brief intervention, referral for treatment (SBIRT)** (% of members 18+ with routine visit in the measurement year screened for alcohol misuse, and referred as necessary).	Adult	TBD	Core Measure: Yes CMS Suggested Access Measure: No NQF Measure: No Exchange Measure: No	For the one-year period April 1, 2011 to March 31, 2012 there were 15 paid SBIRT claims.	Number of paid claims for CPT codes H0050 and H0049 (SAMHSA and CMS recommended method)
69	Quality	Chemical Dependency	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment** (% of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: (a) Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the...	All	NUMERATOR: (a) Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis; (b) Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). DENOMINATOR: Patients age 13 years and older with a medical and chemical dependency benefit who were diagnosed with a new episode of alcohol and drug dependency during the intake period of January 1-November 15 of the measurement year.	Core Measure: Yes CMS Suggested Access Measure: No NQF Measure: 0004 Exchange Measure: Yes	Baseline data pending	HEDIS
261	Quality	Chronic Illness: Diabetes	**Optimal Diabetes Use (D5)** (You achieve the D5 when you meet all five goals: 1. your blood pressure is less than 140/90 mmHG. 2. your bad cholesterol, LDL, is less than 100 mg/dl. 3. Your blood sugar, A1c, is less than 8%. 4. You are tobacco-free. 5. You take an aspirin as appropriate).	Adult	NUMERATOR: Patients ages 18 to 75 with diabetes who meet all of the following targets from the most recent visit during the measurement year: A1c < 8.0, LDL < 100, Blood Pressure < 140/90, Tobacco non-user and Daily aspirin for patients with diagnosis of ischemic vascular disease use unless contraindicated. DENOMINATOR: Patients ages 18 to 75 with diabetes who have at least 2 visits for this diagnosis in the last 2 years (established patient) with at least 1 visit in the last 12 months.	Core Measure: No CMS Suggested Access Measure: No NQF Measure: 0729 Exchange Measure: D4 - eye exam, blood sugar screening, cholesterol screening, and kidney disease screening	No baseline available	n/a

Library #	Domain	Category	Measure and Description	Population	Measure Specifications	Recommended/Used By:	Baseline Data	Specifications for Baseline Data
55	Quality	Chronic Illness: Hypertension	**Controlling High BP** (% of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.)	Adult	NUMERATOR: The number of patients in the denominator whose most recent, representative BP is adequately controlled (both systolic and diastolic must be <140/90 mmHG) during the measurement year. DENOMINATOR: Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.	Core Measure: No CMS Suggested Access Measure: No NQF Measure: 0018 Exchange Measure: No	No baseline available	n/a
265	Quality	End of Life	**Advance Care Plan** (% of patients aged 65 years and older who have an advance care plan or surrogate decision maker)	Adult	NUMERATOR: Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. DENOMINATOR: All patients aged 65 years and older.	Core Measure: Yes CMS Suggested Access Measure: No NQF Measure: 0326 Exchange Measure: No	No baseline available	n/a
127	Quality	Maternal Health	**Elective Delivery Before 39 Weeks** (this measure assesses patients with elective vaginal deliveries or elective cesarean sections at >=37 and <39 weeks of gestation completed.	Adult	NUMERATOR: Patients with elective deliveries with ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for one or more of the following: Medical induction of labor, Cesarean section while not in Active Labor or experiencing Spontaneous Rupture of Membranes. DENOMINATOR: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	Core Measure: No CMS Suggested Access Measure: No NQF Measure: 0469 Exchange Measure: No	Baseline data pending	
42	Quality	Mental Health	**Follow-up After Hospitalization for Mental Illness** (% of members with follow-up visit within 7 days after hospitalization for mental illness).	Adult	NUMERATOR: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. DENOMINATOR: Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members.	Core Measure: Yes CMS Suggested Access Measure: No NQF Measure: 0576 Exchange Measure: No	52% Children's mental health (from CARTS) = 39%	
250a	Quality	Maternal Health	**Prenatal Care** (% of deliveries that received a prenatal care visit as a member of the health plan in the first trimester or within 6 weeks of enrollment in the health plan).	Adult	NUMERATOR: Deliveries of live births for which women receive the following facets of prenatal and postpartum care: Rate 1: Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. Rate 2: Had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. DENOMINATOR: Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year	Core Measure: No CMS Suggested Access Measure: No NQF Measure: 1517 Exchange Measure: Yes	30.5% (2010)	NUMERATOR: Deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. DENOMINATOR: All live birth deliveries from members of the organization, who meet the continuous enrollment criteria.
71	Quality	Mental Health	**Mental Health Assessment for Children in DHS Custody** (% children who receive a mental health assessment within 30 days of DHS custody)	Pediatric		Core Measure: Yes CMS Suggested Access Measure: No NQF Measure: No Exchange Measure: No	58% (Approximately 8,500 children are in DHS Foster Care as of 9-17-12 - 2.3% of the pediatric population)	

