

Oregon Health System Transformation: CCO Metrics 2016 Final Report

 June 2017

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BACKGROUND / CONTEXT

Medicaid waiver

Medicaid (health coverage for people earning less than 138 percent of the federal level, and people with disabilities) is administered by individual states but must follow certain federal requirements. States may obtain an 1115 Medicaid Demonstration waiver from the federal government, which grants them extra flexibility in how they use federal Medicaid funds in their state, with the goal of improving health care programs. Oregon has had such a waiver since 1994. The 1115 Medicaid waiver allows Oregon to deliver Medicaid services in unique ways, such as through the coordinated care model. Some of the key elements of Oregon's coordinated care model include: using best practices to manage and coordinate care; transparency in price and quality; and paying for better quality care and better health outcomes, rather than just more services. So what does coordinated care mean?

Coordinated care

A coordinated care organization (CCO) is a network of health care providers (physical, behavioral, and oral health care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs were formed in Oregon in late 2012. Today there are 16 CCOs operating in communities around Oregon (see maps on page 14).

CCOs have the flexibility to support new models of care that are patient-centered, team-focused, and reduce health disparities. CCOs are able to better coordinate services and also focus on prevention, chronic illness management and person-centered care. They have flexibility within their budgets to provide services alongside today's OHP medical benefits with the goal of meeting the triple aim of better health, better care and lower costs for the population they serve. Before Oregon's CCOs were formed, physical, behavioral and other care were not integrated, making things more difficult for patients and providers and more expensive for the state.

Medicaid expansion

Beginning in 2014 many more Oregonians were able to join the Oregon Health Plan because of the Affordable Care Act, which increased the income eligibility limit. The number of people covered by CCOs increased by 63 percent, from about 614,000 in 2013 to almost 1 million in 2014.

Measuring progress

The measures in this report are an important piece of the coordinated care model. They increase transparency and help us know how well CCOs are improving the quality of care. The measures fall into three categories (see next page).

BACKGROUND / CONTEXT



State performance metrics (also known as quality and access metrics)

OHA is accountable to the Centers for Medicare & Medicaid Services (CMS) for statewide performance on these metrics as part of the 1115 Medicaid waiver. If performance on these measures declines, OHA must pay financial penalties.



Core performance metrics

There are no financial incentives or penalties for performance on these measures. OHA is required to measure and report performance on these metrics to CMS.



CCO incentive metrics

CCOs receive payment based on their performance on incentive metrics, which are selected by the Metrics and Scoring Committee. This is part of Oregon's commitment to pay for better quality care and health outcomes.

Note that there is often crossover between the measure sets; a metric can fall into more than one category. To help readers identify which metrics belong in which measure set, each metric is accompanied by the icons shown.

Measure specifications and more information

- Information about the CCO incentive program, including specifications for the measures included in this report: <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>
- Metrics and Scoring Committee: <http://www.oregon.gov/oha/hpa/analytics/Pages/Metrics-Scoring-Committee.aspx>
- Medicaid Demonstration waiver: <http://www.oregon.gov/oha/HPA/HP-Medicaid-1115-Waiver/Pages/index.aspx>
- This and other metrics reports: <http://www.oregon.gov/oha/hpa/analytics-mtx/Pages/HST-Reports.aspx>

EXECUTIVE SUMMARY

This report lays out the progress of Oregon’s coordinated care organizations (CCOs) on quality measures in 2016. Measuring quality and access to care are key to moving health system transformation forward, to ensure high-quality care for Oregon Health Plan members. Measuring quality and holding CCOs accountable to key metrics is a cornerstone of Oregon’s health system transformation.

This is the fourth year of Oregon’s pay-for-performance program, under which the Oregon Health Authority (OHA) holds back a percentage of monthly payments to CCOs to form a “quality pool.” To earn their full incentive payment, CCOs have to meet benchmarks or improvement targets on at least 13 of the 18 measures and have at least 60 percent of their members enrolled in a patient-centered primary care home.

The quality pool model rewards CCOs for the quality of care provided to Medicaid members. This model increasingly rewards CCOs for outcomes, rather than utilization of services, and is one of several key health system transformation mechanisms for achieving Oregon’s vision for better health, better care, and lower costs.

The 2016 incentive measures set challenging goals for CCOs to continue to improve the quality of care of Medicaid members. As CCOs made large strides on existing measures in the first few years of the program, the aspirational benchmarks, often based on the most exceptional national performance, require focused, sustained efforts to improve quality and be successful on the measures. In addition, the 2016 challenge pool included two new measures: improve care for CCOs on two new measures: (1) cigarette smoking prevalence and (2) childhood immunization status.

The results in this report demonstrate that as the quality pool model continues, the targets and benchmarks become even harder to meet or exceed. This ensures that CCOs continue to focus on metrics and strive toward improvement and better health outcomes for members.

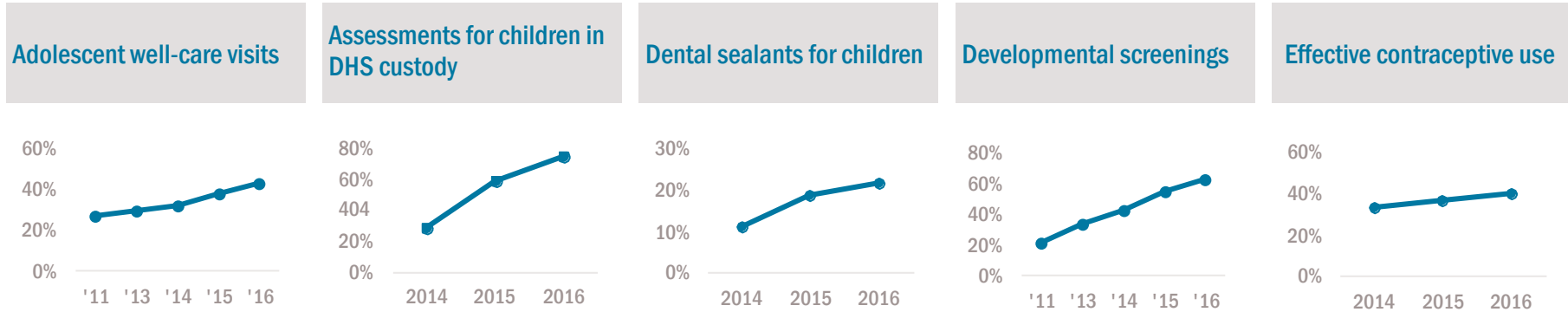
The quality pool amount increased to 4.25 percent of monthly payments in 2016, for a total of almost \$179 million. While all CCOs showed improvement on a majority of measures, only seven earned 100 percent of their quality pool dollars. The results from the quality pool model are demonstrating that this is not just another program to pay CCOs for service, but to push CCOs to focus on performance and improving the health outcomes of members.

This report indicates that through the coordinated care model, there have been continued improvements in a number of areas, such as:

- **Adolescent well-care visits.** CCOs continue to make large strides on this measure, with 15 of 16 CCOs improving in 2016 and 13 achieving their individual improvement target. Statewide, performance on this measure has increased 47 percent since 2013. While CCOs are improving, overall performance remains low, with less than half of adolescents receiving a well-care visit as recommended by clinical guidelines.

EXECUTIVE SUMMARY

- **Dental sealants.** The percentage of children ages 6-14 who received a dental sealant on a permanent molar in the past year continued to increase. Statewide performance surpassed the aspirational benchmark in 2016.
- **Developmental screening in the first three years of life.** CCOs continue to make large strides in the percentage of children who are screened for risks of developmental, behavioral, and social delays. In 2011, only 21 percent of young children received an appropriate screening. Since then, the percentage has more than tripled to over 62 percent in 2016.
- **Effective contraceptive use among women at risk of unintended pregnancy.** A new measure in 2015, the percentage of women ages 18-50 who are using an effective contraceptive has increased 19 percent in two years.
- **Health assessments for children in DHS custody.** The percentage of children in foster care who received a mental, physical, and dental health assessment has increased 168 percent in two years.



Measures to watch:

- **Emergency department utilization.** For the first time since 2011, emergency department utilization increased slightly over the previous year. Statewide, the rate of patient visits to the emergency department returned to 2014 levels. However, it is also important to note that emergency department rates remain relatively low overall; the CCO benchmark is the national Medicaid 90th percentile. Moreover, avoidable emergency department utilization (which looks at the rate of patient visits for conditions that could have been more appropriately managed or referred to by a primary care provider) continues to decline. So, while the overall rate of emergency department utilization increased, members continued to use the emergency department for appropriate reasons. OHA will continue to monitor these trends.

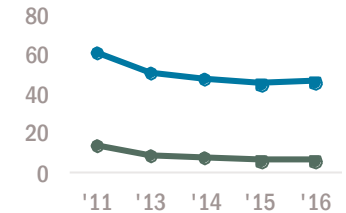
EXECUTIVE SUMMARY

Measures in this report that highlight room for improvement:

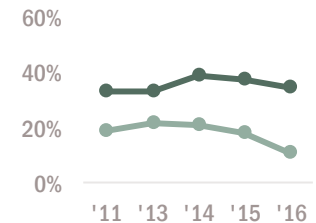
- Initiation and engagement of alcohol or other drug treatment.** The percentage of members newly diagnosed with alcohol or other drug dependences who began treatment within 14 days of the initial diagnosis decreased slightly. Statewide, Oregon remains below the national Medicaid median. Meanwhile, the percentage of members who continued their treatment and had two or more visits within 30 days of their initial treatment was just 11.1%. This is a forty percent decline since 2015.
- Prevention quality indicators.** After a sharp decline in 2014, the rate of adult members who had a hospital stay because of congestive heart failure or short-term diabetes complications increased again slightly in 2016. Lower is better on this measure.

Oregon is leading the nation in transforming our health care system to create better access and better care at a lower cost for all Oregonians. We have long had a national reputation for innovative health system solutions and the reforms that we have made in recent years continue to show Oregon's innovation and leadership. The CCO quality pool model is a hallmark of Oregon's health transformation and a key component in our commitment to transparency and accountability. By measuring Oregon's progress and identifying both success and challenges, the state can identify how we can continue to push for greater health transformation and ways that can we can create better health outcomes for Oregon Health Plan members.

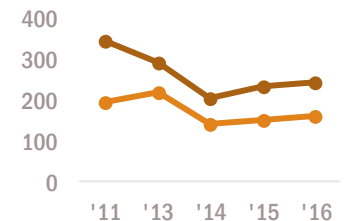
Emergency department use
Overall ED utilization
Avoidable ED utilization



Alcohol or drug treatment
Initiation of treatment
Continuation of treatment



Hospital admissions
Congestive heart failure
Diabetes complications



2016 INCENTIVE METRIC PERFORMANCE OVERVIEW

	AllCare	Cascade	Columbia Pac.	Eastern Oregon	FamilyCare	Health Share	IHN	Jackson	PacSource Central	PacSource Gorge	PrimaryHealth	Trillium	Umpqua	WOAH	WVCH	Yamhill
<ul style="list-style-type: none"> ■ CCO achieved BENCHMARK in 2016 ■ CCO achieved IMPROVEMENT TARGET in 2016 * Top performing CCO in each measure Bolded CCOs earned 100% quality pool ^ indicates challenge pool measure 																
Access to care (CAHPS)		■							■		*			■		
Adolescent well-care visits	■		■	■	■	■	■	■	■	■			■	■	■	*
Alcohol and drug misuse screening (SBIRT) 12+ ^		■	■	■	■	■	■	■	■	■			*	■	■	■
Ambulatory care - ED utilization	■										*					
Assessments for children in DHS custody	■	■	■	■	■	■	■	■	■		*	■	■	■	■	■
Childhood immunization status	■								■	*	■			■		■
Cigarette smoking prevalence (EHR)	■		■	■	■	*	■	■	■	■	■	■	■	■	■	■
Colorectal cancer screening	■	■	■	■	■	■	■	■	■	■	■	■	■	■	*	■
Controlling high blood pressure (EHR)			■	■		■	■	■			■	■	■			*
Dental sealants for children	■	■	■	■	■	■	■	■	■	■	■		*	■	■	■
Depression screening and follow up (EHR) ^	■	■	■	■	■	■	■	■	■	■	■		*	■	■	*
Developmental screening ^	■	■	■	■	■	■	■	■	■	■	*					
Diabetes HbA1c poor control (EHR) ^			■					■			■	*	■	■	■	■
Effective contraceptive use (ages 18-50)	■	■	■	■			■	■	■	■	■	■	*	■	■	■
Follow up after hospitalization for mental illness	■	■		■	■	■			■	*	■	■	■	■	■	■
Prenatal and postpartum care: Prenatal care	■	■	■	■	■	■	■	■	*	■	■	■	■	■	■	■
Patient-Centered Primary Care Home (PCPCH) enrollment	■	■	■	■	■	■	■	■	■	*	*	■	■	■	■	■
Satisfaction with care (CAHPS)	*				■							■	■		■	■

2016 QUALITY POOL DISTRIBUTION

The Oregon Health Authority has established the quality pool—Oregon's incentive payments to coordinated care organizations. Each CCO is being paid for reaching benchmarks or making improvements on incentive measures. This is the fourth time Oregon has paid CCOs for better care, rather than just the volume of services delivered.

The 2016 quality pool is almost \$179 million. This represents 4.25 percent of the total amount all CCOs were paid in 2015. The quality pool is divided among all CCOs based on their number of members ([see page 15](#) for CCO enrollment numbers) and their performance on the 18 incentive metrics (see Appendix A).

Quality Pool: Phase One Distribution

CCOs can earn 100 percent of their quality pool in the first phase of distribution by:

- Meeting the benchmark or improvement target on 13 of 18 measures; and
- Having at least 60 percent of their members enrolled in a patient-centered primary care home (PCPCH).

CCOs must meet both of these conditions to earn 100 percent of their quality pool.

Challenge Pool: Phase Two Distribution

The challenge pool includes funds remaining after quality pool funds are distributed in phase one. The 2016 challenge pool is \$27.4 million. Challenge pool funds are distributed to CCOs that meet the benchmark or improvement target on four measures:

1. Alcohol and drug misuse screening (SBIRT)
2. Depression screening and follow-up plan
3. Developmental screenings
4. Diabetes HbA1c poor control

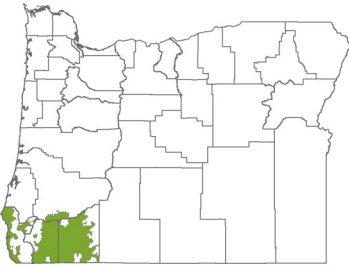
Through the challenge pool, some CCOs earn more than 100 percent of their maximum quality pool funds. The next page shows the percentage and dollar amounts earned by each CCO.

2016 QUALITY POOL DISTRIBUTION

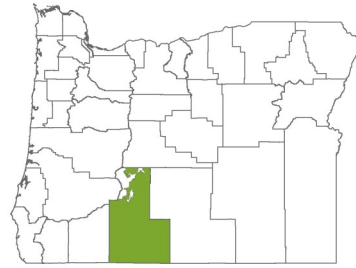
CCO	Phase 1 distribution			Challenge pool		TOTAL	
	Number of measures met (of 18 possible)	Payment earned in Phase 1*	Percent of quality pool funds earned	Number of challenge pool measures met	Challenge pool earned	Total payment (Phase 1 + Challenge pool)	Total quality pool earned
AllCare Health Plan	14.9	\$ 9,289,825	100%	3	\$ 1,231,864	\$ 10,521,689	113%
Cascade Health Alliance	10.8	\$ 2,394,930	70%	3	\$ 413,799	\$ 2,808,729	82%
Columbia Pacific	12.9	\$ 4,598,806	80%	4	\$ 947,924	\$ 5,546,730	96%
Eastern Oregon	12.9	\$ 8,877,570	80%	3	\$ 1,203,801	\$ 10,081,371	91%
FamilyCare	11.9	\$ 16,432,704	80%	3	\$ 3,049,131	\$ 19,481,835	95%
Health Share of Oregon	11.9	\$ 35,401,115	80%	3	\$ 5,575,833	\$ 40,976,948	93%
Intercommunity Health Network	11.8	\$ 9,226,570	80%	3	\$ 1,358,709	\$ 10,585,279	92%
Jackson Care Connect	11.8	\$ 4,490,390	80%	4	\$ 1,122,541	\$ 5,612,931	100%
PacificSource – Central Oregon	13.9	\$ 10,628,001	100%	3	\$ 1,287,801	\$ 11,915,802	112%
PacificSource – Gorge	11.0	\$ 1,877,837	70%	3	\$ 319,133	\$ 2,196,970	82%
PrimaryHealth of Josephine County	16.0	\$ 2,206,010	100%	4	\$ 423,661	\$ 2,629,671	119%
Trillium	12.8	\$ 14,953,435	80%	3	\$ 2,263,925	\$ 17,217,360	92%
Umpqua Health Alliance	14.0	\$ 5,277,015	100%	4	\$ 1,022,051	\$ 6,299,066	119%
Western Oregon Advanced Health	14.9	\$ 4,701,278	100%	4	\$ 765,102	\$ 5,466,380	116%
Willamette Valley Community Health	14.0	\$ 18,540,644	100%	4	\$ 3,761,895	\$ 22,302,539	120%
Yamhill Community Care	13.9	\$ 4,616,761	100%	3	\$ 579,163	\$ 5,195,924	113%
Total		\$ 153,512,891			\$ 25,326,333	\$ 178,839,224	

* Quality pool distribution is based on number of measures met and CCO size (number of members). See page 15 for CCO enrollment.

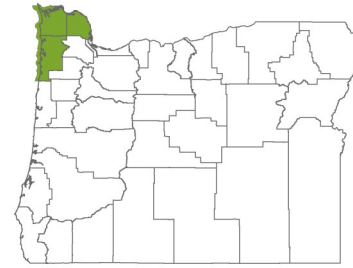
CCO SERVICE AREAS



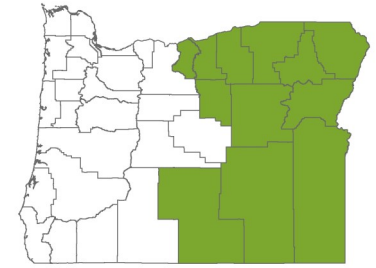
AllCare Health Plan



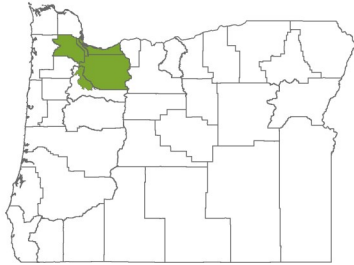
Cascade Health Alliance



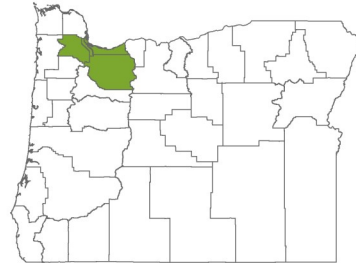
Columbia Pacific



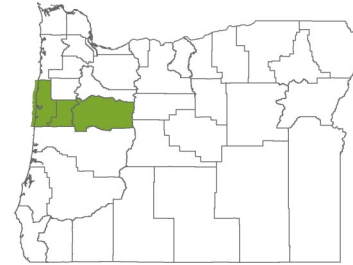
Eastern Oregon



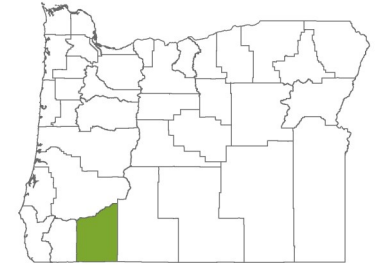
FamilyCare



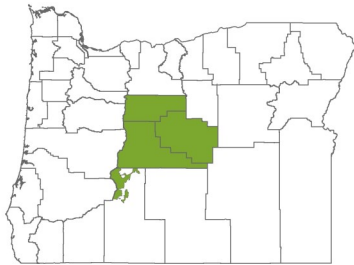
Health Share of Oregon



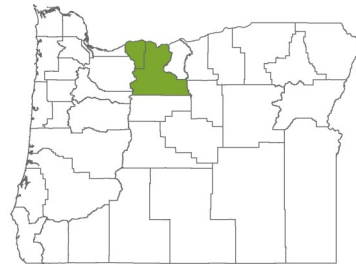
Intercommunity Health Network



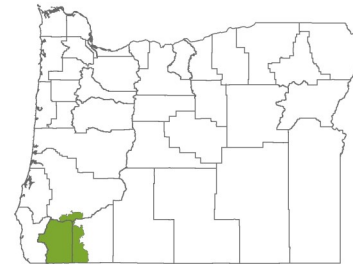
Jackson Care Connect



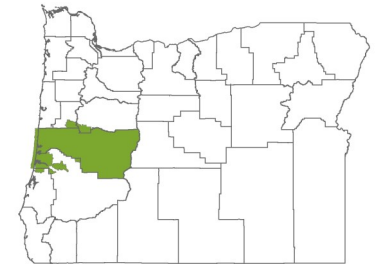
PacificSource - Central Oregon



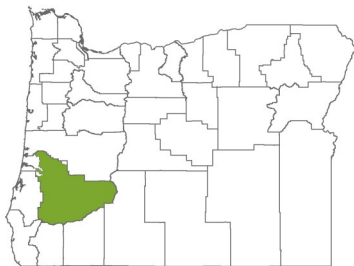
PacificSource - Gorge



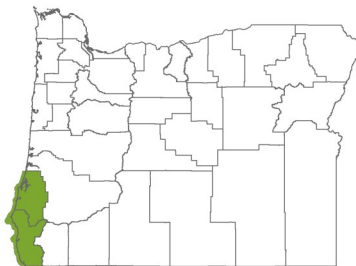
PrimaryHealth of Josephine County



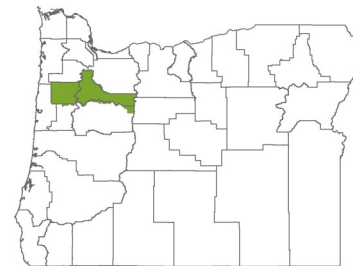
Trillium



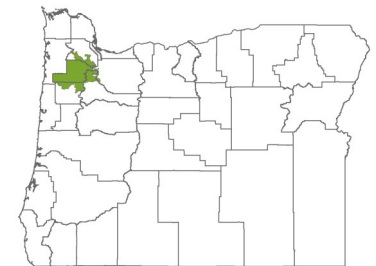
Umpqua Health Alliance



Western Oregon Advanced Health

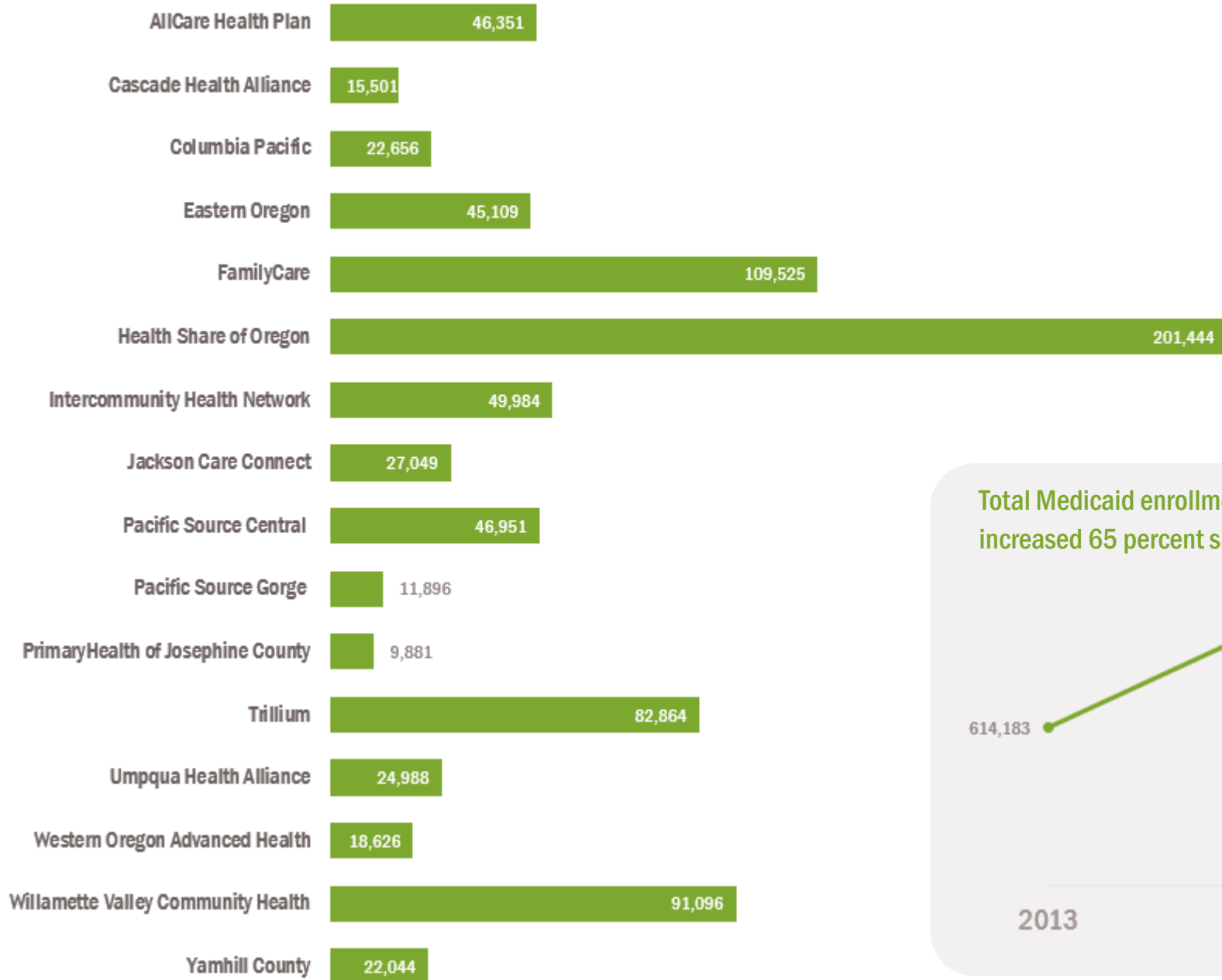


Willamette Valley Community Health



Yamhill Community Care

TOTAL CCO ENROLLMENT (December 2016)



Total Medicaid enrollment has increased 65 percent since 2013.



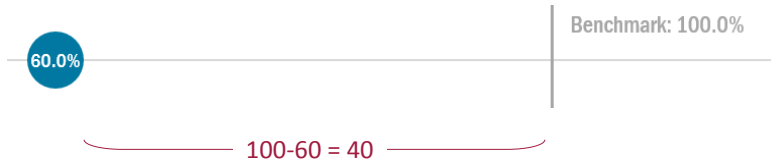
Appendix A

CCO Incentive Measures

ABOUT BENCHMARKS AND IMPROVEMENT TARGETS

Incentive measure benchmarks are selected by the Metrics and Scoring Committee and are meant to be aspirational goals. That is, CCOs are not expected to meet the benchmark each year, but rather to *make improvement toward* the benchmark. To demonstrate this, CCOs can earn quality pool payment for a) achieving the benchmark or b) achieving their individual *improvement target*. Improvement targets are based on the Minnesota Department of Health Quality Incentive Payment System (“Minnesota method”), which requires at least a 10 percent reduction in the gap between baseline and the benchmark to qualify for incentive payments.

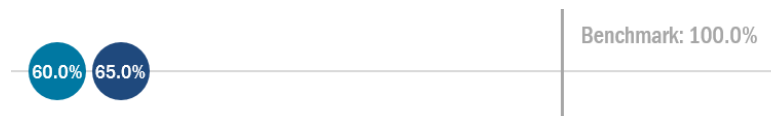
Suppose CCO A’s performance in **2015** (i.e. baseline) on Measure 1 was 60.0%



The gap between baseline and the benchmark is $[100-60] = 40\%$

Ten percent of 40 % = 4%. Thus, **CCO A must improve by 4 percentage points in 2016**. Their **improvement target** is $[baseline + 4\%] = [60\% + 4\%] = 64\%$

CCO A’s performance in **2016** is 65%; they **achieved their improvement target and will receive quality pool payment** on Measure 1.



Stated as a formula:
$$\frac{[\text{Benchmark}] - [\text{CCO baseline}]}{10} = X \longrightarrow [\text{CCO baseline}] + [X] = \text{Improvement target}$$

In some cases, depending on the difference between the CCO’s baseline and the benchmark, the Minnesota method may result in a very small improvement that may not represent a statistically significant change. Using the example above, suppose the benchmark was only *75 percent*. In this case, CCO A’s improvement target using the formula would be:

$$\frac{75\% - 60\%}{10} = 1.5\% \longrightarrow 60\% + 1.5\% = \mathbf{61.5\%}$$

Where the Minnesota method results in small improvement targets like this, the Metrics and Scoring Committee has established a “floor” or minimum level of required improvement before the CCO would meet its improvement target. In this example, suppose the floor is 3 percentage points. The Minnesota method formula only results in 1.5% increase. Instead of 61.5%, CCO A’s improvement target with the 3% floor applied would be: $[baseline + floor] = [60\% + 3\%] = 63\%$.



ACCESS TO CARE (CAHPS SURVEY)

Access to care (CAHPS)

Percentage of members (adults and children) who thought they received appointments and care when they needed them.

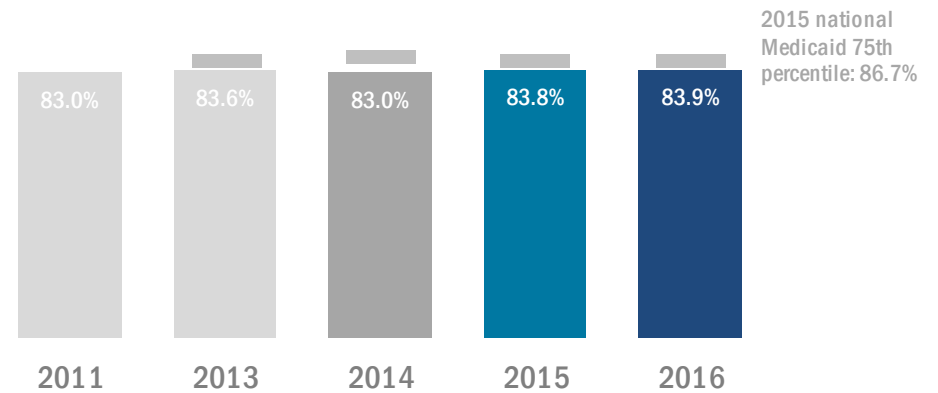
2016 data

- Statewide change since 2015: **+0.1%**
- Number of CCOs that improved: **7**
- Number of CCOs achieving target: **4**

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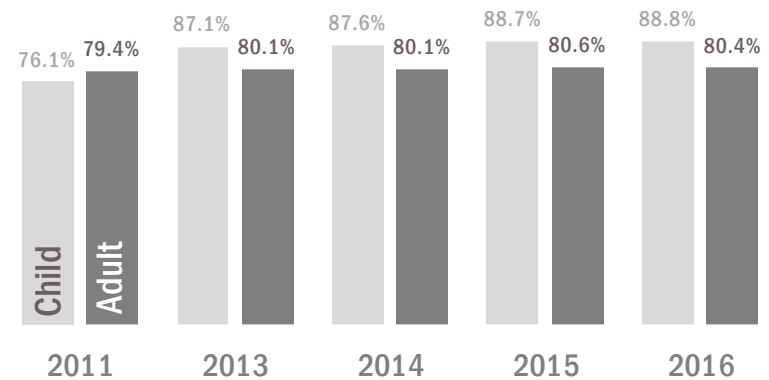
Access to care, statewide.

Data source: Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Access to care among children and adults, statewide.

Data source: Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)





ACCESS TO CARE (CAHPS SURVEY)

Access to care among CHILDREN in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Each race category excludes Hispanic/Latino

*Data suppressed (n<10)



Access to care among ADULTS in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Each race category excludes Hispanic/Latino

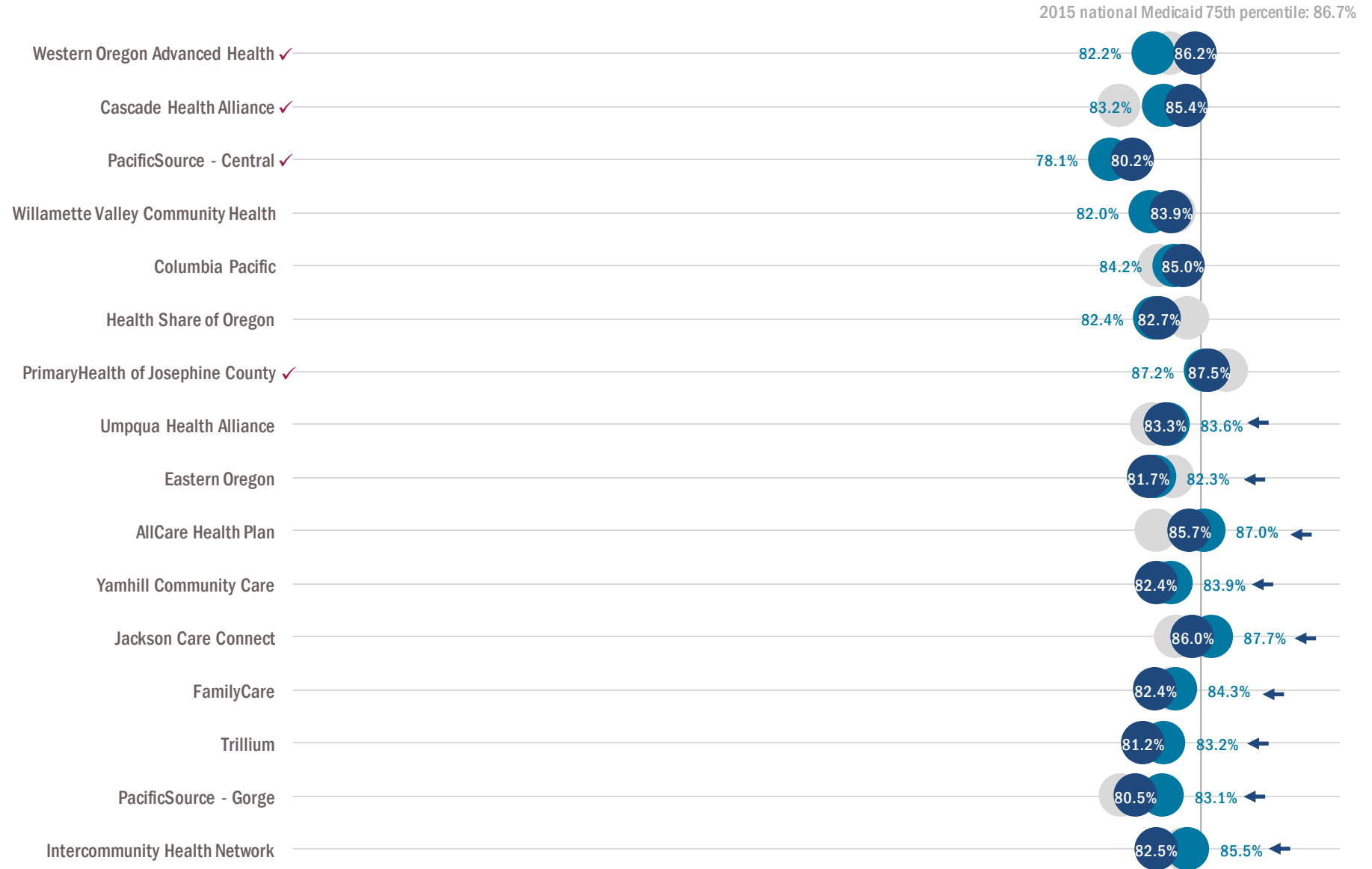




ACCESS TO CARE (CAHPS SURVEY)

Access to care in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014





ADOLESCENT WELL-CARE VISITS

Adolescent well-care visits

Percentage of adolescents and young adults (ages 12-21) who had at least one well-care visit during the measurement year.

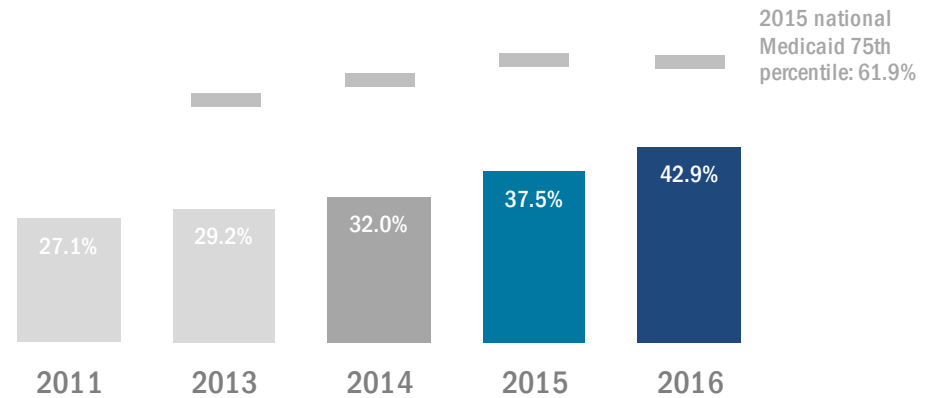
2016 data (n=102,552)

- Statewide change since 2015: **+14.4%**
- Number of CCOs that improved: **15**
- Number of CCOs achieving target: **13**

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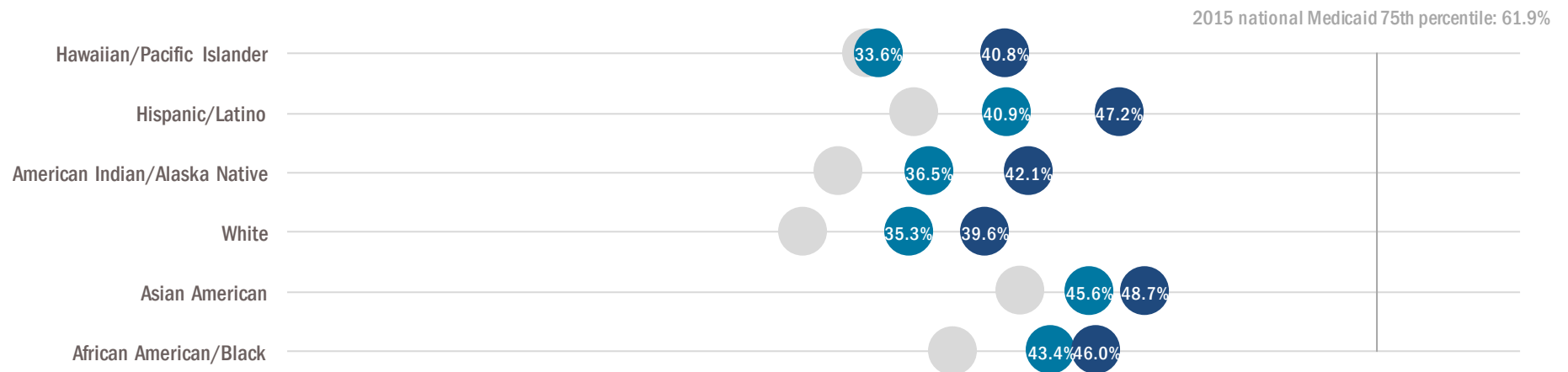
Adolescent well-care visits, statewide.

Data source: Administrative (billing) claims



Adolescent well-care visits in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 36.9% of respondents / Each race category excludes Hispanic/Latino

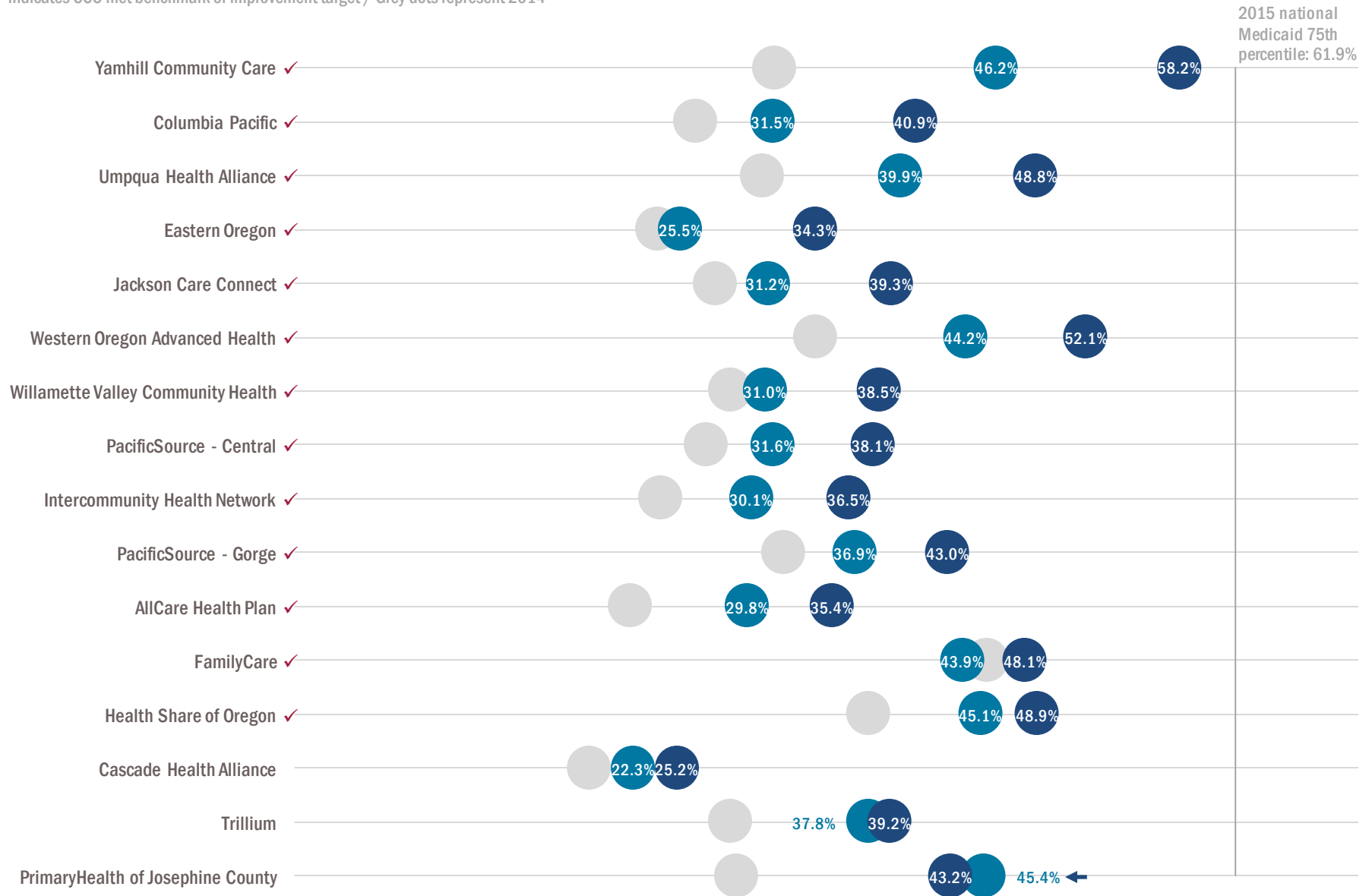




ADOLESCENT WELL-CARE VISITS

Adolescent well-care visits in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014



\$ ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (all ages)

Alcohol or other substance misuse screening (SBIRT) (all ages)

Measures the percentage of members (ages 12 and older) who received appropriate "screening, brief intervention, and referral to treatment" (SBIRT) for alcohol or other substance abuse.

2016 data (n=522,047)

- Statewide change since 2015: **+58.3%**
- Number of CCOs that improved: **15**
- Number of CCOs achieving target: **all 16**

Depression screening and follow-up plan is a challenge pool measure in 2016 ([see page 12](#) for more information).

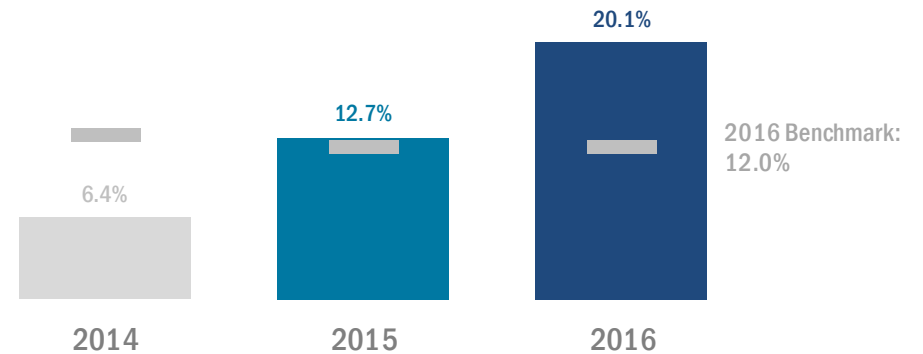
Data notes: 2016 results are not directly comparable to earlier years due to changes in the data source (ICD-10) which occurred in October 2015. Trends should be interpreted with caution.

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Alcohol or other substance misuse screening (ages 12+), statewide.

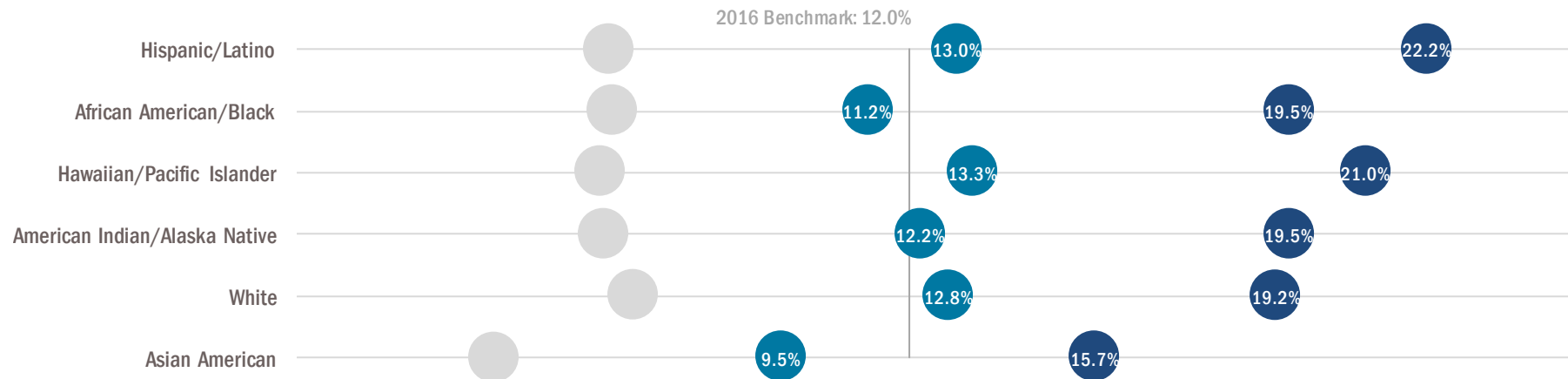
Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



Alcohol or other substance misuse screening (ages 12+) in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 30.5% of respondents / Each race category excludes Hispanic/Latino



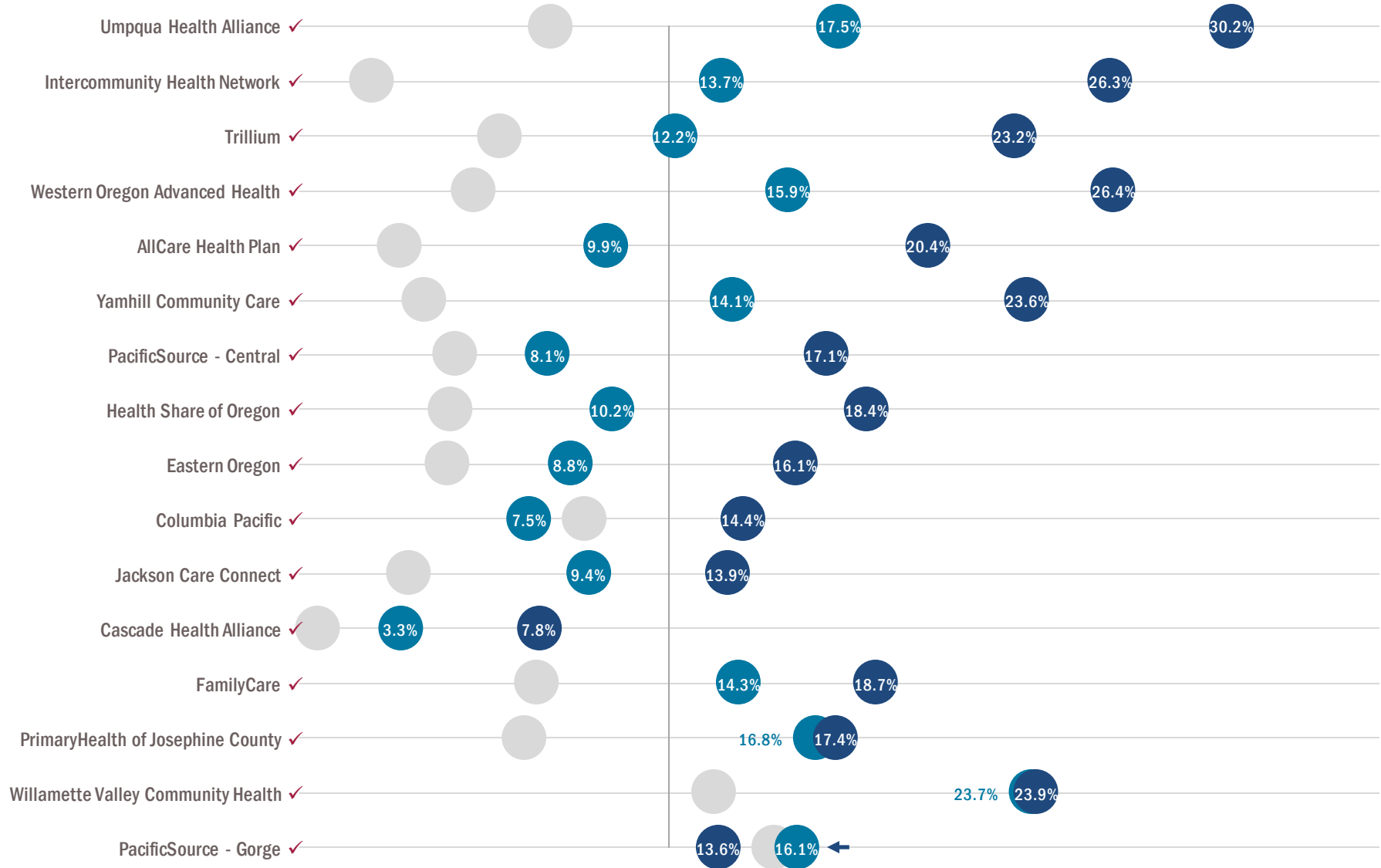


ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (all ages)

Alcohol or other substance misuse screening (ages 12+) in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014

2016 Benchmark: 12.0%



ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ages 12-17)

Alcohol or other substance misuse screening (SBIRT) (ages 12-17)

Measures the percentage of members (ages 12-17) who received appropriate "screening, brief intervention, and referral to treatment" (SBIRT) for alcohol or other substance abuse.

2016 data (n=84,236)

- Statewide change since 2015: **+131.1%**
- Number of CCOs that improved: **15**

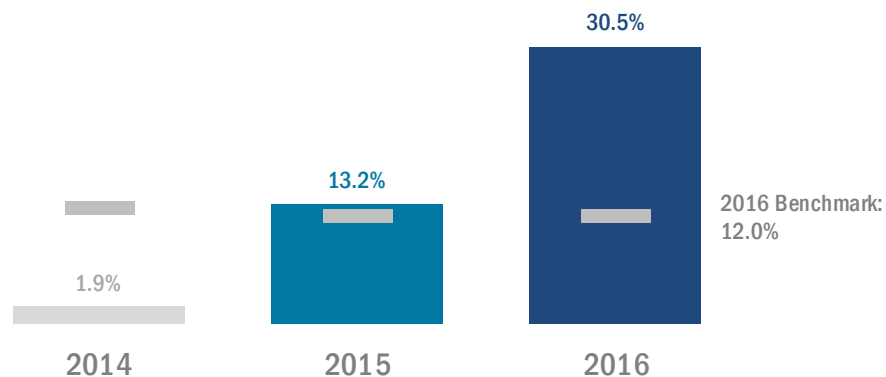
Results are stratified by age group for reporting and monitoring purposes only. Incentive payments are based on all ages combined (see page 23).