Library #	Domain	Category	Measure and Description	Population	Measure Specifications	Recommended/Used By:	Baseline Data	Specifications for Baseline Data
76	Quality	Preventive Care: Screening	Developmental screening by 36 months	Pediatric	NUMERATOR: Children who were screened for risk of developmental, behavioral and social delays using a standardized tool. National recommendations call for children to be screened at the 9, 18, and 24- OR 30-month well visits to ensure periodic screening over the first three years. The measure is based on three, age-specific indicators: Children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 12 months of age, by 24 months of age, and by 36 months of age. DENOMINATOR: Members who turn 12, 24, or 36 months of age between January 1 of the measurement year and December 31 of the measurement year.	Core Measure: Yes CMS Suggested Access Measure: No NQF Measure: 1448 Exchange Measure: No	14.6%	
278	Quality	Preventive Care: Screening	Colorectal cancer screening	Adult	NUMERATOR: One or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the four criteria below: fecal occult blood test (FOBT) during the measurement year, flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year, double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year, Colonoscopy during the measurement year or the nine years prior to the measurement year. DENOMINATOR: Patients 51–75 years of age as of December 31 of the measurement year.	Core Measure: No CMS Suggested Access Measure: No NQF Measure: 0033 Exchange Measure: No	30.5% (2010 HEDIS)	NUMERATOR: Fecal Occult Blood Test during measurement year and/or Flexible Sigmoidoscopy during the measurement year or the four years prior to the measurement year and/or Colonoscopy during the measurement year or the nine years prior to the measurement year. DENOMINATOR: Patients 50-75 during the measurement year (excluding dual eligibles).
277	Quality	Preventive Care: Well Visits	Adolescent well-care visits	Pediatric	DENOMINATOR: Members 12-21 years of age continuously enrolled in a specific helath plan, fee for service (FFS), or primary care mangement (PCM) for the measurement year with up to one 45 day gap in enrollment allowed. NUMERATOR: received at least one comprehensive well-care visit during the measurement year.	Core Measure: No CMS Suggested Access Measure: No NQF Measure: No Exchange Measure: No	26.3% (2010 HEDIS Trend Report)	
135	Quality	Preventive: Resource Distribution	Ratio of primary care spending to speciality & hospital spending over time.	All			No baseline available.	
	Satisfaction	Administrative Service	Composite measure that relies on CAHPS data that includes: #178, #177, and how well your doctor listens to you OR align with measure exchange is using.	Adult			Baseline data pending	
			% of patients assigned to a tier 1 or better patient centered primary care home with 30 days of plan enrollment	All			Baseline data pending	
			Measure of follow up primary care or specialty visits after hospitalization within a specified time of discharge (7 days)?					

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Requested Background Information on Selected Measures
Metrics & Scoring Committee Meeting #3

1) The Committee requested that we identify additional measures for health disparities and efficiency:

The Office of Equity and Inclusion Report "State of Equity" provides baseline data for the Oregon Health Plan population, broken out by race and ethnicity on three measures:

- Utilization rate of preventive services for children birth through 10 years old covered by the Oregon Health Plan per person year;
- Rate of ambulatory care sensitive condition hospitalizations of Oregon Health Plan clients per 100,000 person years;
- Utilization rate of preventive services for youth and adults 11 years old and older covered by the Oregon Health Plan per person year. http://www.oregon.gov/oha/oei/soe/docs/state-of-equity-report.pdf

2) The Committee expressed interest in including a measure to incentivize development and use of patient centered primary care homes. The Committee considered the following measure: "the percentage of patients assigned to a tier one PCMH within 30 days of enrollment in the plan." This is not a national measure so we identified other existing measures for patient-centered primary care homes:

Patient Centered Medical Home Performance Metrics for Employers, 2011 has recommended the following measures to assess the adoption and utilization of patient centered medical homes. http://www.pcpcc.net/files/metrics_guide_2011.pdf

- Rate of PCPCH adoption: number of enrollees enrolled in PCPCH / total # eligible.
- Rate of PCPCH utilization: # of visits to PCPCH / total # PCPCH enrollees.

3) The Committee requested that we identify additional measures on overuse or over-utilization:

NQF endorsed measures that address overuse or inappropriate use of care (see excel document for more details):

- Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
- Appropriate treatment for children with upper respiratory infection (URI)
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Cardiac stress imaging not meeting appropriate use criteria: Testing in asymptomatic, low risk patients
- Cardiac stress imaging not meeting appropriate use criteria: Routine testing after percutaneous coronary intervention (PCI)

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- Cardiac stress imaging not meeting appropriate use criteria: Preoperative evaluation in low risk surgery patients
- Emergency Department Use without Hospitalization (during home health stays)
- LBP: Appropriate Imaging for Acute Back Pain
- LBP: Repeat Imaging Studies
- LBP: Surgical Timing
- LBP: Appropriate Use of Epidural Steroid Injections
- Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
- Thorax CT: Use of Contrast Material

4) Measure #72: Identify existing evidence-base for depression screening and follow-up planning:

- The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to ensure accurate diagnosis, effective treatment, and follow-up. Grade: B (2009)
- The USPTF recommends against routinely screening adults for depression when staff-assisted depression care supports are not in place. There may be considerations that support screening for depression in an individual patient. Grade: C (2009)
- The USPSTF concludes the evidence is insufficient to recommend for or against routine screening of children or adolescents for depression. http://www.uspreventiveservicestaskforce.org/uspstf/uspsaddepr.htm

5) Measure #43: Provide definition for medication reconciliation:

- Medication Reconciliation Definitions:
    - The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider. -- Meaningful Use Measure #6 definition, 2010 http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/6_Medication_Reconciliation.pdf
    - A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. – HEDIS, 2010 http://www.qualitymeasures.ahrq.gov/content.aspx?id=34032
- Meaningful Use Measure – The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.

http://www.ncqa.org/Portals/0/Public%20Policy/NCQA_PCMH_2011_Meaningful_Use_Crosswalk_11.21.2011.pdf

- HEDIS Measure - Medication reconciliation post-discharge: percentage of discharges from January 1 to December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge. http://www.qualitymeasures.ahrq.gov/content.aspx?id=34032

6) Measure #28: Provide more information on SBIRT:

Screening, Brief Intervention and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders. SBIRT is a brief conversation, about 10 to 15 minutes, about hazardous alcohol and/or drug consumption.

Risky drinkers who receive a brief intervention have reduced their drinking 10 - 30% at 12 month follow-up (Kaner, Cochrane Database Systematic Review; Moyer et al, 2002; Whitlock et al, 2004; Bertholet et al, 2005).

Literature suggests a four to one savings with the SBIRT approach (SAMHSA 2008). One study (Fleming et al, 2002) suggests that every dollar invested in an SBIRT-like approach saved $4.30 in future health care costs, and benefits increase when other societal costs, such as motor vehicle accidents and legal fees are factored in.

The SAMHSA and CMS recommended way to track SBIRT is through CPT codes: H0050 and H0049. Between April 1, 2011 and March 31, 2012 – there were 15 paid claims for SBIRT.