Data notes: 2016 results are not directly comparable to earlier years due to changes in the data source (ICD-10) which occurred in October 2015. Trends should be interpreted with caution.

Alcohol or other substance misuse screening (ages 12-17), statewide.

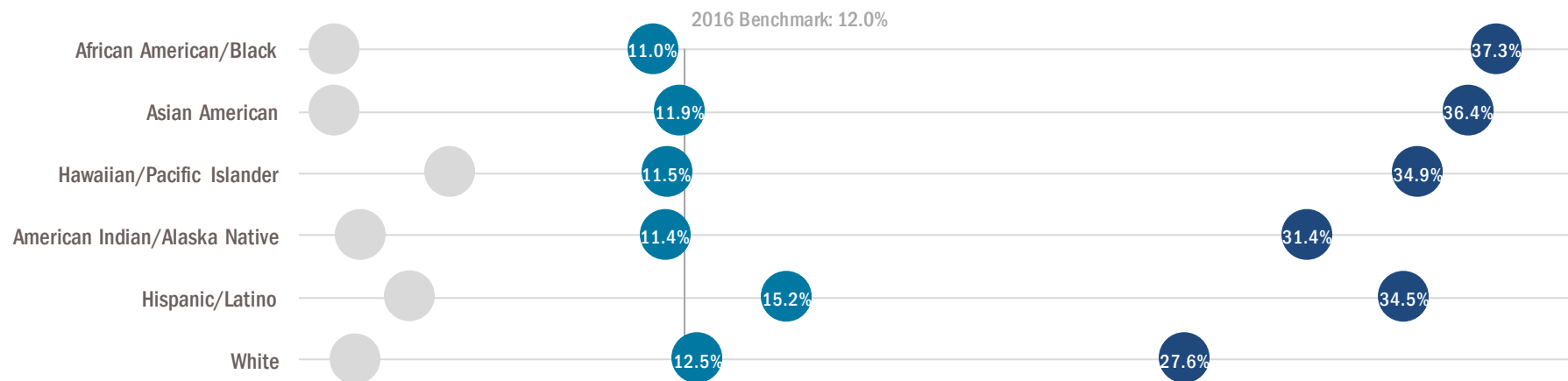
Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



Alcohol or other substance misuse screening (ages 12-17) in 2015 and 2016, by race and ethnicity.

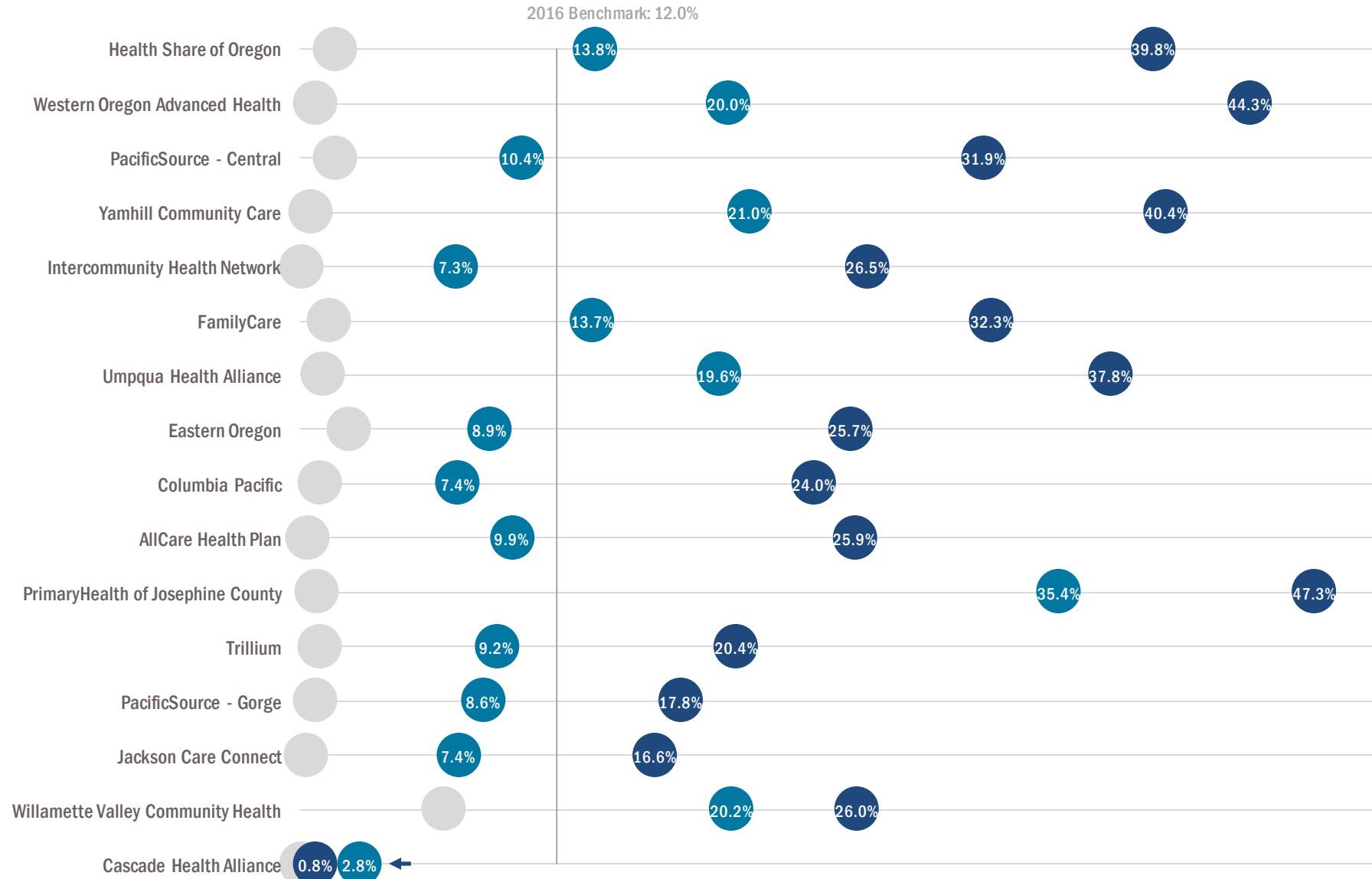
Grey dots represent 2014 / Race and ethnicity data missing for 38.8% of respondents / Each race category excludes Hispanic/Latino



ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ages 12-17)

Alcohol or other substance misuse screening (ages 12-17) in 2015 and 2016, by CCO.

Grey dots represent 2014



ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ages 18+)

Alcohol or other substance misuse screening (SBIRT) (ages 18+)

Measures the percentage of members (ages 18 and older) who received appropriate "screening, brief intervention, and referral to treatment" (SBIRT) for alcohol or other substance abuse.

2016 data (n=437,811)

- Statewide change since 2015: **+43.7%**
- Number of CCOs that improved: **13**

Results are stratified by age group for reporting and monitoring purposes only. Incentive payments are based on all ages combined (see page 23).

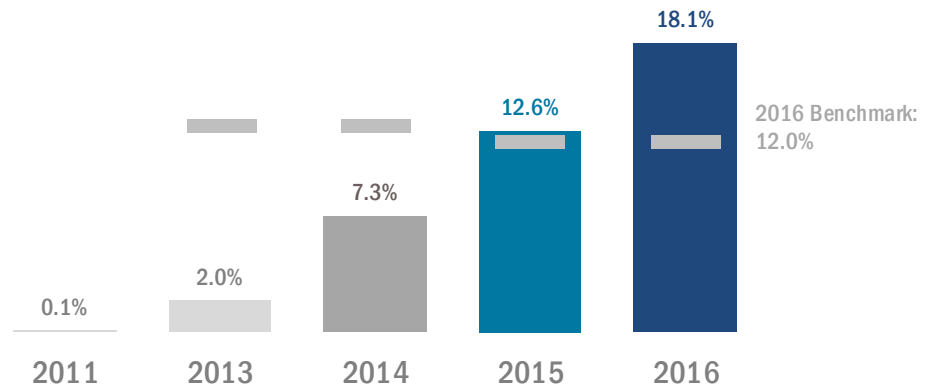
Data notes: 2016 results are not directly comparable to earlier years due to changes in the data source (ICD-10) which occurred in October 2015. Trends should be interpreted with caution.

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Alcohol or other substance misuse screening (ages 18+), statewide.

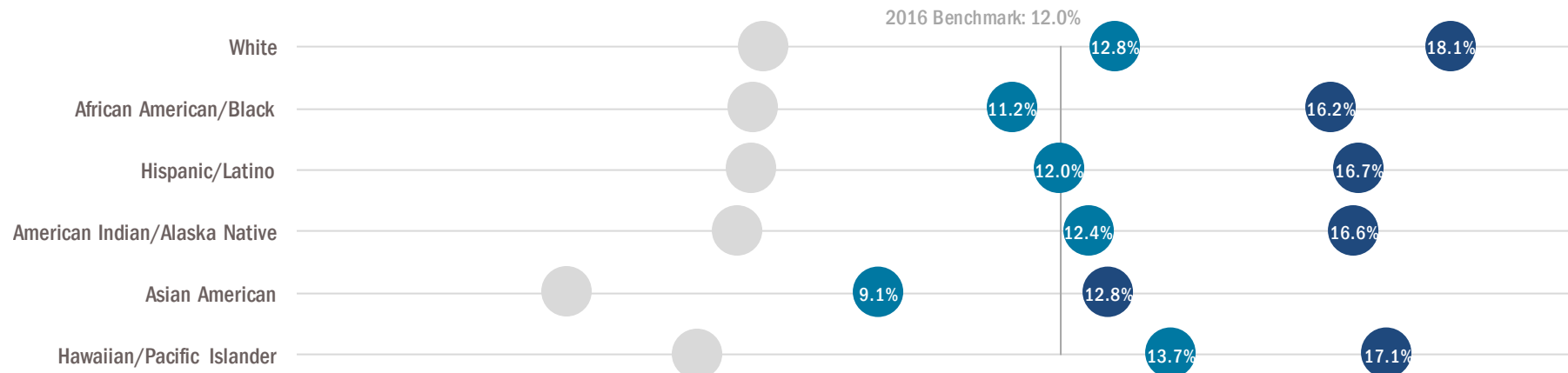
Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



Alcohol or other substance misuse screening (ages 18+) in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 28.9% of respondents / Each race category excludes Hispanic/Latino

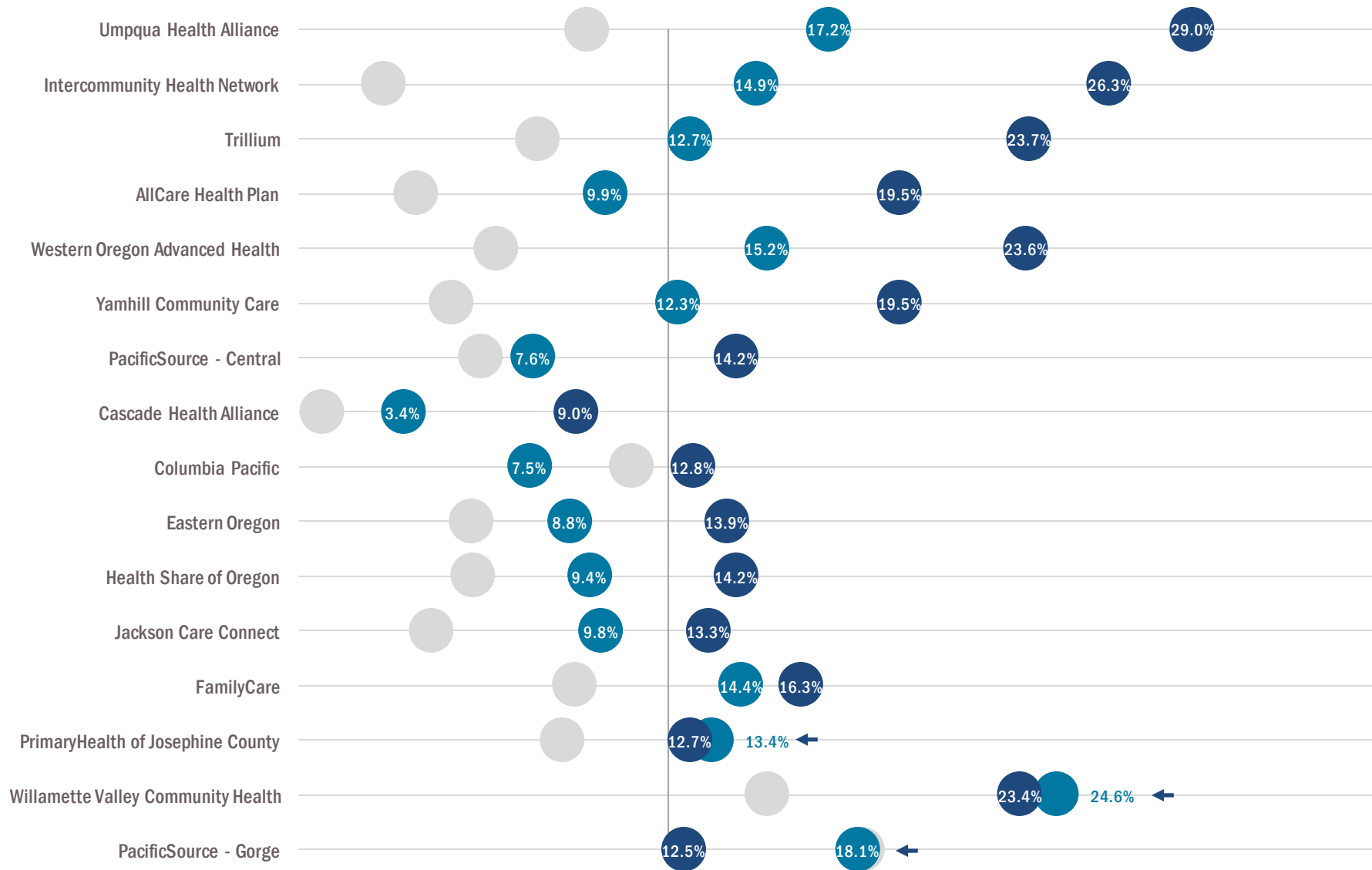


ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ages 18+)

Alcohol or other substance misuse screening (ages 18+) in 2015 and 2016, by CCO.

Grey dots represent 2014

2016 Benchmark: 12.0%





AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

Ambulatory care: Emergency department utilization

Rate of patient visits to an emergency department. Rates are reported per 1,000 member months and a lower number suggests more appropriate use of care.

2016 data (n=10,560,968 member months)

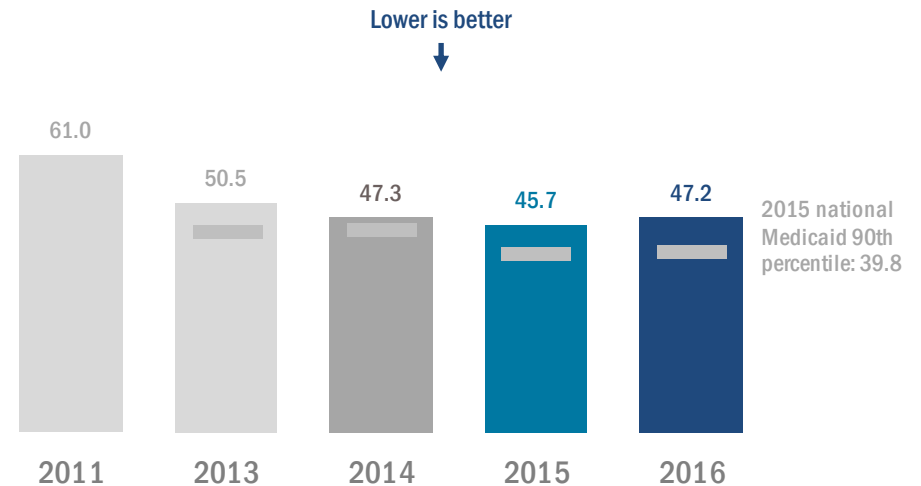
- Statewide change since 2015: **+3.3%** (lower is better)
- Number of CCOs that improved: **5**
- Number of CCOs achieving target: **2**

Data notes: 2015 results have been revised and differ from previously published reports due to algorithm refinements for better capturing visits billed with ED-specific procedure codes, as well as better exclusion for ED resulted in inpatient stays. The result is a 6 percent increase in ED visit count for 2015, statewide. Comparing results prior to 2015 should be done with caution, since the specifications are different.

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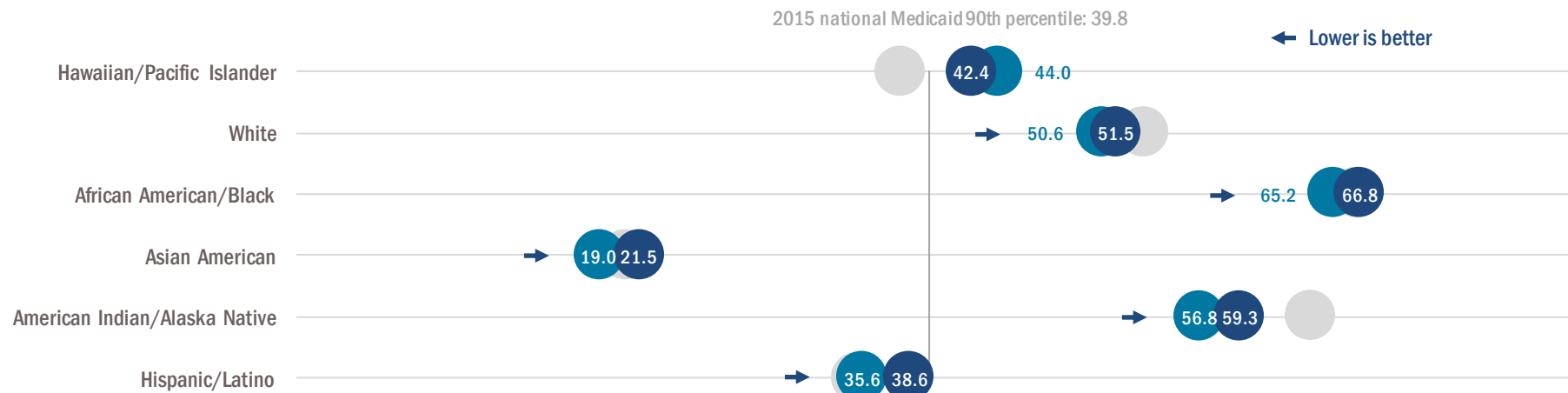
Emergency department utilization, statewide.

Data source: Administrative (billing) claims
Rates are per 1,000 member months



Emergency department utilization in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 33.1% of respondents / Each race category excludes Hispanic/Latino

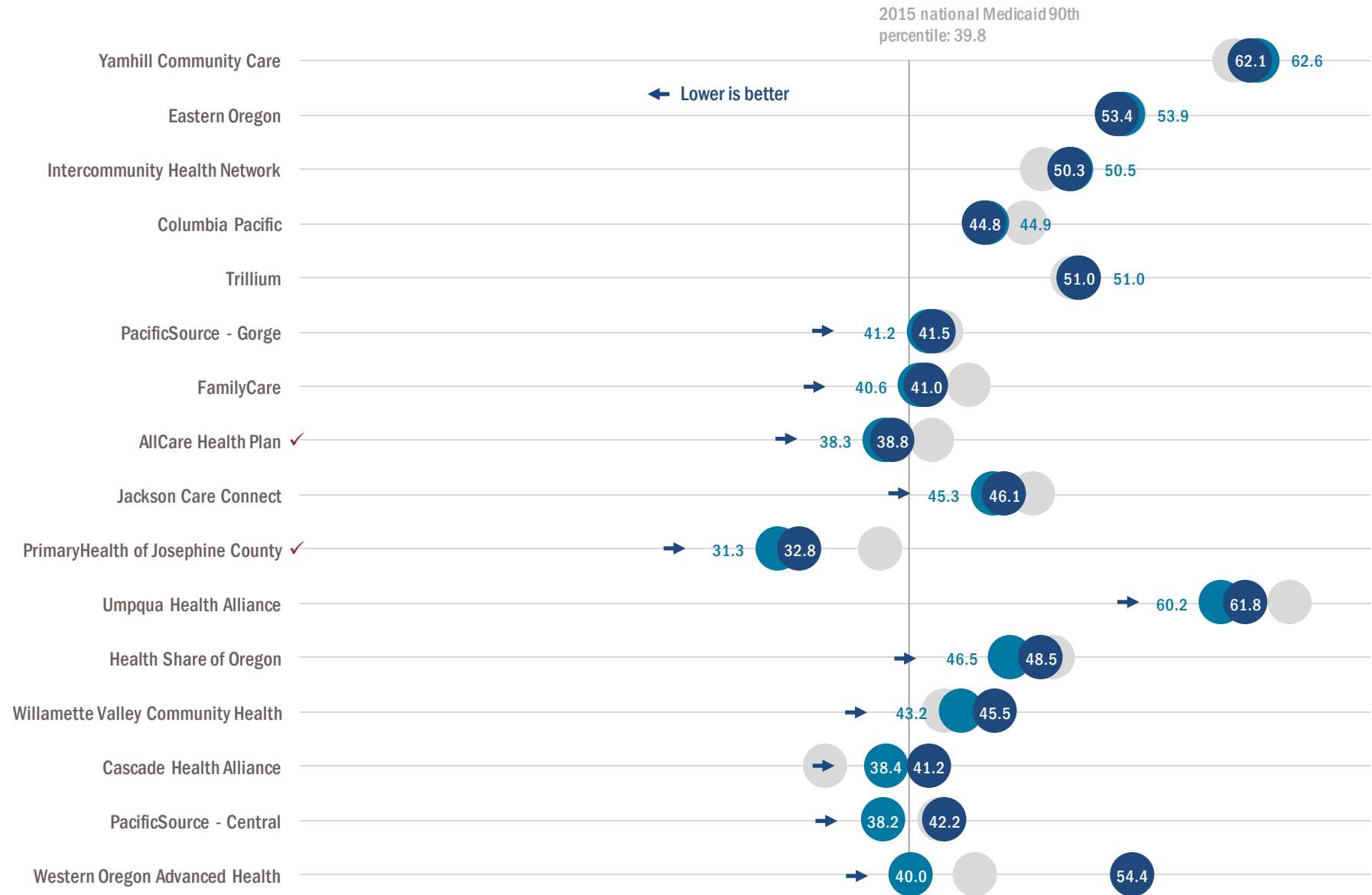




AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

Emergency department utilization in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014





ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Health assessments for children in DHS custody

Percentage of children ages 4+ who received a mental, physical, and dental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care). Physical and dental health assessments are required for children under age 4, but not mental health assessments.

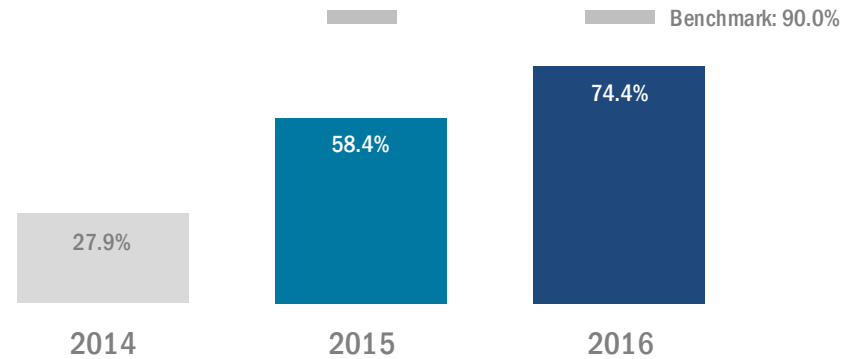
2016 data (n=1,799)

- Statewide change since 2015: **+27.4%**
- Number of CCOs that improved: **14**
- Number of CCOs achieving target: **14**

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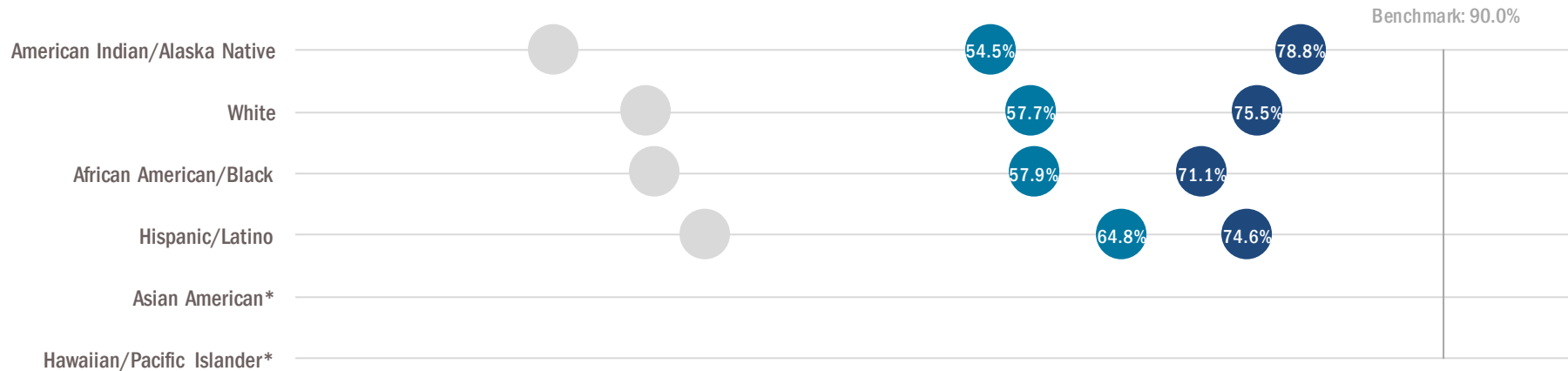
Percentage of children in DHS custody who received health assessments, statewide.

Data source: Administrative (billing) claims + ORKids
Benchmark source: Metrics and Scoring Committee consensus



Percentage of children in DHS custody who received health assessments in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 8.9% of respondents / Each race category excludes Hispanic/Latino
*Data suppressed (n<30)



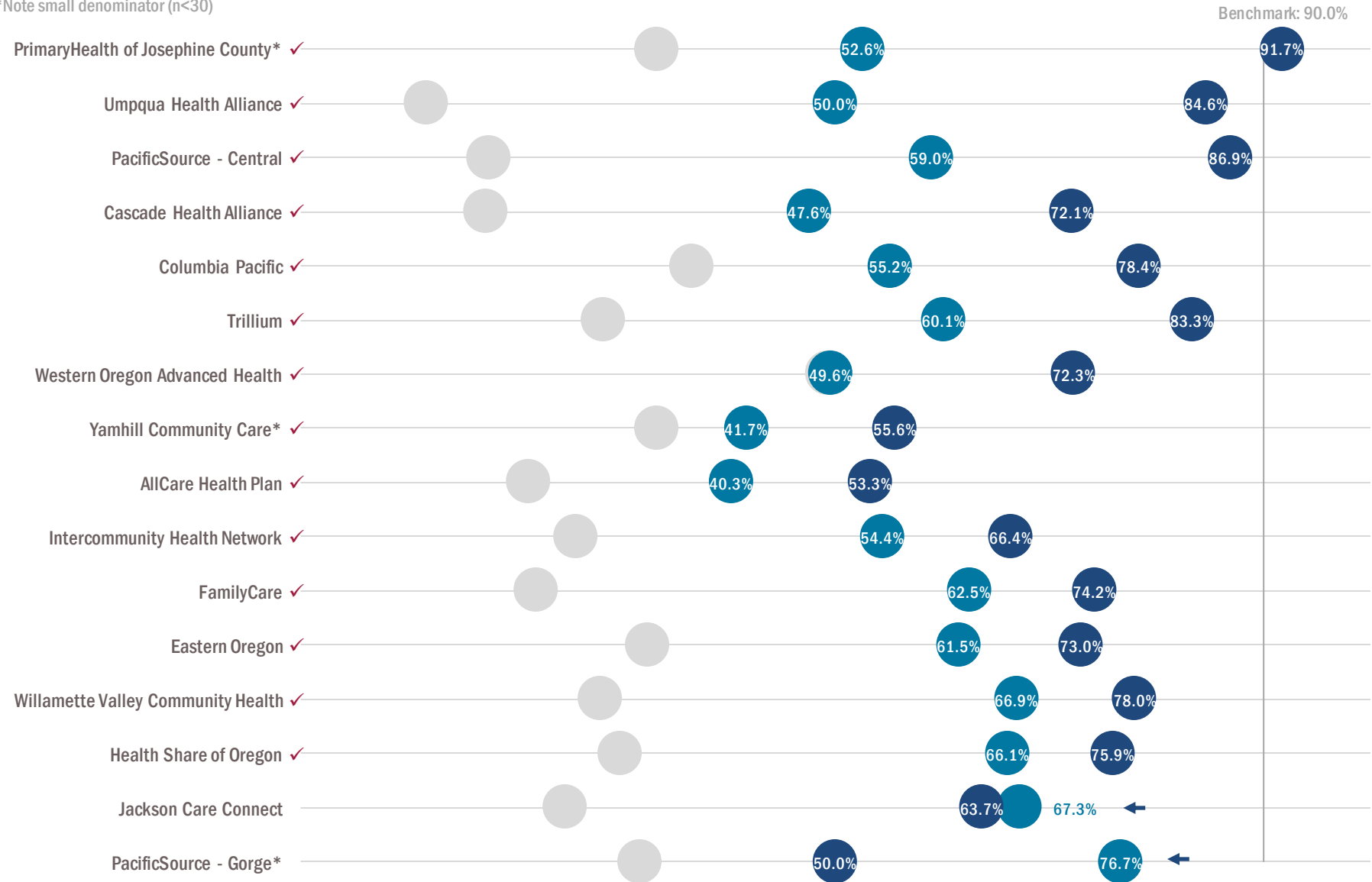


ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Percentage of children in DHS custody who received health assessments in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014

*Note small denominator (n<30)





CHILDHOOD IMMUNIZATION STATUS

Childhood immunization status

Percentage of children who received recommended vaccines (DTaP, IPV, MMR, HiB, Hepatitis B, VZV) before their second birthday.

2016 data (n=14,710)

- Statewide change since 2015: **+0.3%**
- Number of CCOs that improved: **9**
- Number of CCOs achieving target: **5**

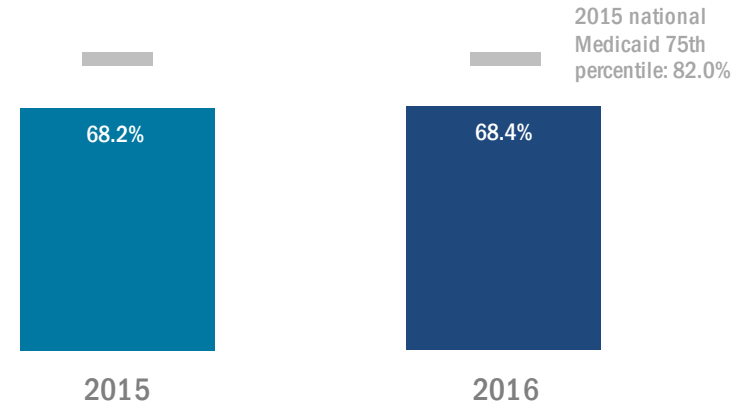
Childhood immunization status is a new incentive measure in 2016.

Data notes: 2015 results have been revised and will differ from previously published reports. 2014 and earlier are not available; results published here should not be directly compared to previously published reports.

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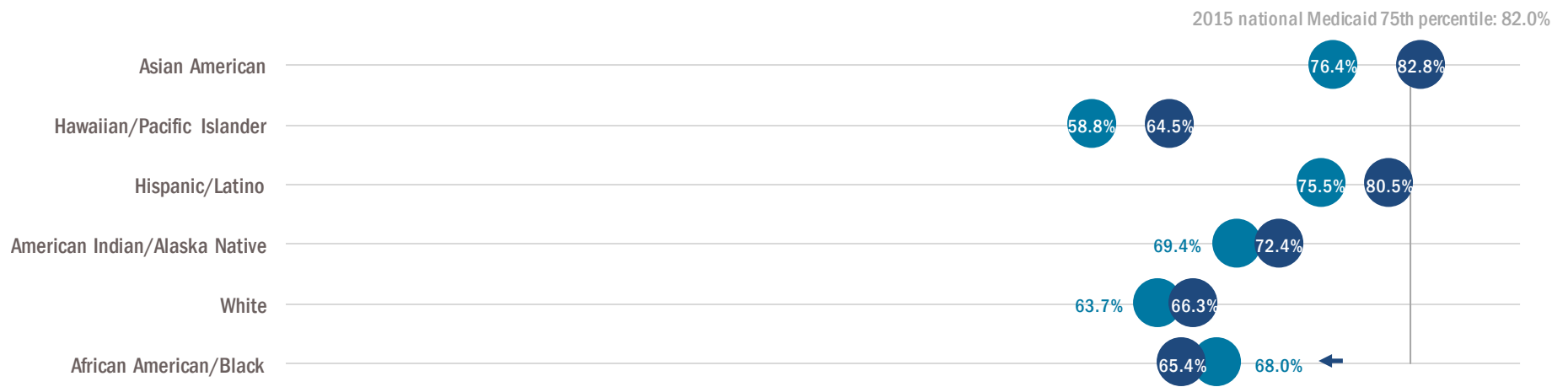
Percentage of children who received recommended vaccines before their second birthday, statewide.

Data source: Administrative (billing) claims and ALERT immunization data



Percentage of children who received recommended vaccines in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 40.3% of respondents / Each race category excludes Hispanic/Latino

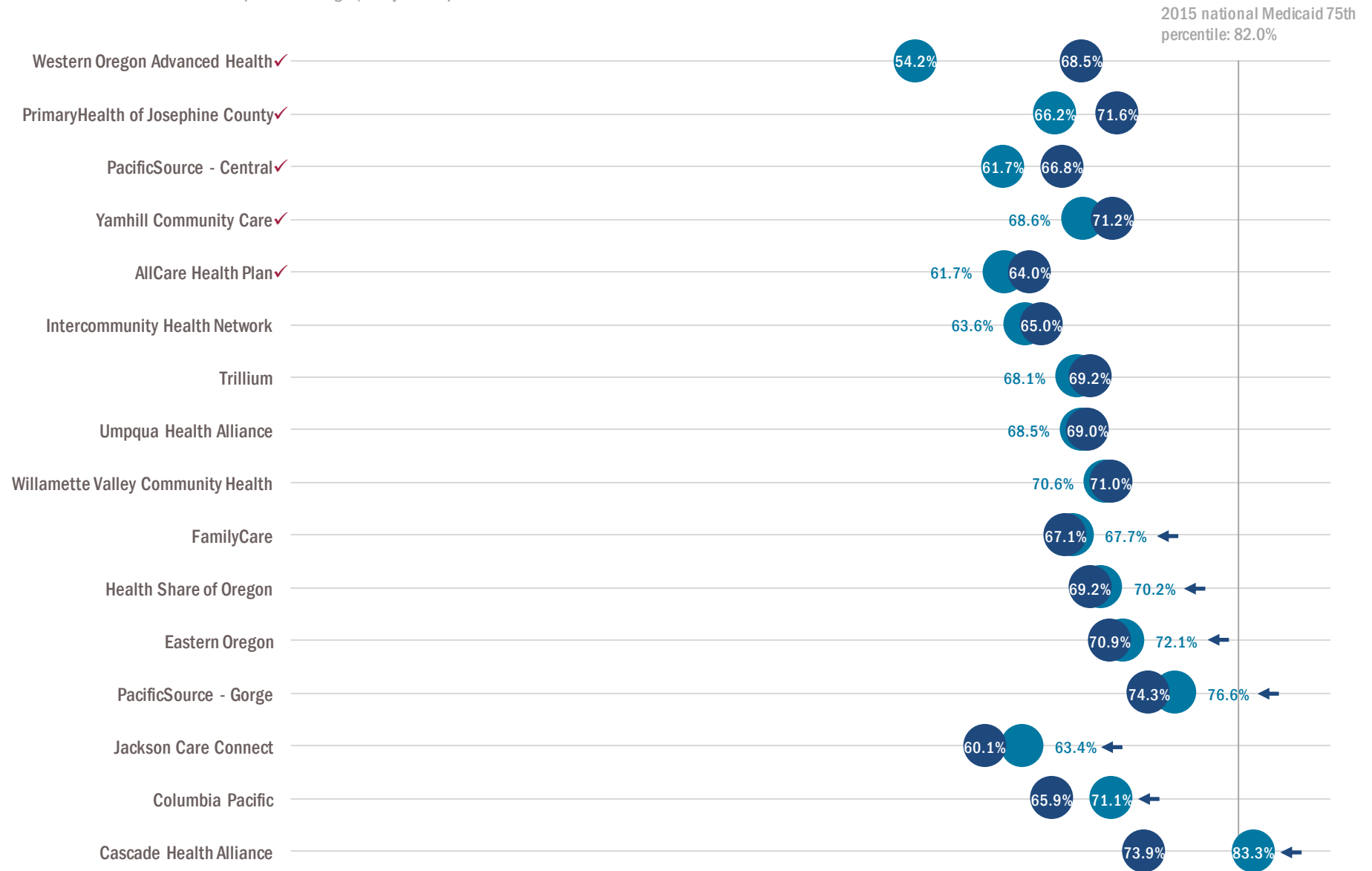




CHILDHOOD IMMUNIZATION STATUS

Percentage of children who received recommended vaccines before their second birthday in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014



\$ CIGARETTE SMOKING PREVALENCE

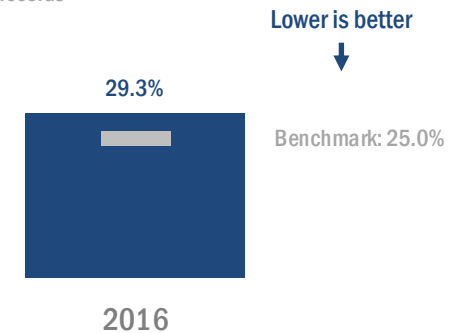
Cigarette smoking prevalence

Cigarette smoking prevalence is a new incentive measure in 2016. This bundled measure is intended to address both cessation benefits offered by CCOs and cigarette smoking prevalence. The bundled measure has three components, each worth a certain score. CCOs must meet a certain threshold score to meet the measure in a given year. The scoring, or weighting, of the components changes over the years, to allow CCOs time to phase in efforts to reduce prevalence (see table below).

The intent of the measure is to address tobacco prevalence (including cigarette smoking and other tobacco products such as chew, snuff, and cigars). However, due to variation in how EHRs capture smoking and tobacco use data, and to ensure comparability across EHRs and CCOs, the measure looks at two separate rates: 1) cigarette smoking; and 2) tobacco use. As not all EHRs are able to report on tobacco use, only the cigarette smoking prevalence is used for comparison to the benchmark.

Cigarette smoking prevalence, statewide.

Data source: Electronic health records



2016 data (n=204,266)

- 1) Number of CCOs meeting cessation benefit requirement: **15**
 - 2) Number of CCOs reporting EHR data: **16**
 - 3) Number of CCOs achieving benchmark: **2**
- Number of CCOs earning incentive payment: **15**

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Measure components	2016		2017		2018	
	Component weighting	Threshold to earn incentive	Weighting	Threshold	Weighting	Threshold
1) Meeting cessation benefit requirement (pass/fail) <i>CCO <u>must</u> meet this component to meet the measure</i>	40%	60%	33%	66%	25%	70%
2) Reporting EHR-based prevalence data	40%		33%		25%	
3) Reducing prevalence (meeting benchmark/target)	20%		33%		50%	

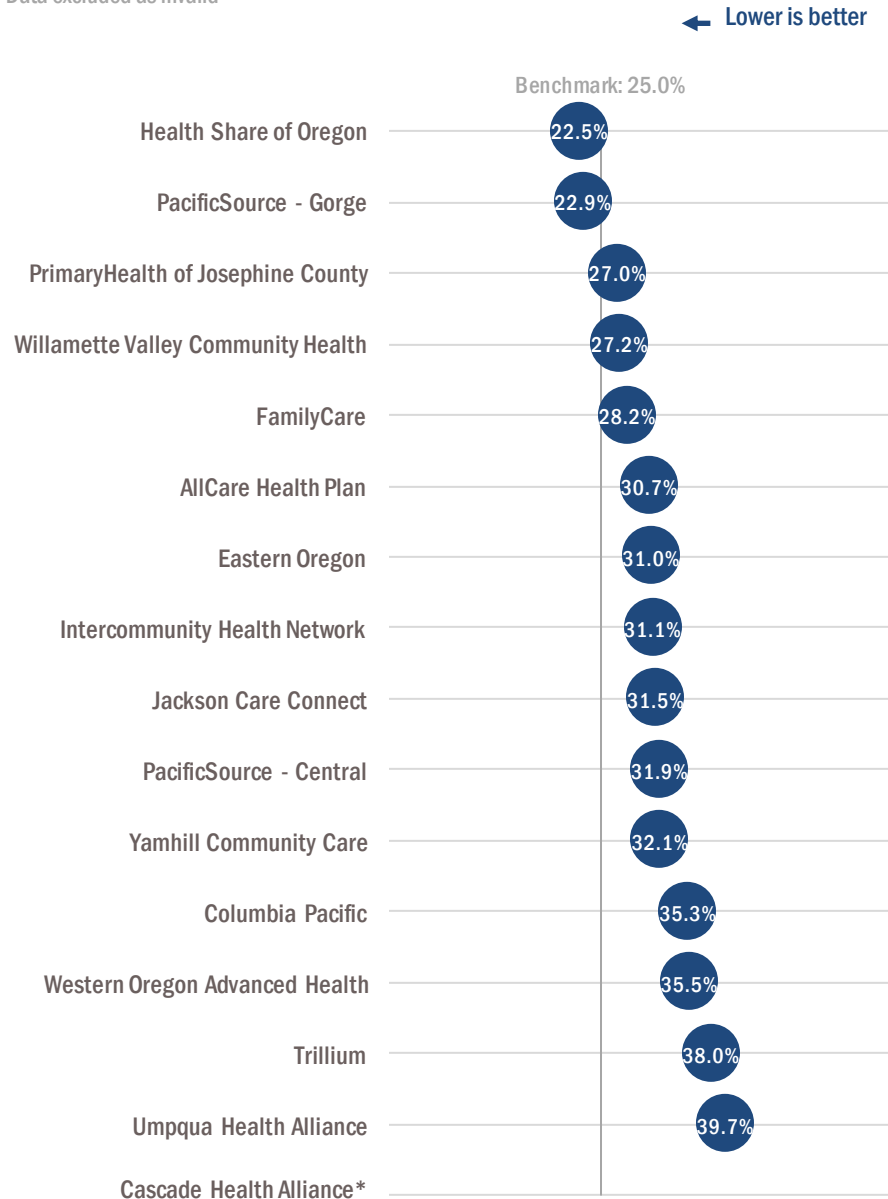
\$ CIGARETTE SMOKING PREVALENCE

✓ indicates CCO achieved measure by achieving at least 60% composite score	Measure component (and weight in 2016)			Composite score
	Providing cessation benefit (40%)	Reporting EHR data (40%)	Achieving benchmark (20%)	
✓ AllCare Health Plan	✓	✓		80%
Cascade Health Alliance		✓		40%
✓ Columbia Pacific	✓	✓		80%
✓ Eastern Oregon	✓	✓		80%
✓ FamilyCare	✓	✓		80%
✓ Health Share of Oregon	✓	✓	✓	100%
✓ Intercommunity Health Network	✓	✓		80%
✓ Jackson Care Connect	✓	✓		80%
✓ PacificSource - Central	✓	✓		80%
✓ PacificSource - Gorge	✓	✓	✓	100%
✓ PrimaryHealth of Josephine County	✓	✓		80%
✓ Trillium	✓	✓		80%
✓ Umpqua Health Alliance	✓	✓		80%
✓ Western Oregon Advanced Health	✓	✓		80%
✓ Willamette Valley Community Health	✓	✓		80%
✓ Yamhill Community Care	✓	✓		80%

\$ CIGARETTE SMOKING PREVALENCE

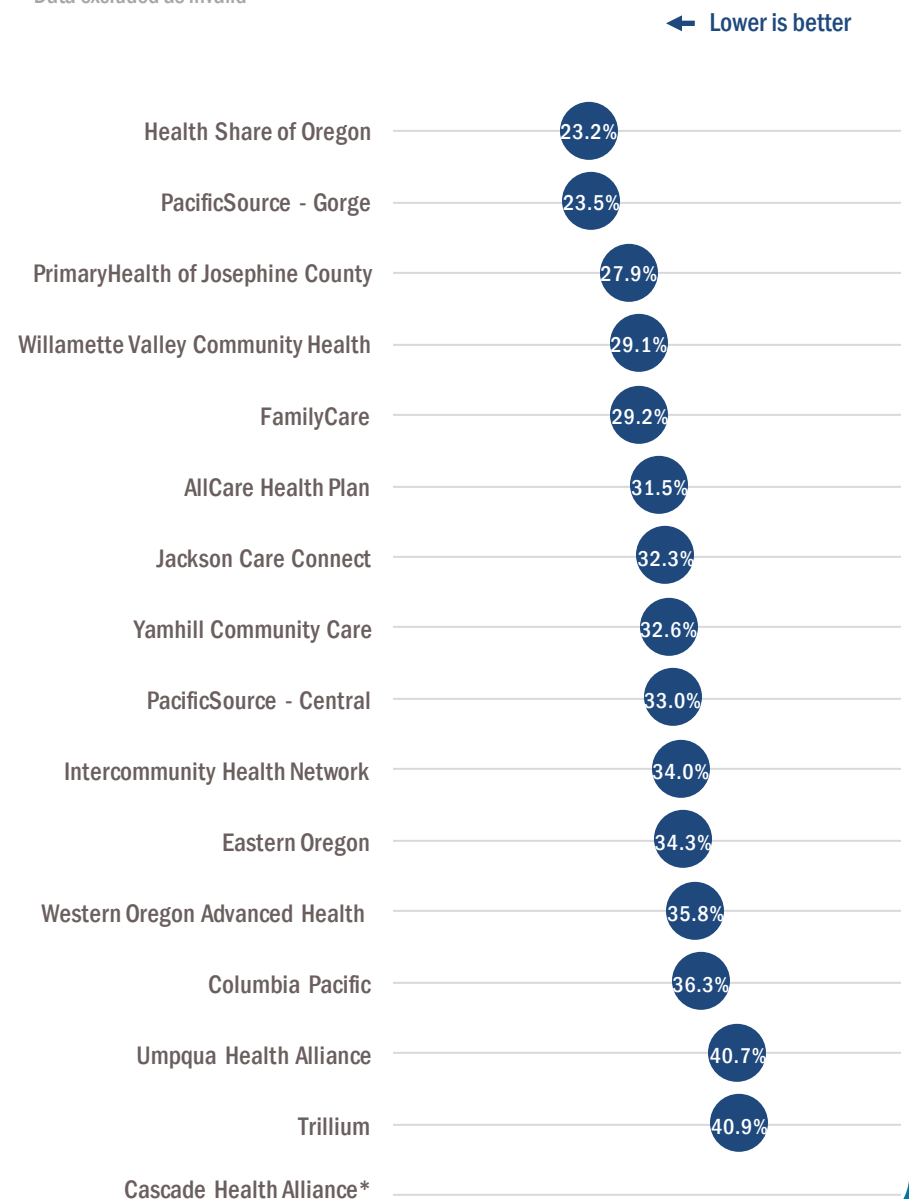
Cigarette smoking prevalence in 2016, by CCO.

*Data excluded as invalid



Tobacco use prevalence in 2016, by CCO.

*Data excluded as invalid





COLORECTAL CANCER SCREENING

Colorectal cancer screening

Percent of adult members (ages 50-75) who had appropriate screening for colorectal cancer.

2016 data (n=6,575)

- Statewide change since 2015: **+6.7%**
- Number of CCOs that improved: **14**
- Number of CCOs achieving target: **all 16**

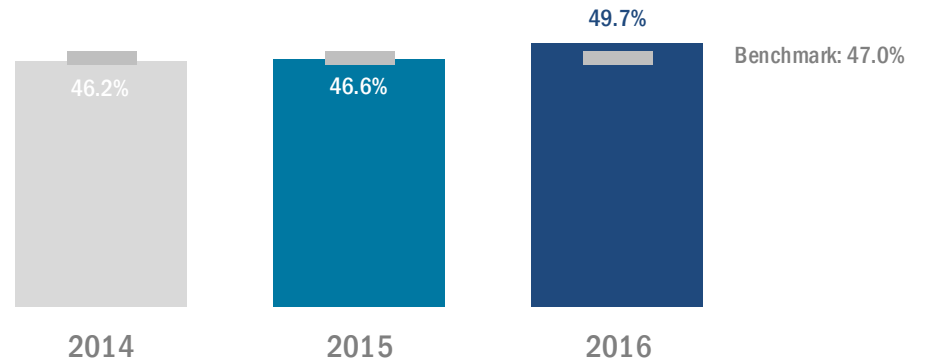
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Race and ethnicity are not available for this measure.

Percentage of adult members who had appropriate screening for colorectal cancer, statewide.

Data source: Administrative (billing) claims and medical record review

Benchmark source: Metrics and Scoring Committee consensus

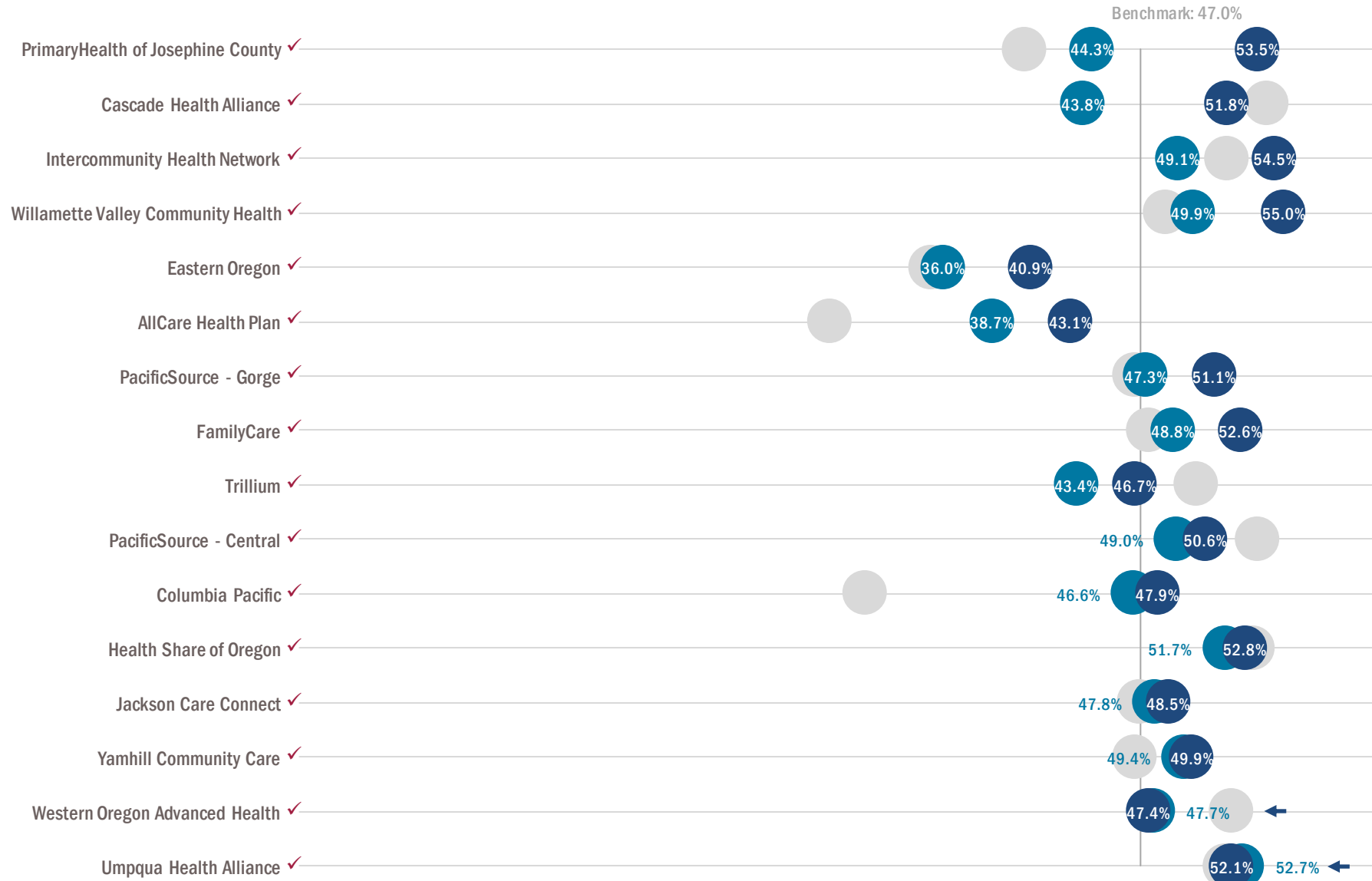




COLORECTAL CANCER SCREENING

Percentage of adult members who had appropriate screening for colorectal cancer in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014





CONTROLLING HIGH BLOOD PRESSURE

Controlling high blood pressure

Percentage of adult patients (ages 18–85) with a diagnosis of hypertension (high blood pressure) whose condition was adequately controlled.