Resources:

- The Oregon Health and Science University SBIRT Primary Care Residency Initiative (www.sbirtoregon.org) is helping disseminate SBIRT practices by training the next generation of primary care physicians. Training for physicians and primary care practitioners is free and available online.
- The Northwest Frontier Addiction Technology Transfer Center (NWATTC) works with the SBIRT Primary Care Residency Initiative and is a good source of information and partnership for implementing SBIRT in primary care settings. www.attcnetwork.org/regcenters/generalContent.asp?rcid=10&content=STCUSTOM1

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7) Measure #261: Provide more information on the use of the D3. Is there any baseline data we could use?

[On the possibility of using D3] "You could use the other three components as a composite. Aspirin doesn't have a large impact anymore (average rate is about 95%), but still a lot of variation in smoking rates, but biggest drivers are BP and LDL. I know Better Health Greater Cleveland reports a D5 that swaps out weight management (BMI<30) for aspirin, and reports percent of patients that achieve at least 4 out of 5. Not sure of any that report a composite of just three, but it would be valid, and would give you more variation in results than rewarding on the components individually." – Minnesota Community Measurement

8) Measure #265: Provide more information on how to collect the Advance Care Plan measure.

While some limited information may be available from the POLST (Physician Orders for Life-Sustaining Treatment) registry, determining the percent of patients aged 65 years or older who have an advance care plan or surrogate decision maker would require chart review.

Alternative End of Life Measures: These measures do not require chart reviews but require the administration of another survey.

- **CARE - Consumer Assessments and Reports of End of Life (NQF 1632)** is a survey measure developed by the *Center for Gerontology and Health Care Research* administered to bereaved families of adult persons (age 18 and older) who died of a chronic progressive illness receiving services for at least 48 hours from a home health agency, nursing homes, hospice, or acute care hospital. The survey measures perceptions of the quality of care either in terms of unmet needs, family reports of concerns with the quality of care, and overall rating of the quality of care. The time frame is the last 2 days of life up to last week of life spent in a hospice, home health agency, hospital, or nursing home.
- **Family Evaluation of Hospice Care (NQF 0282)** is a survey measure developed by *National Hospice and Palliative Care Organization.* The FEHC survey is an after-death survey administered to bereaved family caregivers of individuals who died while enrolled in hospice. Timeframe: The survey measures family members perception of the quality of hospice care for the entire enrollment period, regardless of length of service. Composite Score: Derived from responses to 17 items on the Family Evaluation of Hospice Care(FEHC)survey presented as a single score ranging from 0 to 100.
  Global Score: Percentage of best possible response (Excellent) to the overall rating question on the FEHC survey.

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9) Measure #250a: The Committee was interested in adopting the prenatal care measure but wanted to know how many women are coming on to Medicaid in their third trimester.

In 2011, 2,182 (9.7 percent) clients delivering babies while on Medicaid became eligible in their third trimester, compared to 10.4 percent in 2010 and 12 percent in 2009.

10) Measure #71: How many children are in DHS custody? By CCO? Are the numbers too small to incentivize?

- Approximately 8,500 children are in DHS custody (2.3% of all children on Medicaid).
- Age breakdowns by CCO are not yet available.

11) Measure #76: What does the developmental screening measure consist of? Does it include referral to follow-up services?

NQF Definition of Measure: The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age, and by 36 months of age.

- This measure does not require referral to community services/resources. No alternate measures have been identified that include referrals.
- Oregon is currently validating this measure and has been using it in the current ABCDIII performance improvement project.

The other NQF endorsed developmental screening measure (NQF# 1385: Developmental screening using a parent completed screening tool (Parent report, Children 0-5)) does not include follow-up or require referral either.

12) Measure #278: what number (or percent) of the Medicaid population is 50-74? How will this change when the expansion population comes on?

As of August 2012, there were 78,906 adults on Medicaid age 50-74 (11.9 percent of the population), and an additional 21,934 adults age 75+ (3.4 percent of the population).

When the expansion population is added in 2014, we can reasonably project an additional 51,000 adults ages 50+ becoming eligible. This would bring the percent of adult Medicaid members age 50+ to 17%.

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13) Measure #277: What are the Bright Futures Standards and/or USPSTF recommendations for adolescent well-care visits?

The Bright Futures Periodicity Schedule recommends 11 visits over 11 years (ages 11 to 21). Oregon has adopted this schedule for the Prioritized List as well as for the Early Periodic Screening Diagnosis and Treatment program standards and reporting.

- Periodicity Schedule http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf
- Brief summaries for each age groups' visits http://brightfutures.aap.org/pdfs/Guidelines_PDF/18-Adolescence.pdf
- Adolescent Health Program's Bright Futures Policy Brief

14) The Committee requested that we identify options for patient experience of care composite measures:

Option 1: Align with the Health Insurance Exchange measure, which is a composite of 5 CAHPS questions:

1. In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?
2. In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you needed?
3. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?
4. Using any number from 0 to 10 where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?
5. In the last 12 months, how often did your health plan's customer service give you the information or help you needed?

Option 2: Roll up of 3 questions from the CAHPS 4.0H Adult Questionnaire selected by the committee:

1. In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?
2. In the last 12 months, how often did your personal doctor show respect for what you had to say?
3. In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

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Option 3: Roll of up 4 questions from the CAHPS 4.0 Adult Questionnaire that make up the Adult Composite core measure: getting care, getting care quickly, how well doctor communicates, and health plan information and customer service

15) Measure #93: The committee requested that we identify national specifications for the access measure selected: percentage of adults with a chronic disease w/any outpatient visit in past year (specific chronic diseases could include diabetes, COPD/asthma, coronary artery disease, HTN, schizophrenia).

This measure does not have national specifications, it does not align with any other state measures set and we don't have any baseline data for it.

16) The Committee expressed interest in encouraging CCOs to move away from fee for service payment models and towards alternative methodologies and requested that we identify measures to capture this movement across CCOs.

Catalyst for Payment Reform is developing metrics for assessing provider payment methodologies used by health plans, as part of its National Scorecard project. This kind of a measure would CCOs are pay their providers (e.g., bundled payments). CPR metrics will be available for our consideration in several weeks.
http://www.catalyzepaymentreform.org/National_Scorecard.html

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HEALTHY PEOPLE 2020

CRITICAL INDICATORS FOR ADOLESCENTS AND YOUNG ADULTS

Percent of adolescents and young adults who had a well-visit in the past 12 months

Overview

Adolescents and young adults must receive preventive health services for Oregon to move toward its Triple Aim of better care for everyone, lower costs and a healthy population.

Prevention and wellness, nurtured by regular preventive health visits or "well-visits," are major building blocks to national and state health care transformation. Youth who can easily access developmentally appropriate, evidence-based preventive health services are more likely to be healthy and able to reach milestones such as high school graduation and entry into the work force, higher education or military service.[1]

The American Academy of Pediatrics Bright Futures provides the most comprehensive and widely adopted service guidelines for the supervision of infants', children's and adolescents' health.

Linking clinical and community prevention:

The health assessment and prevention topics covered in a well-visit support the Oregon Public Health Division's priorities designed to make Oregon one of the healthiest states.

Bright Futures recommends annual preventive health visits for adolescents and young adults aged 11 to 21 years.

During a visit, the provider conducts a risk and strength assessment, listens to parent and youth concerns, conducts necessary screening and provides guidance on key health promotion priorities such as family support, healthy weight, nutrition and physical activity, mental health, healthy sexuality development, safety and injury prevention, and oral health. However, research shows that most adolescents and young adults have not had an annual well-visit in the past year. One study using national medical expenditure data found that, between 2001 and 2004, only 38 percent of adolescents 12 to 17 years of age had a well-visit in the past year.[2]

Adolescent well-visits in Oregon

In 2011, just over half of Oregon's eighth and 11th graders had a well-visit in the past year (see Figure 1). Both male and female youth who had a well-visit in the past year reported excellent or very good physical and emotional health more often than youth who had not had a well-visit in that time.[3]