2016 data (n=114,749)

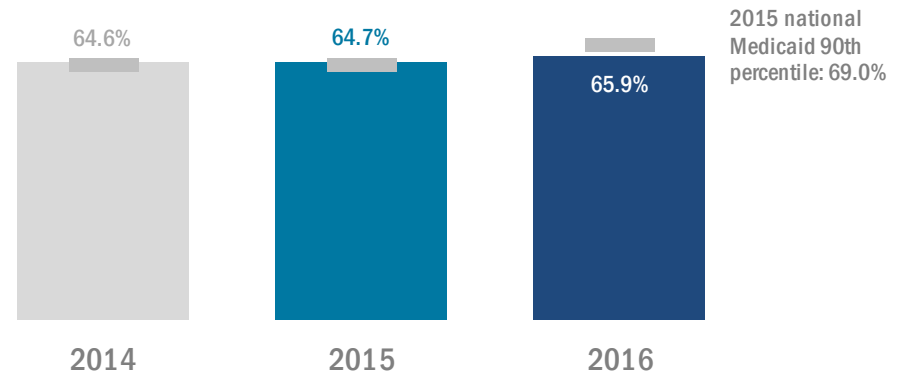
- Statewide change since 2015: **+1.9%**
- Number of CCOs that improved: **9**
- Number of CCOs achieving target: **9**

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Race and ethnicity are not available for this measure.

Percentage of adult with high blood pressure whose condition was adequately controlled, statewide.

Data source: Electronic Health Records

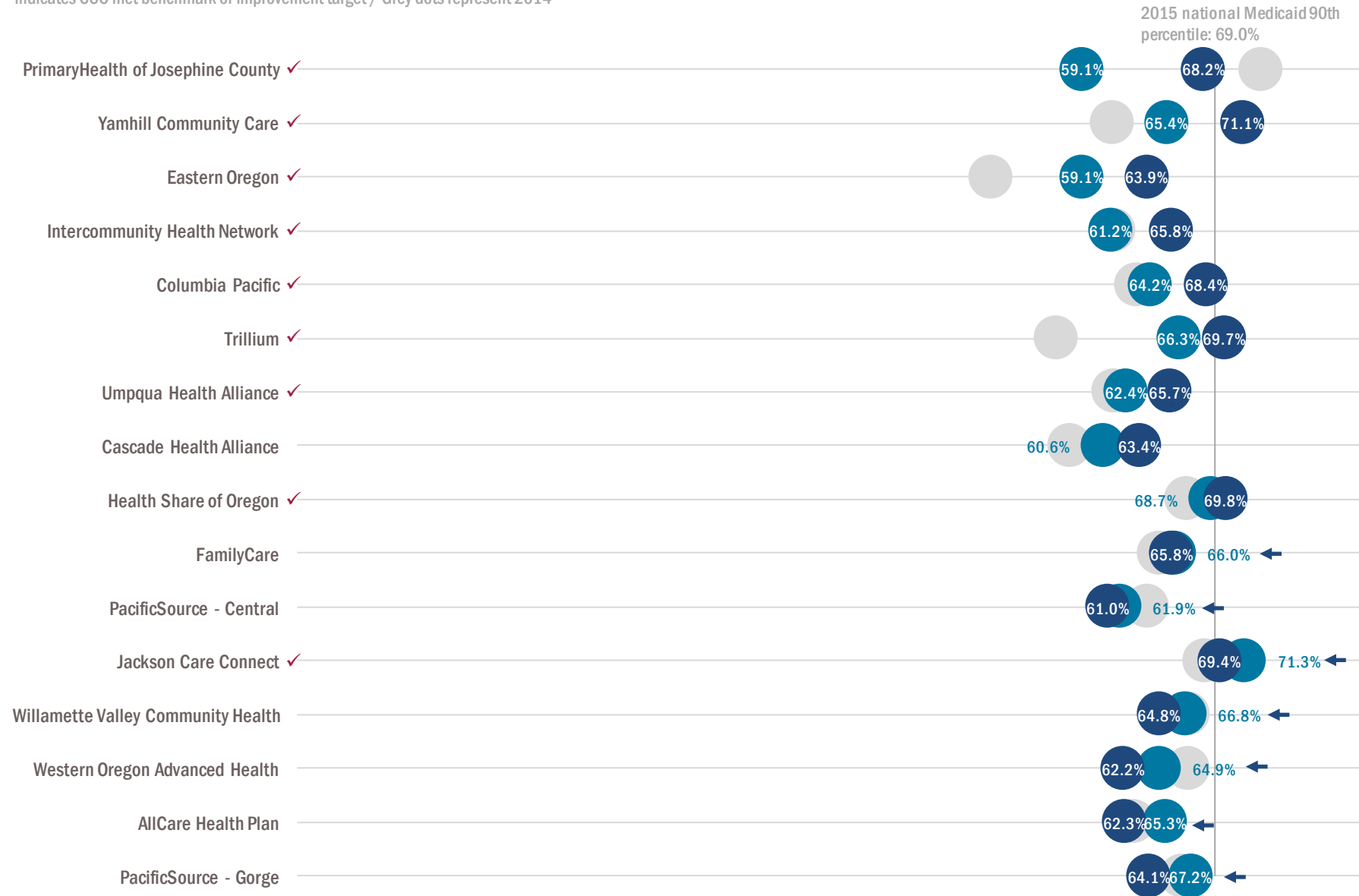




CONTROLLING HIGH BLOOD PRESSURE

Percentage of adult with high blood pressure whose condition was adequately controlled in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014



\$ DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (all ages)

Dental sealants on permanent molars for children (all ages)

Percentage of children ages 6-14 who received a dental sealant during the measurement year.

2016 data (n=119,169)

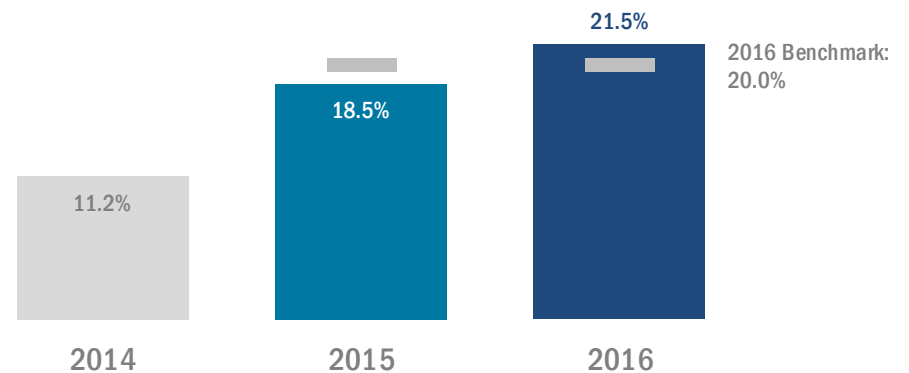
- Statewide change since 2015: **+16.2%**
- Number of CCOs that improved: **14**
- Number of CCOs achieving target: **15**

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Dental sealants for children ages 6-14, statewide.

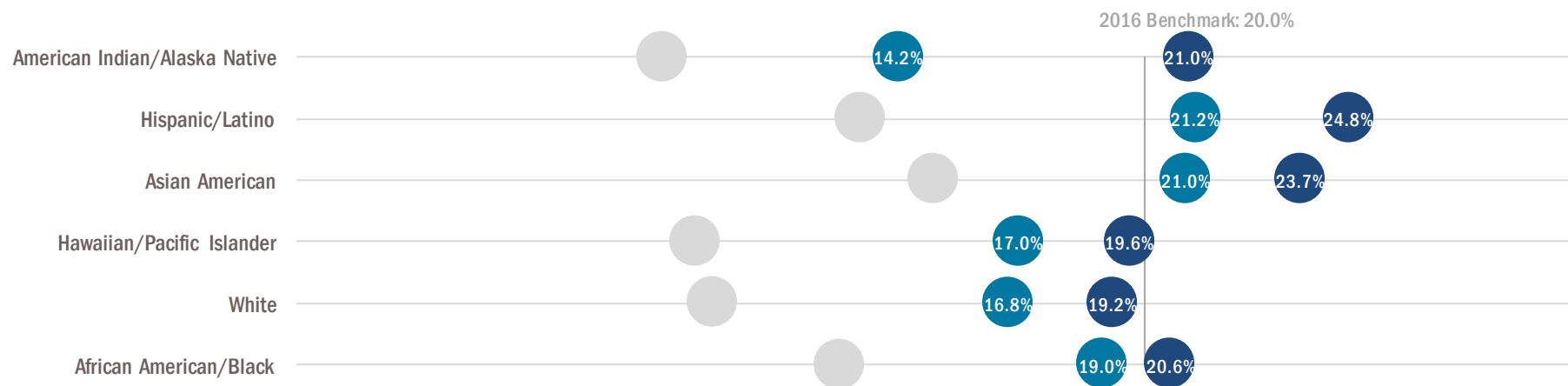
Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



Dental sealants for children ages 6-14 in 2015 and 2016, by race and ethnicity.

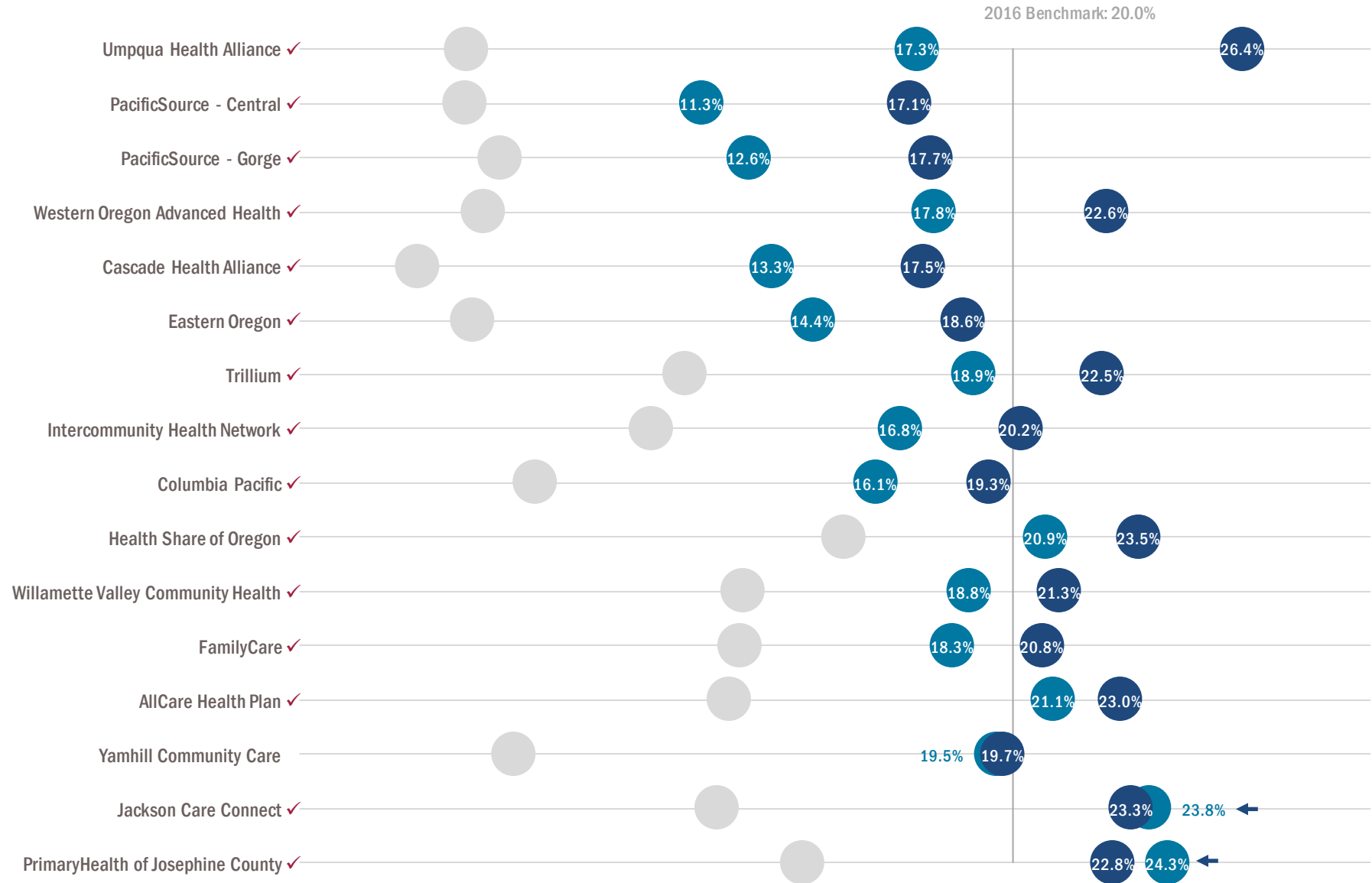
Grey dots represent 2014 / Race and ethnicity data missing for 39.6% of respondents / Each race category excludes Hispanic/Latino



\$ DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (all ages)

Dental sealants for children ages 6-14 in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 6-9)

Dental sealants on permanent molars for children (ages 6-9)

Percentage of children ages 6-9 who received a dental sealant during the measurement year.

2016 data (n=56,167)

- Statewide change since 2015: **+17.4%**
- Number of CCOs that improved: **15**

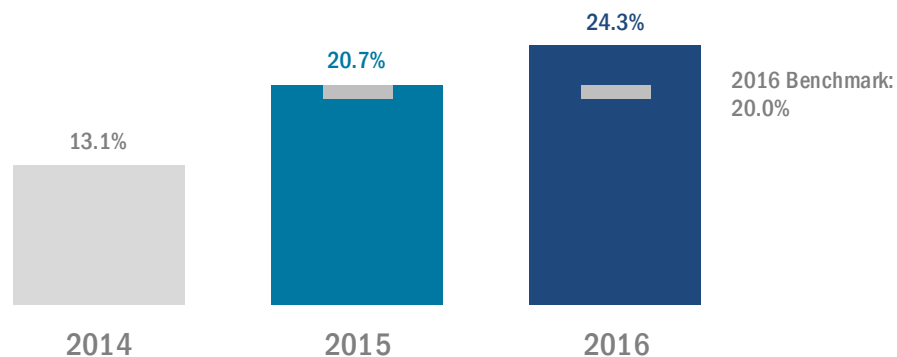
Results are stratified by age group (6-9 and 10-14) for reporting and monitoring purposes only. Incentive payments are based on all ages combined ([see page 42](#)).

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Dental sealants for children ages 6-9, statewide.

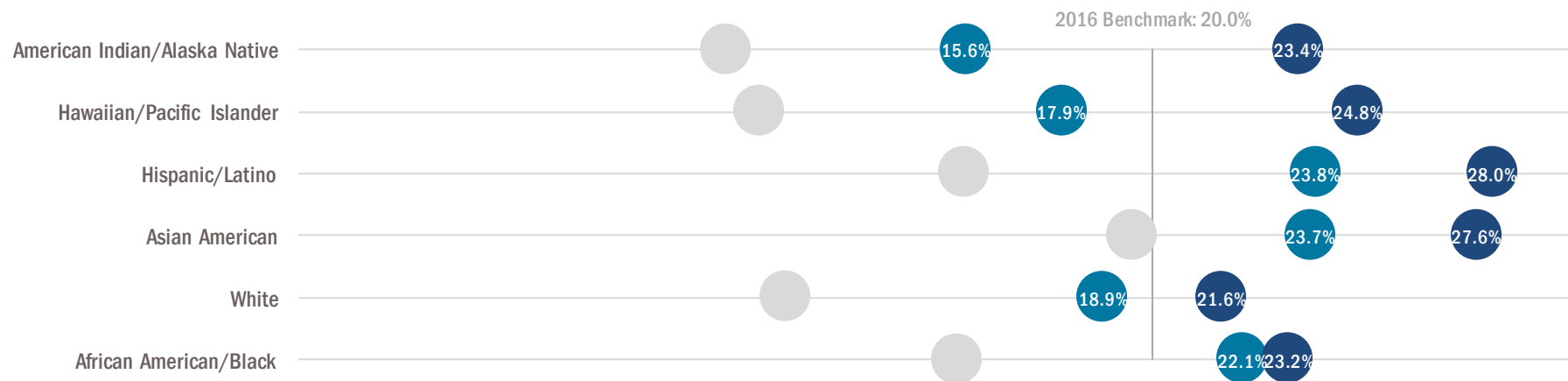
Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



Dental sealants for children ages 6-9 in 2015 and 2016, by race and ethnicity.

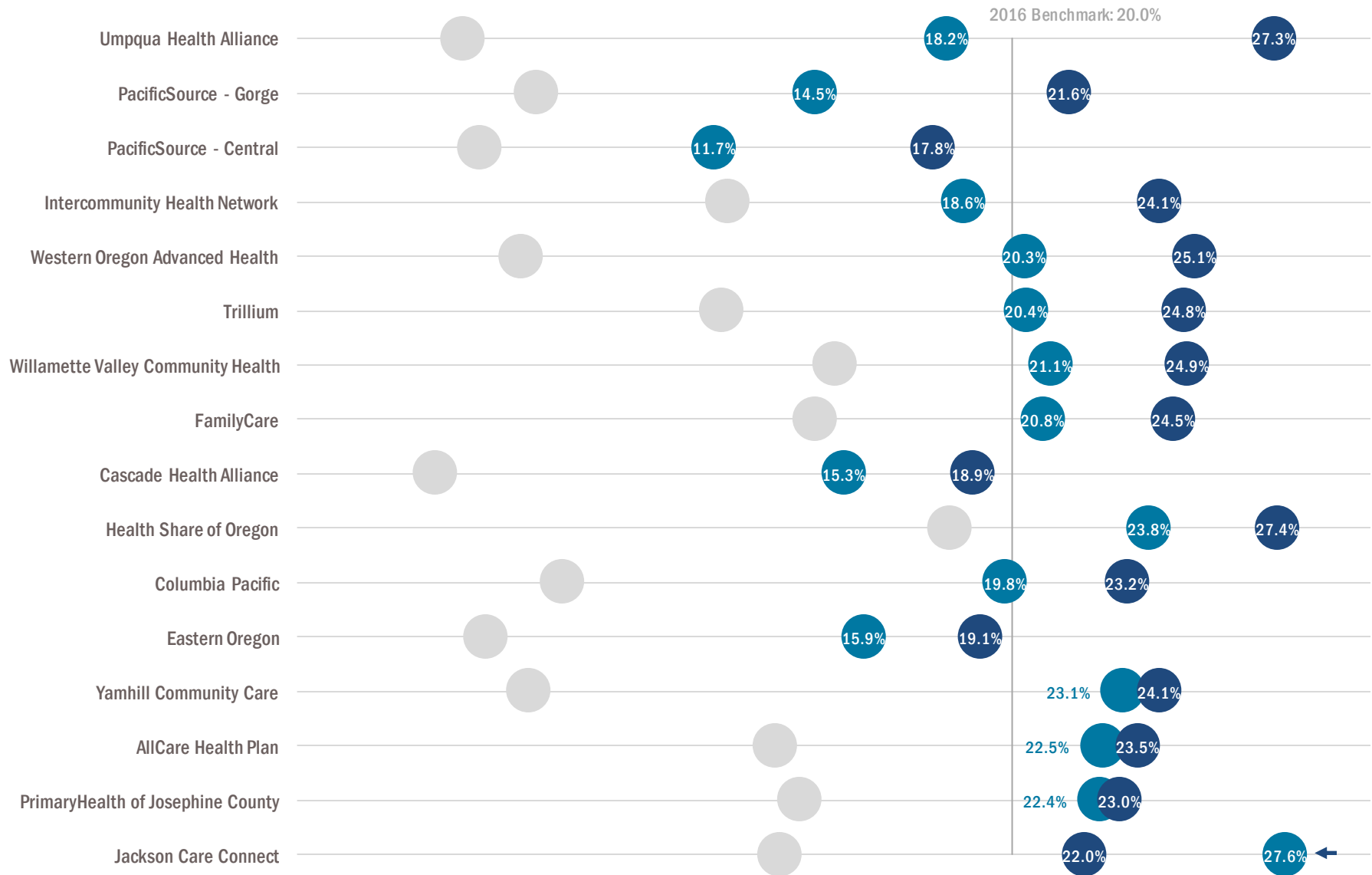
Grey dots represent 2014 / Race and ethnicity data missing for 40.1% of respondents / Each race category excludes Hispanic/Latino



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 6-9)

Dental sealants for children ages 6-9 in 2015 and 2016, by CCO.

Grey dots represent 2014



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 10-14)

Dental sealants on permanent molars for children (ages 10-14)

Percentage of children ages 10-14 who received a dental sealant during the measurement year.

2016 data (n=63,002)

- Statewide change since 2015: **+15.8%**
- Number of CCOs that improved: **14**

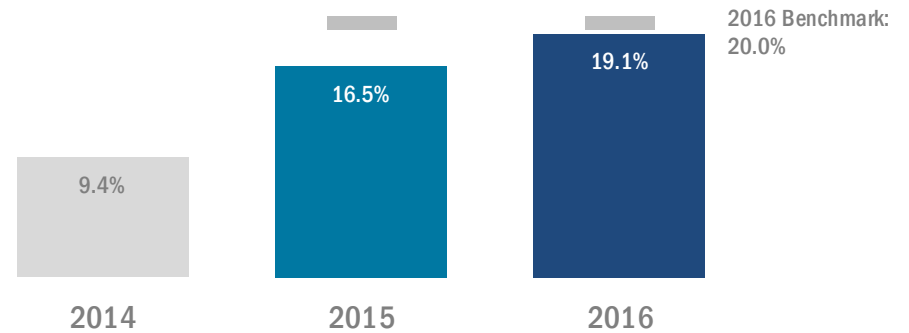
Results are stratified by age group (6-9 and 10-14) for reporting and monitoring purposes only. Incentive payments are based on all ages combined ([see page 42](#)).

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Dental sealants for children ages 10-14, statewide.

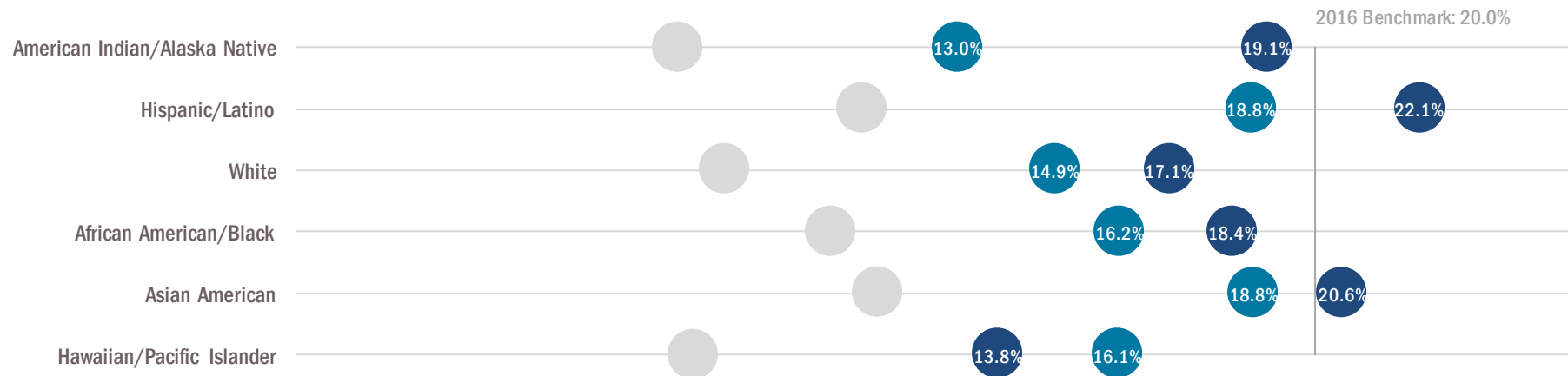
Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



Dental sealants for children ages 10-14 in 2015 and 2016, by race and ethnicity.

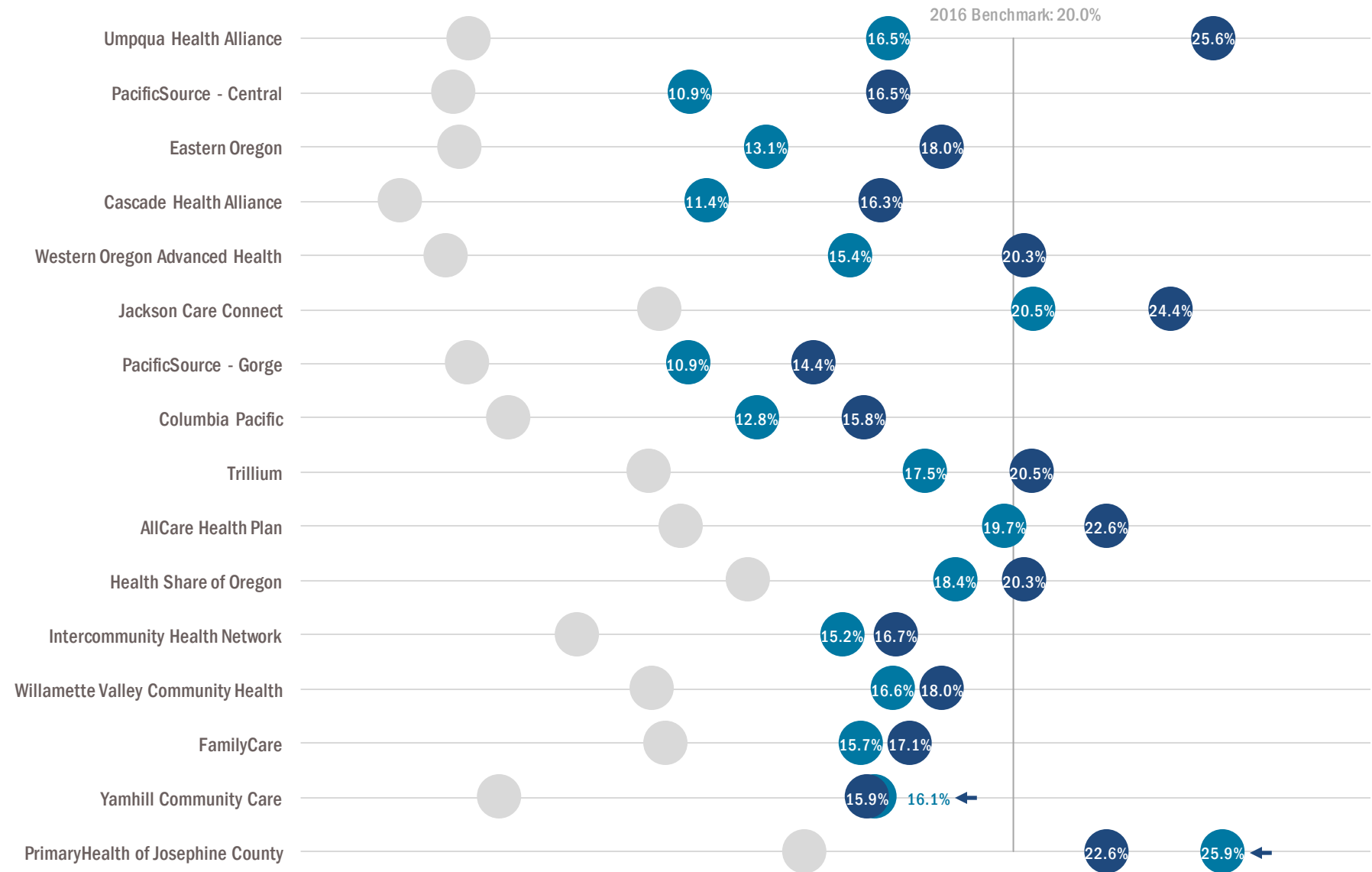
Grey dots represent 2014 / Race and ethnicity data missing for 39.1% of respondents / Each race category excludes Hispanic/Latino



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 10-14)

Dental sealants for children ages 10-14 between 2015 and 2016, by CCO.

Grey dots represent 2014





DEPRESSION SCREENING AND FOLLOW-UP PLAN

Depression screening and follow-up plan

Percentage of adult patients (ages 12 and older) who had appropriate screening and follow-up planning for major depression.

2016 data (n= 408,895)

- Statewide change since 2015: **+28.3%**
- Number of CCOs that improved: **14**
- Number of CCOs achieving target: **all 16**

Depression screening and follow-up plan is a challenge pool measure in 2016 ([see page 12](#) for more information).

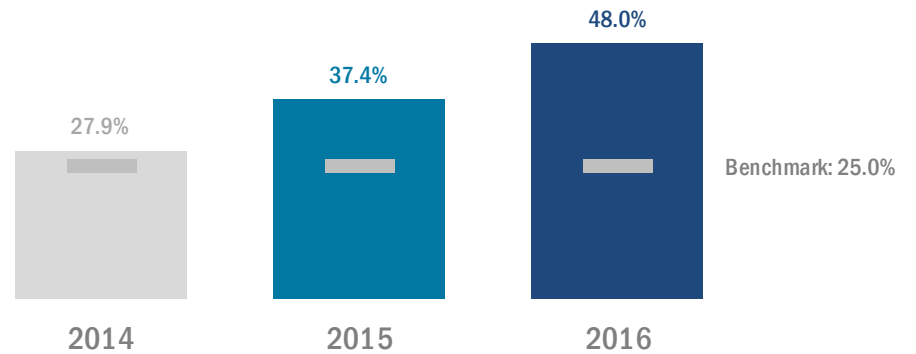
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Race and ethnicity are not available for this measure.

Percentage of adult members who were screened for depression and had an appropriate follow-up plan, statewide.

Data source: Electronic health records

Benchmark source: Metrics and Scoring Committee consensus

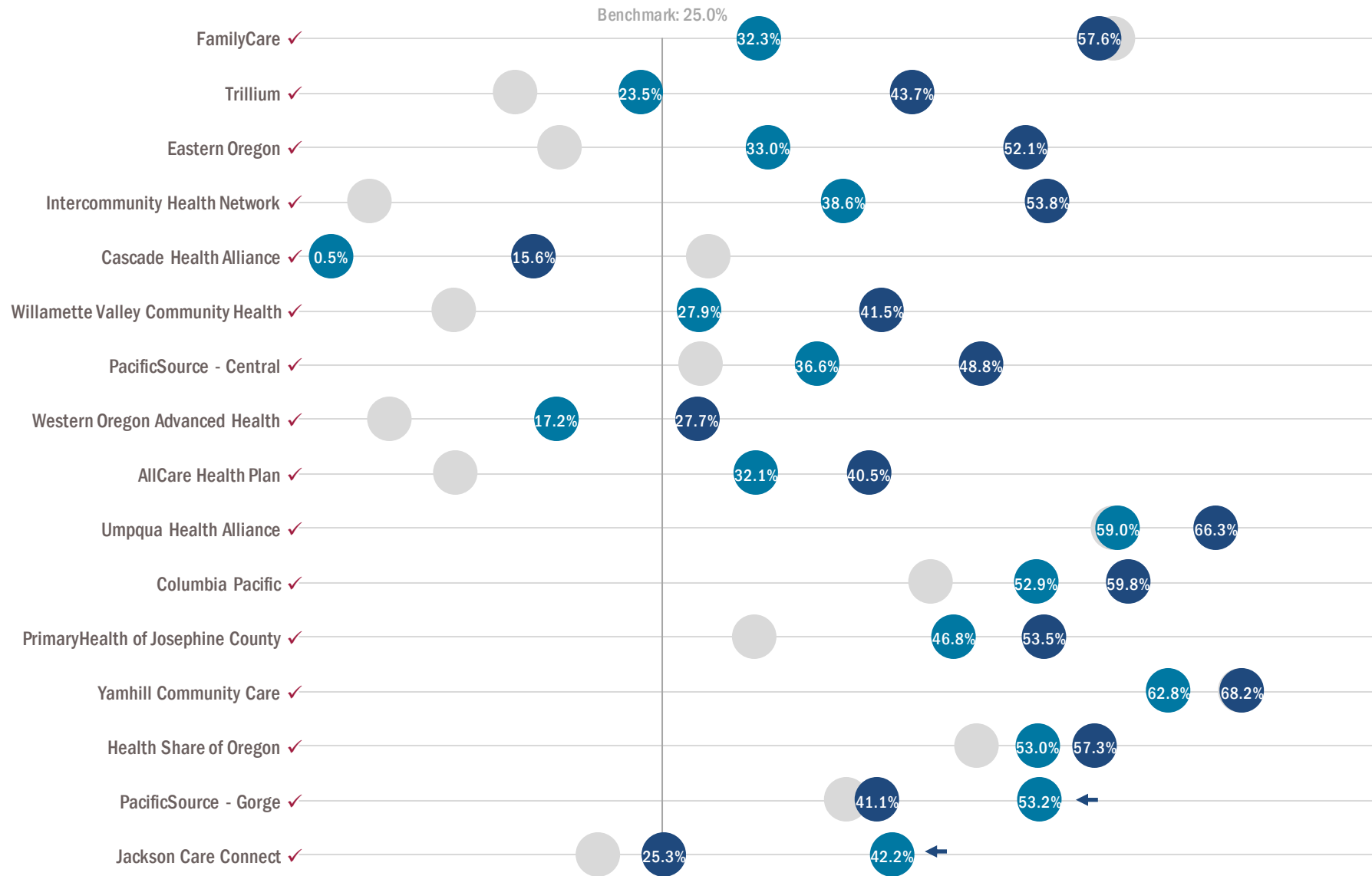




DEPRESSION SCREENING AND FOLLOW-UP PLAN

Percentage of adult members who were screened for depression and had an appropriate follow-up plan in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014





DEVELOPMENTAL SCREENING IN THE FIRST 36 MONTHS OF LIFE

Developmental screening in the first 36 months of life

Percentage of children who were screened for risks of developmental, behavioral and social delays using standardized screening tools in the 12 months preceding their first, second or third birthday.

2016 data (n=47,754)

- Statewide change since 2015: **+13.7%**
- Number of CCOs that improved: **all 16**
- Number of CCOs achieving target: **all 16**

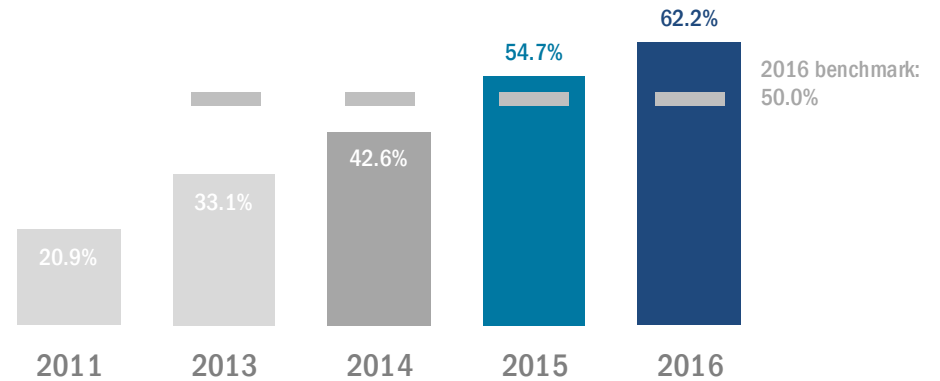
Developmental screening is a 2016 challenge pool measure ([see page 12](#) for more information).

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Developmental screening, statewide.

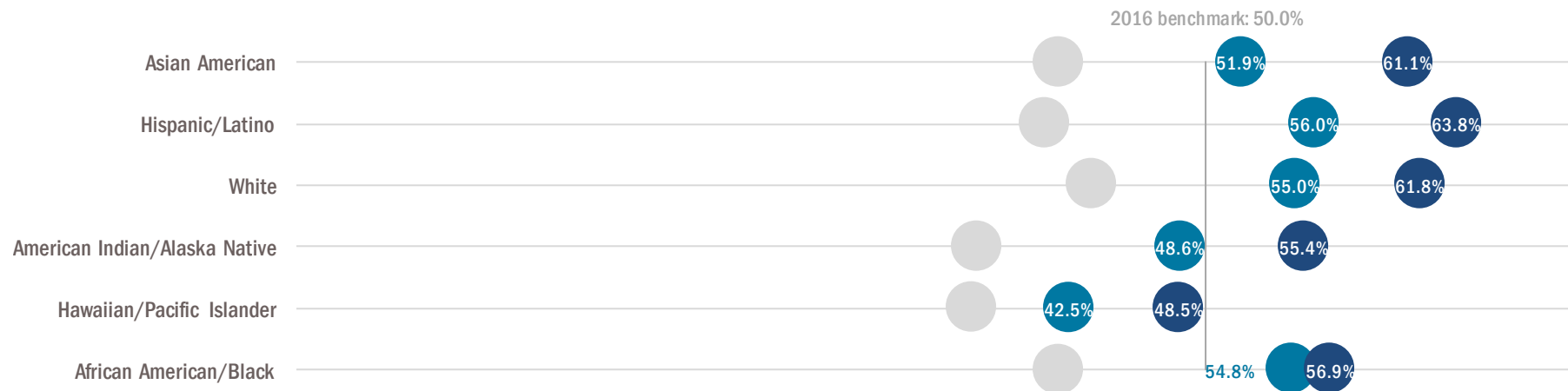
Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



Developmental screening in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 39.9% of respondents / Each race category excludes Hispanic/Latino

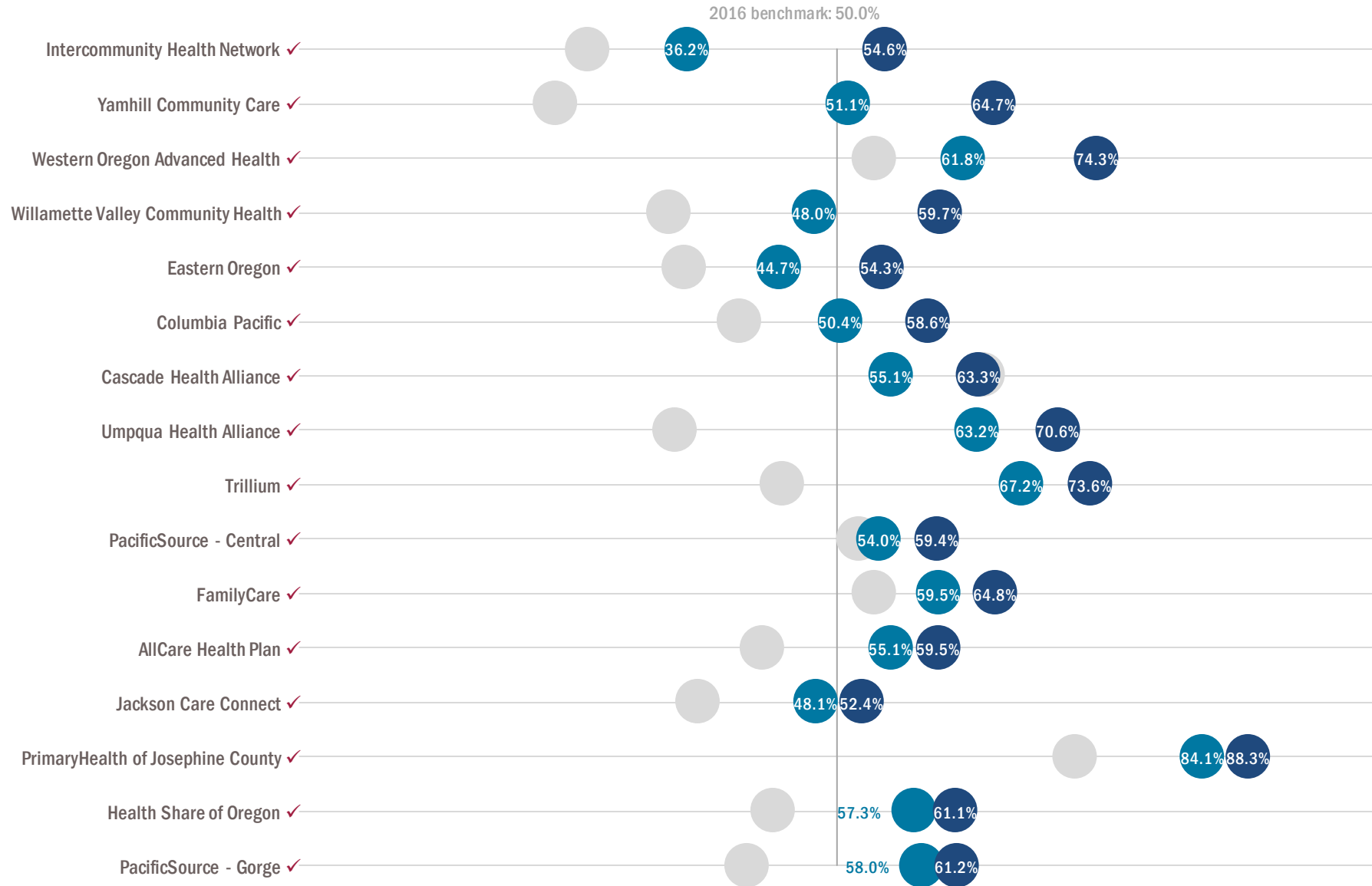




DEVELOPMENTAL SCREENING IN THE FIRST 36 MONTHS OF LIFE

Developmental screening in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014





DIABETES CARE: HbA1c POOR CONTROL

Diabetes care: HbA1c poor control.

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. A lower score is better.

2016 data (n=57,308)

- Statewide change since 2015: **-4.9%**
- Number of CCOs that improved: **10**
- Number of CCOs achieving target: **6**

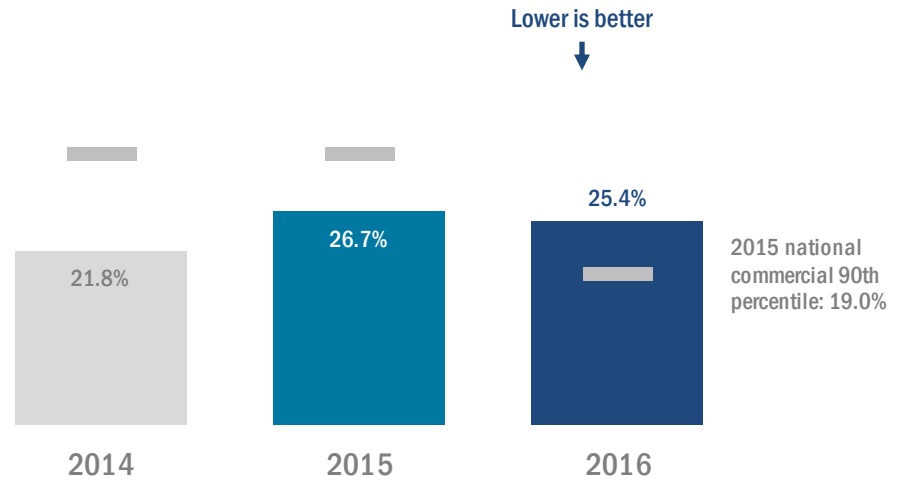
Diabetes HbA1c poor control is a 2016 challenge pool measure ([see page 12](#) for more information).

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Race and ethnicity are not available for this measure.

Percentage of adult members with diabetes whose hemoglobin A1c was poorly controlled, statewide.

Data source: Electronic Health Records





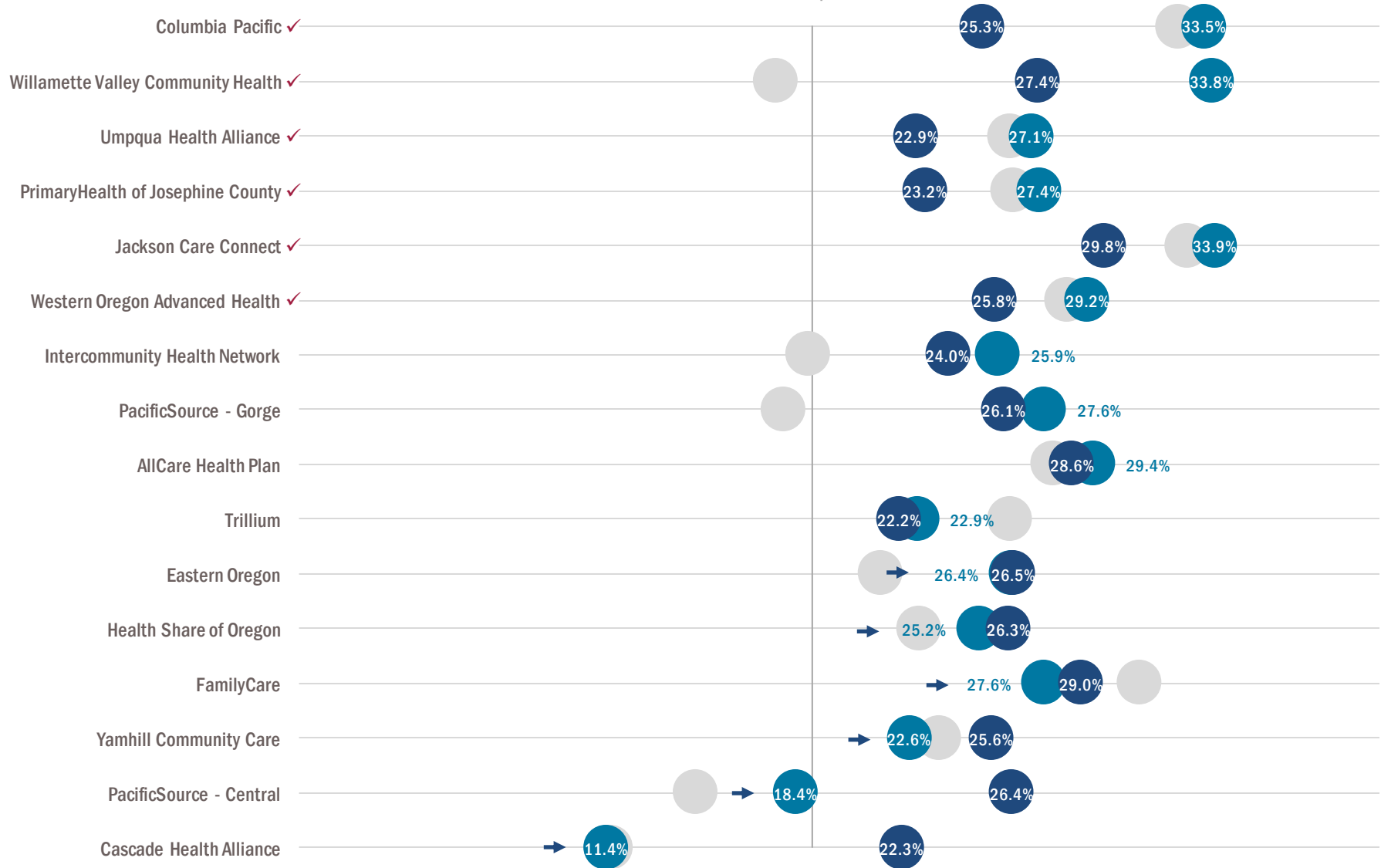
DIABETES CARE: HbA1c POOR CONTROL

Percentage of adult members with diabetes whose hemoglobin A1c was poorly controlled in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014

2015 national commercial 90th percentile: 19.0%

← Lower is better





EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 18-50)

Effective contraceptive use among women at risk of unintended pregnancy (ages 18-50)

Percentage of adult women (ages 18-50) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

2016 data (n=110,590)

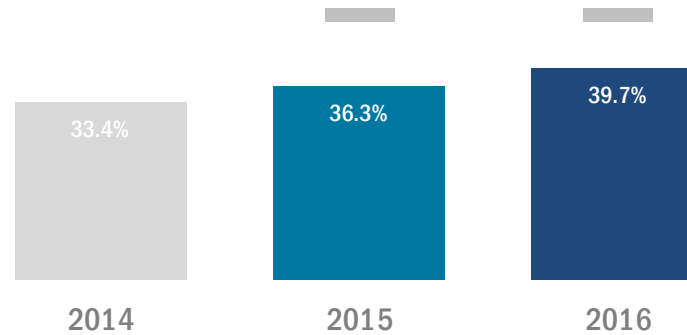
- Statewide change since 2015: **+9.4%**
- Number of CCOs that improved: **15**
- Number of CCOs achieving target: **13**

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Effective contraceptive use among adults, statewide.

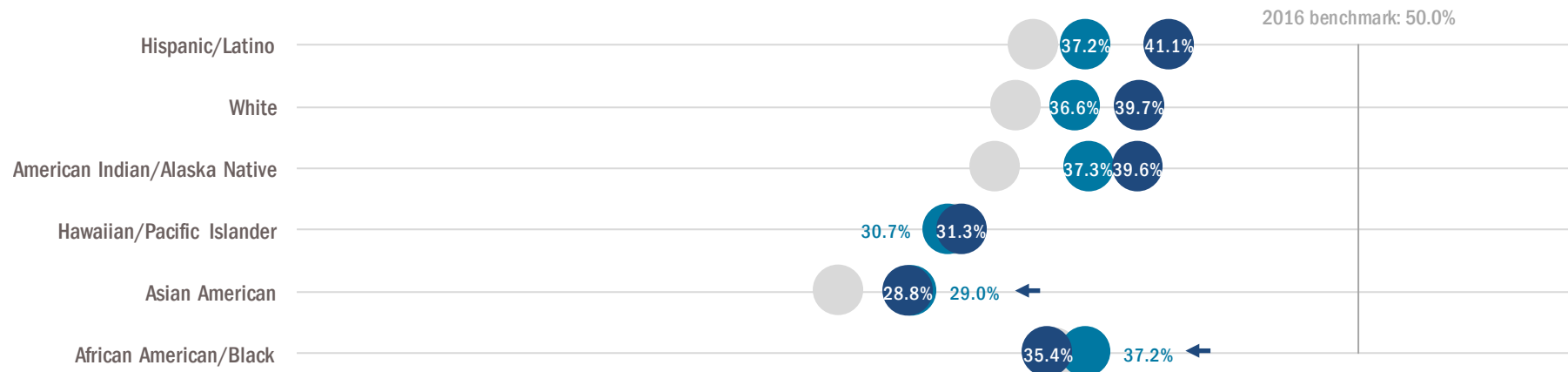
Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



Effective contraceptive use among adults in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 32.4% of respondents / Each race category excludes Hispanic/Latino

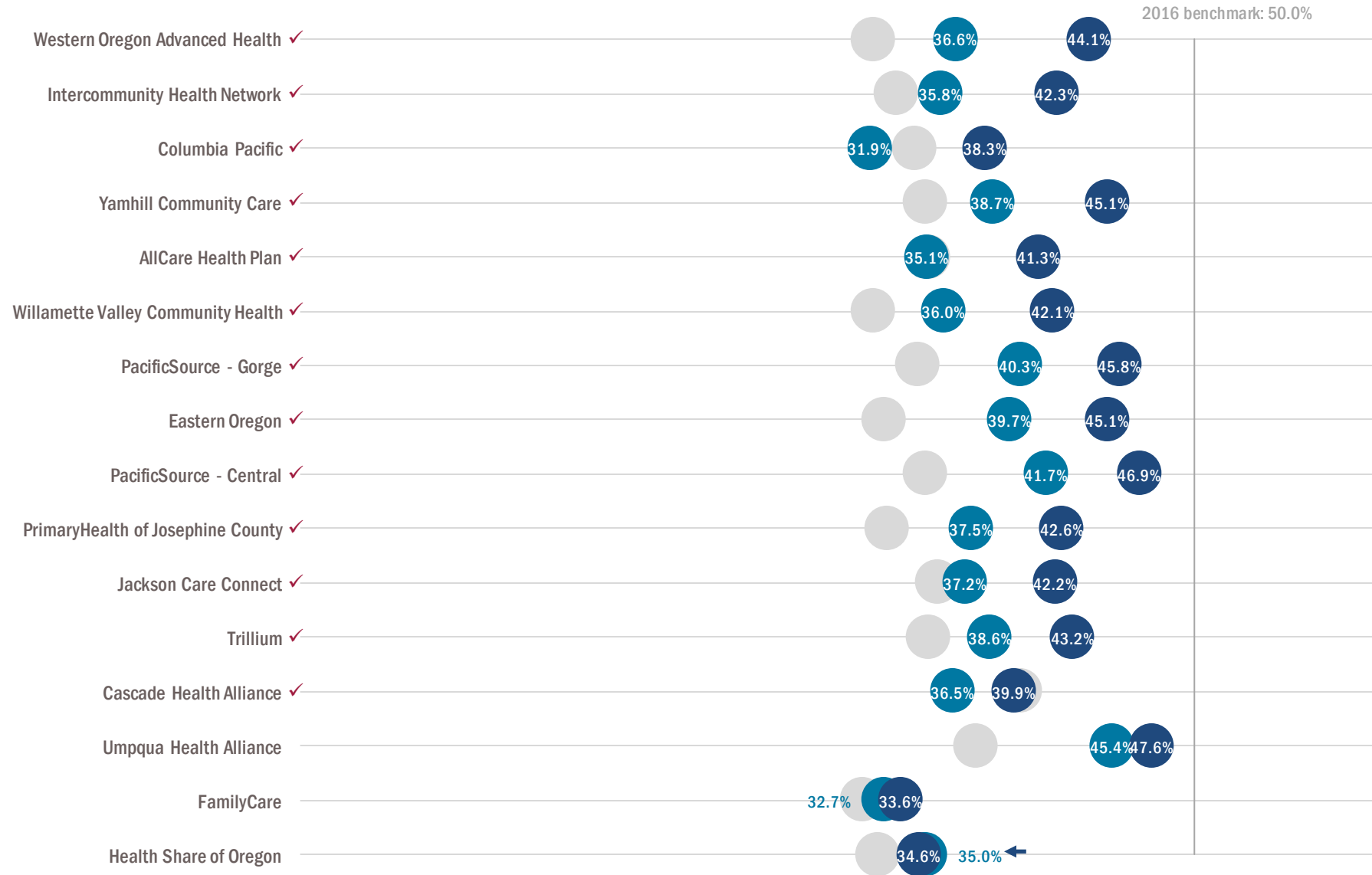




EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 18-50)

Effective contraceptive use among adults in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 15-17)

Effective contraceptive use among women at risk of unintended pregnancy (ages 15-17)

Percentage of adolescent women (ages 15-17) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

2016 data (n=16,433)

- Statewide change since 2015: **+3.1%**
- Number of CCOs that improved: **8**

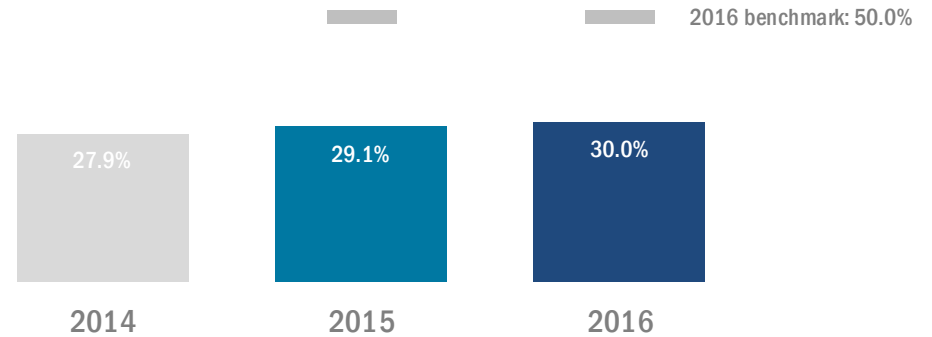
Results are stratified by age group (adolescents and all ages combined) for reporting and monitoring purposes only. Incentive payments are based on adults only ([see page 54](#)).

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Effective contraceptive use among adolescents, statewide.

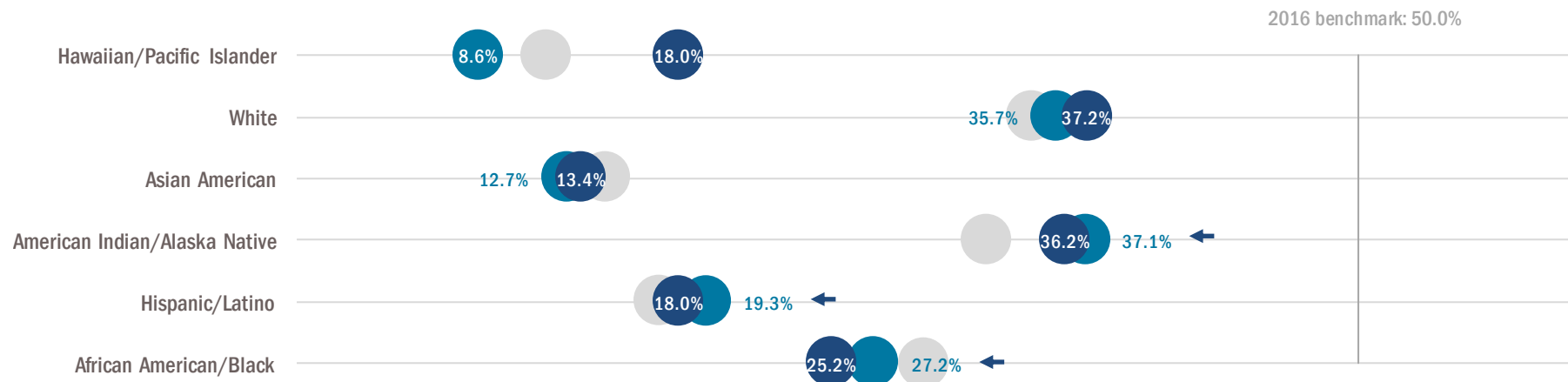
Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



Effective contraceptive use among adolescents in 2015 and 2016, by race and ethnicity.

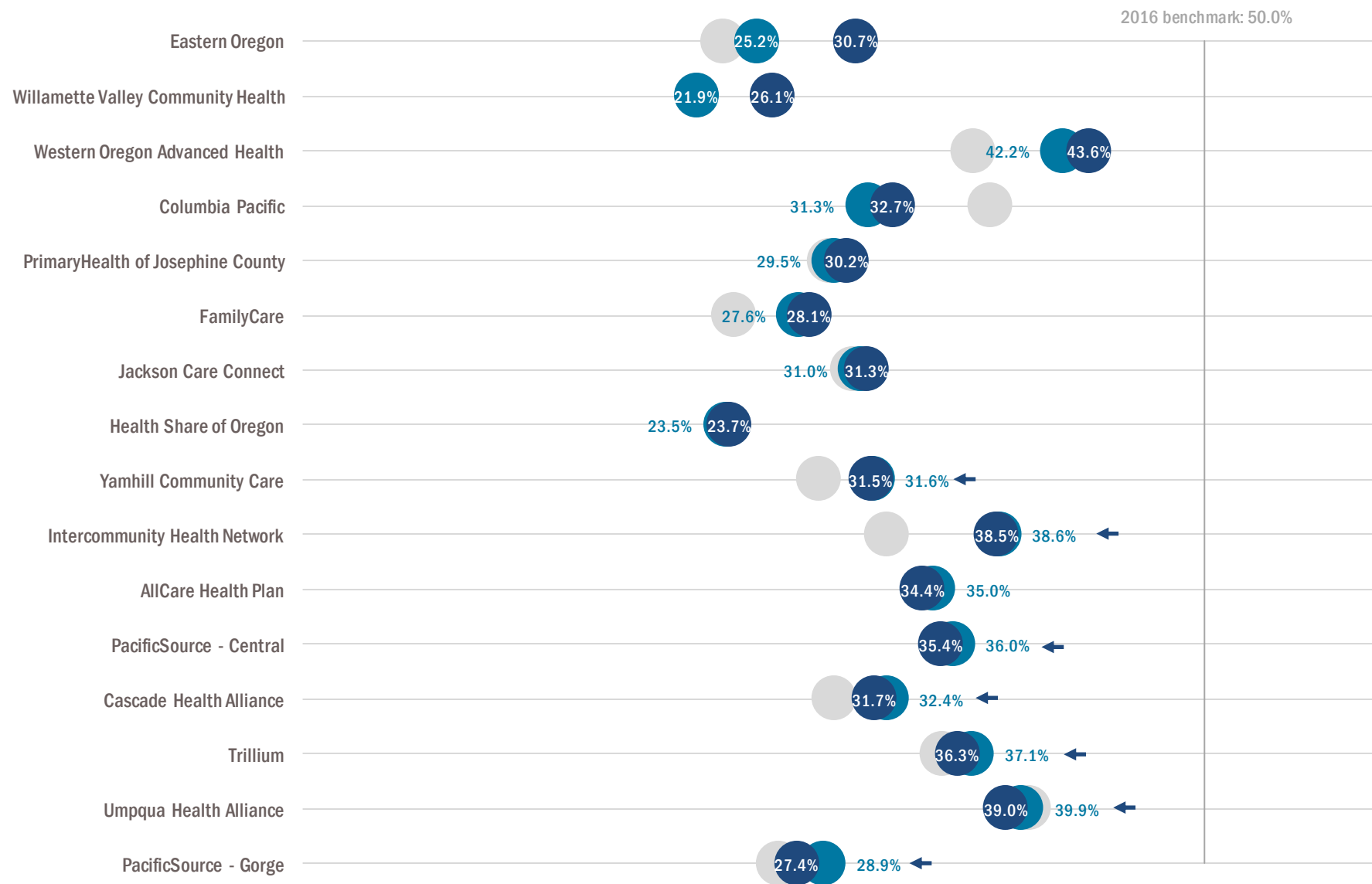
Grey dots represent 2014 / Race and ethnicity data missing for 38.5% of respondents / Each race category excludes Hispanic/Latino



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 15-17)

Effective contraceptive use among adolescents in 2015 and 2016, by CCO.

Grey dots represent 2014



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (all ages 15-50)

Effective contraceptive use among women at risk of unintended pregnancy (ages 15-50)

Percentage of women (ages 15-50) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

2016 data (n=127,023)

- Statewide change since 2015: **+8.8%**
- Number of CCOs that improved: **15**

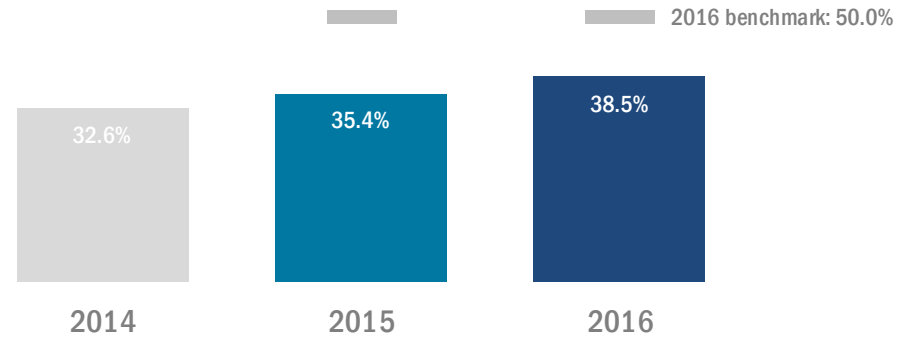
Results are stratified by age group (adolescents and all ages combined) for reporting and monitoring purposes only. Incentive payments are based on adults only ([see page 54](#)).

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Effective contraceptive use (all ages 15-50), statewide.

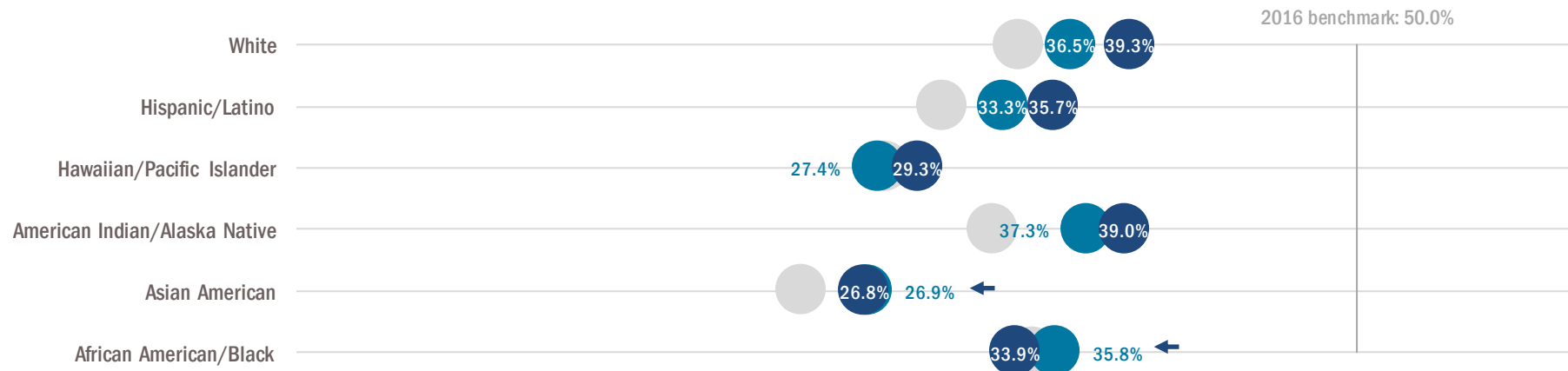
Data source: Administrative (billing) claims

Benchmark source: Metrics and Scoring Committee consensus



Effective contraceptive use (all ages 15-50) in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 33.2% of respondents / Each race category excludes Hispanic/Latino

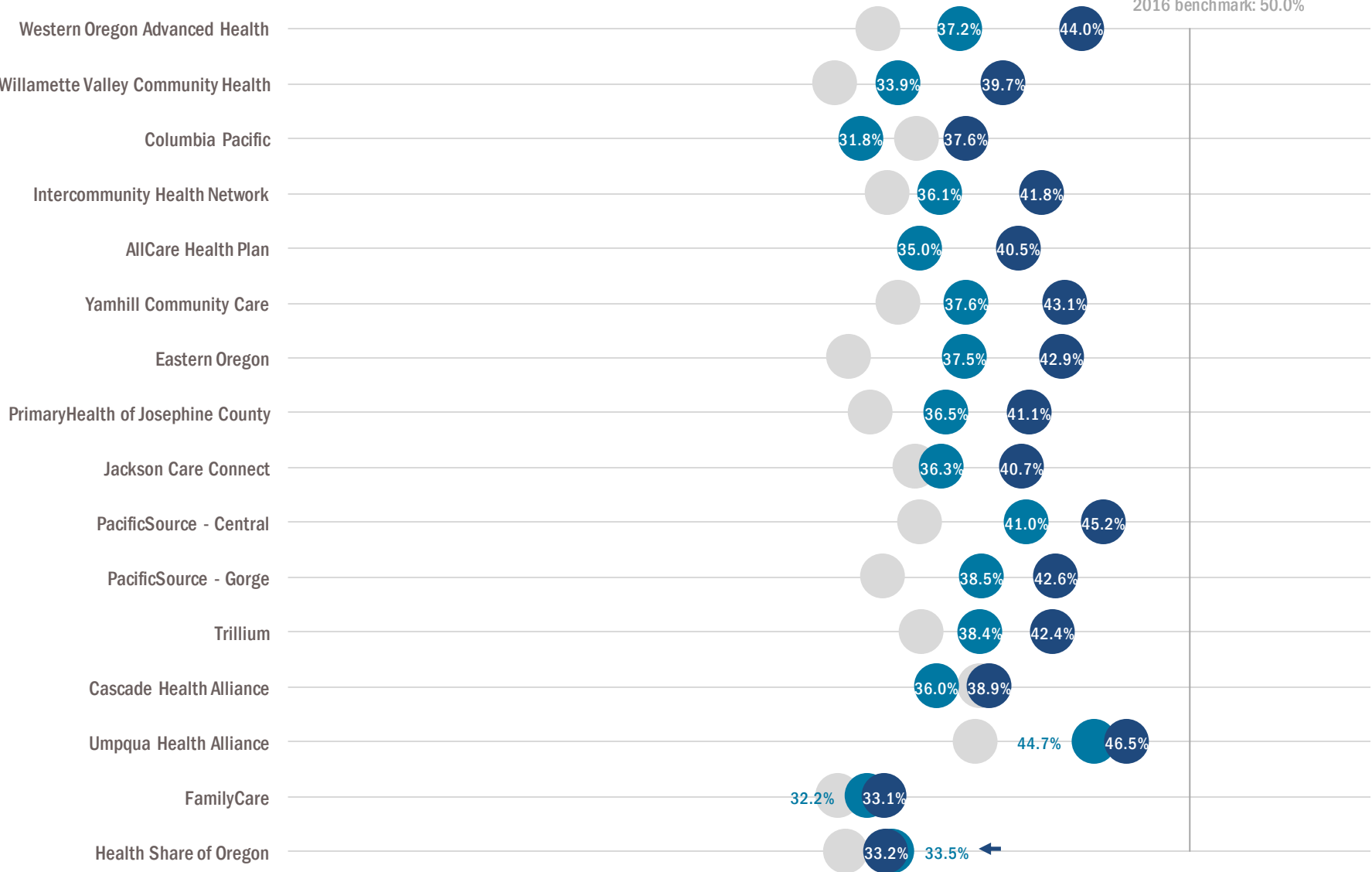


EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (all ages 15-50)

Effective contraceptive use (all ages 15-50) between 2015 and 2016, by CCO.

Grey dots represent 2014

2016 benchmark: 50.0%





FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Follow-up after hospitalization for mental illness

Percentage of members (ages 6 and older) who received a follow-up visit with a health care provider within seven days of being discharged from a mental illness-related hospitalization.

2016 data (n=3,074)

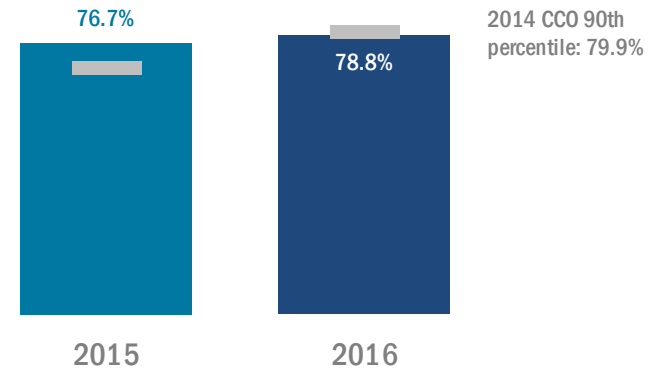
- Statewide change since 2015: **+2.7%**
- Number of CCOs that improved: **12**
- Number of CCOs achieving target: **13**

Data notes: Specifications were changed in 2015 to include same-day follow up. Results from 2014 and earlier published elsewhere cannot be directly compared to later years.

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Follow-up after hospitalization for mental illness, statewide.

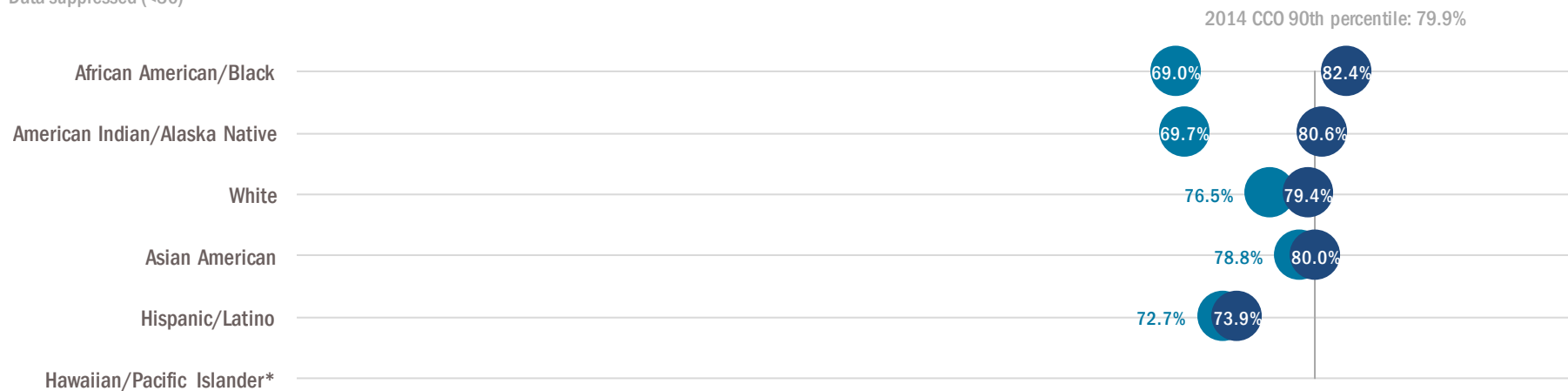
Data source: Administrative (billing) claims



Follow-up after hospitalization for mental illness in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 23.5% of respondents / Each race category excludes Hispanic/Latino

*Data suppressed (<30)



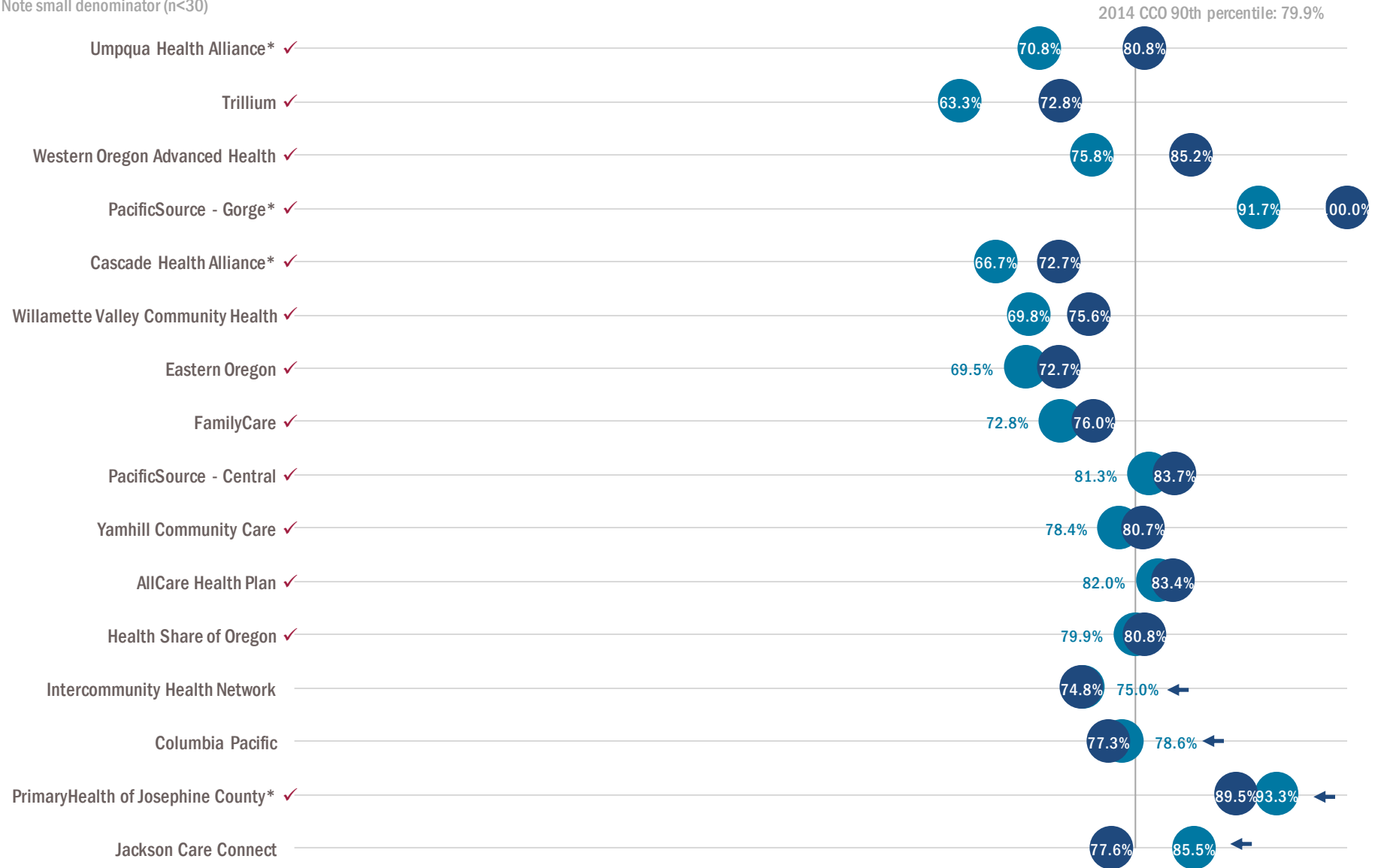


FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Follow-up after hospitalization for mental illness in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014

*Note small denominator (n<30)





PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Patient-centered primary care home enrollment

Percentage of CCO members who were enrolled in a recognized patient-centered primary care home (PCPCH).

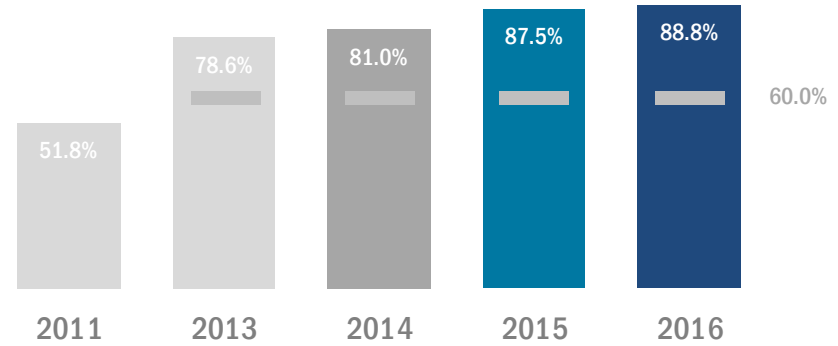
2016 data (n=823,073)

- Statewide change since 2015: **+1.5%**
- Number of CCOs that improved: **13**
- Number of CCOs achieving target: **all 16**

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Percentage of members enrolled in a patient-centered primary care home, statewide.

Data source: CCO quarterly reporting



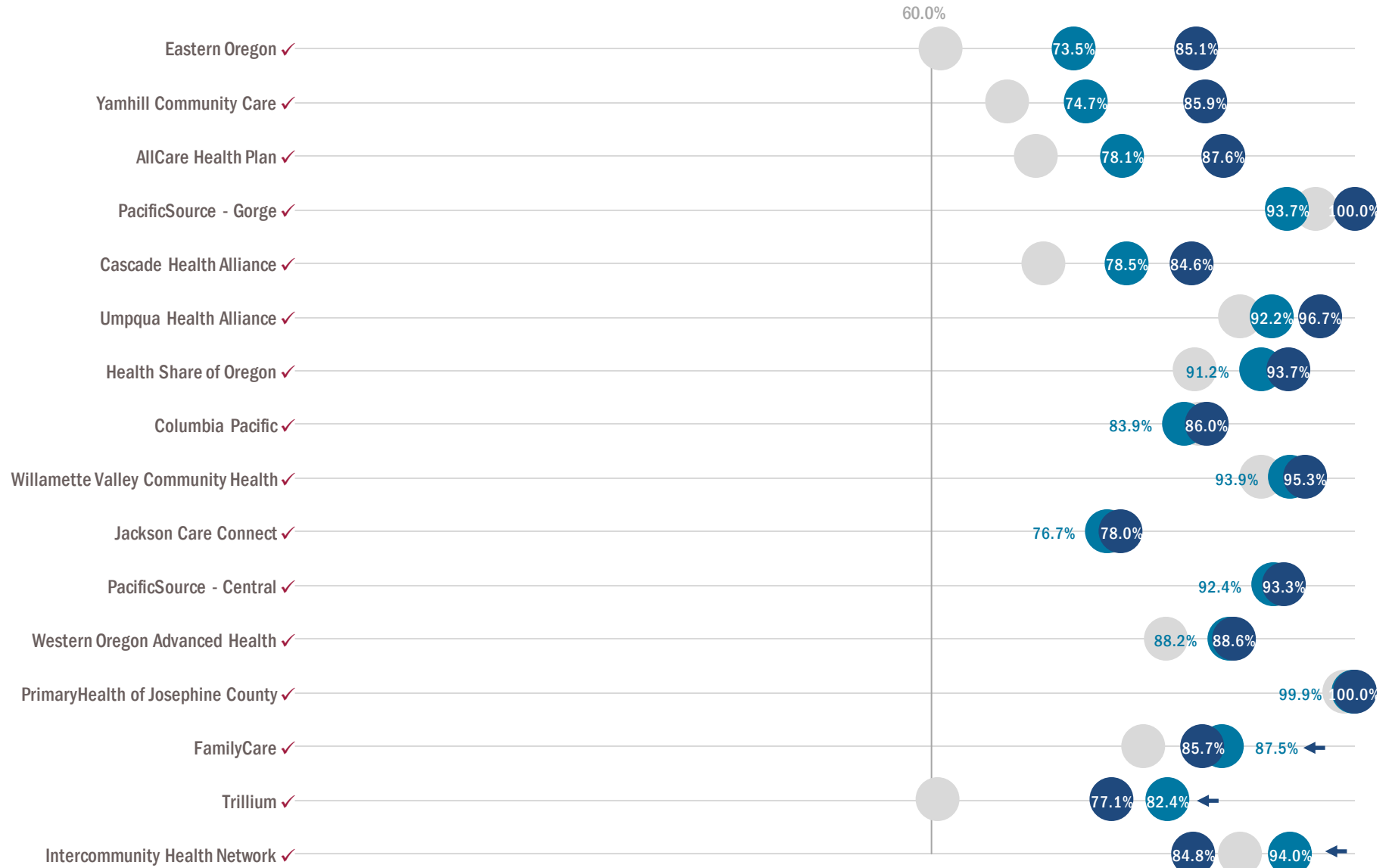
Race and ethnicity data are not available for this measure.



PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Percentage of members enrolled in a patient-centered primary care home in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014





PRENATAL AND POSTPARTUM CARE: TIMELINESS OF PRENATAL CARE

Timeliness of prenatal care

Percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days of enrollment in Medicaid.

2016 data (n=5,716)

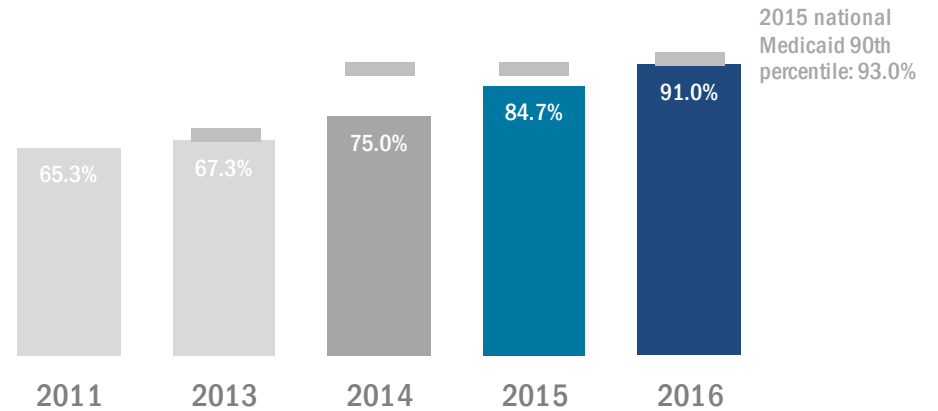
- Statewide change since 2015: **+7.4%**
- Number of CCOs that improved: **all 16**
- Number of CCOs achieving target: **all 16**

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Race and ethnicity data are not available for this measure.

Percentage of pregnant members who had a prenatal visit within the first trimester, statewide.

Data source: Administrative (billing) claims and medical record review

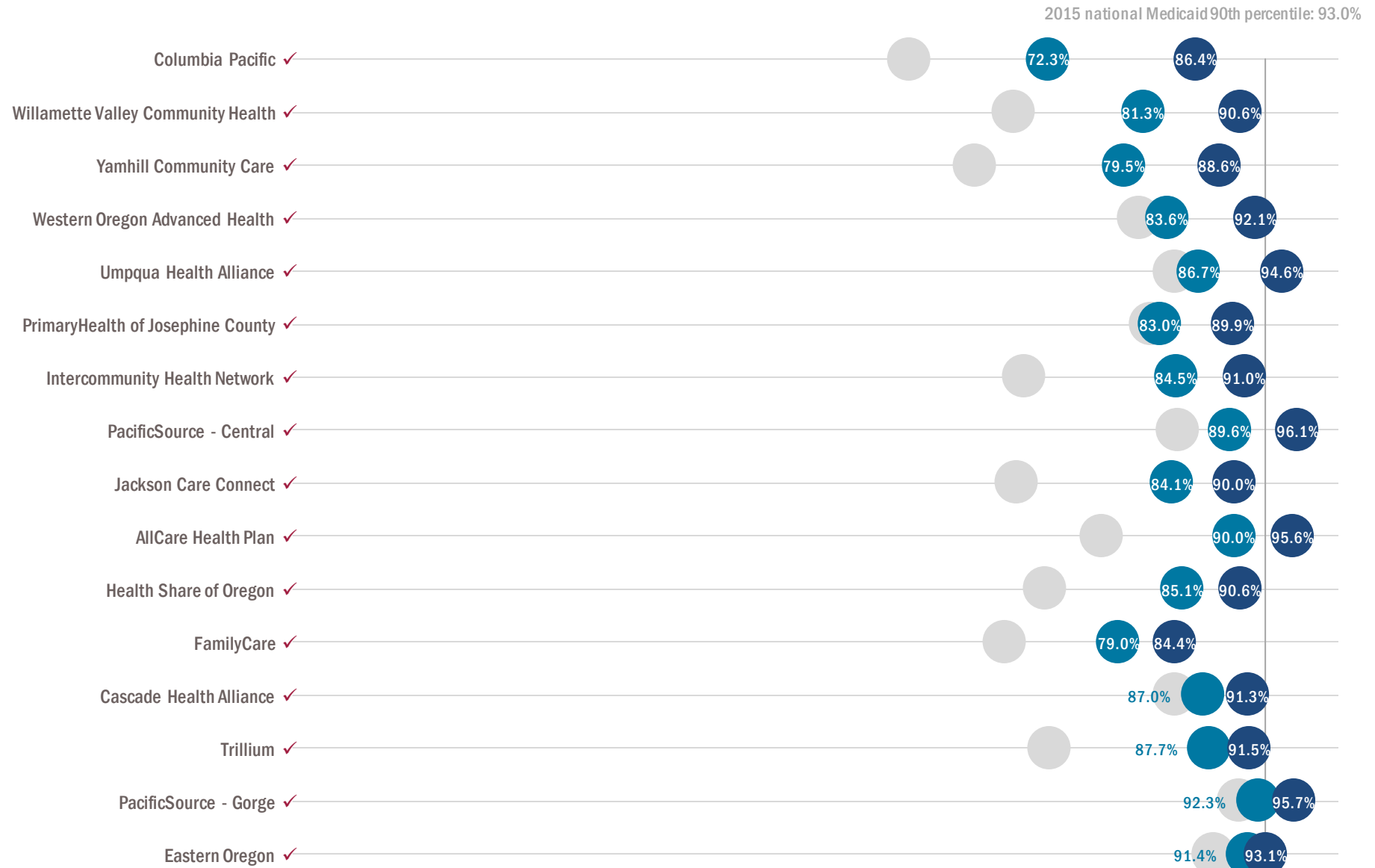




PRENATAL AND POSTPARTUM CARE: TIMELINESS OF PRENATAL CARE

Prenatal care in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014





SATISFACTION WITH CARE (CAHPS SURVEY)

Satisfaction with care (CAHPS)

Percentage of members (adults and children) who received needed information or help and thought they were treated with courtesy and respect by customer service staff.

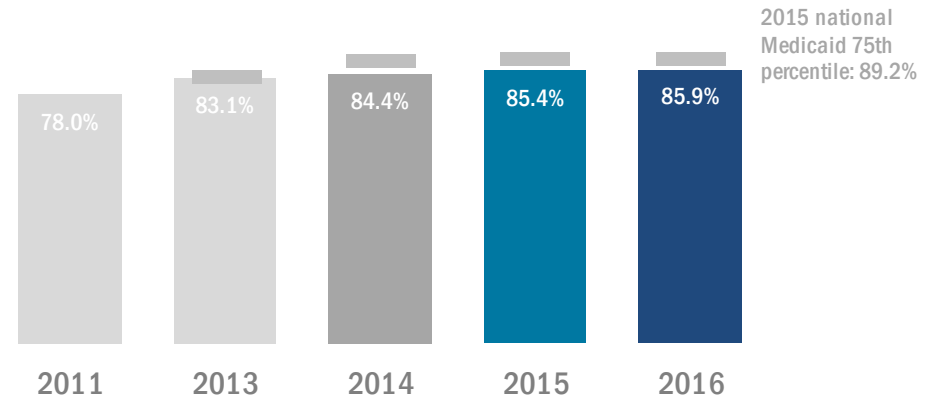
2016 data

- Statewide change since 2015: **+0.6%**
- Number of CCOs that improved: **7**
- Number of CCOs achieving target: **6**

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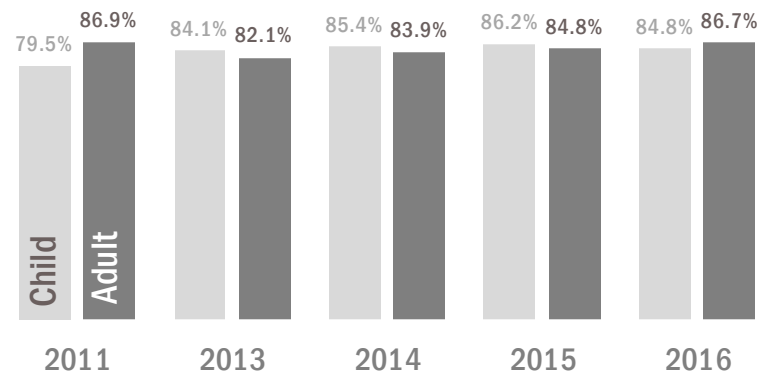
Satisfaction with care, statewide.

Data source: Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Satisfaction with care among children and adults, statewide.

Data source: Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)





SATISFACTION WITH CARE (CAHPS SURVEY)

Satisfaction with care among CHILDREN in 2015 and 2016, by race and ethnicity.

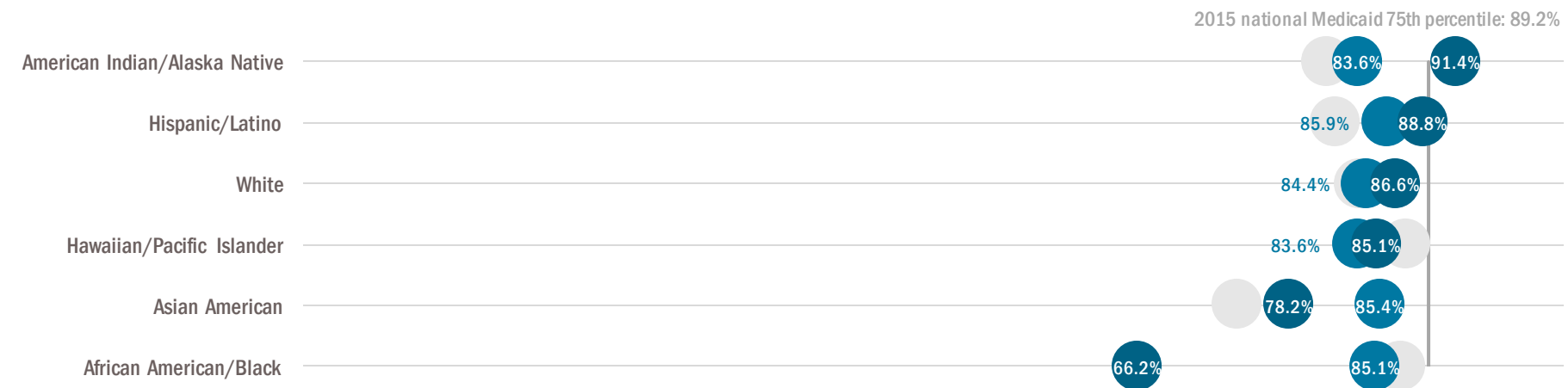
Grey dots represent 2014 / Each race category excludes Hispanic/Latino

*Data suppressed (n<10)



Satisfaction with care among ADULTS in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Each race category excludes Hispanic/Latino



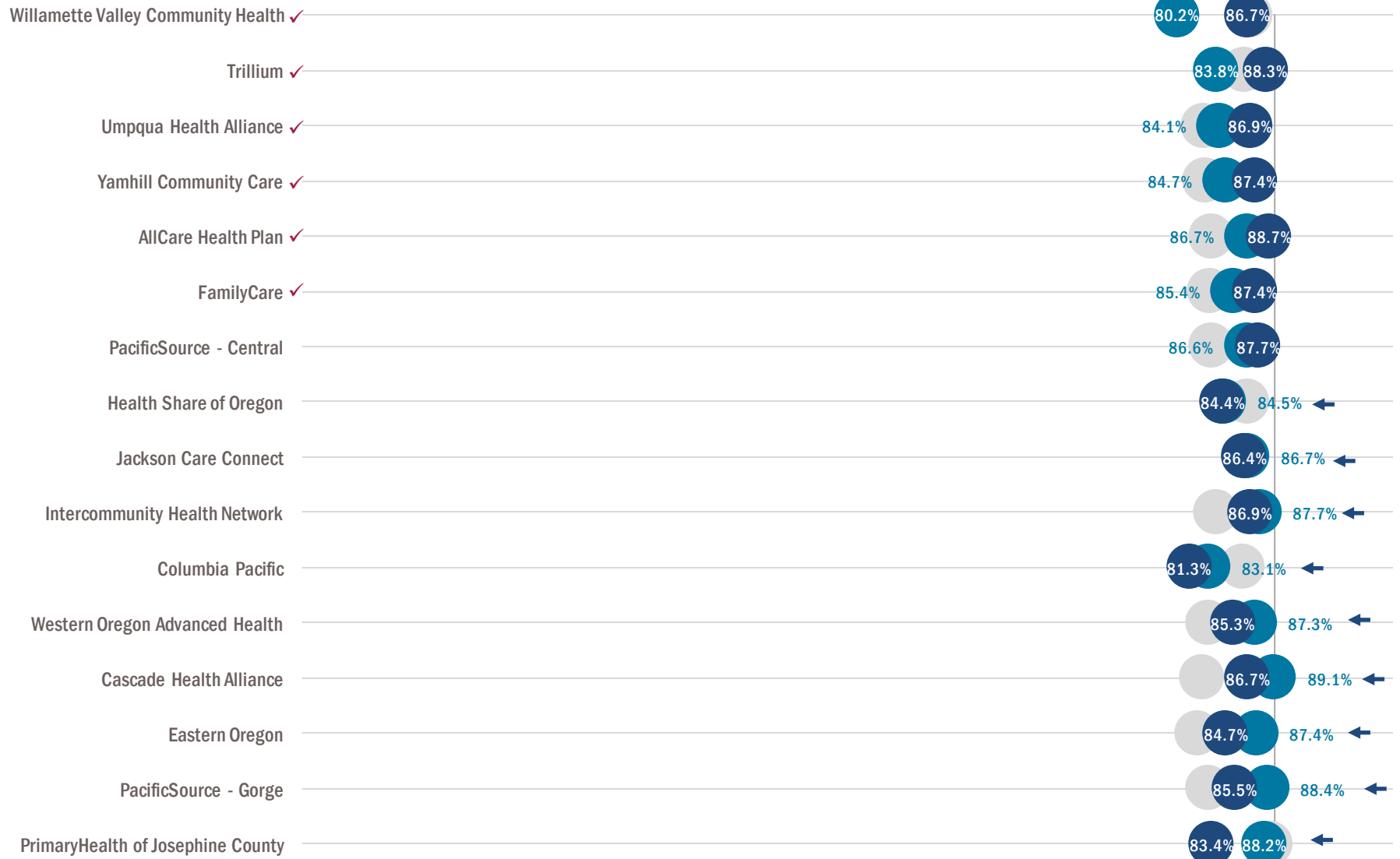


SATISFACTION WITH CARE (CAHPS SURVEY)

Satisfaction with care in 2015 and 2016, by CCO.

✓ indicates CCO met benchmark or improvement target / Grey dots represent 2014

2015 national Medicaid 75th percentile: 89.2%



Appendix B



State performance and



Core measures



ALL-CAUSE READMISSIONS

All-cause readmissions

Percentage of adult members (ages 18 and older) who had a hospital stay and were readmitted for any reason within 30 days of discharge. A lower score for this measure is better.

2016 data (n=33,582)

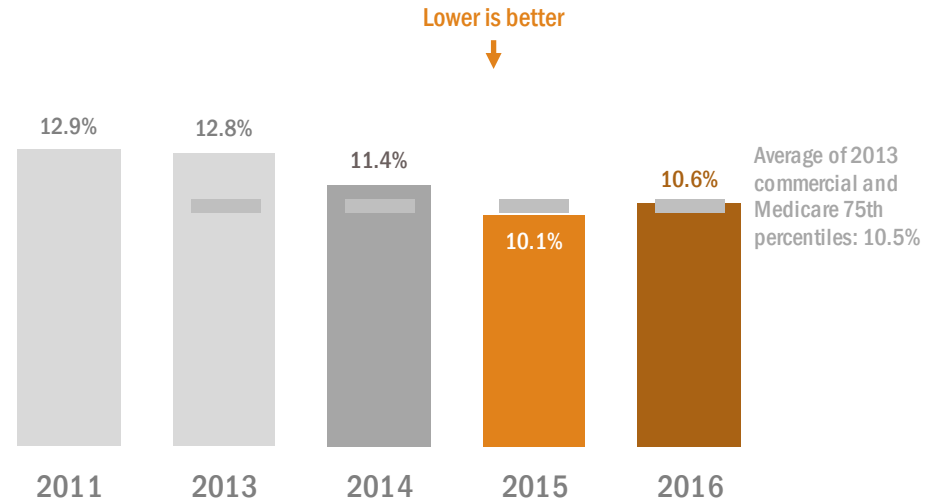
- Statewide change since 2015: **+5.0%** (lower is better)
- Number of CCOs that improved: **6**

Data notes: 2015 results have been revised and differ from previously-published reports due to algorithm refinements. Comparing results prior to 2015 should be done with caution, since the specifications are different.

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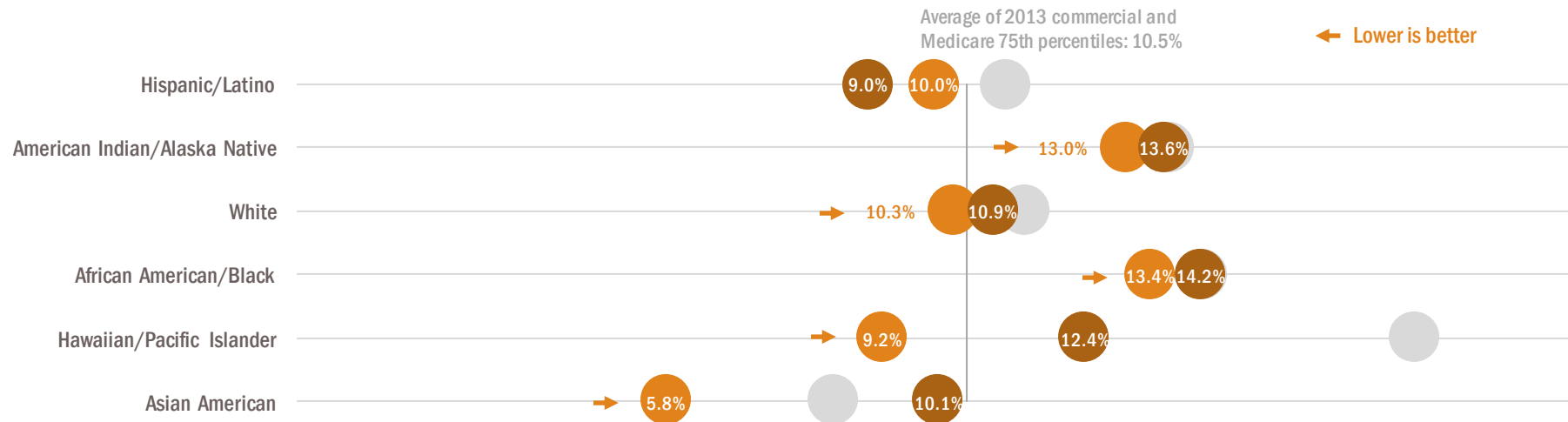
All-cause readmissions, statewide.

Data source: Administrative (billing) claims



All-cause readmissions in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 20.1% of respondents / Each race category excludes Hispanic/Latino





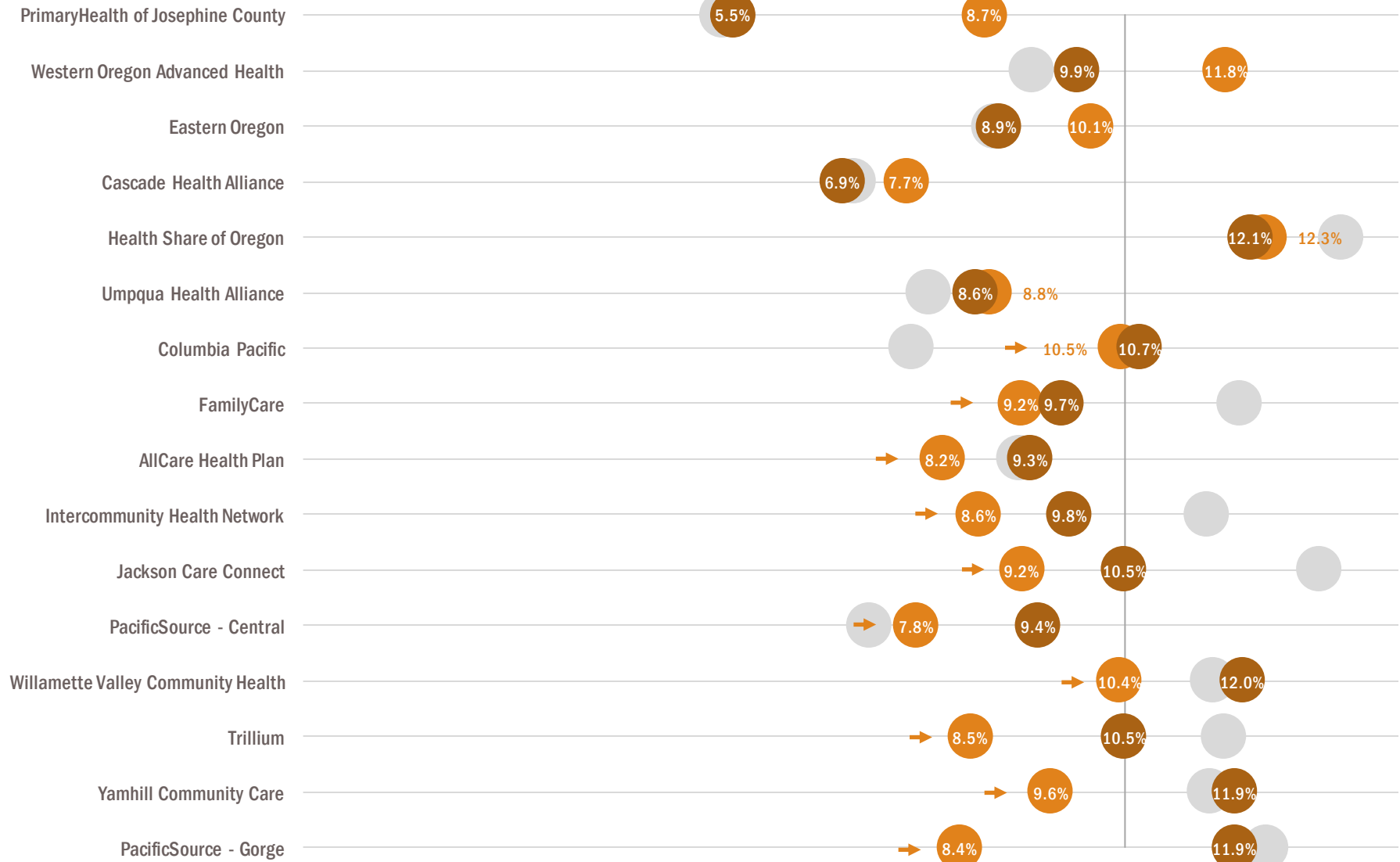
ALL-CAUSE READMISSIONS

All-cause readmissions in 2015 and 2016, by CCO.