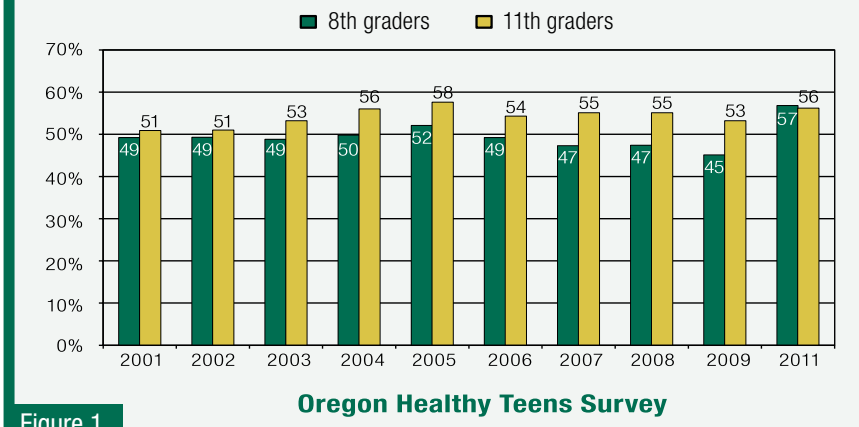

Figure 1

Why are young people not receiving recommended preventive health services?

Oregon has greatly reduced the number of uninsured children through the Healthy Kids program. However, insurance coverage disparities based on age, race/ethnicity and income still exist.[4]

Other barriers persist for providers and youth, with or without health insurance. Youth, especially those with high-risk behavior, are very concerned about confidentiality.[5] Other common barriers for youth include lack of transportation or access to a convenient source of care; finding the health care system hard to navigate; lack of culturally, linguistically and youth-friendly providers; and inadequate coordination between providers and referral services.[6]

Providers cite lack of patient interest and lack of time during the visit as the biggest barriers to preventive service delivery, especially counseling-based interventions.[7] Other barriers are inadequate compensation, absence of clear practice guidelines, and an overwhelming number of recommended services. Providers are also concerned about providing confidential care, responding to youth with risky behavior, and dealing with cultural barriers.[8]

Promoting adolescent preventive health services

Increased focus on preventive health care is a cornerstone of both federal and state health care transformation. The Patient Protection and Affordable Care Act of 2010 extends Medicaid coverage to thousands of young people and allows them to stay on their parents' or guardians' insurance until age 26. The act requires insurance companies cover preventive services without cost sharing and increases payments to primary care physicians.[9] Oregon Coordinated Care Organizations (CCOs) integrate and deliver physical, mental, dental and preventive health services to Medicaid and Medicare clients. CCOs work to lower costs, strengthen health outcomes and health equity, and improve patient experiences. Patient-centered Primary Care Homes (PCPCH) are key to Oregon's health care transformation. In order to focus on prevention and wellness, recognized primary care homes have more funding and support than non-recognized providers have; PCPCHs must collect specific outcome data on their population and attest to certain quality standards.

What can policymakers do?

Policymakers can encourage local providers that serve youth to become recognized Patient-centered Primary Care Homes. They can also support quality assurance measures that align with best practice recommendations, and health systems change such as the development of alternative payment structures based on health outcomes rather than patient volume. New payment methods could reduce provider barriers to providing preventive care due to lack of funding and time.

Policymakers can support school-based health centers and school health services, like school nurses. School-based health services help youth stay in school and out of more costly care settings. Investing in these and other youth services will pay dividends in both health and education outcomes.[10, 11]

What can providers do?

Providers can familiarize all office staff with the consent and confidentiality laws pertaining to minors' rights to access services and health care information. Offices can also create confidential appointment-making, confirmation and billing systems; they can also ensure private time with providers. Posters and handouts showing the office's confidentiality policies and expectations may help patients, parents and providers transition to care that is more confidential. Find sample posters at the Society for Adolescent Health and Medicine's website, www.adolescenthealth.org.

What can parents and youth do?

Open and honest communication among parents/guardians and youth is a vital support to preventive care providers. Because parents are youths' most significant source of health information, they should talk often about topics like relationships, friends, alcohol and drug use, and how things are going in school. Parents and guardians can also ensure youth have an annual well-visit with a trusted provider, and understand the need for private time between the youth and provider.

Resources for providers, parents and youth

PCPCH Program: Find information on certification and standards. www.primarycarehome.oregon.gov/oha/ohpr/Pages/healthreform/pcpch/index.aspx

Bright Futures: Find preventive care guidelines, screening recommendations, a comprehensive risk and strength assessment, tools, and encounters forms for review and download. www.brightfutures.aap.org

Minor Rights in Oregon: This guide provides an overview of federal and Oregon rules regarding minor consent and confidentiality. http://public.health.oregon.gov/HealthyPeopleFamilies/Youth/Documents/MinorConsent.pdf

Oregon Public Health Division: Find more information on the Public Health Priorities. http://public.health.oregon.gov/About/Pages/Goals.aspx

Children Now: Find information for parents on how to talk with youth about sexuality, drugs, alcohol and other topics. www.talkingwithkids.org

Planned Parenthood Teens: Find important information for youth, including specific information for LGBTQ youth on topics related to reproductive health. www.teenwire.com

Coordinated Care Organizations. Find out about Oregon's CCOs and health transformation efforts. www.cco.health.oregon.gov.

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Oregon Health Authority

PUBLIC HEALTH DIVISION
Adolescent Health Program

This document can be provided upon request in alternate formats for individuals with disabilities or in a language other than English for people with limited English skills. To request this form in another format or language, contact the Adolescent Health Program at 971-673-0249 or 971-673-0372 for TTY.

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Library #	Domain	Category	Measure and description	Population	Currently used by:	NQF #	Type (process/ outcome)	Data type, source	Specifications
268	Quality	Oral Health	**Annual Dental Visit** (The percentage of members 2-21 years of age who had at least one dental visit during the measurement year.)	Pediatric	HEDIS/ Oregon Performance Measures for Medicaid Managed Care Plans	1388	Process	Administrative claims	Measure Description: Percentage of members 2-21 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the organization's Medicaid contract. Numerator Statement: Had at least one dental visit during the measurement year Denominator Statement: Members 2–21 years of age as of December 31 of the measurement year. Report six age stratifications and a total rate: 2-3 years, 4-6 years, 7-10 years, 11-14 years, 15-18 years, 19-21 years, and Total. EXCLUSIONS: None Risk Adjustment: No
	Quality	Oral Health	Preventive Dental Services (Line 12b)		Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416)				Enter the unduplicated number of children receiving at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999 -(CDT codes D1000 - D1999).
	Quality	Oral Health	Sealant on a Permanent Molar Tooth (Line 12d)						Line 12d -– Total Eligibles Receiving a Sealant on a Permanent Molar Tooth -- Enter the unduplicated number of children in the age categories of 6-9 and 10-14 who received a sealant on a permanent molar tooth regardless of whether the sealant was provided by a dentist or a non-dentist, as defined by HCPCS code D1351 (CDT code D1351).

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Library #	Domain	Category	Measure and description	Population	Currently used by:	NQF #	Type (process / outcome)	Data type, source	Specifications
140	EHR Adoption	EHR Adoption	Implement drug-drug and drug-allergy interaction checks (The EP has enabled this functionality for the entire EHR reporting period.)	all	CMS EHR incentive program		Process		Attestation Requirements YES / NO Eligible professionals (EPs) must attest YES to having enabled drug-drug and drug-allergy interaction checks for the length of the reporting period to meet this measure.
142	EHR Adoption	EHR Adoption	Generate and transmit permissible prescriptions electronically (eRx) (More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.)	all	CMS EHR incentive program		Process		Definition of Terms Permissible Prescriptions – The concept of only permissible prescriptions refers to the current restrictions established by the Department of Justice on electronic prescribing for controlled substances in Schedule II-V. (The substances in Schedule II-V can be found at http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf). Any prescription not subject to these restrictions would be permissible. Prescription – The authorization by an EP to a pharmacist to dispense a drug that the pharmacist would not dispense to the patient without such authorization. Attestation Requirements NUMERATOR / DENOMINATOR / EXCLUSION • DENOMINATOR: Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period. • NUMERATOR: Number of prescriptions in the denominator generated and transmitted electronically. • EXCLUSION: EPs who write fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. EPs must enter the number of prescriptions written during the EHR reporting period in the Exclusion box to The resulting percentage (Numerator ÷ Denominator) must be more than 40 percent in order for an EP to meet this meas e-Prescribing (eRx) Objective Generate and transmit permissible prescriptions electronically (eRx). Measure More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR Exclusion