Grey dots represent 2014

← Lower is better

Average of 2013 commercial and Medicare 75th percentiles: 10.5%





AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

Avoidable emergency department utilization

Rate of patient visits to an emergency department for conditions that could have been more appropriately managed by or referred to a primary care provider in an office or clinic setting.

Rates are derived from the *Ambulatory care: emergency department utilization* measure and are reported per 1,000 member months. A lower number suggests more appropriate emergency department utilization.

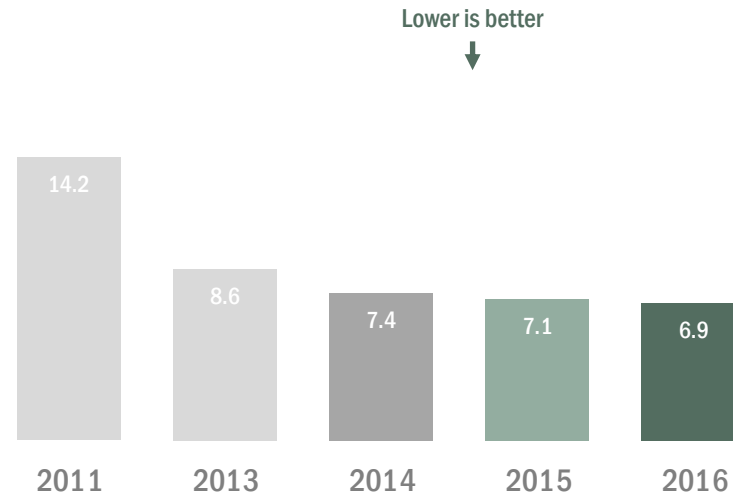
2016 data (n=10,560,686 member months)

- Statewide change since 2015: **-2.8%** (lower is better)
- Number of CCOs that improved: **12**

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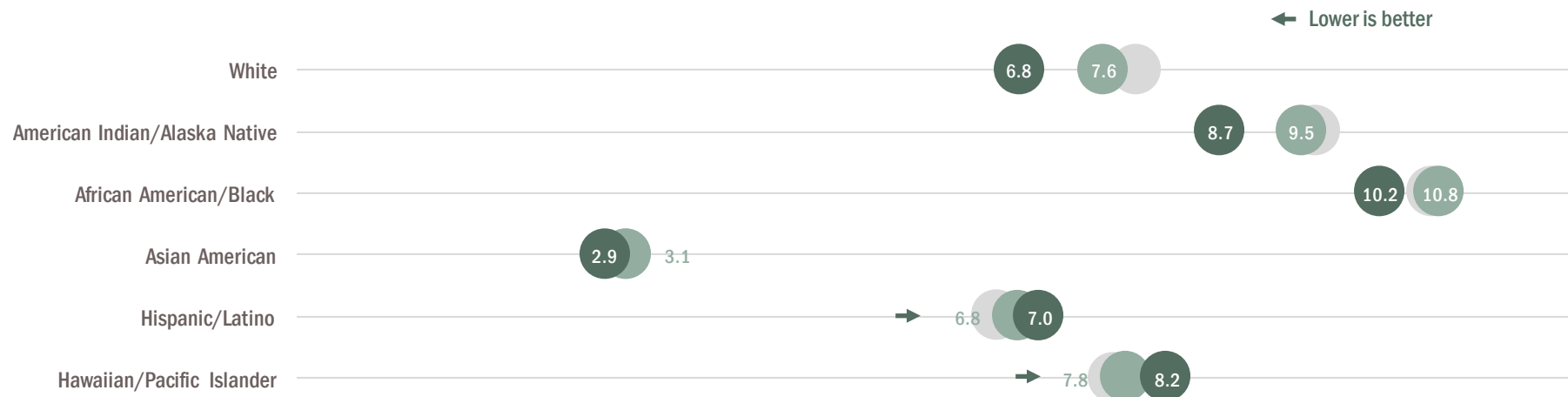
Avoidable emergency department utilization, statewide.

Data source: Administrative (billing) claims
Rates are per 1,000 member months



Avoidable emergency department utilization in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 33.1% of respondents / Each race category excludes Hispanic/Latino





AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

Avoidable emergency department utilization in 2015 and 2016, by CCO.

Grey dots represent 2014

← Lower is better





AMBULATORY CARE: OUTPATIENT UTILIZATION

Outpatient utilization

Rate of outpatient services, such as office visits, home visits, nursing home care, urgent care and counseling or screening services. Rates are reported per 1,000 member months.

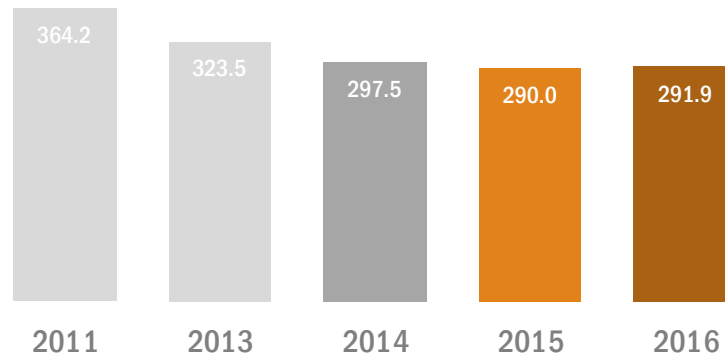
2016 data (n==10,560,968 member months)

- Statewide change since 2015: **+0.7%**
- Number of CCOs that improved: **9**

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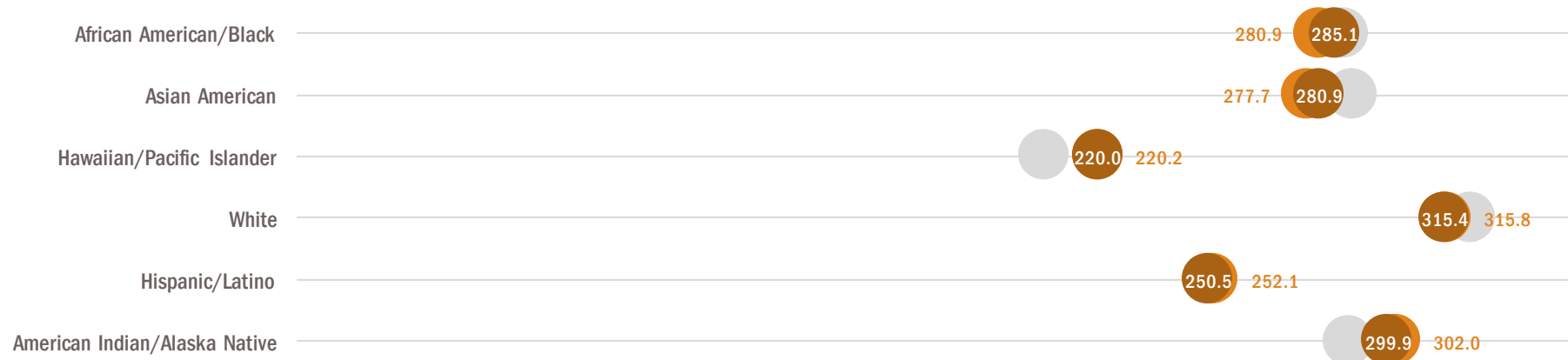
Outpatient utilization, statewide.

Data source: Administrative (billing) claims
Rates are per 1,000 member months



Outpatient utilization in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 33.1% of respondents / Each race category excludes Hispanic/Latino

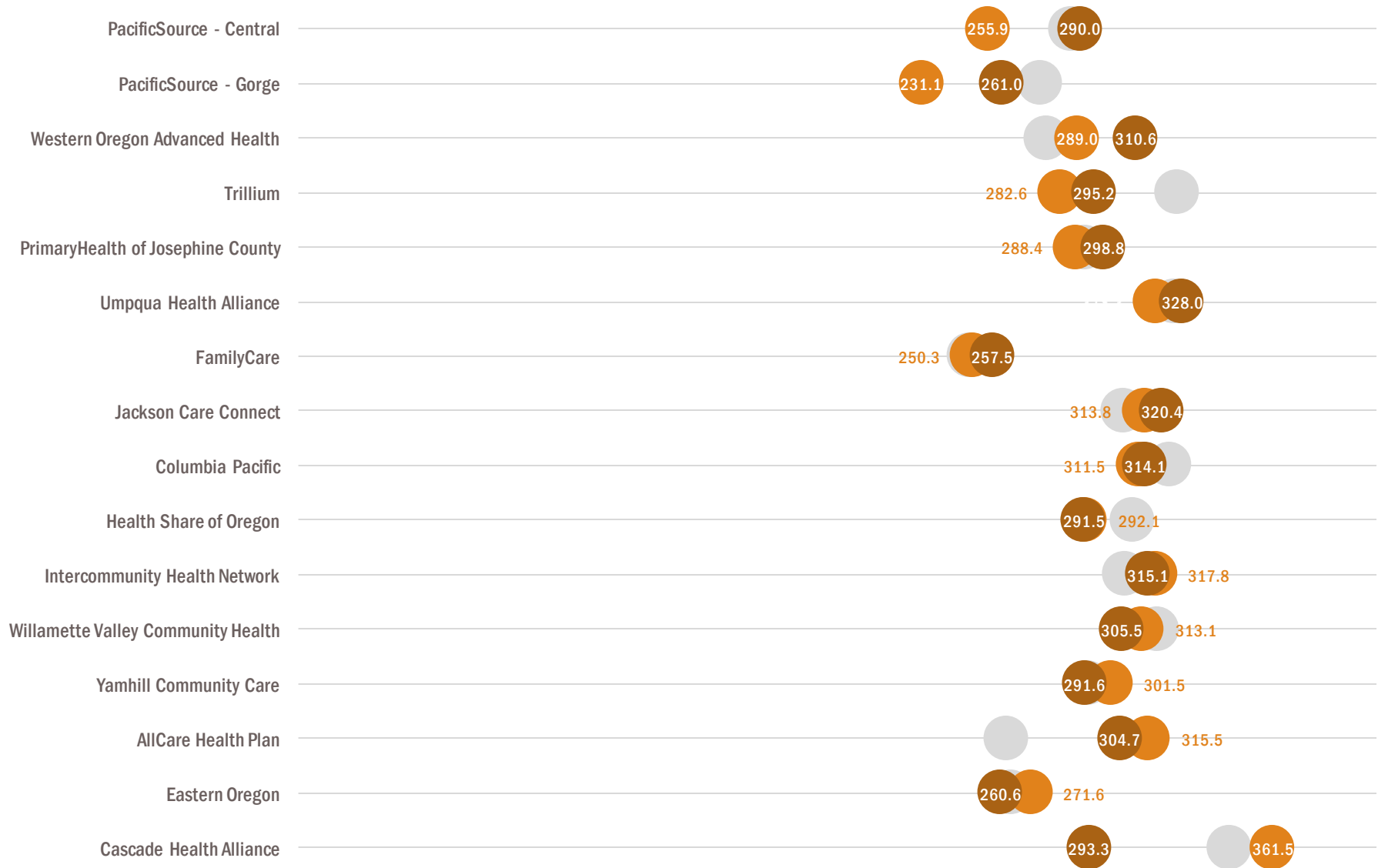




AMBULATORY CARE: OUTPATIENT UTILIZATION

Outpatient utilization in 2015 and 2016, by CCO.

Grey dots represent 2014





APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Appropriate testing for children with pharyngitis

Percentage of children with a sore throat (pharyngitis) who were given a strep test before getting an antibiotic.

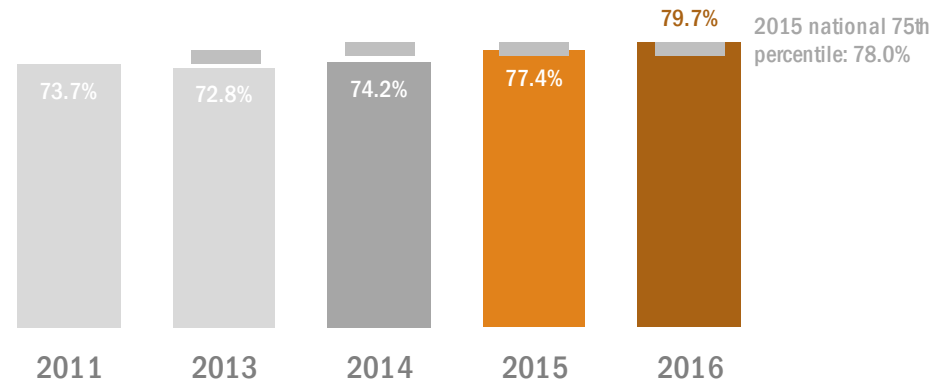
2016 data (n=9,328)

- Statewide change since 2015: **+3.0%**
- Number of CCOs that improved: **13**

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Appropriate testing for children with pharyngitis, statewide.

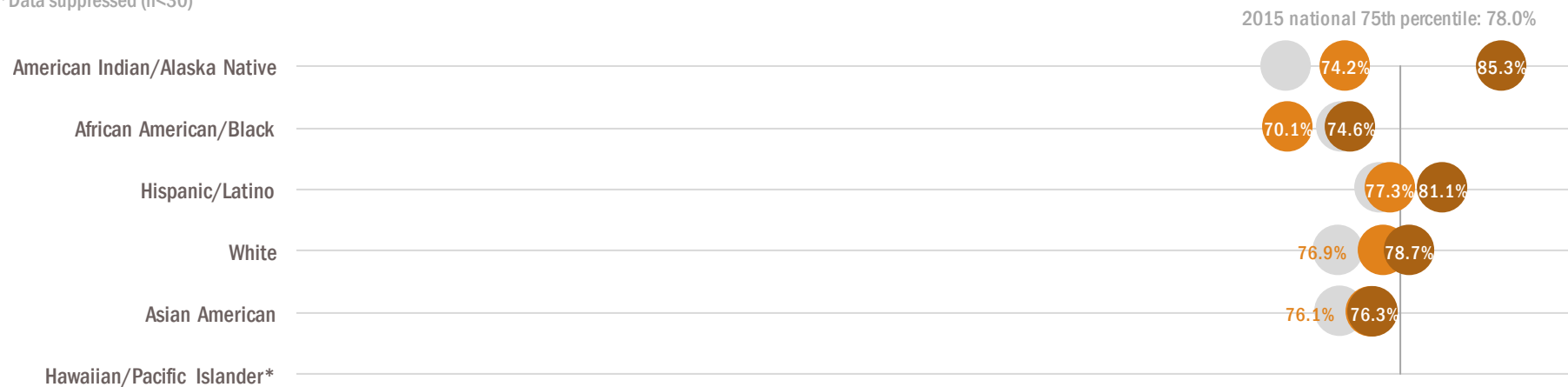
Data source: Administrative (billing) claims



Appropriate testing for children with pharyngitis in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 39.9% of respondents / Each race category excludes Hispanic/Latino

*Data suppressed (n<30)



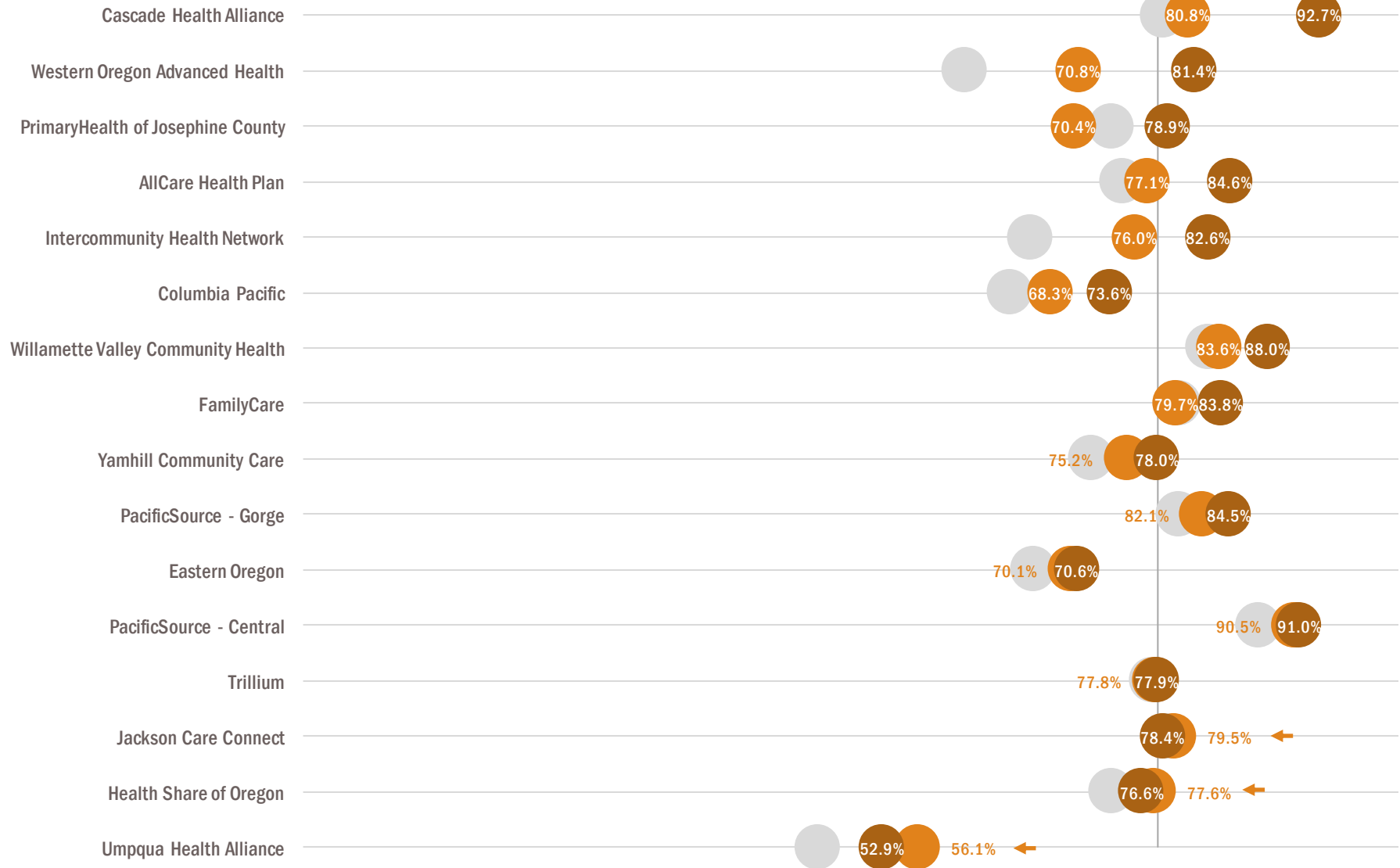


APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Appropriate testing for children with pharyngitis in 2015 and 2016, by CCO.

Grey dots represent 2014

2015 national 75th percentile: 78.0%





CERVICAL CANCER SCREENING

Cervical cancer screening

Percentage of women (ages 21 to 64) who received one or more Pap tests for cervical cancer during the past three years.

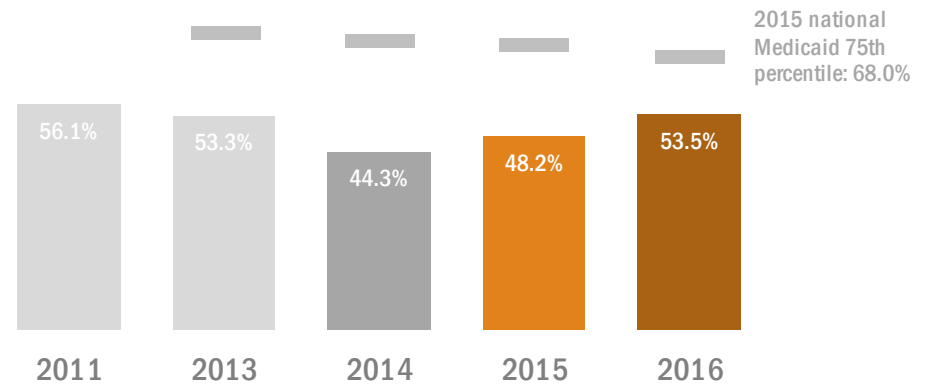
2016 data (n=138,623)

- Statewide change since 2015: **+11.0%**
- Number of CCOs that improved: **all 16**

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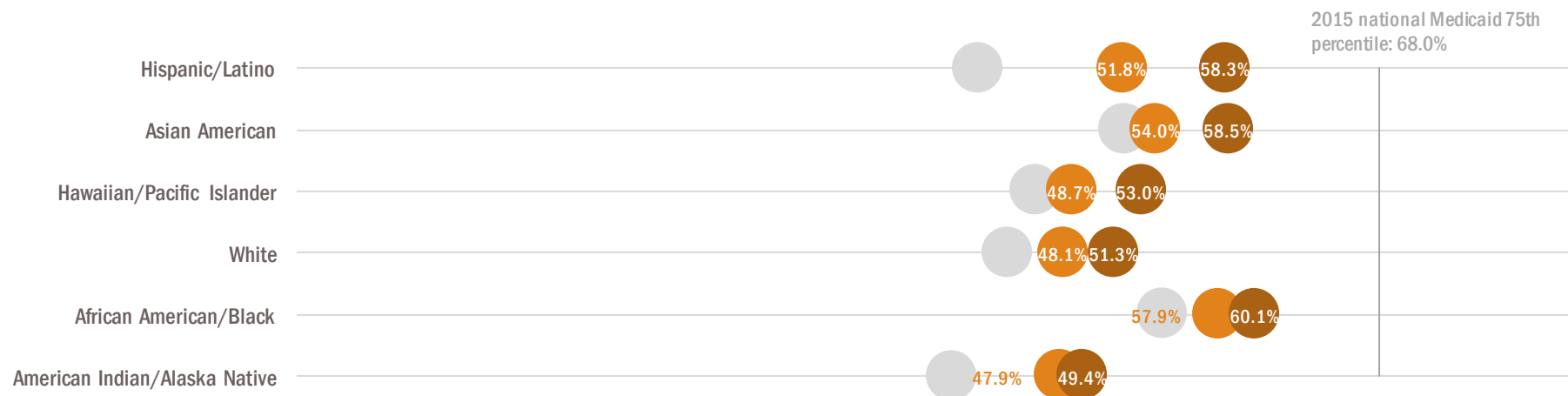
Cervical cancer screening, statewide.

Data source: Administrative (billing) claims



Cervical cancer screening in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 30.0% of respondents / Each race category excludes Hispanic/Latino



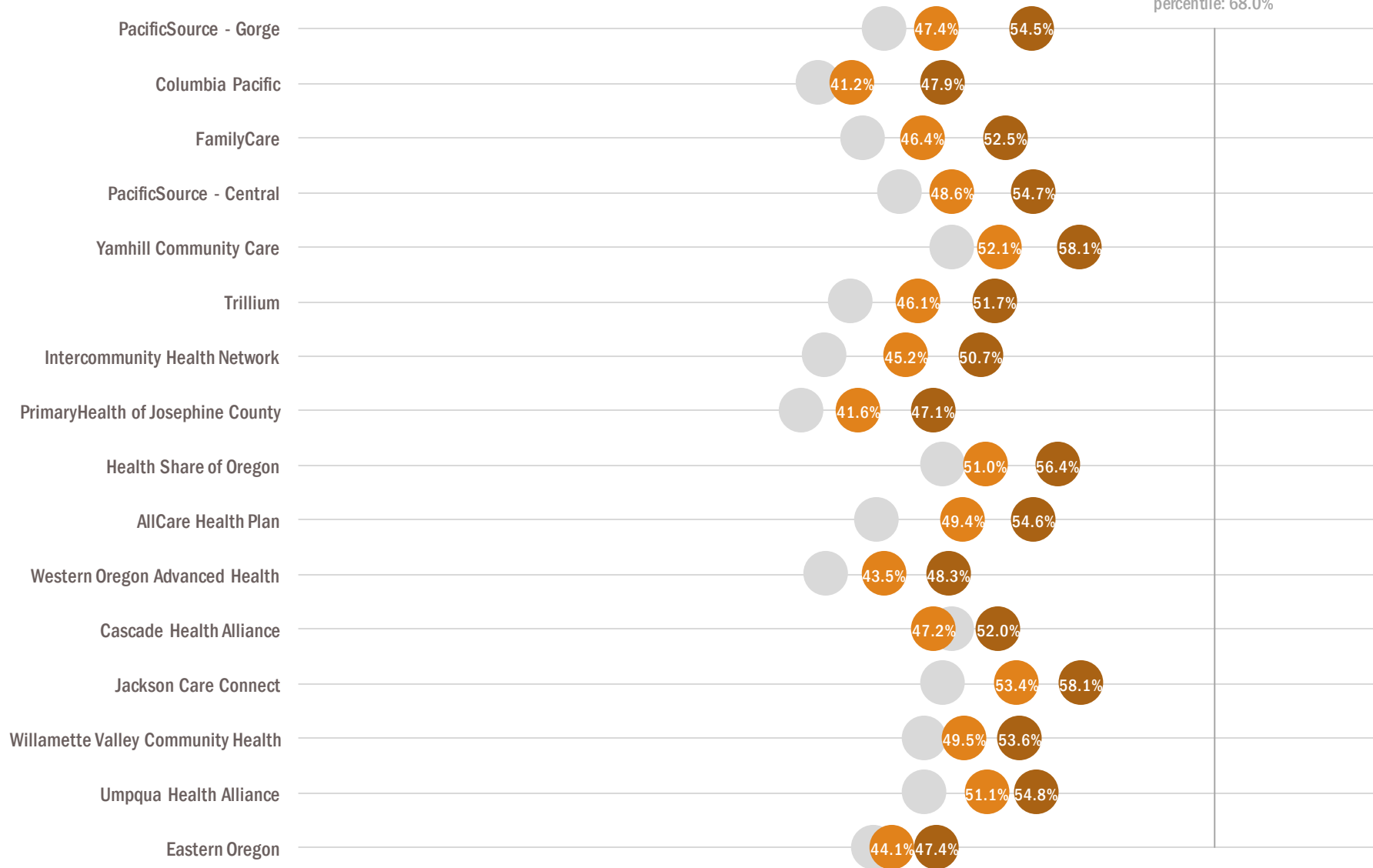


CERVICAL CANCER SCREENING

Cervical cancer screening in 2015 and 2016, by CCO.

Grey dots represent 2014

2015 national Medicaid 75th percentile: 68.0%





CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (ALL AGES)

Childhood and adolescent access to primary care providers (all ages)

Percentage of children and adolescents (ages 12 months: 19 years) who had a visit with a primary care provider.

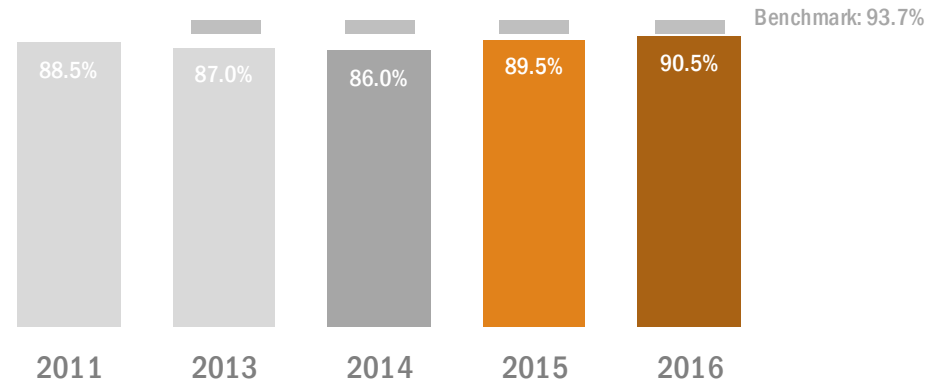
2016 data (n=201,592)

- Statewide change since 2015: **+1.1%**
- Number of CCOs that improved: **15**

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Percentage of children and adolescents (all ages) who had a visit with a primary care provider, statewide.

Data source: Administrative (billing) claims



Percentage of children (all ages) who had a visit with a primary care provider in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 39.7% of respondents / Each race category excludes Hispanic/Latino





CHILDHOOD ACCESS TO PRIMARY CARE PROVIDERS (12-24 months)

Childhood access to primary care providers (12-24 months)

Percentage of children and adolescents (ages 12-24 months) who had a visit with a primary care provider.

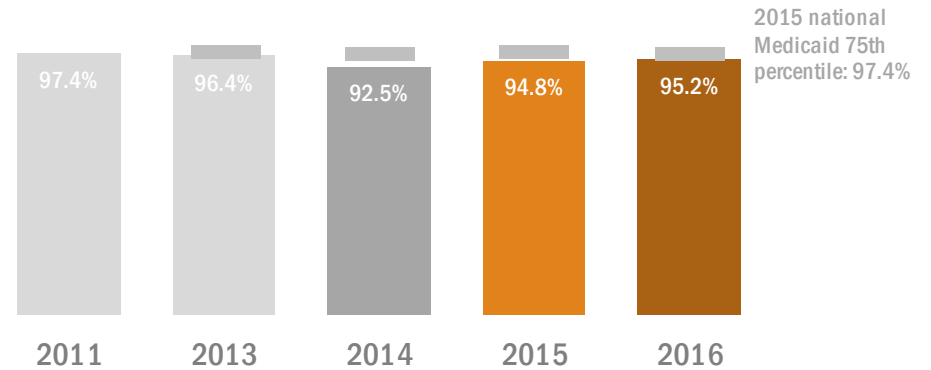
2016 data (n=28,668)

- Statewide change since 2015: **+0.4%**
- Number of CCOs that improved: **8**

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Percentage of children (ages 12-24 months) who had a visit with a primary care provider, statewide.

Data source: Administrative (billing) claims



Percentage of children (all 12-24 months) who had a visit with a primary care provider in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 41.4% of respondents / Each race category excludes Hispanic/Latino





CHILDHOOD ACCESS TO PRIMARY CARE PROVIDERS (25 months - 6 years)

Childhood access to primary care providers (25 months - 6 years)

Percentage of children (ages 25 months - 6 years) who had a visit with a primary care provider.

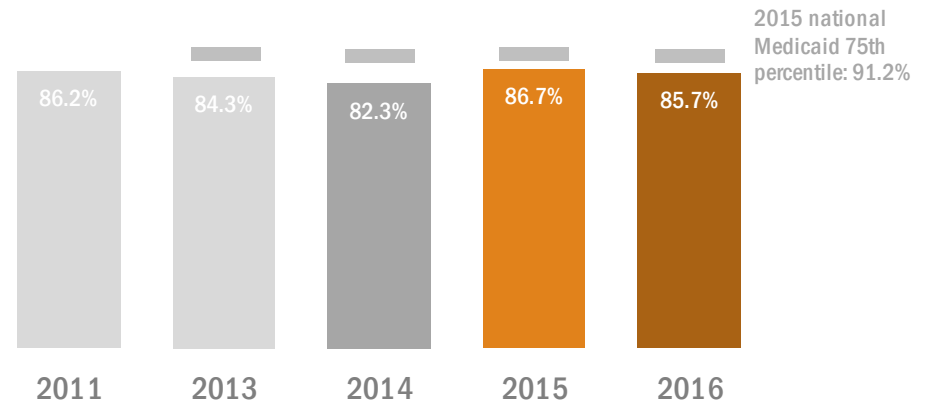
2016 data (n=53,889)

- Statewide change since 2015: **-1.4%**
- Number of CCOs that improved: **4**

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Percentage of children (25 months - 6 years) who had a visit with a primary care provider, statewide.

Data source: Administrative (billing) claims



Percentage of children (25 months - 6 years) who had a visit with a primary care provider in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 40.9% of respondents / Each race category excludes Hispanic/Latino





CHILDHOOD ACCESS TO PRIMARY CARE PROVIDERS (7-11 years)

Childhood access to primary care providers (7-11 years)

Percentage of children and adolescents (7-11 years) who had a visit with a primary care provider.

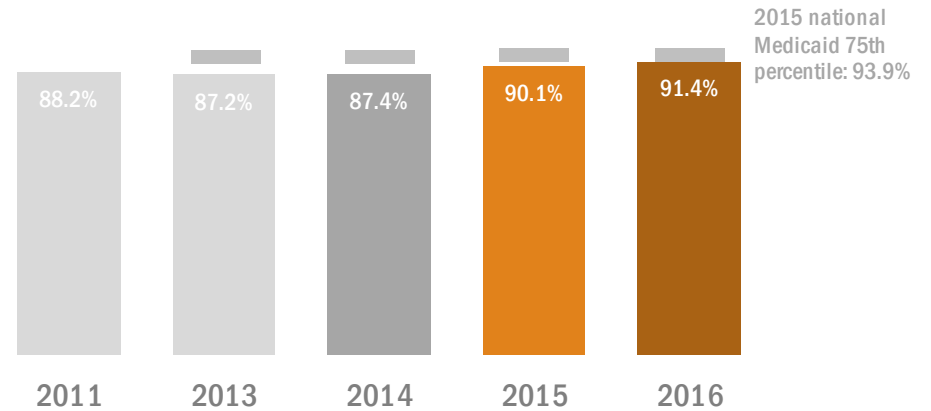
2016 data (n=51,842)

- Statewide change since 2015: **+1.5%**
- Number of CCOs that improved: **15**

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Percentage of children (7-11 years) who had a visit with a primary care provider, statewide.

Data source: Administrative (billing) claims



Percentage of children (7-11 years) who had a visit with a primary care provider in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 40.2% of respondents / Each race category excludes Hispanic/Latino





ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (12-19 years)

Childhood access to primary care providers (12-19 years)

Percentage of children and adolescents (ages 12-19 years) who had a visit with a primary care provider.

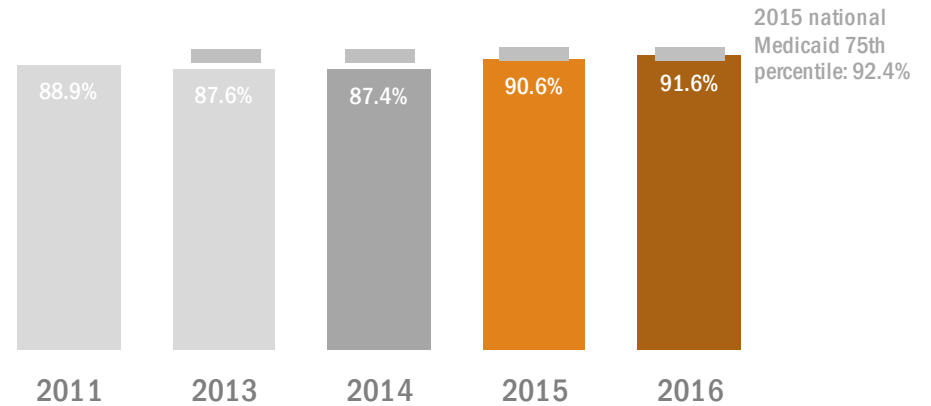
2016 data (n=67,193)

- Statewide change since 2015: **+1.1%**
- Number of CCOs that improved: **15**

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Percentage of children (12-19 years) who had a visit with a primary care provider, statewide.

Data source: Administrative (billing) claims



Percentage of children (12-19 years) who had a visit with a primary care provider in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 37.6% of respondents / Each race category excludes Hispanic/Latino



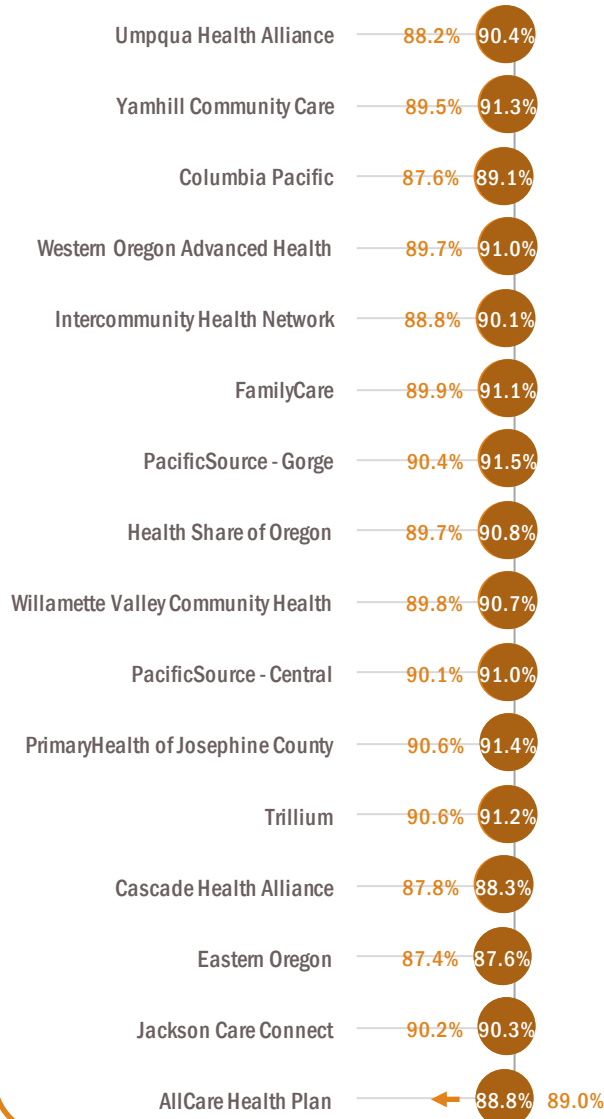


CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS - by CCO

Percentage of children and adolescents (all ages) who had a visit with a primary care provider in 2015 and 2016, by CCO.

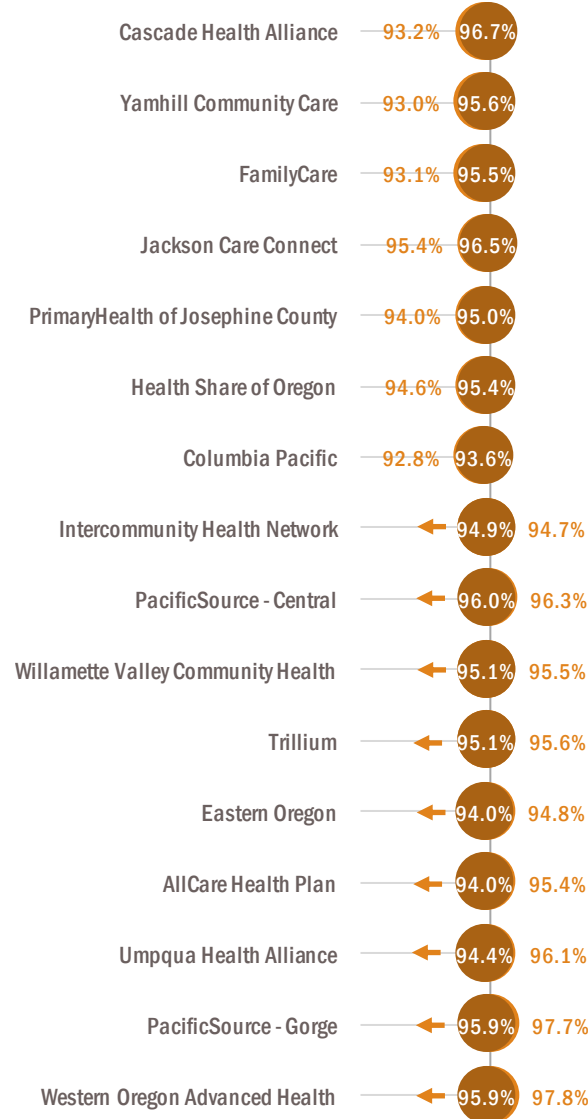
All ages (1-19 years)

Benchmark: 93.7%



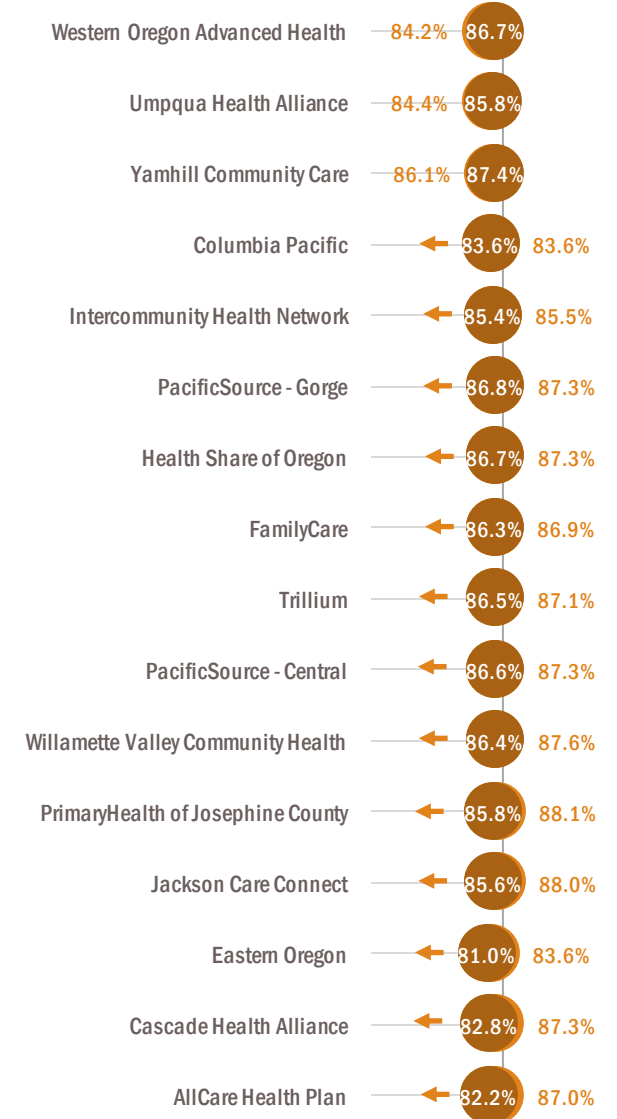
Ages 12-24 months

97.4%



Ages 25 months - 6 years

91.2%

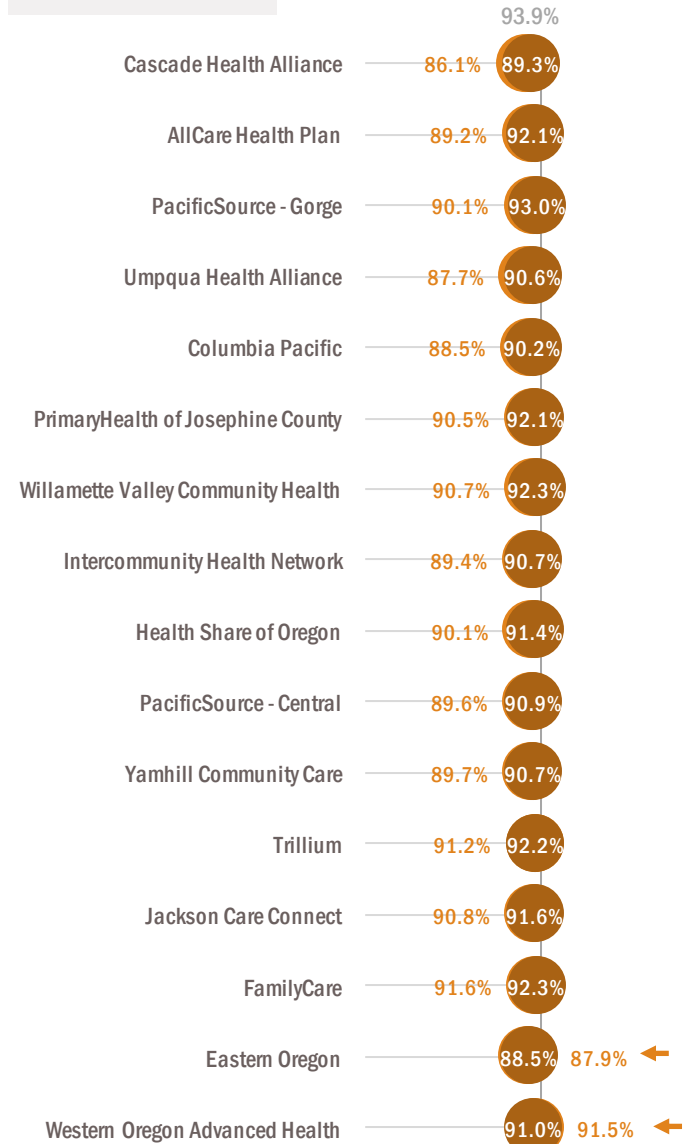




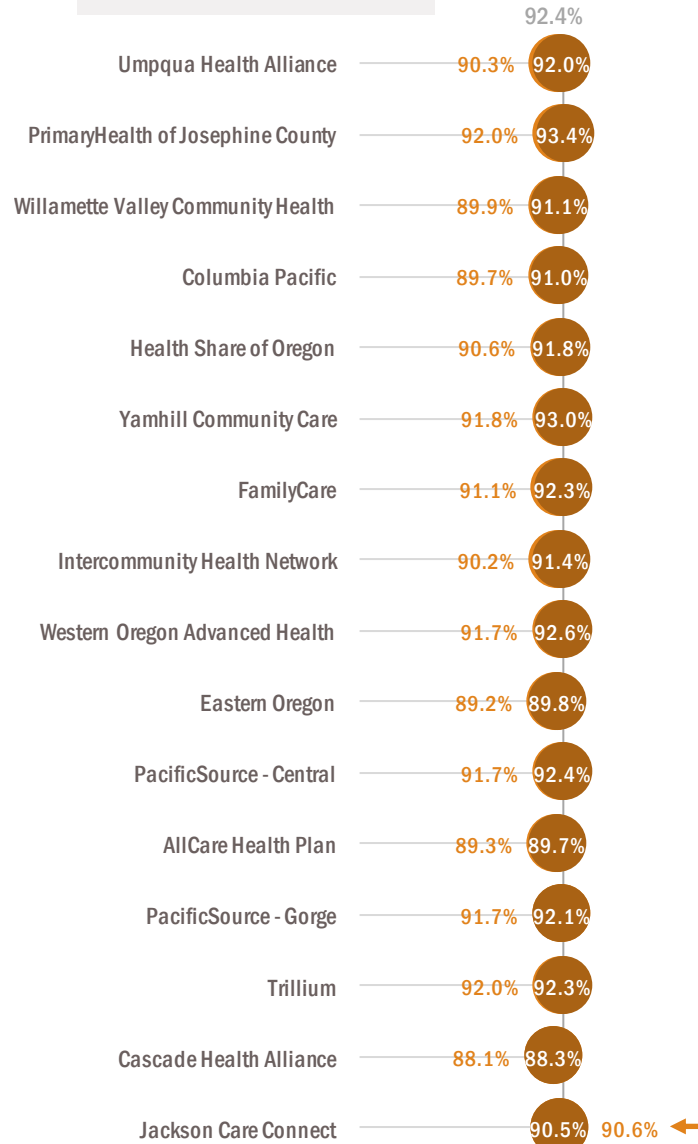
CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS - by CCO

Percentage of children and adolescents (all ages) who had a visit with a primary care provider in 2015 and 2016, by CCO.

Ages 7 - 11 years



Ages 12 - 19 years





CHLAMYDIA SCREENING

Chlamydia screening

Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection.

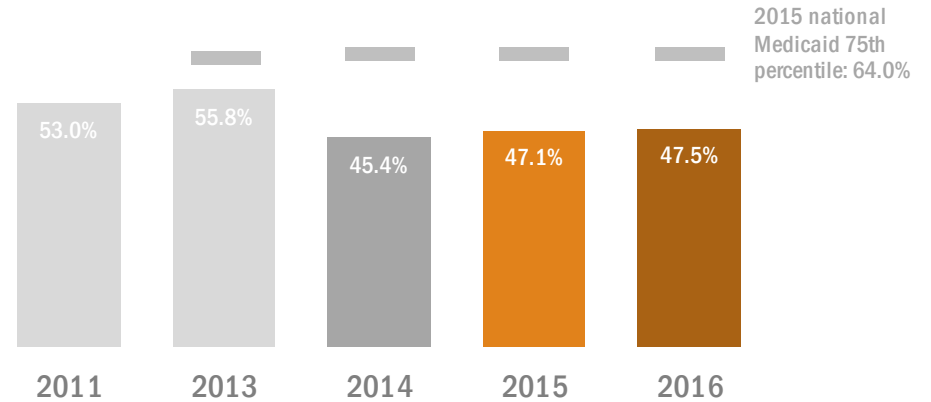
2016 data (n=23,278)

- Statewide change since 2015: **+0.9%**
- Number of CCOs that improved: **14**

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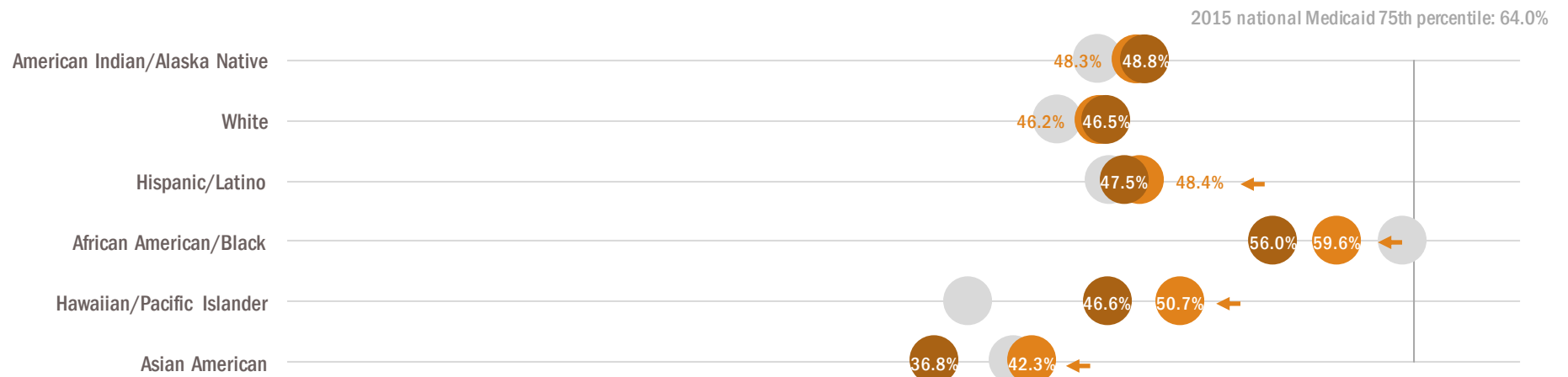
Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection, statewide.

Data source: Administrative (billing) claims



Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection in 2015 and 2016, by race and ethnicity.

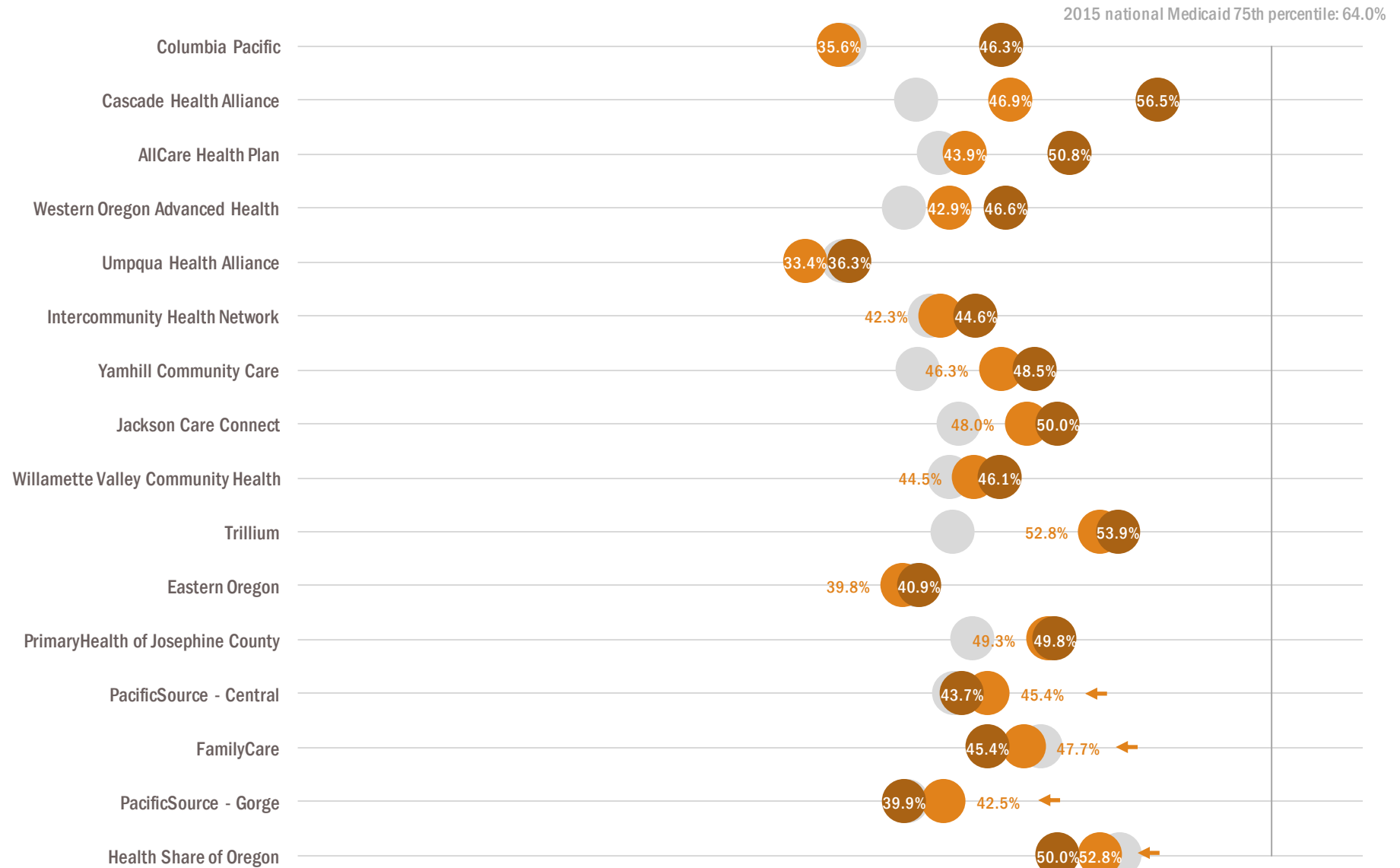
Grey dots represent 2014 / Race and ethnicity data missing for 35.1% of respondents / Each race category excludes Hispanic/Latino



CHLAMYDIA SCREENING

Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection in 2015 and 2016, by CCO.

Grey dots represent 2014



COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

Comprehensive diabetes care: HbA1c testing

Percentage of adult patients (ages 18-75) with diabetes who received at least one A1c blood sugar test.

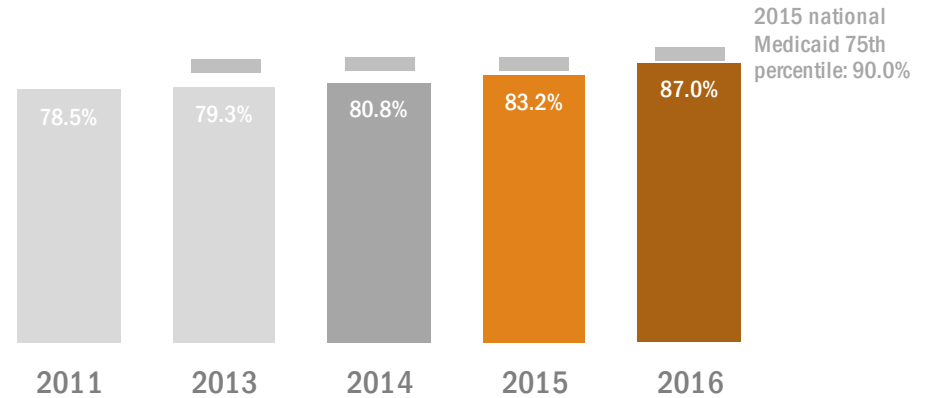
2016 data (n=30,712)

- Statewide change since 2015: **+4.6%**
- Number of CCOs that improved: **all 16**

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Percentage of adults with diabetes who received an A1c blood sugar test, statewide.

Data source: Administrative (billing) claims



Percentage of adults with diabetes who received an A1c blood sugar test in 2015 and 2016, by race and ethnicity.

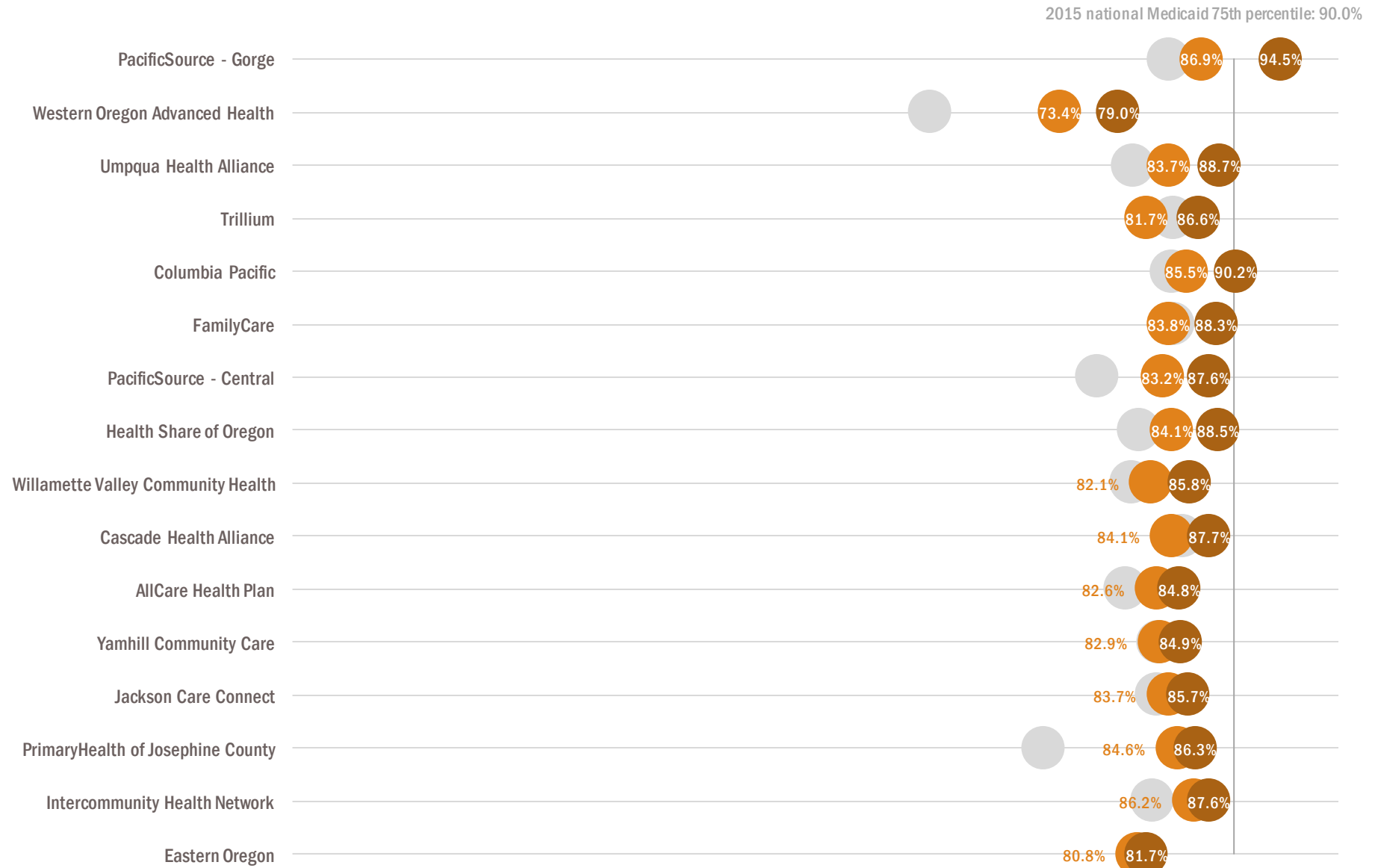
Grey dots represent 2014 / Race and ethnicity data missing for 21.5% of respondents / Each race category excludes Hispanic/Latino



COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

Percentage of adults with diabetes who received an A1c blood sugar test in 2015 and 2016, by CCO.

Grey dots represent 2014





COMPREHENSIVE DIABETES CARE: LDL-C SCREENING

Comprehensive diabetes care: LDL-C screening

Percentage of adult patients (ages 18-75) with diabetes who received an LDL-C (cholesterol) test.

2016 data (n=30,712)

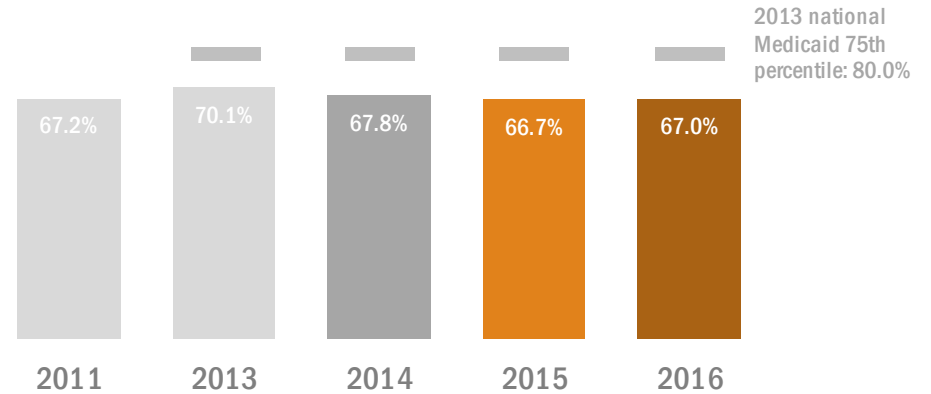
- Statewide change since 2015: **+0.4%**
- Number of CCOs that improved: **12**

The American College of Cardiology / American Heart Association released updated guidelines in 2013 that removed treatment targets for LDL-C for primary or secondary prevention of arteriosclerotic cardiovascular disease and recommended statin therapy instead. LDL-C screening and control measures were removed from the Healthcare Effectiveness Data and Information set (HEDIS) measures in 2015.

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Percentage of adults with diabetes who received an LDL-C (cholesterol) test, statewide.

Data source: Administrative (billing) claims



Percentage of adults with diabetes who received an LDL-C (cholesterol) test in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 21.5% of respondents / Each race category excludes Hispanic/Latino

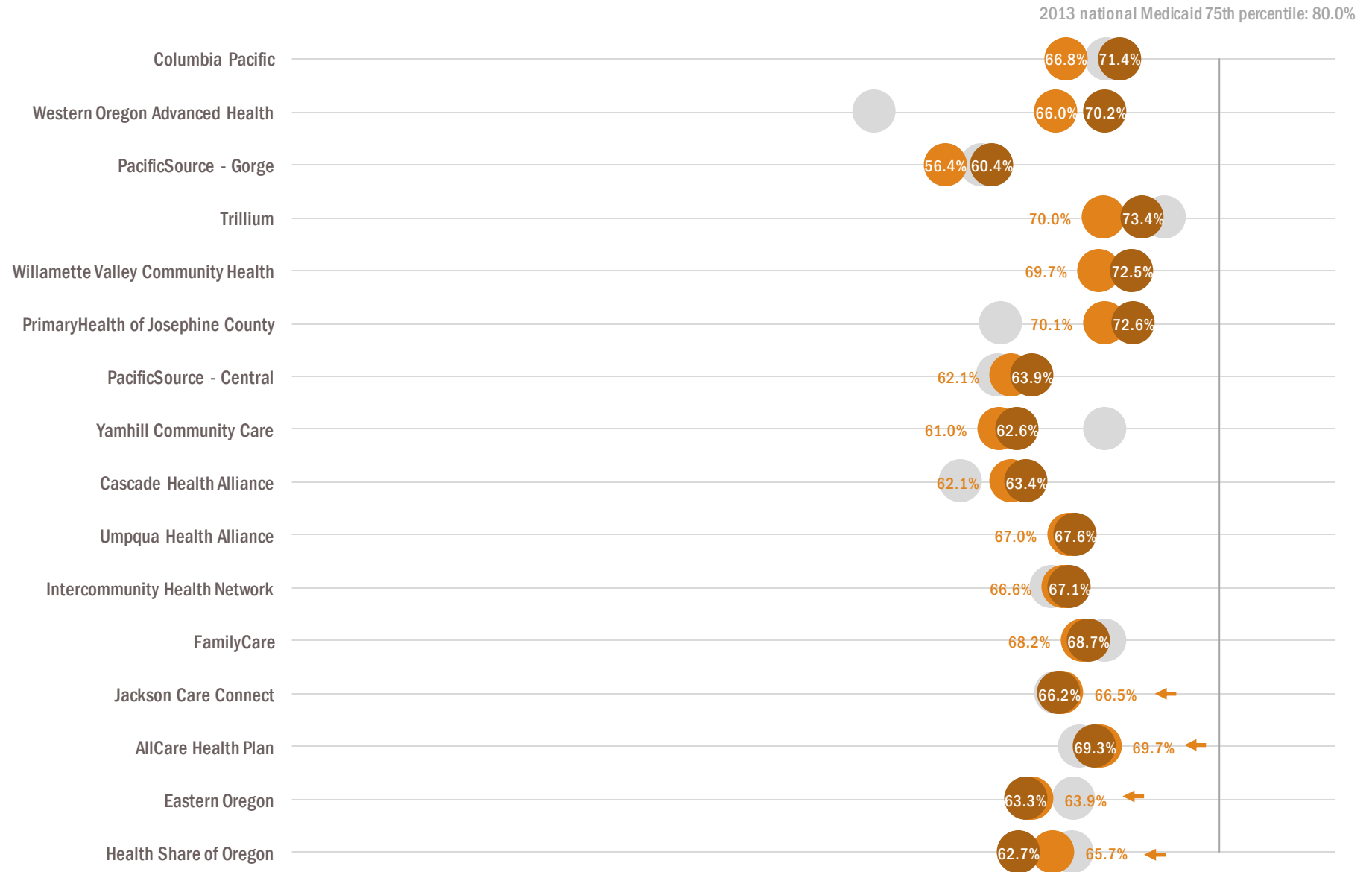




COMPREHENSIVE DIABETES CARE: LDL-C SCREENING

Percentage of adults with diabetes who received an LDL-C (cholesterol) test in 2015 and 2016, by CCO.

Grey dots represent 2014





EARLY ELECTIVE DELIVERY

Early elective delivery

Percentage of women delivering a newborn who had an elective delivery between 37 and 39 weeks of gestation (lower score is better).

2016 data

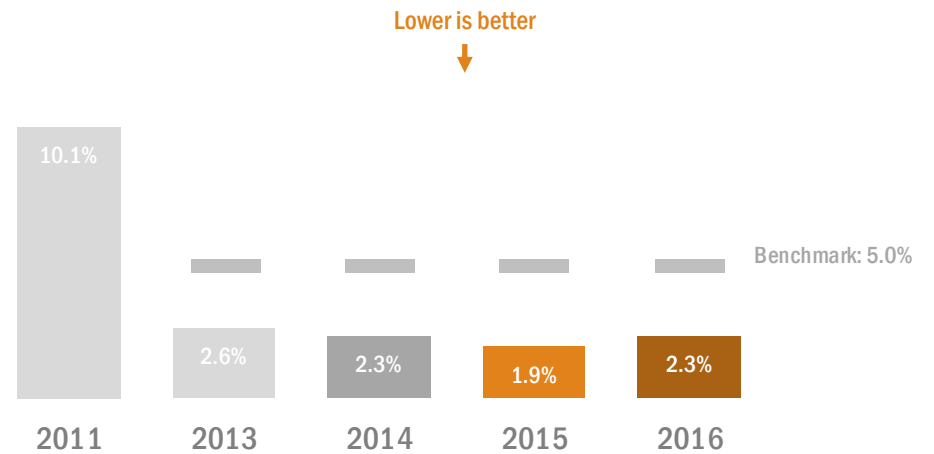
- Statewide change since 2015: **+21.1%** (lower is better)
- Number of CCOs that improved: **5**

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Race and ethnicity data are not available for this measure.

Early elective delivery, statewide.

Data source: Administrative (billing) claims, Vital Records, and hospitals
Benchmark source: Metrics and Scoring Committee consensus





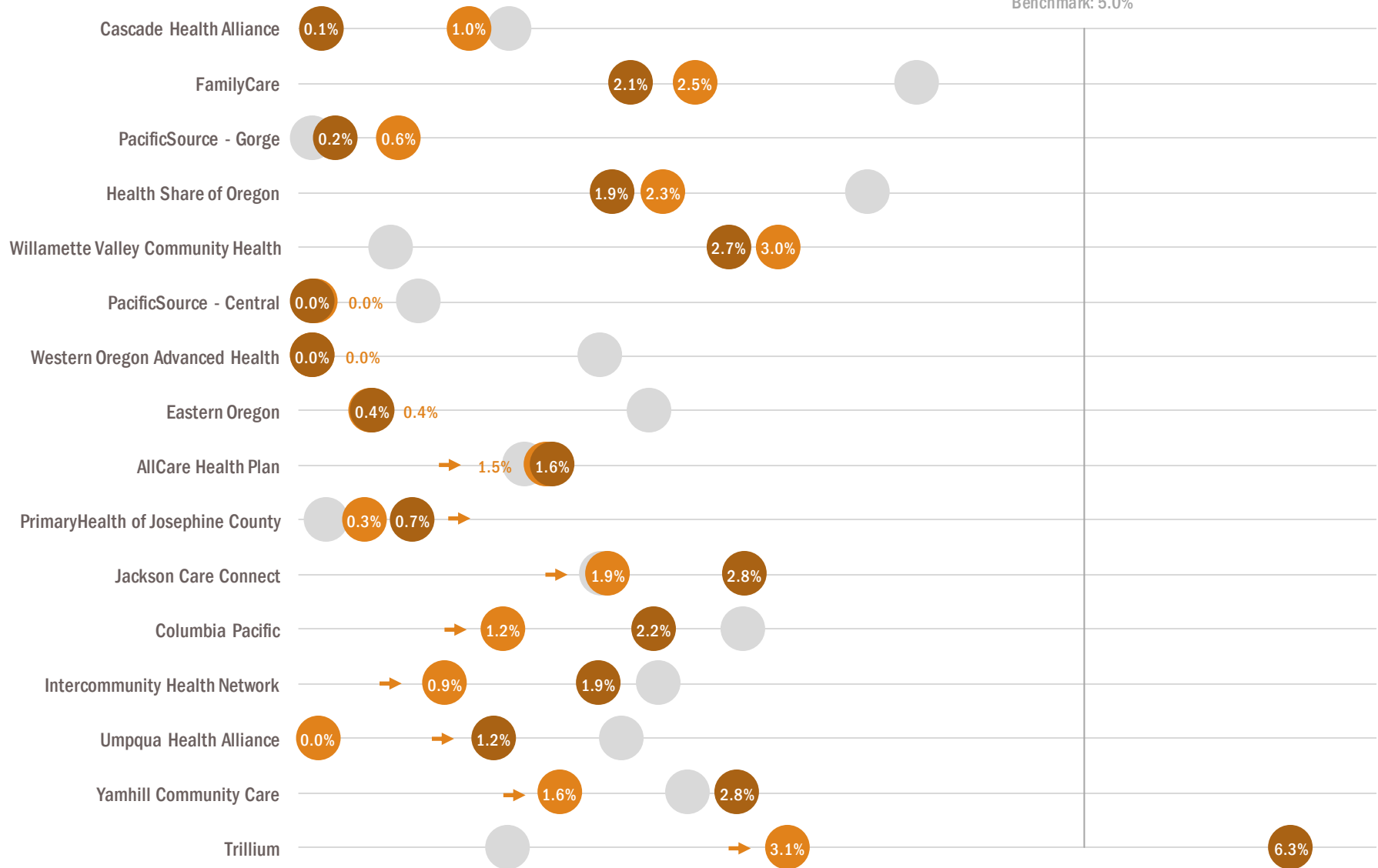
EARLY ELECTIVE DELIVERY

Early elective delivery in 2015 and 2016, by CCO.

Grey dots represent 2014

← Lower is better

Benchmark: 5.0%





ELECTRONIC HEALTH RECORD ADOPTION

Electronic health record adoption

Percentage of eligible providers within a CCO’s network and service area who qualified for a “meaningful use” incentive payment during the measurement year through the Medicaid, Medicare, or Medicare Advantage EHR Incentive Programs.

2016 data (n=7,236)

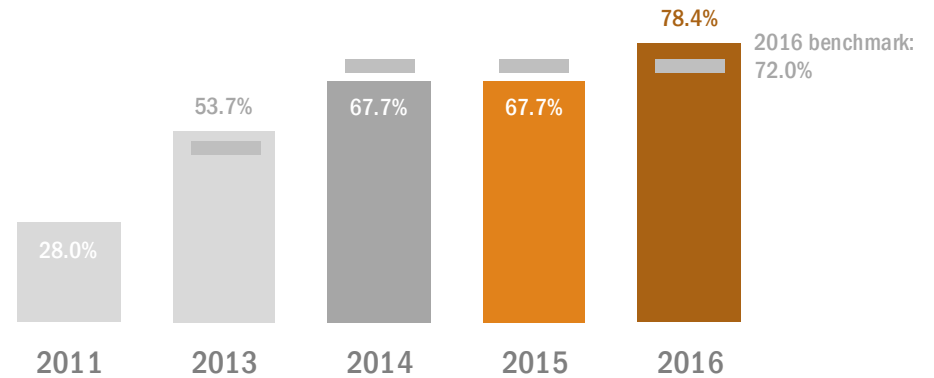
- Statewide change since 2015: **+15.8%**
- Number of CCOs that improved: **4**

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Race and ethnicity data are not available for this measure.

Electronic health record adoption, statewide.

Data source: State and federal EHR Incentive Program
Benchmark source: Metrics and Scoring Committee consensus

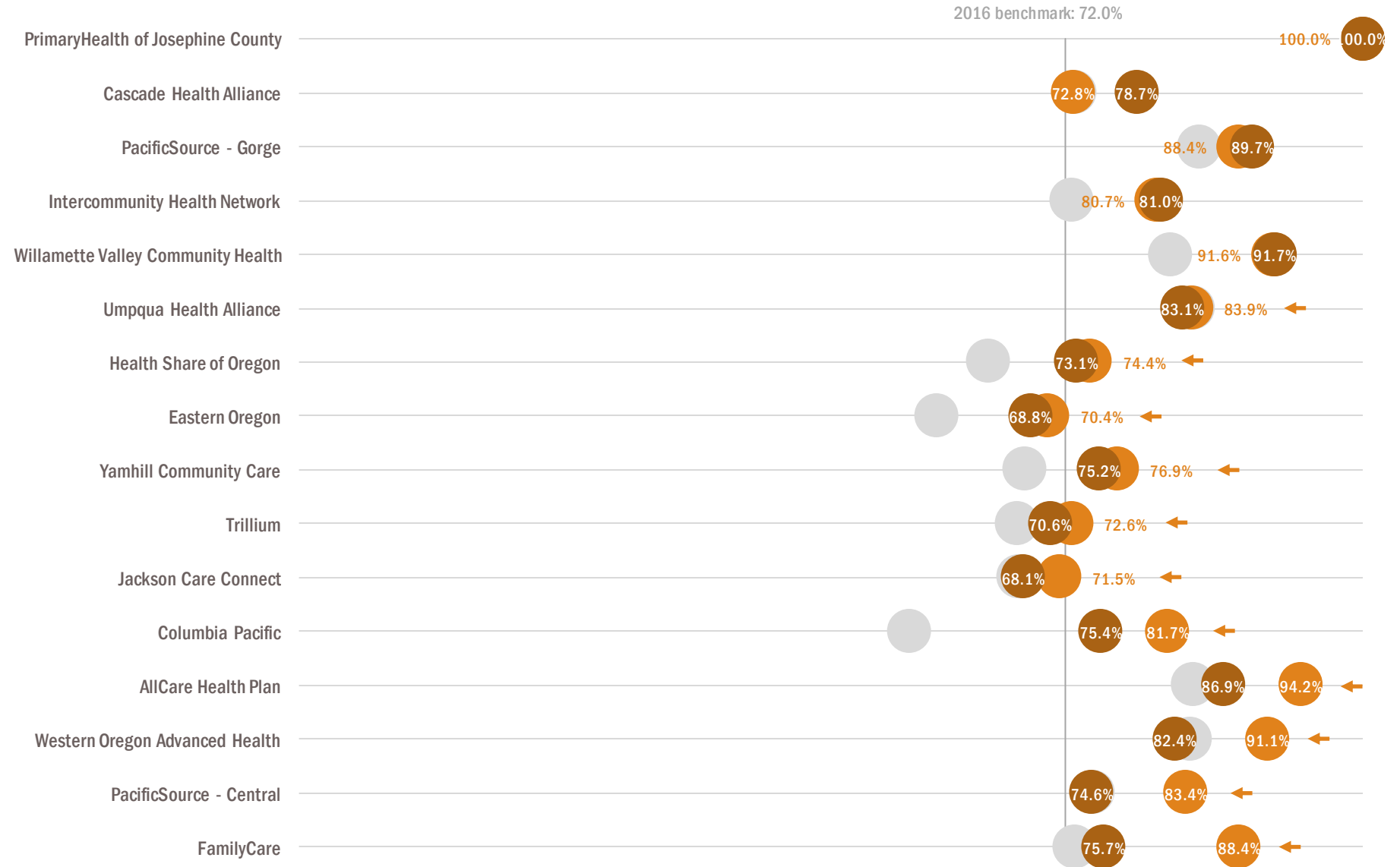




ELECTRONIC HEALTH RECORD ADOPTION

Electronic health record adoption in 2015 and 2016, by CCO.

Grey dots represent 2014





FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (INITIATION PHASE)

Follow-up care for children prescribed ADHD medication (initiation phase)

Percentage of children (ages 6-12) who had one follow-up visit with a provider during the 30 days after receiving a new prescription for ADHD medication.

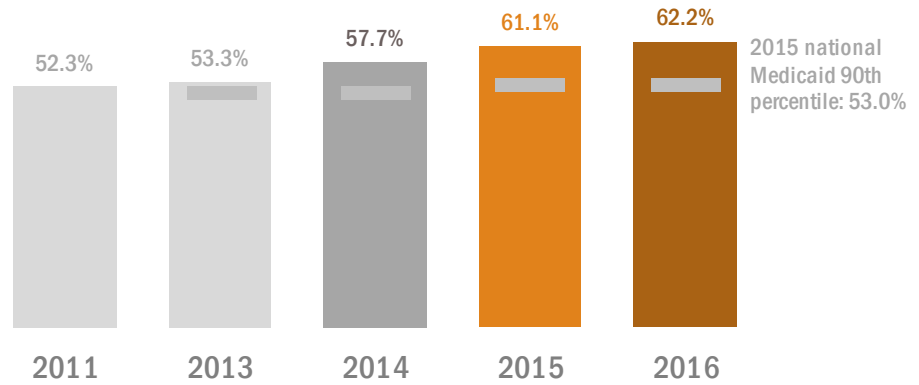
2016 data (n=2,337)

- Statewide change since 2015: **+1.8%**
- Number of CCOs that improved: **9**

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Initiation of follow-up care for children prescribed ADHD medication, statewide.

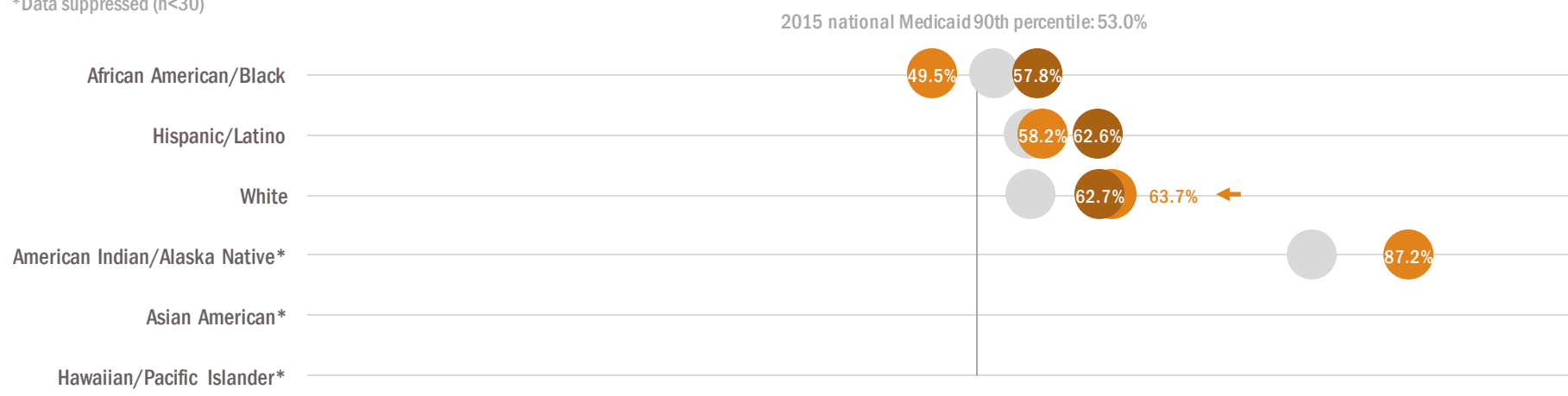
Data source: Administrative (billing) claims



Initiation of follow-up care for children prescribed ADHD medication in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 33.8% of respondents / Each race category excludes Hispanic/Latino

*Data suppressed (n<30)





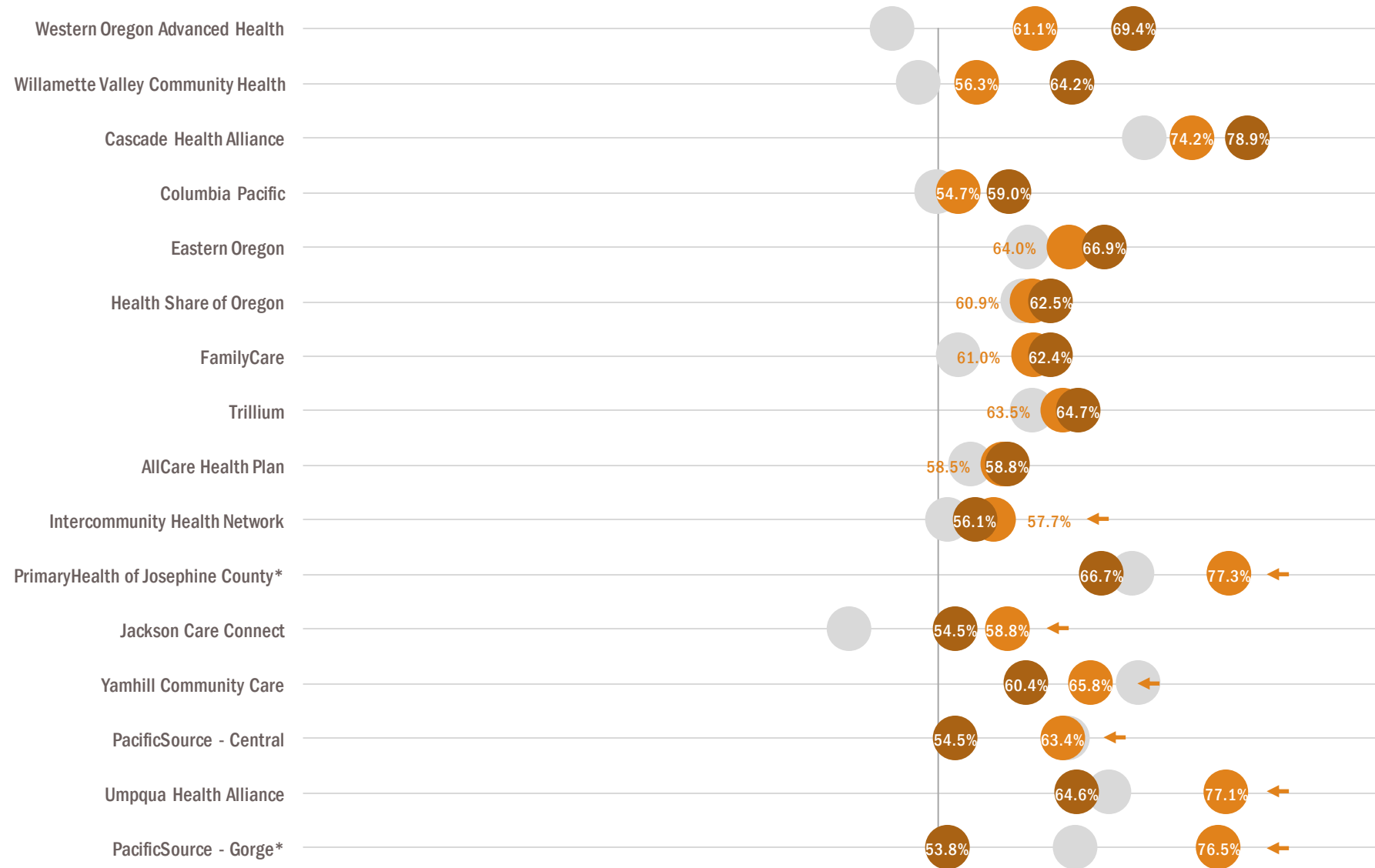
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (INITIATION PHASE)

Initiation of follow-up care for children prescribed ADHD medication in 2015 and 2016, by CCO.

Grey dots represent 2014

* note small denominator (n<30)

2015 national Medicaid 90th percentile: 53.0%





FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (CONTINUATION AND MAINTENANCE PHASE)

Follow-up care for children prescribed ADHD medication (continuation and maintenance phase)

Percentage of children (ages 6-12) who remained on attention deficit hyperactivity disorder (ADHD) medication for 210 days after receiving a new prescription and who had at least two follow-up visits with a provider within 270 days after the initiation phase ([see page 97](#)).

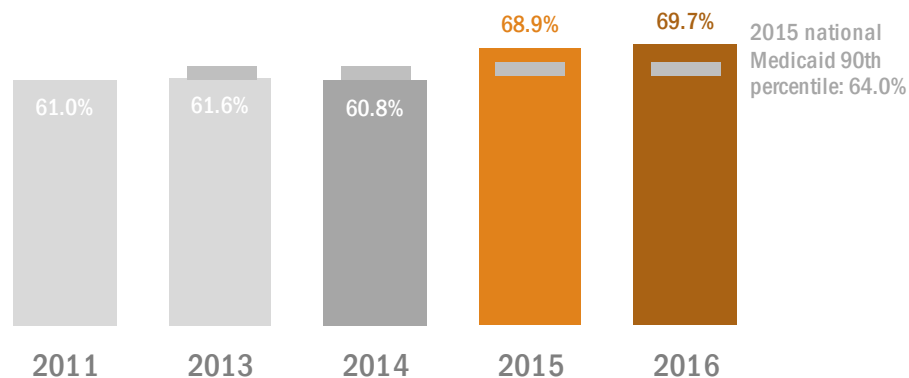
2016 data (n=768)

- Statewide change since 2015: **+1.2%**
- Number of CCOs that improved: **6**

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Ongoing follow-up care for children prescribed ADHD medication, statewide.

Data source: Administrative (billing) claims



Ongoing follow-up care for children prescribed ADHD medication in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 30.9% of respondents / Each race category excludes Hispanic/Latino

*Data suppressed (n<30)



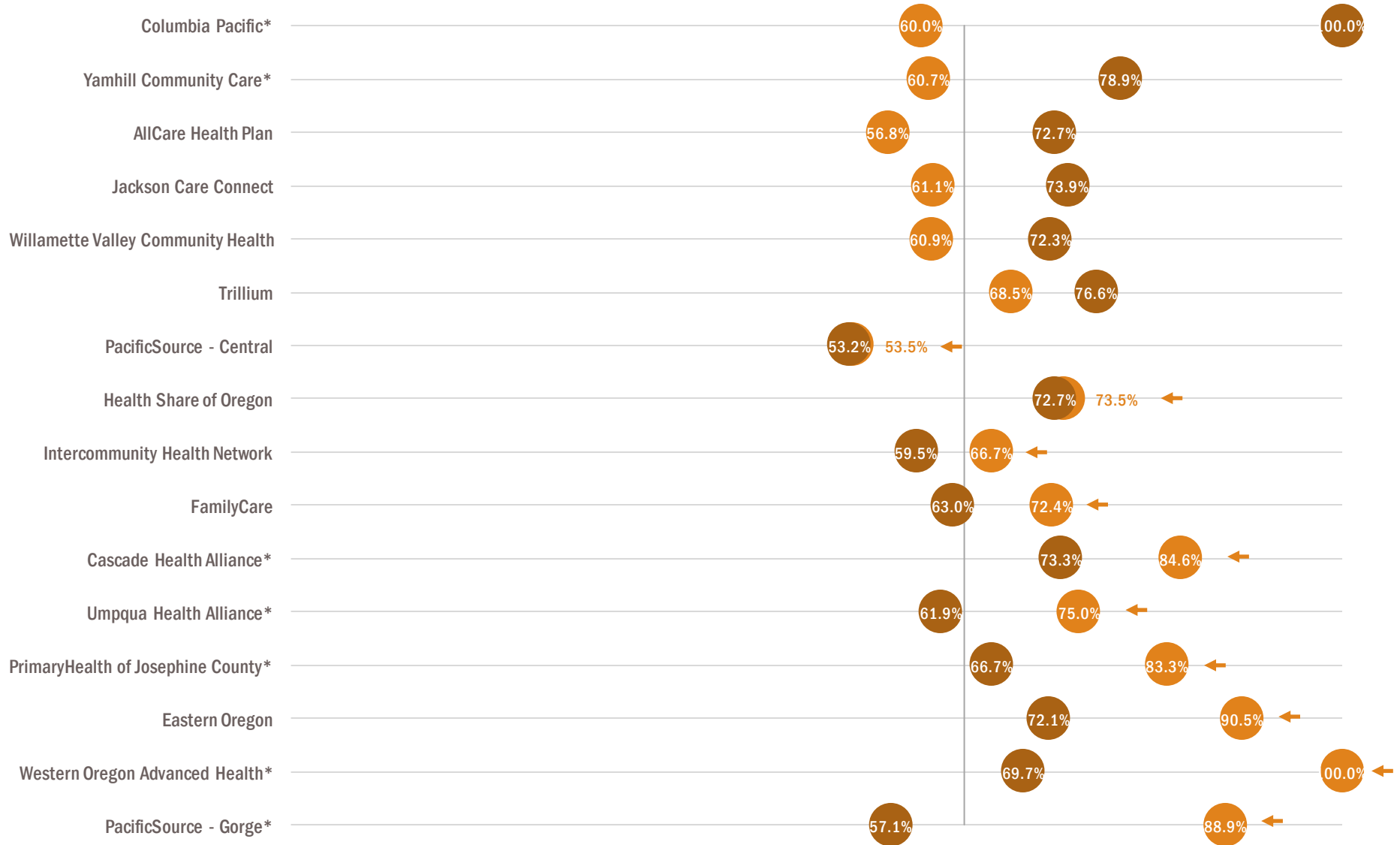


FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (CONTINUATION AND MAINTENANCE PHASE)

Ongoing follow-up care for children prescribed ADHD medication in 2015 and 2016, by CCO.

* note small denominator (n<30)

2015 national Medicaid 90th percentile: 64.0%





HEALTH STATUS (CAHPS SURVEY)

Health status (CAHPS)

Percentage of Medicaid members (adults and children) who report their overall health as good, very good, or excellent.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

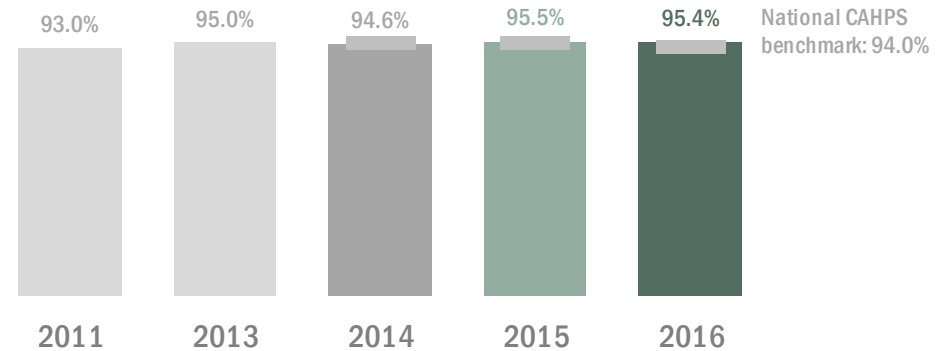
2016 data

- Statewide change since 2015: **children -0.1%; adults -0.7%**
- Number of CCOs that improved: **children 9; adults 4**

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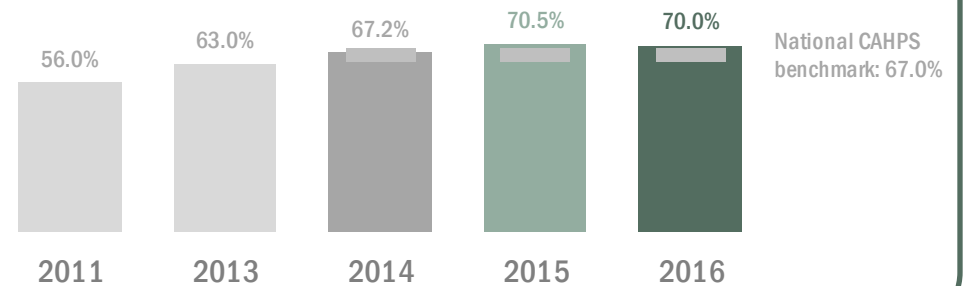
Self-reported health status among CHILDREN, statewide.

Data source: Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Self-reported health status among ADULTS, statewide.

Data source: Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)





HEALTH STATUS (CAHPS SURVEY)

Self-reported health status among CHILDREN in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Each race category excludes Hispanic/Latino

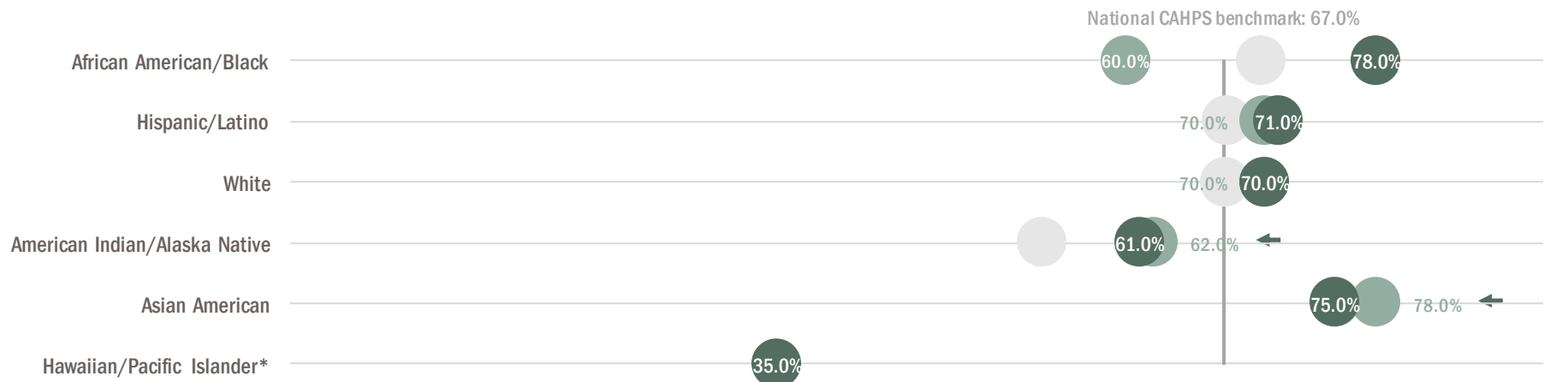
*Data suppressed (n<10)



Self-reported health status among ADULTS in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Each race category excludes Hispanic/Latino

*Data suppressed (n<10)

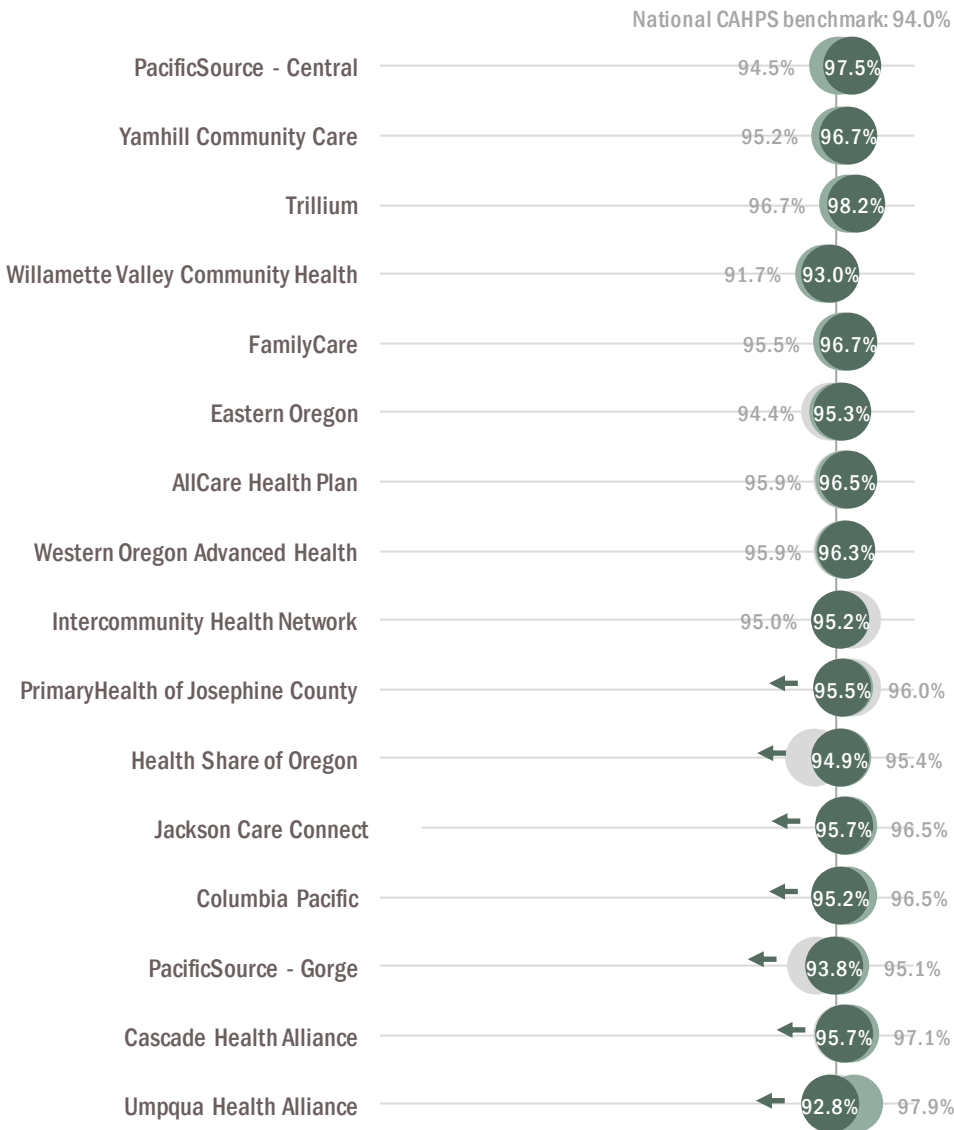




HEALTH STATUS (CAHPS SURVEY)

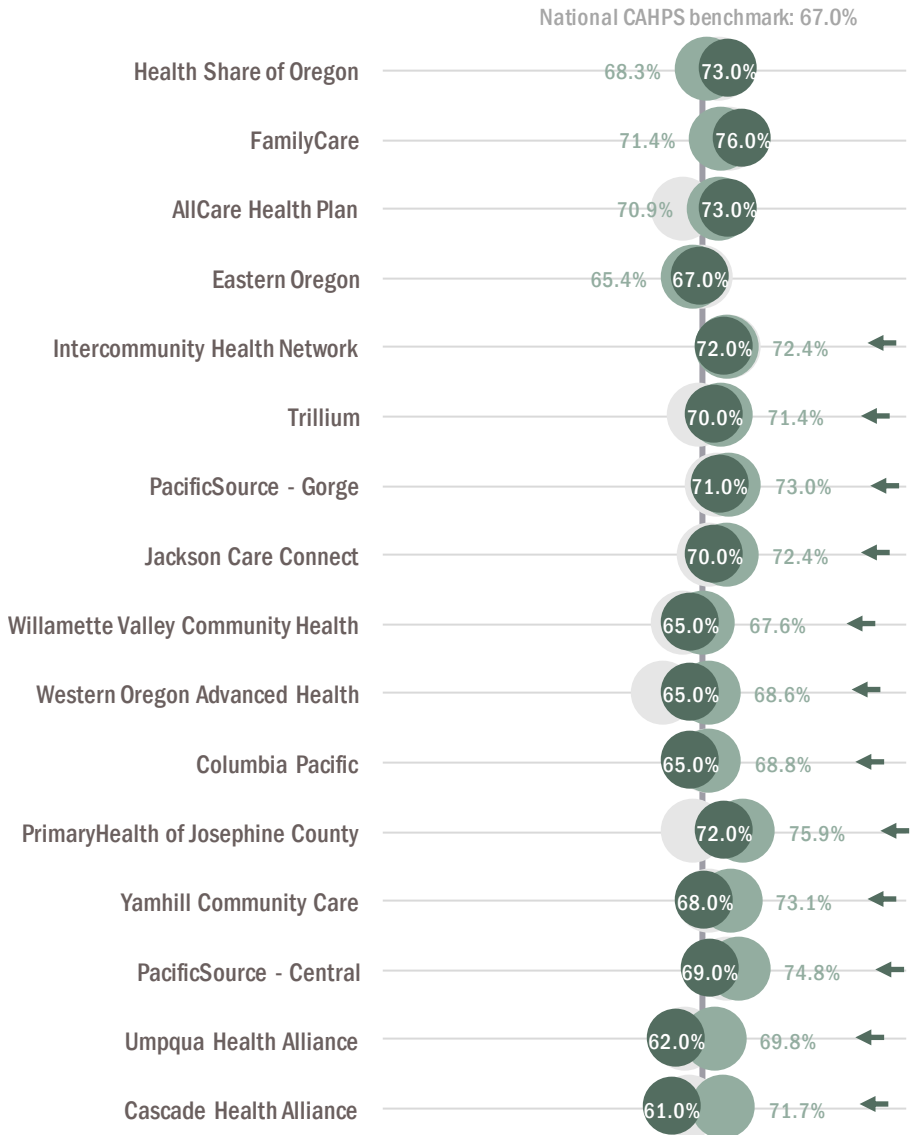
Health status among CHILDREN in 2015 and 2016, by CCO.

Grey dots represent 2014



Health status among ADULTS in 2015 and 2016, by CCO.

Grey dots represent 2014





IMMUNIZATION FOR ADOLESCENTS

Immunization for adolescents

Percentage of adolescents who received recommended vaccines (meningococcal and Tdap/TD) before their 13th birthday.