Library #	Domain	Category	Measure and description	Population	Currently used by:	NQF #	Type (process / outcome)	Data type, source	Specifications
146	EHR Adoption	EHR Adoption	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.	all	CMS EHR incentive program		Process		Definition of Terms Clinical Decision Support – HIT functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care. Attestation Requirements YES / NO Eligible professionals (EPs) must attest YES to having implemented one clinical decision support rule for the length of the reporting period to meet the measure. Additional Information • CMS will not issue additional guidance on the selection of appropriate clinical decision support rules for Stage 1 Meaningful Use. This determination is best left to the EP taking into account their workflow, patient population, and quality improvement efforts. • Drug-drug and drug-allergy interaction alerts cannot be used to meet the meaningful use objective for implementing one clinical decision support rule. EPs must implement one clinical decision support rule in addition to drug-drug and drug-allergy interaction checks.
	EHR Adoption	EHR Adoption	Eligible Professional Meaningful Use Core Measure #5: Active Medication List: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	all	CMS EHR incentive program		Process		Definition of Terms Active Medication List – A list of medications that a given patient is currently taking. Unique Patient – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term ''unique patient'' relate to what is contained in the patient's medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period. Attestation Requirements NUMERATOR / DENOMINATOR DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period. NUMERATOR: Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data. The resulting percentage (Numerator ÷ Denominator) must be more than 80 percent in order for an EP to meet this measure. Additional Information For patients with no active medications, an entry must still be made to the active medication list indicating that there are An EP is not required to update this list at every contact with the patient. The EP can then use his or her clinical judgment

Library #	Domain	Category	Measure and description	Population	Currently used by:	NQF #	Type (process / outcome)	Data type, source	Specifications
	EHR Adoption	EHR Adoption	Eligible Hospital and Critical Access Hospital Meaningful Use Core Measure #4 Active Medication List: More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	all	CMS EHR incentive program		Process		Definition of Terms Active Medication List – A list of medications that a given patient is currently taking. Admitted to the Emergency Department – There are two methods for calculating ED admissions for the denominators for measures associated with Stage 1 of Meaningful Use objectives. Eligible hospitals and CAHs must select one of the methods below for calculating ED admissions to be applied consistently to all denominators for the measures. That is, eligible hospitals and CAHs must choose either the "Observation Services method" or the "All ED Visits method" to be used with all measures. Providers cannot calculate the denominator of some measures using the "Observation Services method," while using the "All ED Visits method" for the denominator of other measures. Before attesting, eligible hospitals and CAHs will have to indicate which method they used in the calculation of denominators. Observation Services method. The denominator should include the following visits to the ED: The patient is admitted to the inpatient setting (place of service (POS) 21) through the ED. In this situation, the orders entered in the ED using certified EHR technology would count for purposes of determining the computerized provider ord All ED Visits method. An alternate method for computing admissions to the ED is to include all ED visits (POS 23 only) in th Unique Patient – If a patient is admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or NUMERATOR / DENOMINATOR DENOMINATOR: Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departme NUMERATOR: Number of patients in the denominator who have a medication (or an indication that the patient is not cur The resulting percentage (Numerator ÷ Denominator) must be more than 80 percent in order for an eligible hospital or C.
259	EHR Adoption	Meaningful Use	Professional Meaningful Use Composite (The percent of practices in the CCOs network that meet the performance requirements of the Eligible Professional Meaningful Use Core set (some or all measures.))				Process		
260	EHR Adoption	Meaningful Use	Hospital Meaningful Use Composite (The percent of hospitals in the CCOs network that meet the performance requirements of the Hospital Meaningful Use Core set (some or				Process		