2016 data (n=13,123)

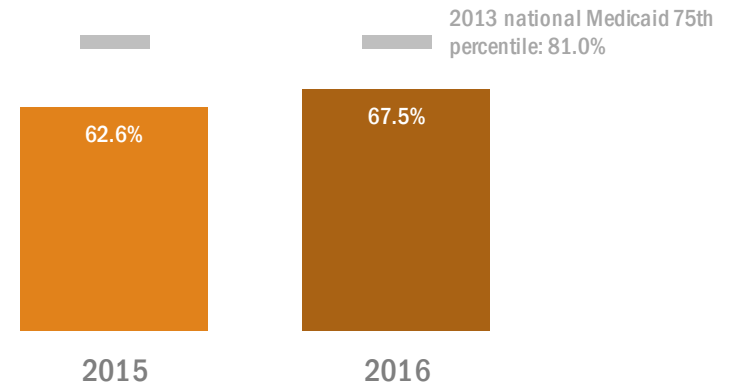
- Statewide change since 2015: **+7.8%**
- Number of CCOs that improved: **15**

Data notes: 2015 results have been revised and will differ from previously published reports. 2014 and earlier are not available; results published here should not be directly compared to previously published reports.

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Percentage of children who received recommended vaccines, statewide.

Data source: Administrative (billing) claims and ALERT immunization data



Percentage of children who received recommended vaccines in 2015 and 2016, by race and ethnicity.

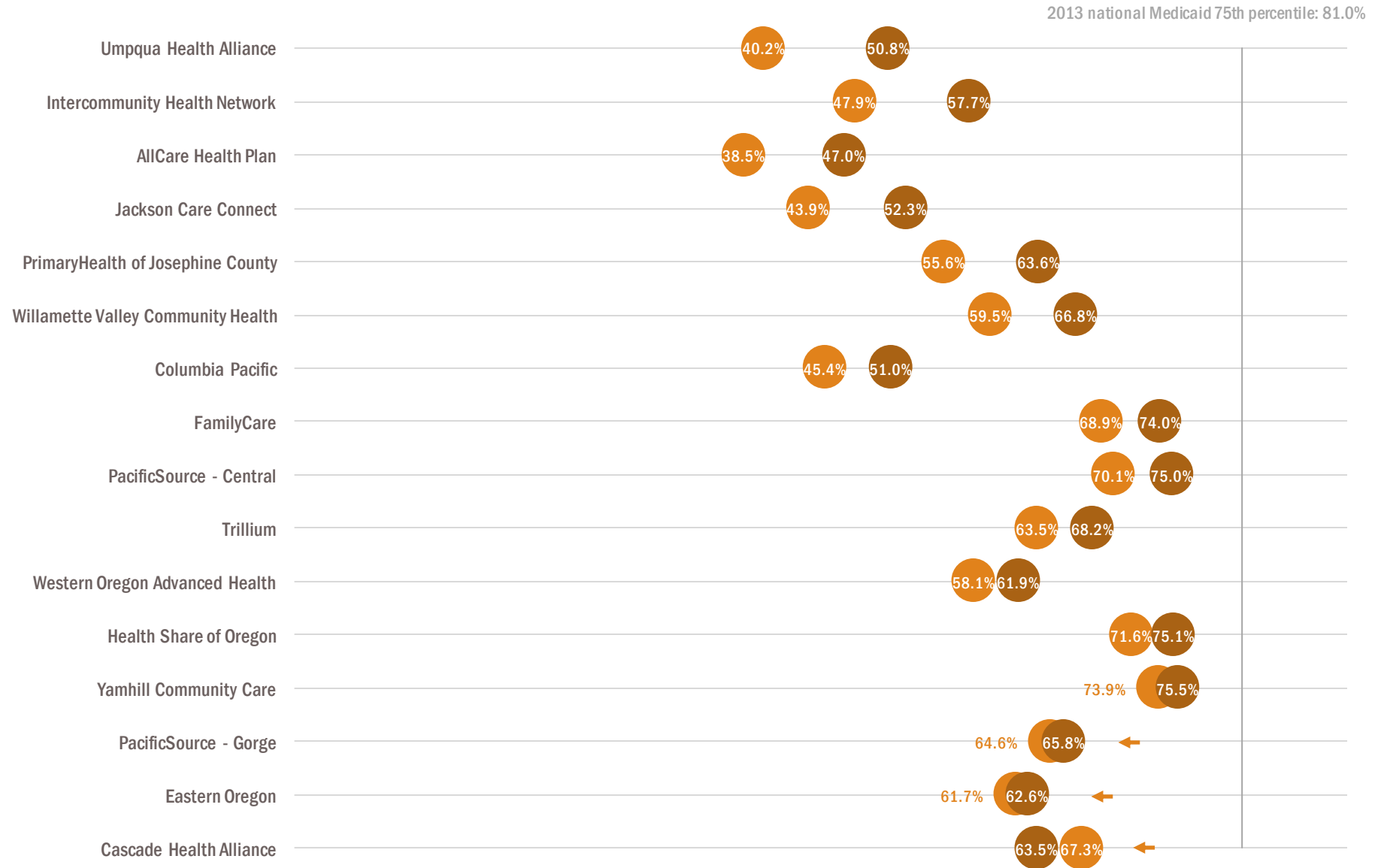
Grey dots represent 2014 / Race and ethnicity data missing for 38.6% of respondents / Each race category excludes Hispanic/Latino





IMMUNIZATION FOR ADOLESCENTS

Percentage of children who received recommended vaccines in 2015 and 2016, by CCO.





INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (INITIATION PHASE)

Initiation and engagement of alcohol or other drug treatment (initiation phase)

Percentage of members (ages 13 and older) newly diagnosed with alcohol or other drug dependence and who began treatment within 14 days of the initial diagnosis.

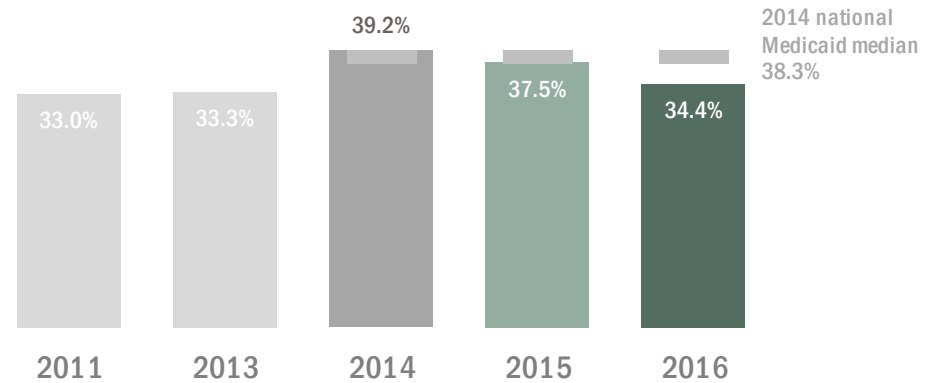
2016 data (n=14,727)

- Statewide change since 2015: **-8.2%**
- Number of CCOs that improved: **4**

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Initiation of treatment for members diagnosed with alcohol or other drug dependence, statewide.

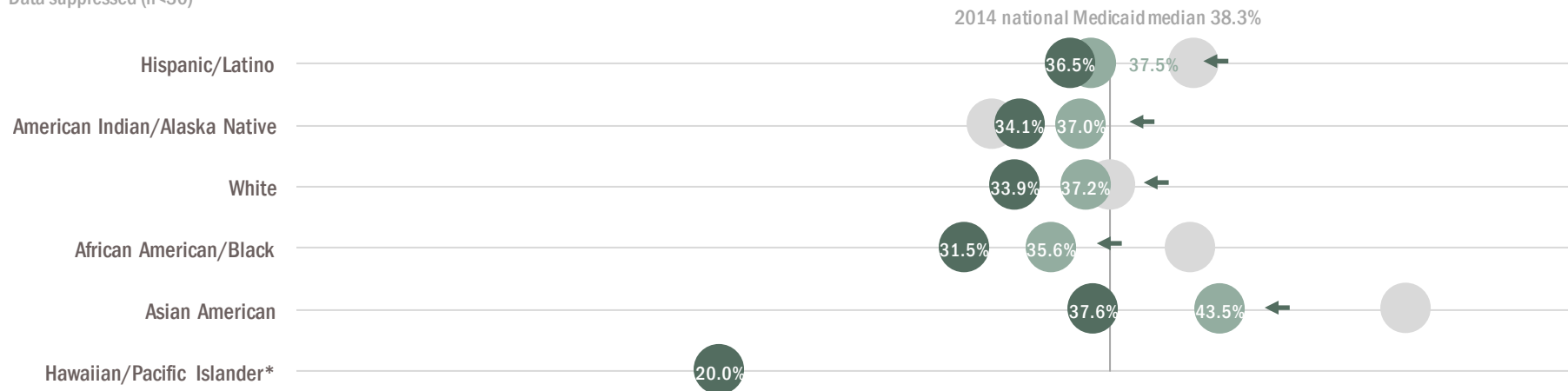
Data source: Administrative (billing) claims



Initiation of treatment for members diagnosed with alcohol or other drug dependence in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 19.8% of respondents / Each race category excludes Hispanic/Latino

*Data suppressed (n<30)





INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (INITIATION PHASE)

Initiation of treatment for members diagnosed with alcohol or other drug dependence in 2015 and 2016, by CCO.

Grey dots represent 2014

2014 national Medicaid median 38.3%





INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (ENGAGEMENT PHASE)

Initiation and engagement of alcohol or other drug treatment (engagement phase)

Percentage of members (ages 13 and older) newly diagnosed with alcohol or other drug dependence who had two or more additional services for alcohol or other drug dependence within 30 days of their initial treatment.

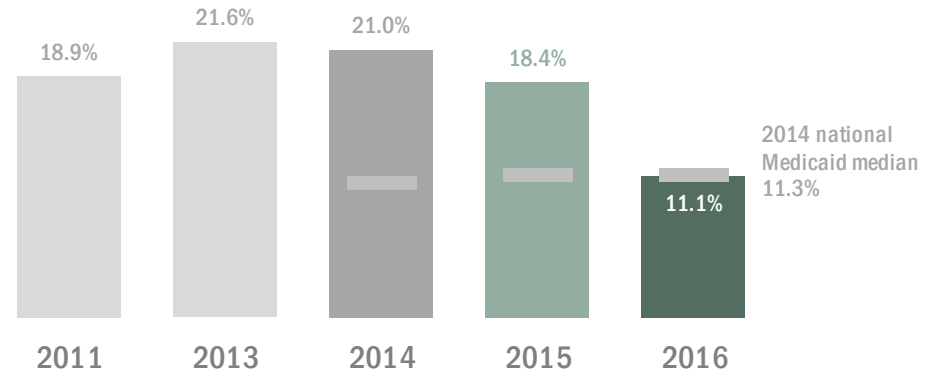
2016 data (n=14,727)

- Statewide change since 2015: **-39.8%**
- Number of CCOs that improved: **2**

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Engagement of alcohol or other drug treatment, statewide.

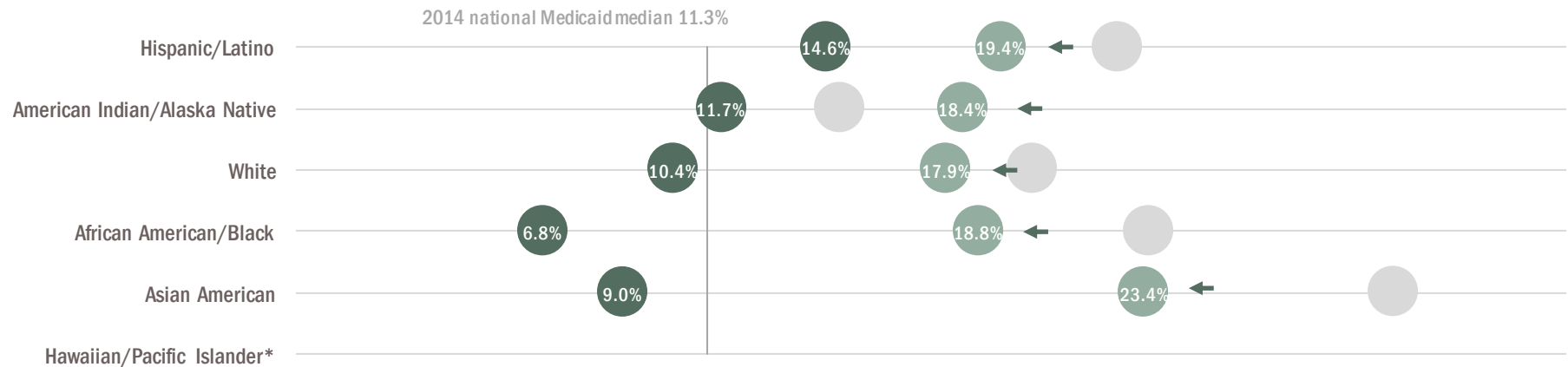
Data source: Administrative (billing) claims



Engagement of alcohol or other drug treatment in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 19.8% of respondents / Each race category excludes Hispanic/Latino

*Data suppressed (n<30)

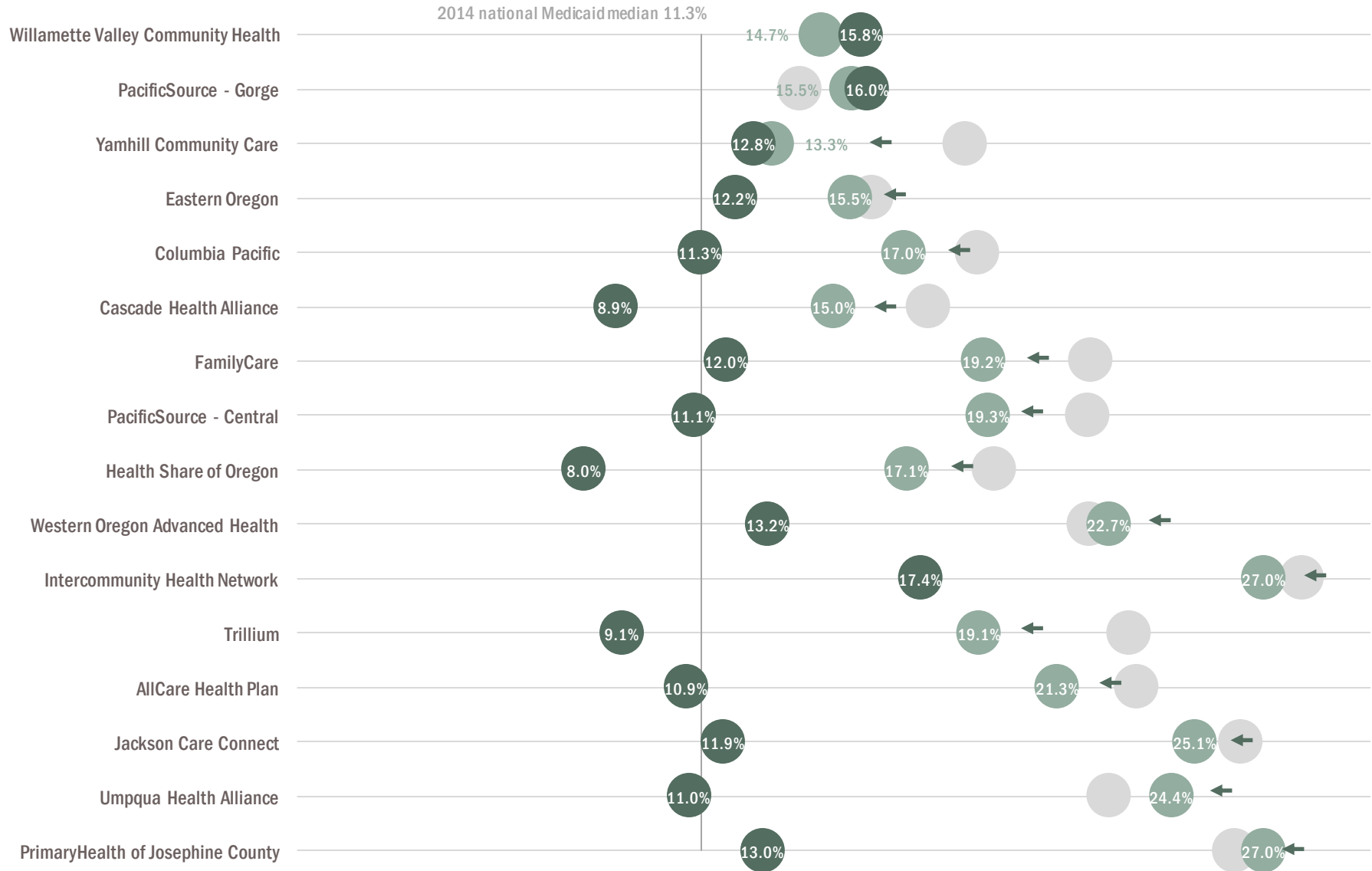




INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (ENGAGEMENT PHASE)

Engagement of alcohol or other drug treatment in 2015 and 2016, by CCO.

Grey dots represent 2014





MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION: ADVISED TO QUIT (CAHPS SURVEY)

Medical assistance with smoking and tobacco use cessation: doctor advised to quit (CAHPS)

Percentage of adult tobacco users advised to quit by their doctor.

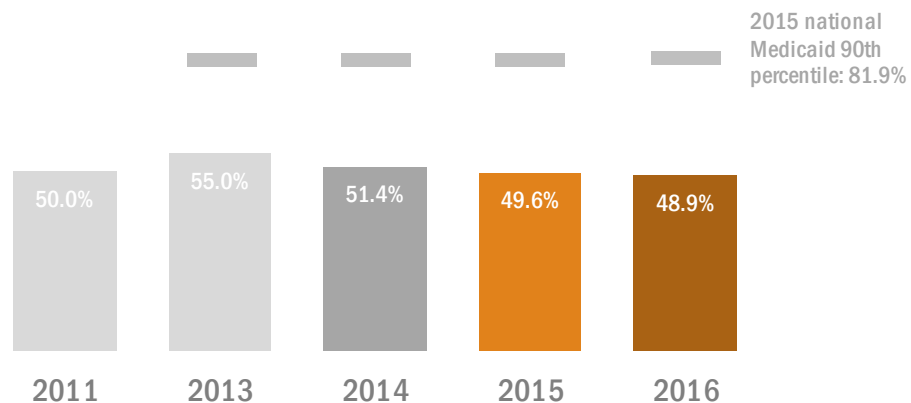
2016 data

- Statewide change since 2015: **-1.4%**
- Number of CCOs that improved: **5**

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Percentage of tobacco users who were advised by their doctor to quit, statewide.

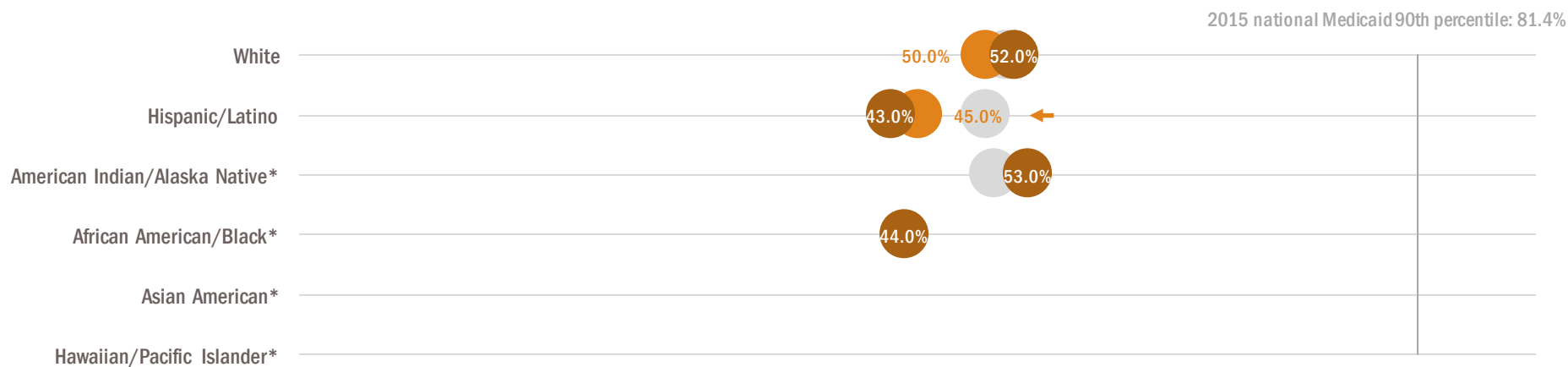
Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Percentage of tobacco users who were advised by their doctor to quit in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Each race category excludes Hispanic/Latino

*Data suppressed (n<10)



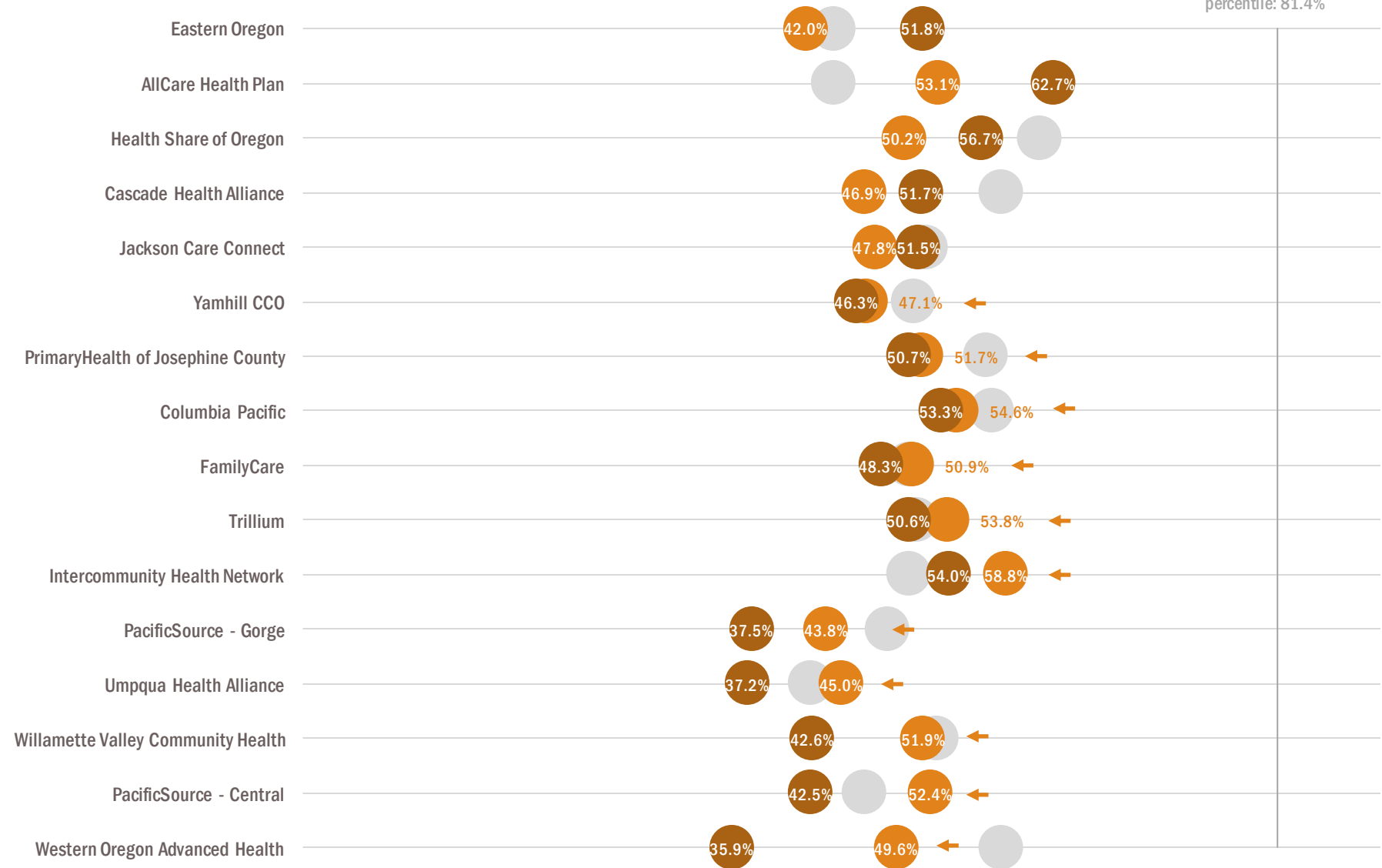


MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION: ADVISED TO QUIT (CAHPS SURVEY)

Percentage of tobacco users who were advised by their doctor to quit in 2015 and 2016, by CCO.

Grey dots represent 2014

2015 national Medicaid 90th percentile: 81.4%





MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION: ADVISED MEDICATION (CAHPS SURVEY)

Medical assistance with smoking and tobacco use cessation: doctor recommended medication to quit (CAHPS)

Percentage of adult tobacco users whose doctor discussed or recommended medication to quit smoking.

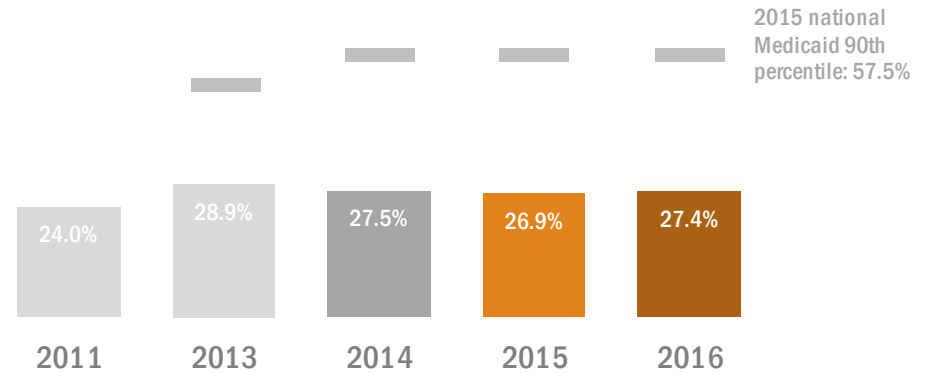
2016 data

- Statewide change since 2015: **+1.9%**
- Number of CCOs that improved: **7**

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Percentage of tobacco users who said their doctor recommended medication to quit smoking, statewide.

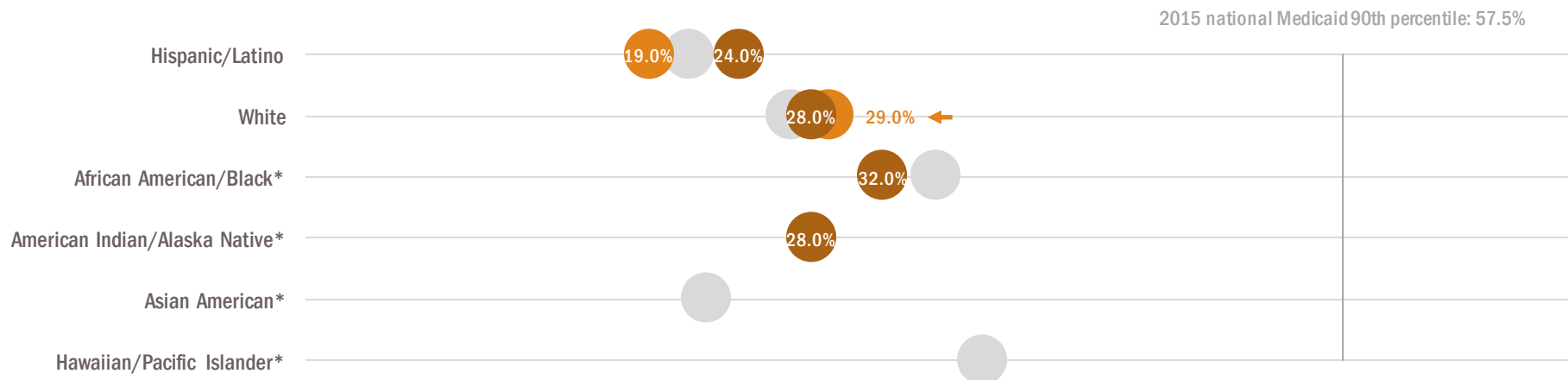
Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Percentage of tobacco users who said their doctor recommended medication to quit smoking in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Each race category excludes Hispanic/Latino

*Data suppressed (n<10)



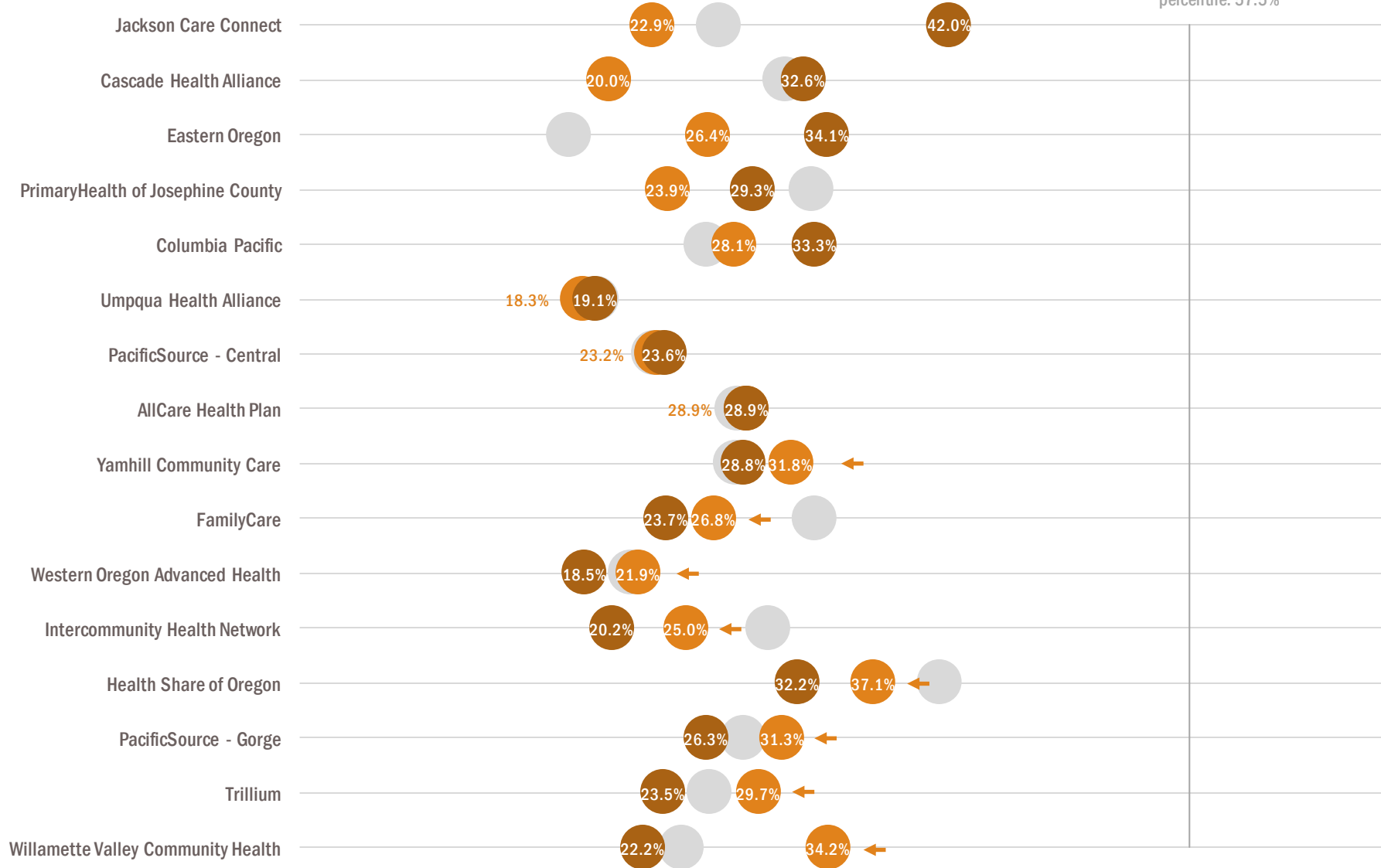


MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION: ADVISED MEDICATION (CAHPS SURVEY)

Percentage of tobacco users who said their doctor recommended medication to quit smoking in 2015 and 2016, by CCO.

Grey dots represent 2014

2015 national Medicaid 90th percentile: 57.5%





MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION: ADVISED STRATEGIES (CAHPS SURVEY)

Medical assistance with smoking and tobacco use cessation: doctor recommended strategies to quit (CAHPS)

Percentage of adult tobacco users whose doctor discussed or recommended strategies to quit smoking.

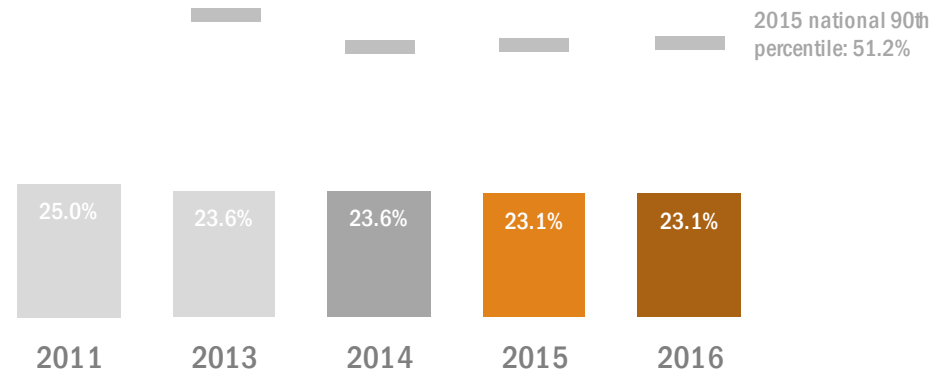
2016 data

- Statewide change since 2015: **+0.0%**
- Number of CCOs that improved: **6**

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Percentage of members who said their doctor advised alternate methods to quit smoking, statewide.

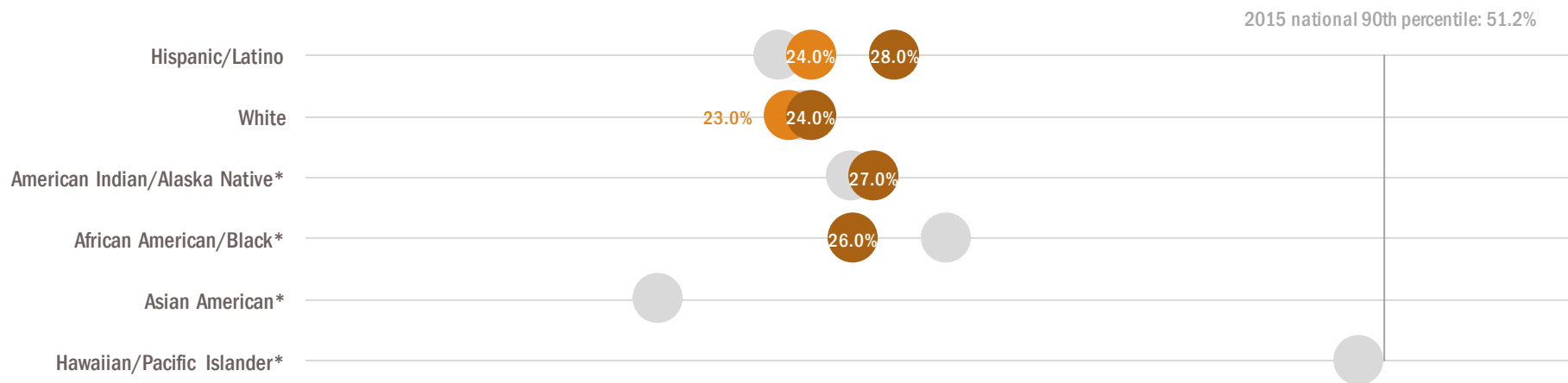
Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Percentage of members who said their doctor advised alternate methods to quit smoking in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Each race category excludes Hispanic/Latino

*Data suppressed (n<10)



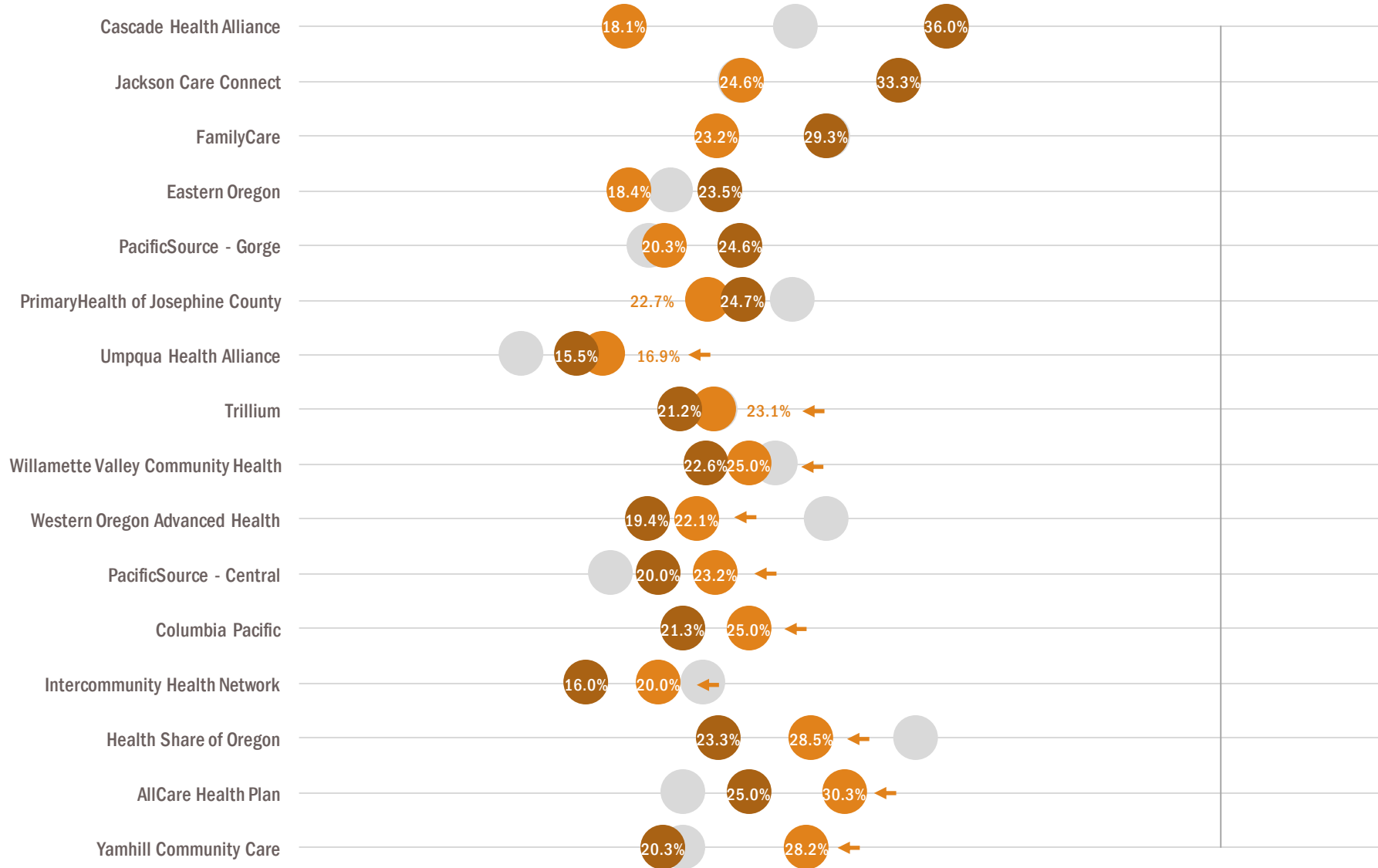


MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION: ADVISED STRATEGIES (CAHPS SURVEY)

Percentage of members who said their doctor advised alternate methods to quit smoking in 2015 and 2016, by CCO.

Grey dots represent 2014

2015 national 90th percentile: 51.2%





OBESITY PREVALENCE AMONG ADULTS

Obesity prevalence

Percentage of adult Medicaid members (ages 18 and older) who are obese, defined as body mass index greater than 30.

2015 data

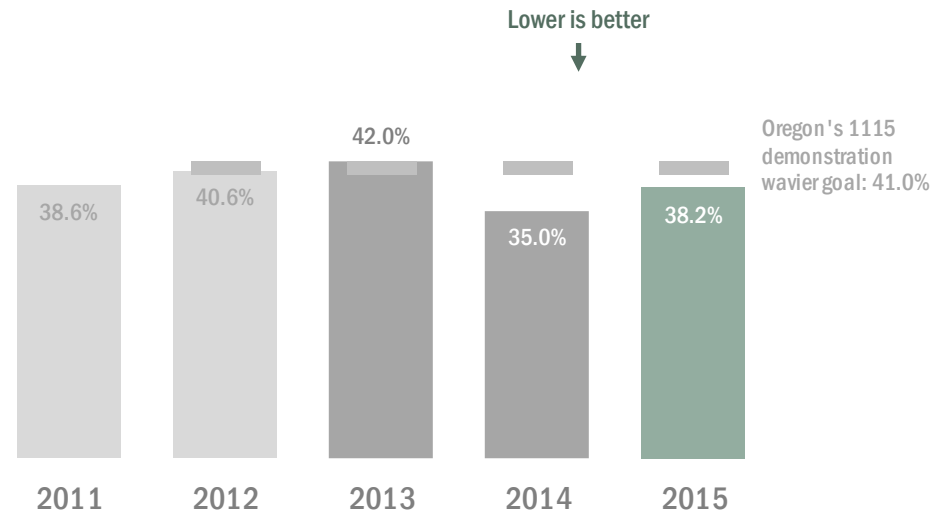
- Statewide change since 2015: **+9.1%** (lower is better)

This measure is not available by race and ethnicity or by CCO; however, 2014 results by CCO can be found in the Medicaid-BRFSS (MBRFSS) report available online at www.oregon.gov/oha/hpa/analytics/Pages/MBRFSS.aspx.

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Obesity prevalence, statewide.

Data source: Oregon Behavioral Risk Factor Surveillance System (BRFSS) Survey



PQI 01: DIABETES SHORT-TERM COMPLICATION ADMISSION RATE

Diabetes short-term complications admission rate

Rate of adult members (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease. Rates are reported per 100,000 member years. A lower score is better.

PQI stands for Prevention Quality Indicators, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

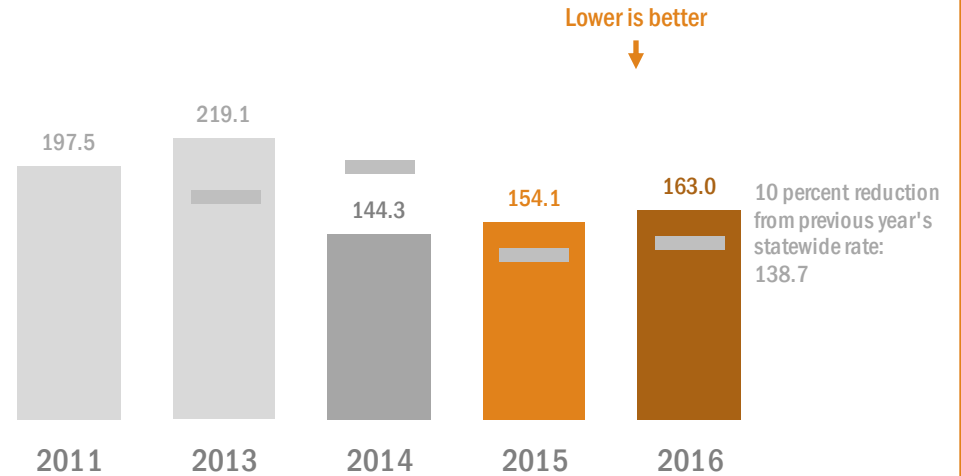
2016 data (n=6,456,424 member years)

- Statewide change since 2015: **+5.8%** (lower is better)
- Number of CCOs that improved: **7**

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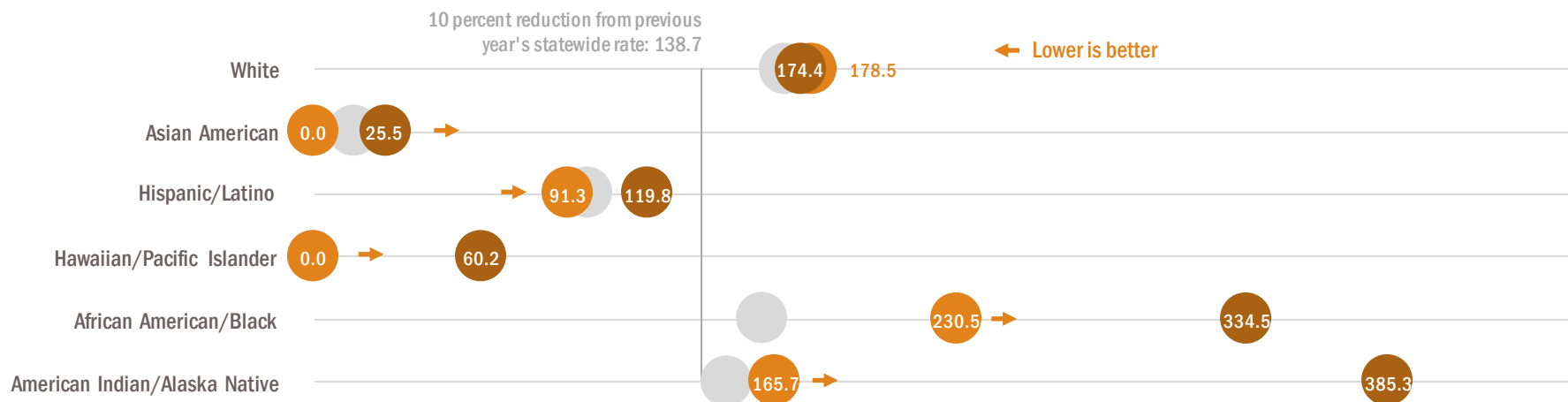
Admissions for diabetes short-term complications, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years



Admissions for diabetes short-term complications in 2015 and 2016, by race and ethnicity.

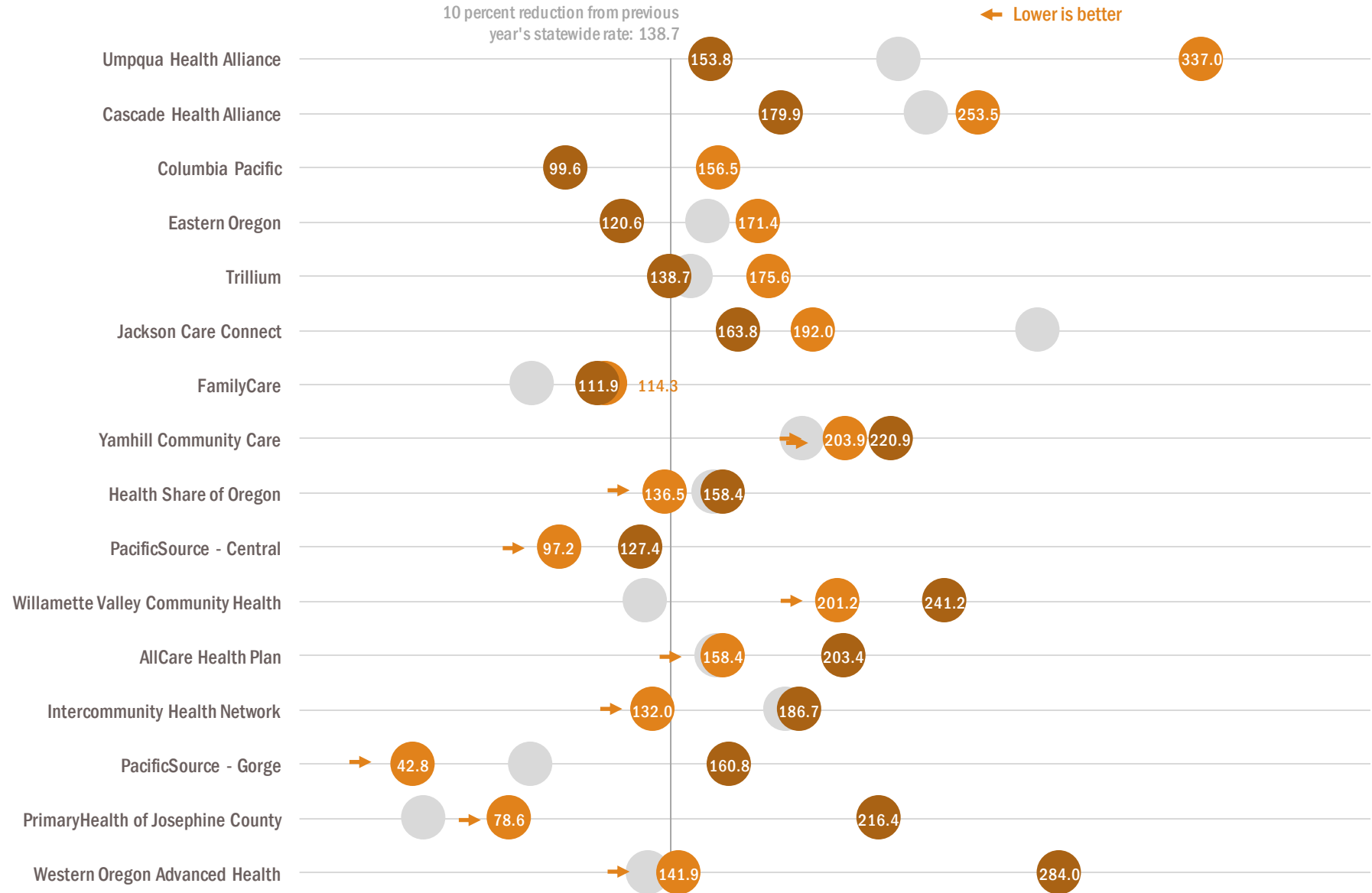
Grey dots represent 2014 / Race and ethnicity data missing for 28.8% of respondents / Each race category excludes Hispanic/Latino



PQI 01: DIABETES SHORT-TERM COMPLICATION ADMISSION RATE

Admissions for diabetes short-term complications in 2015 and 2016, by CCO.

Grey dots represent 2014





PQI 05: CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE

COPD or asthma in older adults admission rate

Rate of adult members (ages 40 and older) who had a hospital stay because of chronic obstructive pulmonary disease or asthma. Rates are reported per 100,000 member years. A lower score is better.

PQI stands for Prevention Quality Indicators, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

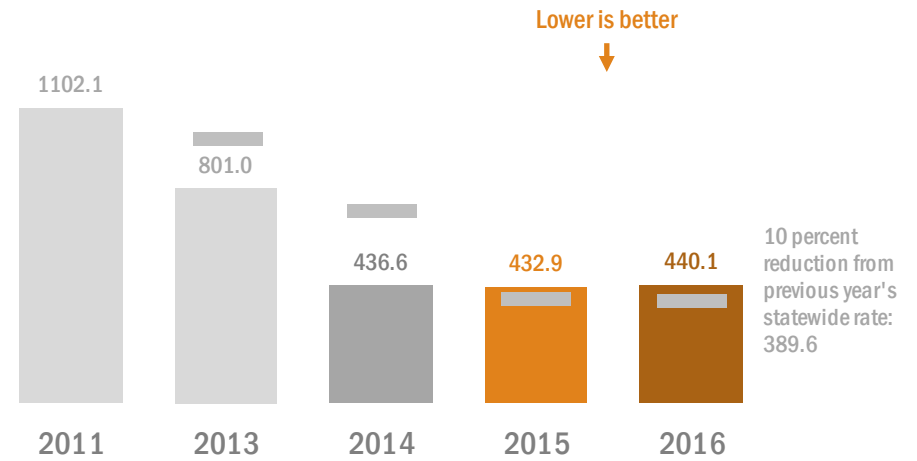
2016 data (n=6,456,424 member years)

- Statewide change since 2015: **+1.7%** (lower is better)
- Number of CCOs that improved: **8**

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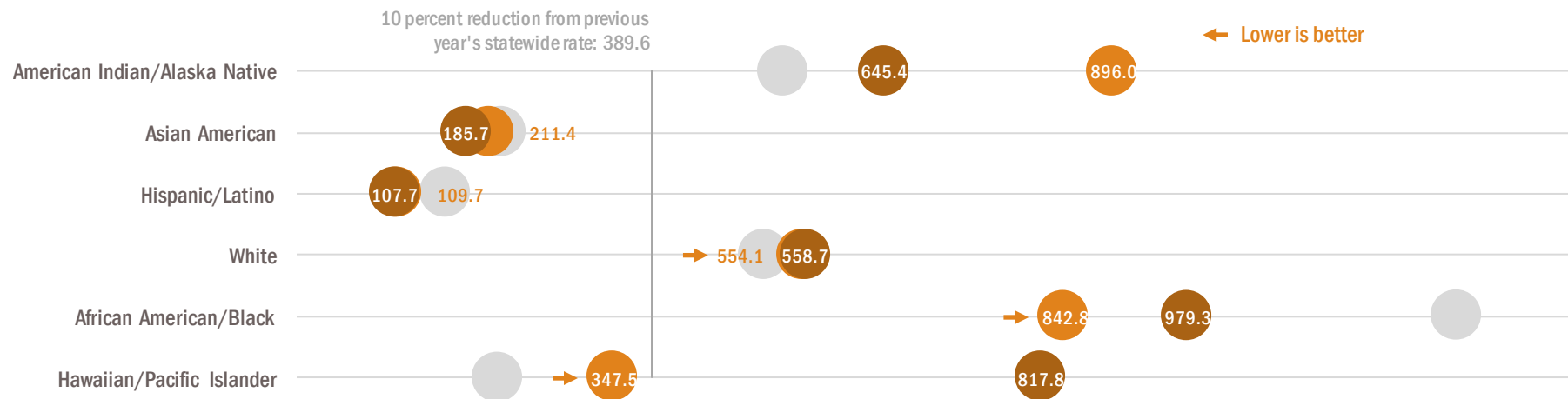
Admissions for COPD or asthma in older adults, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years



Admissions for COPD or asthma in older adults in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 25.2% of respondents / Each race category excludes Hispanic/Latino

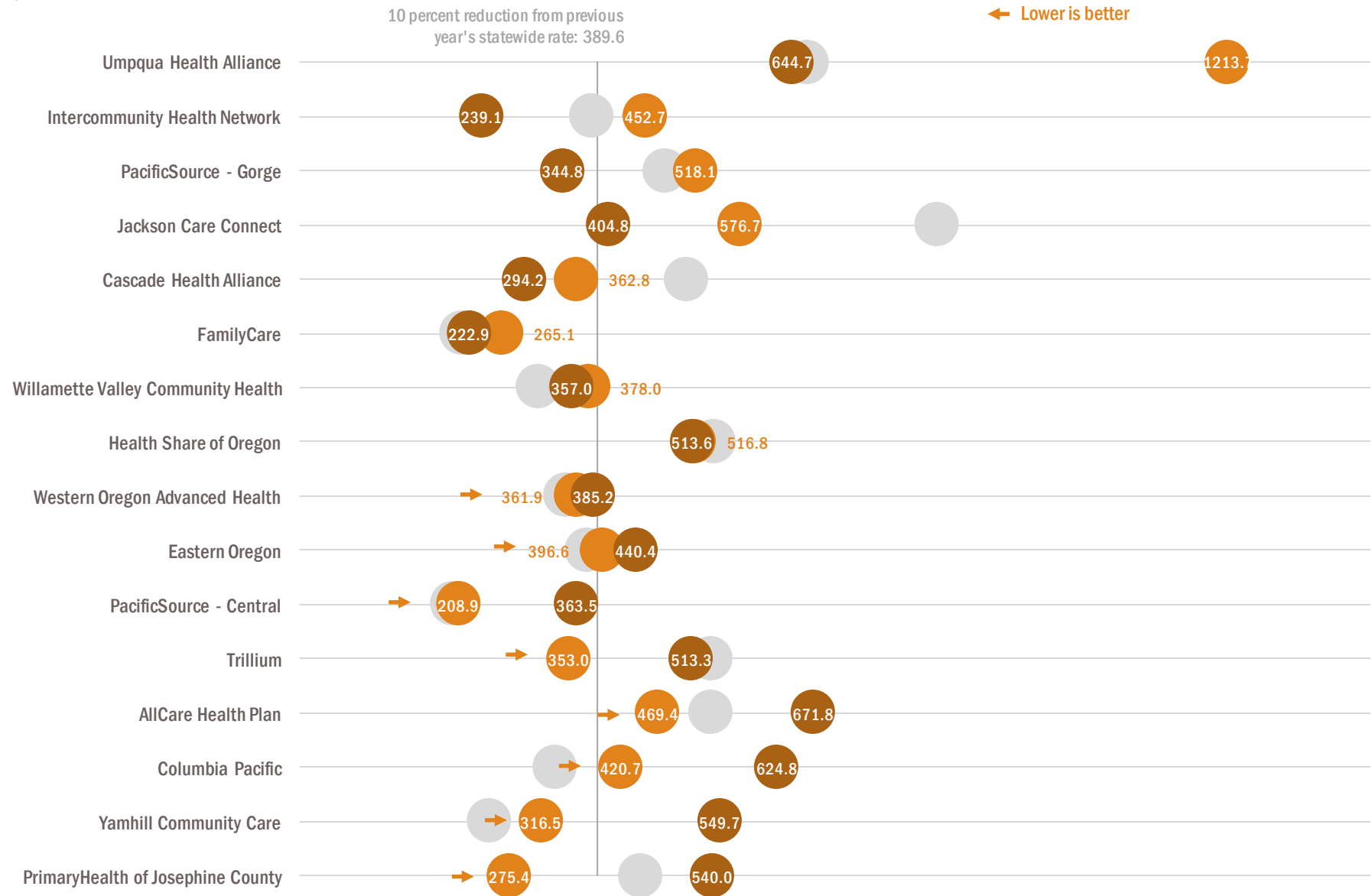




PQI 05: CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE

Admissions for COPD or asthma in older adults in 2015 and 2016, by CCO.

Grey dots represent 2014





PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

Congestive heart failure admission rate

Rate of adult members (ages 18 and older) who had a hospital stay because of congestive heart failure. Rates are reported per 100,000 member years. A lower score is better.

PQI stands for Prevention Quality Indicators, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

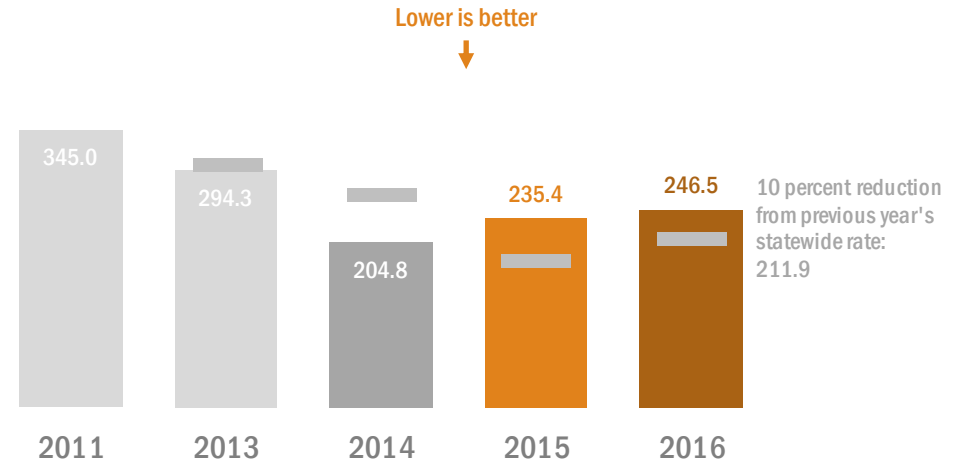
2016 data (n=6,456,424 member years)

- Statewide change since 2015: **+4.7%** (lower is better)
- Number of CCOs that improved: **7**

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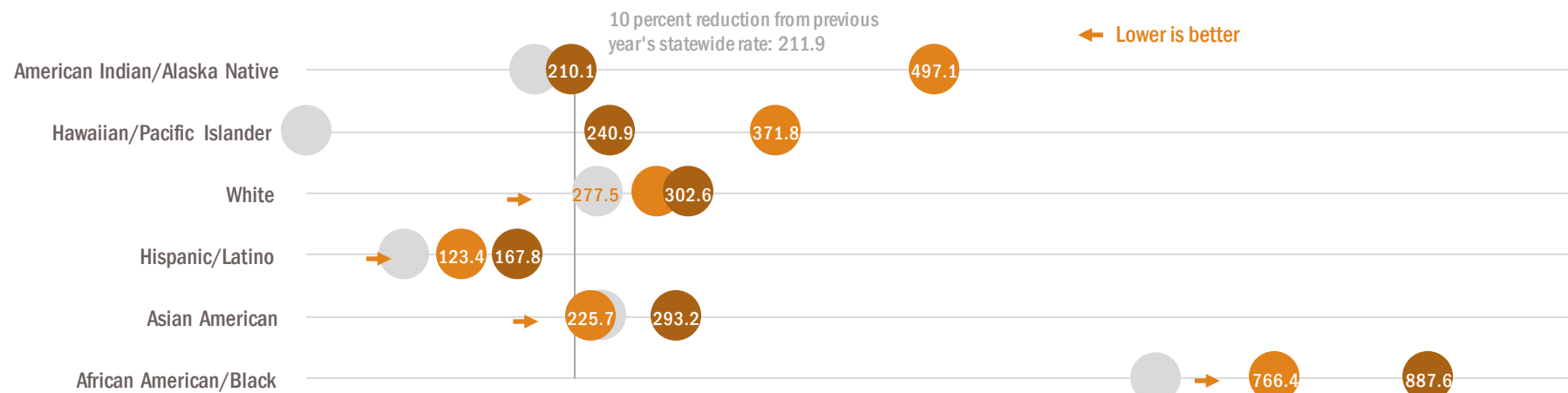
Admissions for congestive heart failure in 2015 and 2016, by CCO.

Grey dots represent 2014



Admissions for congestive heart failure in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 28.8% of respondents / Each race category excludes Hispanic/Latino

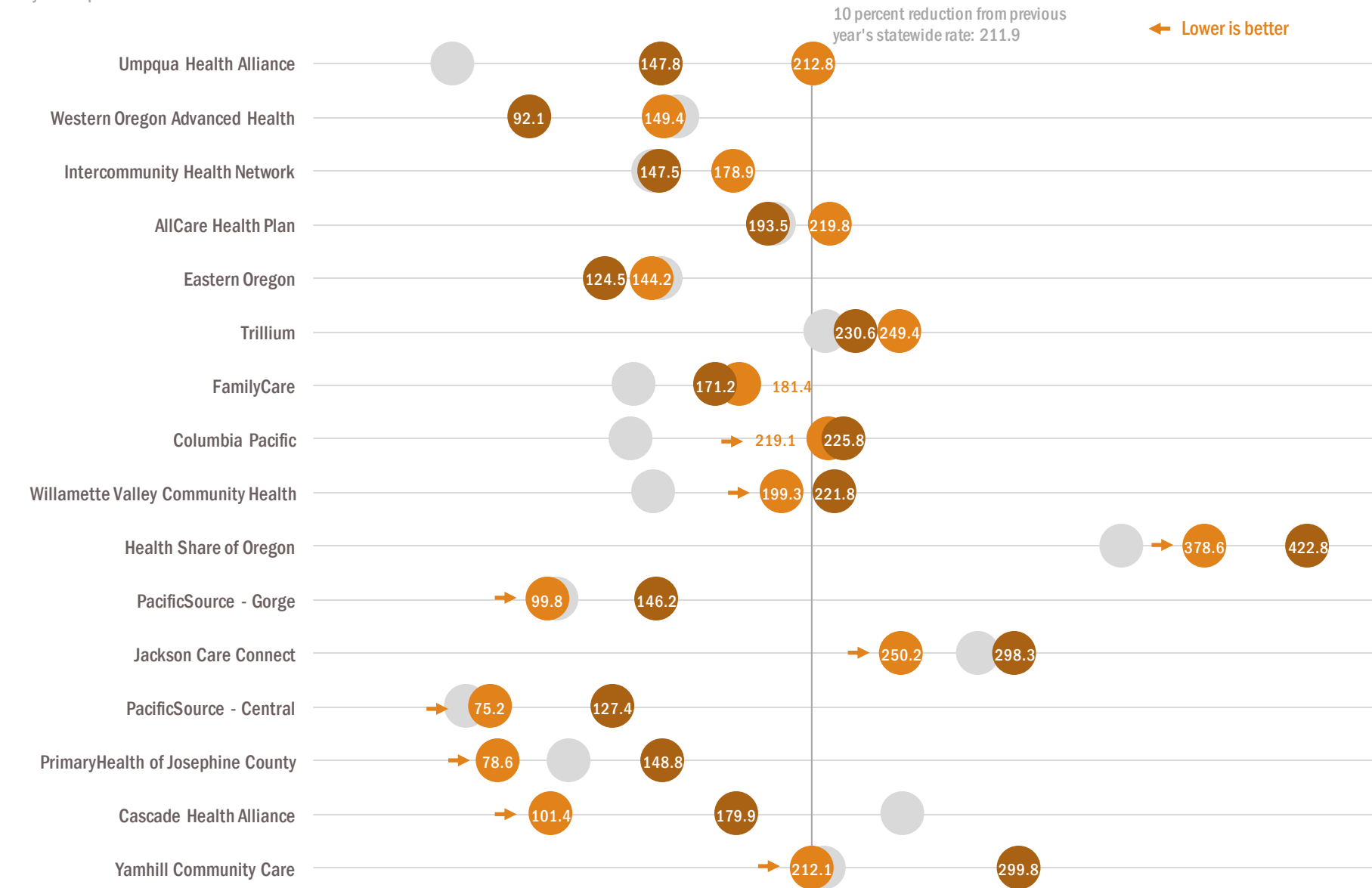




PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

Admissions for congestive heart failure in 2015 and 2016, by CCO.

Grey dots represent 2014





PQI 15: ASTHMA IN YOUNGER ADULTS ADMISSION RATE

Asthma in younger adults admission rate

Rate of adult members (ages 18-39) who had a hospital stay because of asthma. Rates are reported per 100,000 member years. A lower score is better.

PQI stands for Prevention Quality Indicators, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

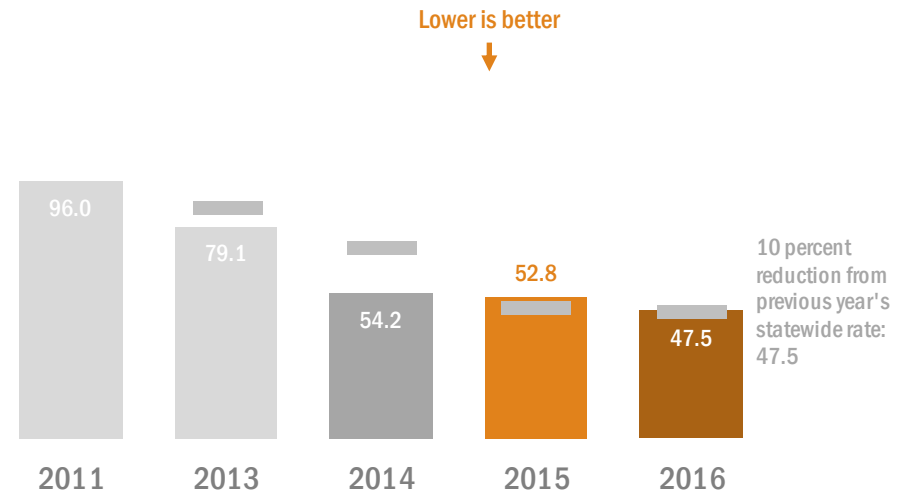
2016 data (n=6,456,424 member years)

- Statewide change since 2015: **-10%** (lower is better)
- Number of CCOs that improved: **6**

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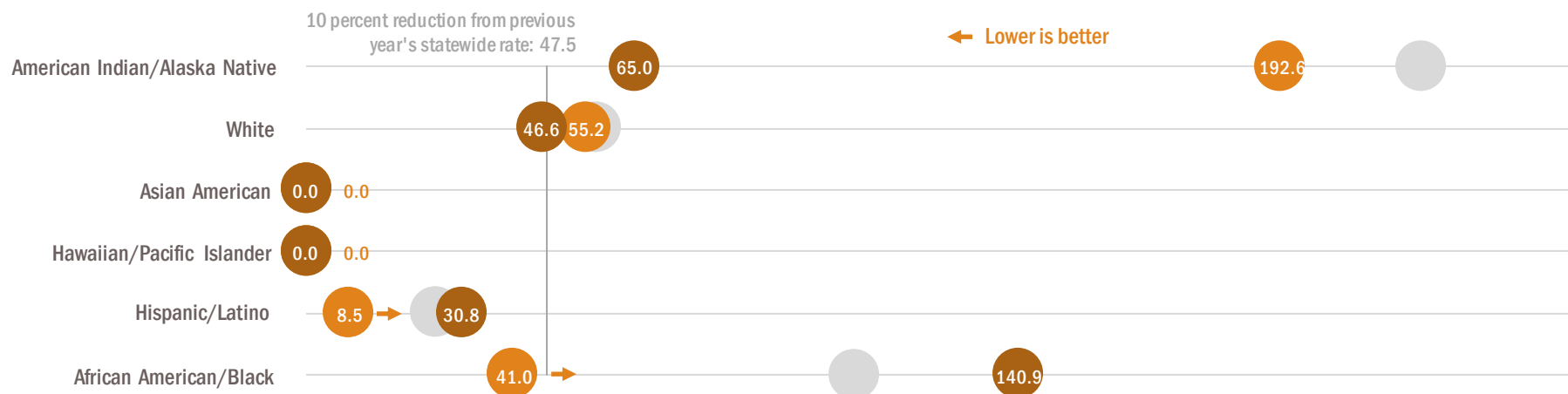
Admissions for asthma in younger adults, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years



Admissions for asthma in younger adults in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 31.9% of respondents / Each race category excludes Hispanic/Latino

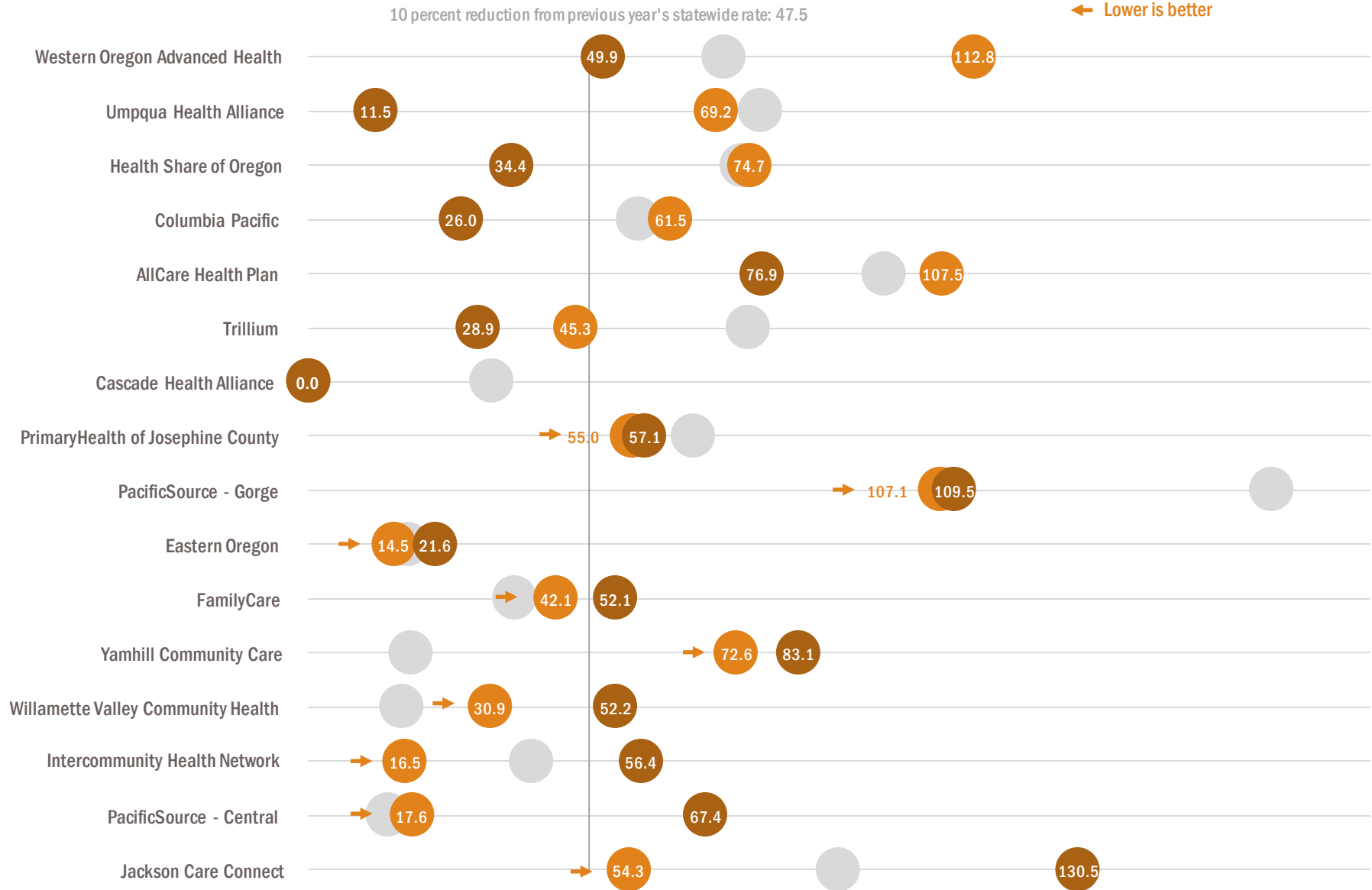




PQI 15: ASTHMA IN YOUNGER ADULTS ADMISSION RATE

Admissions for asthma in younger adults in 2015 and 2016, by CCO.

Grey dots represent 2014





PQI 90: PREVENTION QUALITY OVERALL COMPOSITE

PQI 90: Prevention quality overall composite

Composite rate of adult members who were admitted to a hospital for any of the following preventable conditions:

- Diabetes with short-term complications (PQI 1, [see page 117](#))
- Diabetes with long-term complications
- Uncontrolled diabetes without complications
- Diabetes with lower-extremity amputation
- COPD (PQI 5, [see page 119](#))
- Asthma (PQI 15, [see page 123](#))
- Hypertension
- Heart failure (PQI 8, [see page 121](#))
- Angina
- Dehydration
- Bacterial pneumonia
- Urinary tract infection

Rates are reported per 100,000 member months and a lower score is better. PQI stands for Prevention Quality Indicator, which is a set of indicators developed by the Agency for Healthcare Research and Quality (AHRQ) to track avoidable hospital admissions.

2016 data (n=6,624,872 member years)

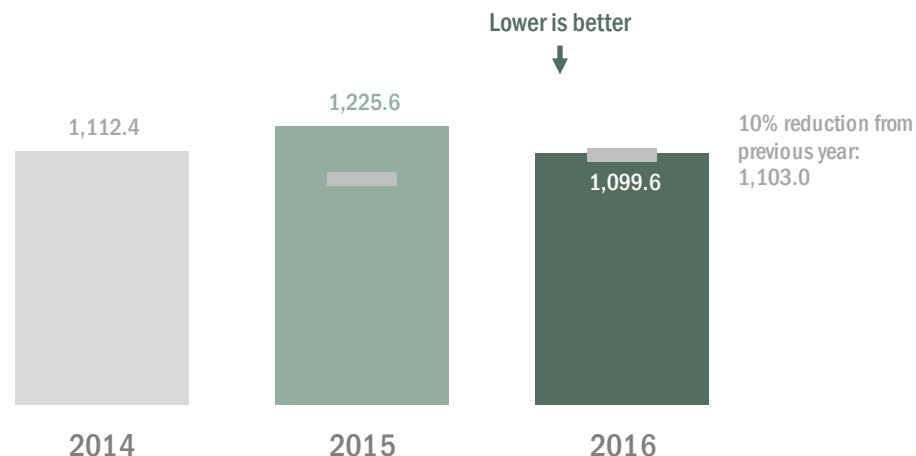
- Statewide change since 2015: **-10.3%** (lower is better)
- Number of CCOs that improved: **5**

Data notes: 2015 results have been slightly revised and differ from previously published reports.

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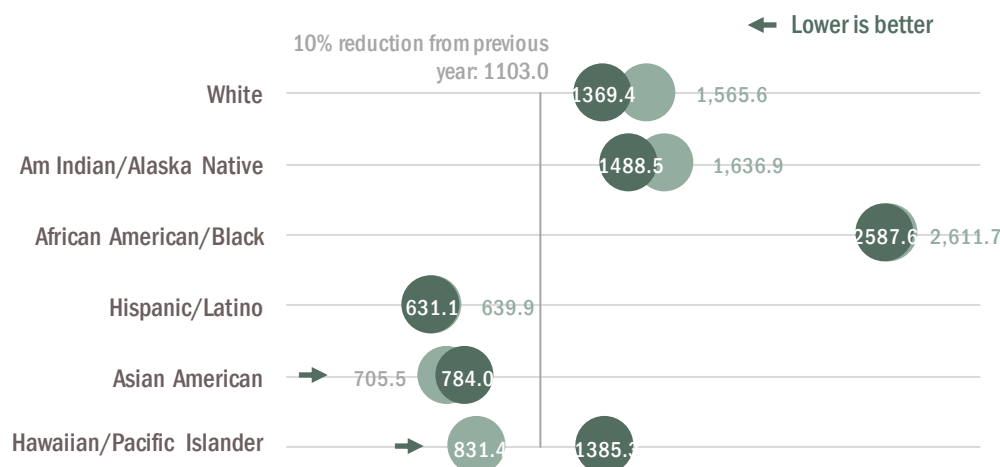
Overall rate of hospitalizations for preventable conditions, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years



Overall rate of hospitalizations for preventable conditions in 2015 and 2016, by race and ethnicity.

Race and ethnicity data missing for 28.8% of respondents / Each race category excludes Hispanic/Latino

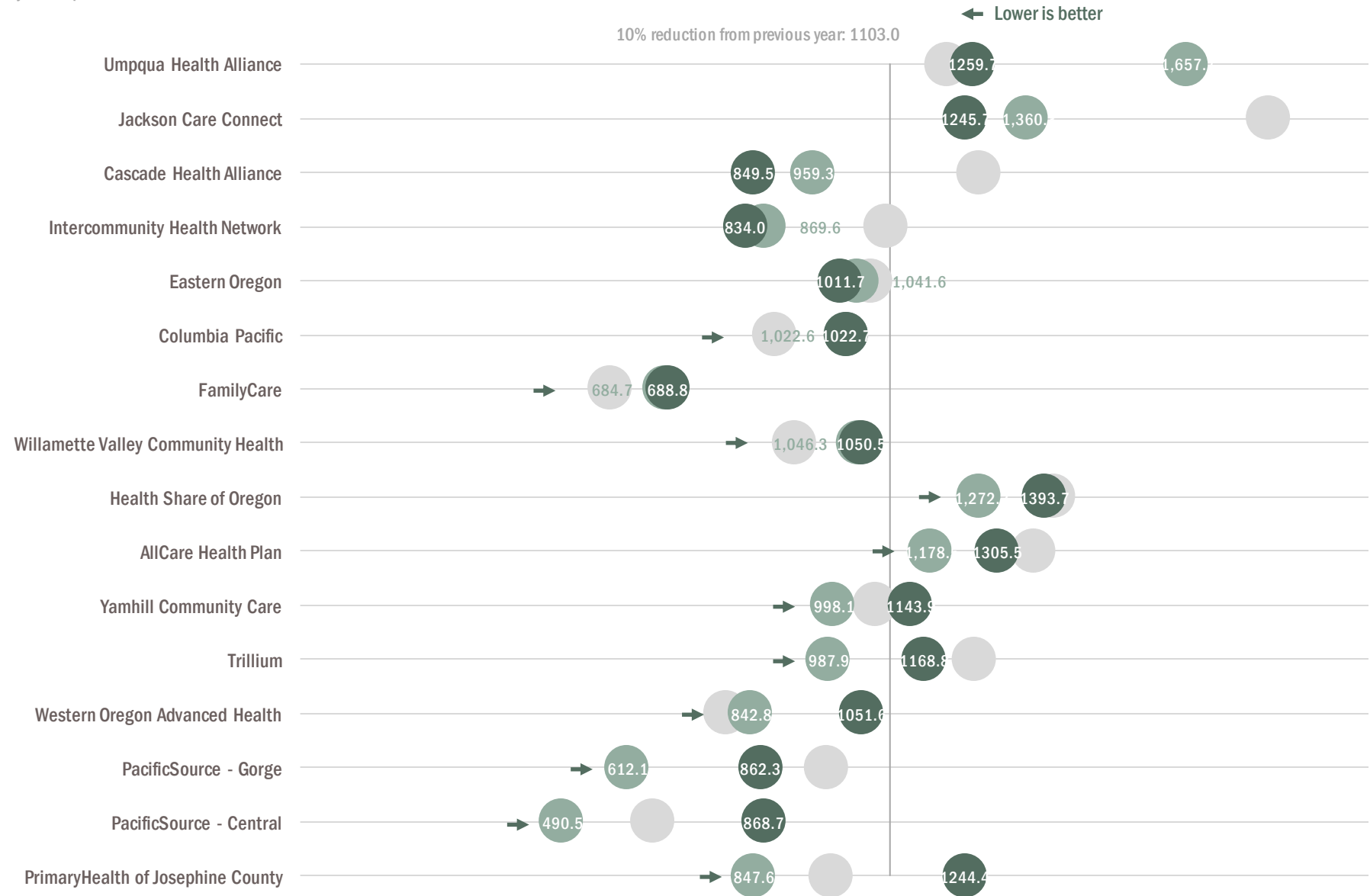




PQI 90: PREVENTION QUALITY OVERALL COMPOSITE

Overall rate of hospitalizations for preventable conditions in 2015 and 2016, by CCO.

Grey dots represent 2014





PQI 91: PREVENTION QUALITY ACUTE COMPOSITE

PQI 91: Prevention quality acute composite

Composite rate of adult members who were admitted to a hospital for any of the following acute conditions:

- Dehydration
- Bacterial pneumonia
- Urinary tract infection

Rates are reported per 100,000 member months and a lower score is better. PQI stands for Prevention Quality Indicator, which is a set of indicators developed by the Agency for Healthcare Research and Quality (AHRQ) to track avoidable hospital admissions.

2016 data (n=6,624,872 member years)

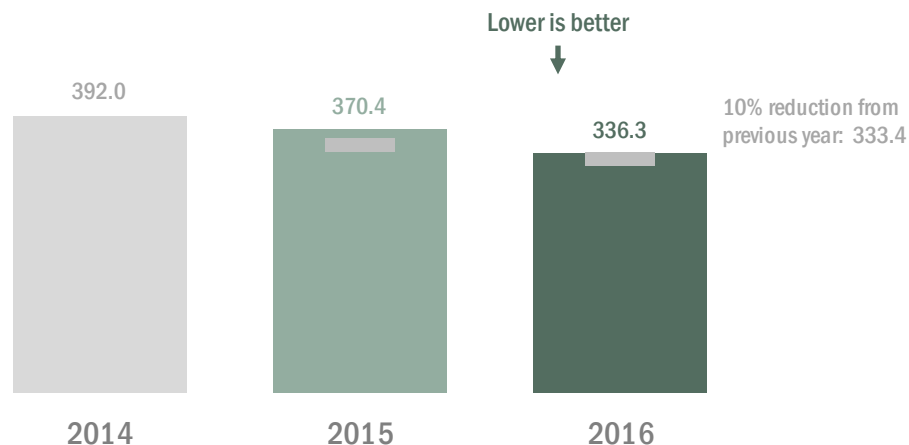
- Statewide change since 2015: **-9.2%** (lower is better)
- Number of CCOs that improved: **13**

Data notes: 2015 results have been slightly revised and differ from previously published reports.

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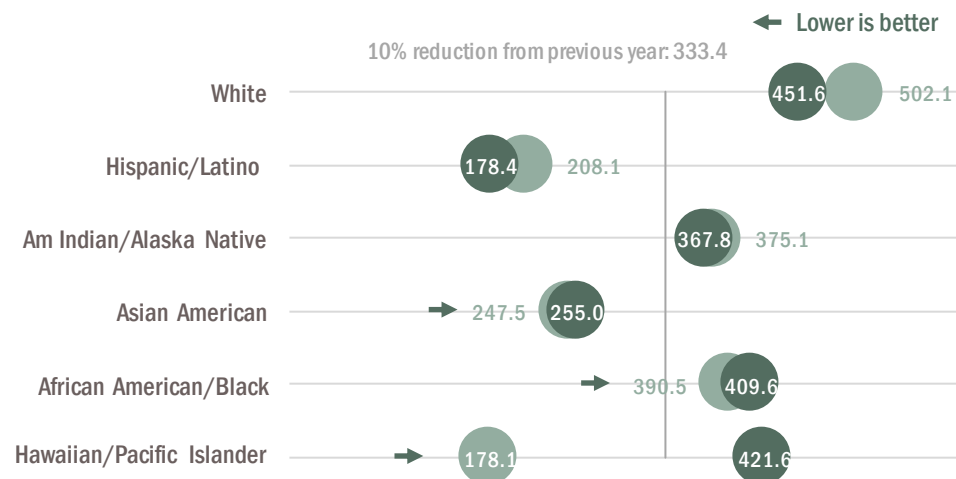
Admissions for acute conditions, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years



Admissions for acute conditions in 2015 and 2016, by race & ethnicity.

Race and ethnicity data missing for 28.8% of respondents / Each race category excludes Hispanic/Latino

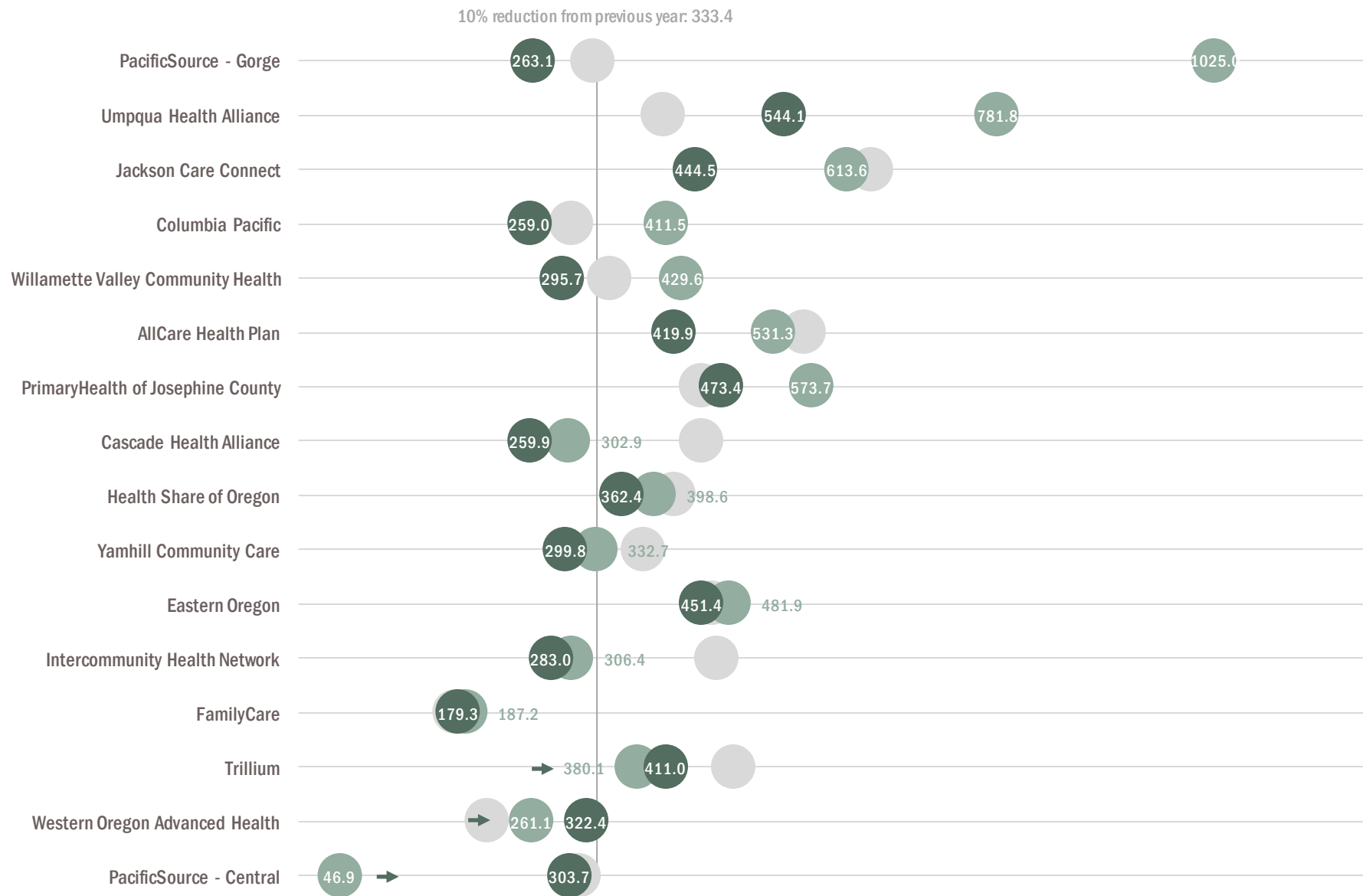




PQI 91: PREVENTION QUALITY ACUTE COMPOSITE

Admissions for acute conditions in 2015 and 2016, by CCO.

Grey dots represent 2014





PQI 92: PREVENTION QUALITY CHRONIC COMPOSITE

PQI 92: Prevention quality chronic composite

Composite rate of adult members who were admitted to a hospital for any of the following acute conditions:

- Diabetes with short-term complications (PQI 1, [see page 117](#))
- Diabetes with long-term complications
- Uncontrolled diabetes without complications
- Diabetes with lower-extremity amputation
- COPD (PQI 5, [see page 119](#))
- Asthma (PQI 15, [see page 123](#))
- Hypertension
- Heart failure (PQI 8, [see page 121](#))
- Angina

Rates are reported per 100,000 member months and a lower score is better. PQI stands for Prevention Quality Indicator, which is a set of indicators developed by the Agency for Healthcare Research and Quality (AHRQ) to track avoidable hospital admissions.

2016 data (n=6,624,872 member years)

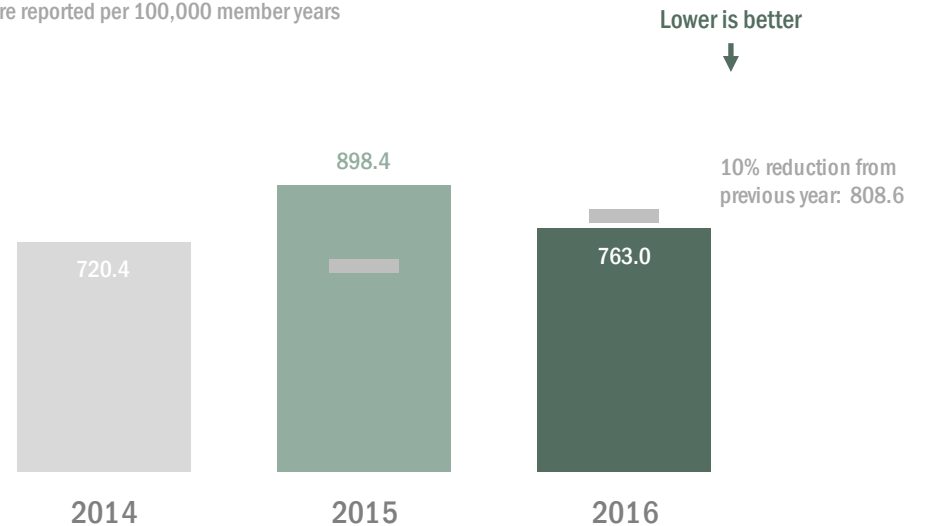
- Statewide change since 2015: **-15.1%** (lower is better)
- Number of CCOs that improved: **12**

Data notes: 2015 results have been slightly revised and differ from previously published reports.

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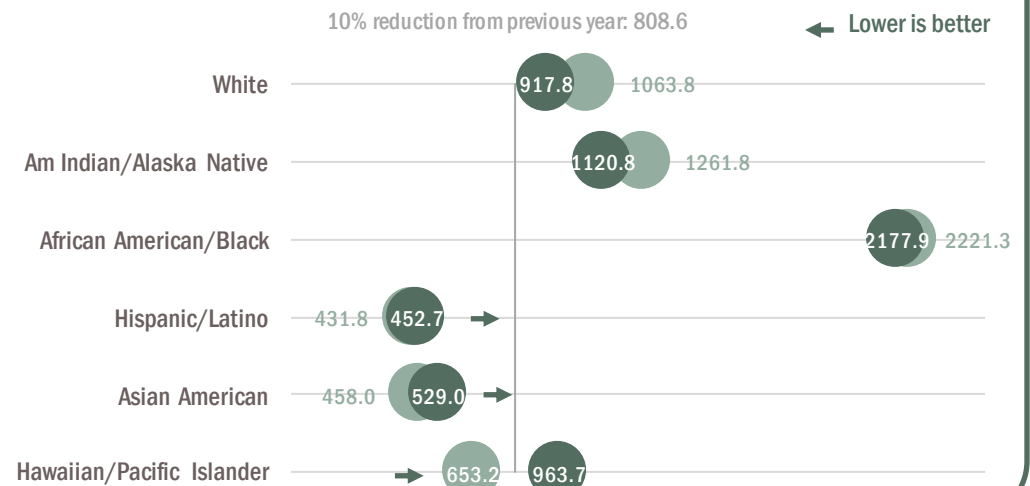
Admissions for chronic conditions, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years



Admissions for chronic conditions in 2015 and 2016, by race & ethnicity.

Race and ethnicity data missing for 28.8% of respondents / Each race category excludes Hispanic/Latino

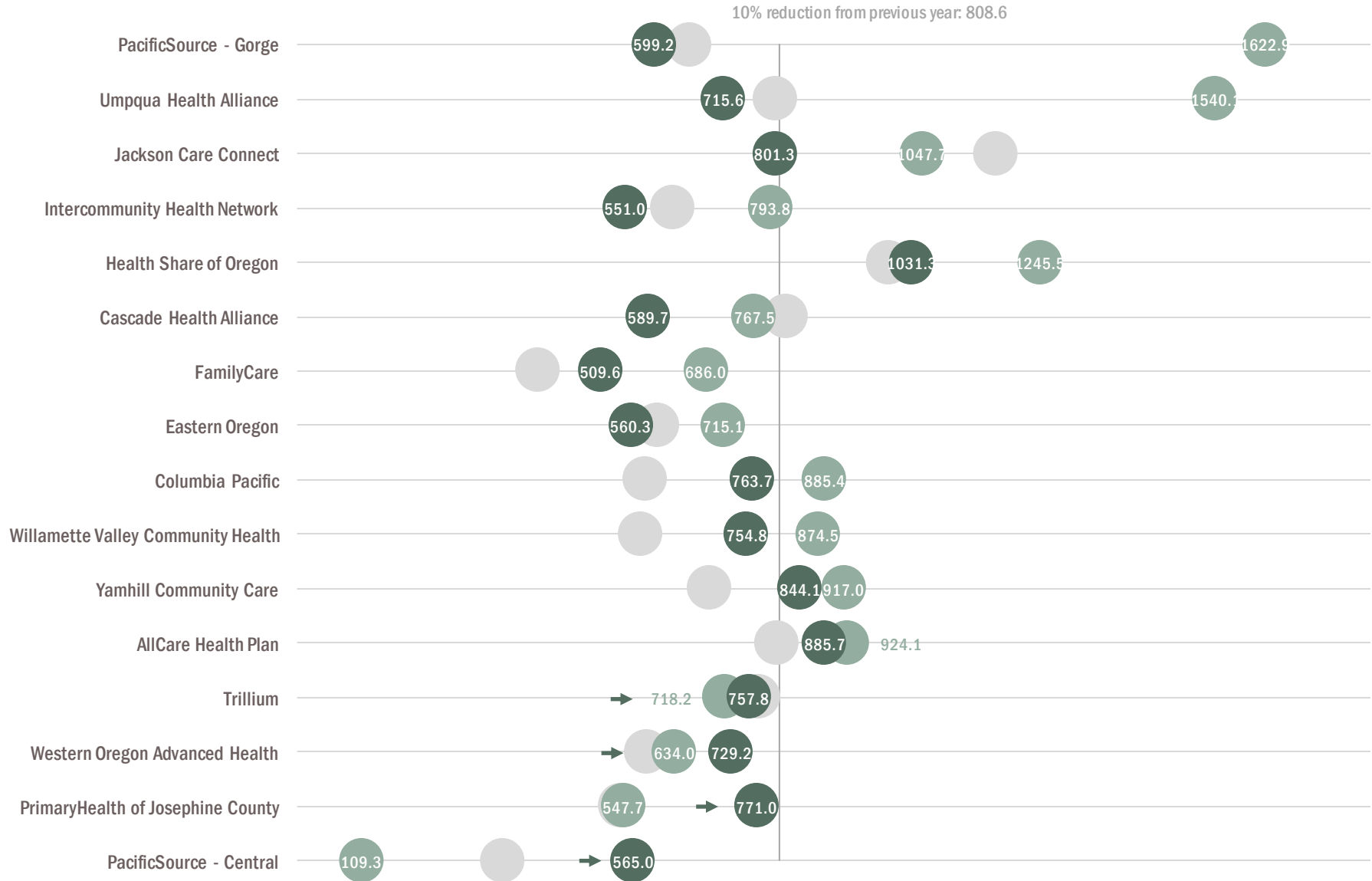




PQI 92: PREVENTION QUALITY CHRONIC COMPOSITE

Admissions for chronic conditions 2015 and 2016, by CCO.

Grey dots represent 2014



PRENATAL AND POSTPARTUM CARE: POSTPARTUM CARE RATE

Postpartum care rate

Percentage of women who had a postpartum care visit on or between 21 and 56 days after delivery.

2016 data

- Statewide change since 2015: **+13.1%**
- Number of CCOs that improved: **12**

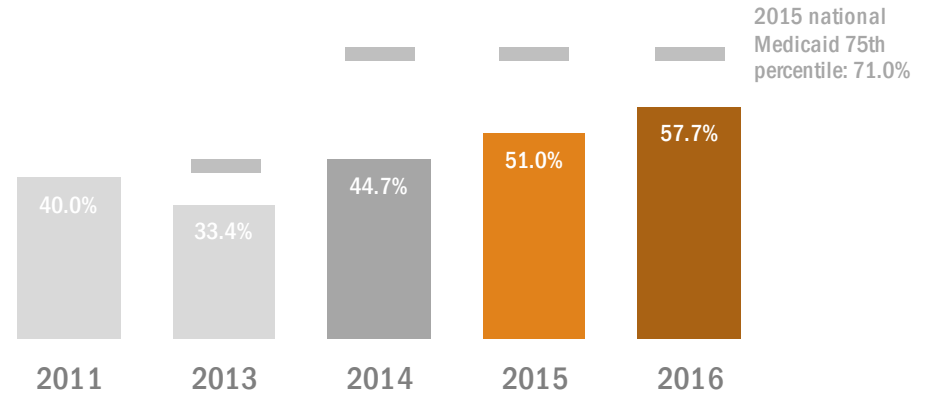
Data notes: 2011 and 2013 are not directly comparable to later years due to changes in the methodology.

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Race and ethnicity data are not available for this measure.

Timeliness of postpartum care, statewide.

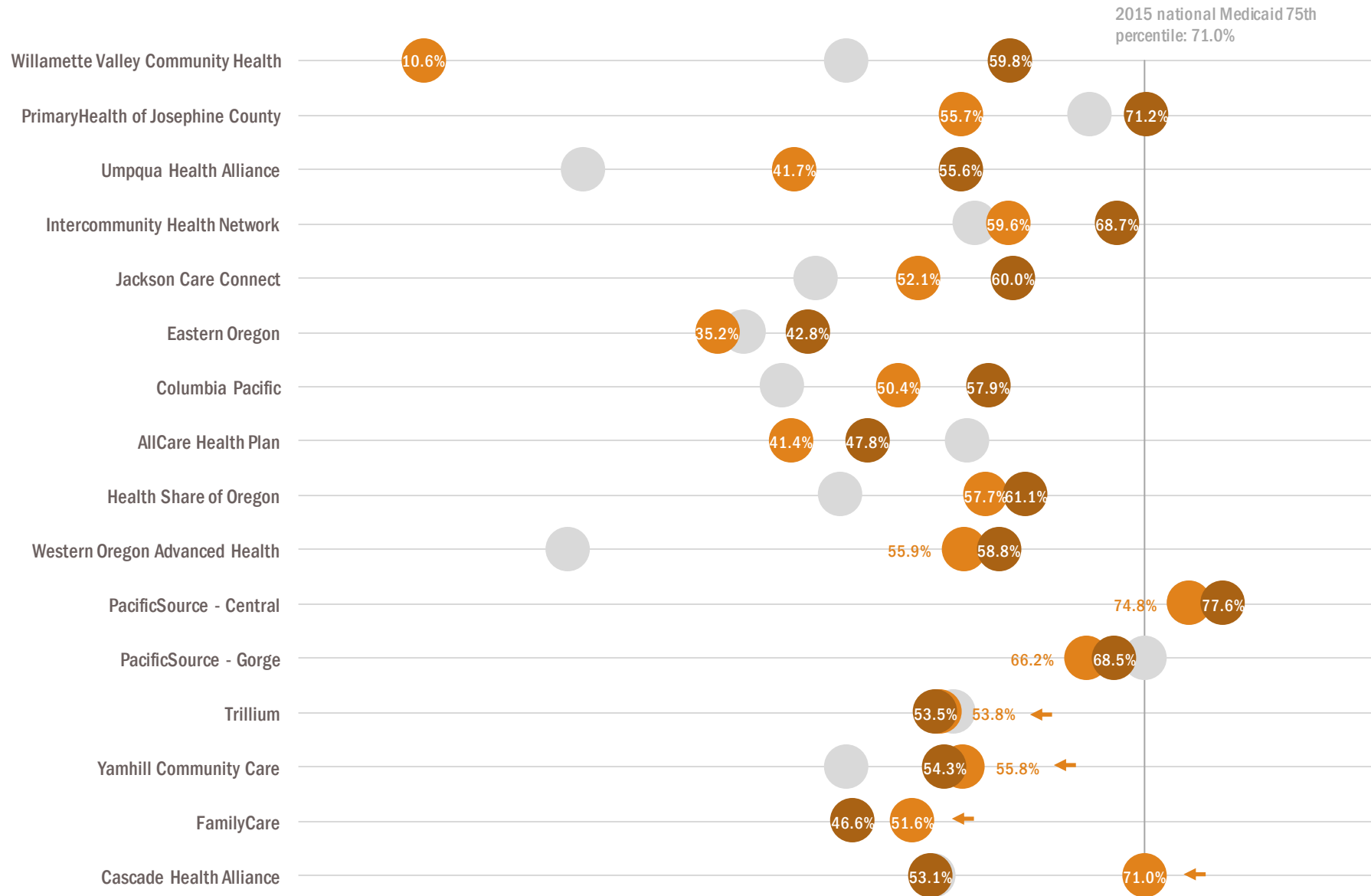
Data source: Administrative (billing) claims and medical record review



PRENATAL AND POSTPARTUM CARE: POSTPARTUM CARE RATE

Timeliness of postpartum care in 2015 and 2016, by CCO.

Grey dots represent 2014





PROVIDER QUESTIONS FROM THE PHYSICIAN WORKFORCE SURVEY

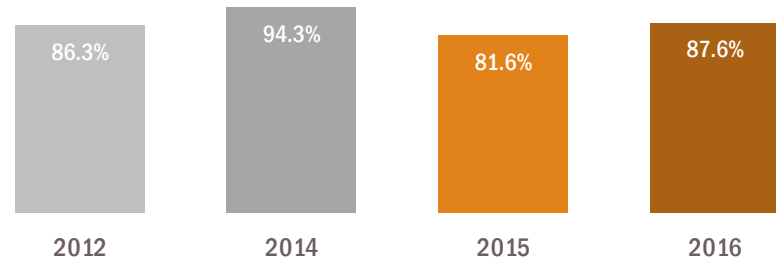
Component 1: Extent to which providers are accepting new Medicaid patients.

Percentage of providers who are accepting new Medicaid / Oregon Health Plan patients.

Statewide change since 2015: **+7%**

Providers **accepting new** Medicaid patients.

Data source: Physician Workforce Survey



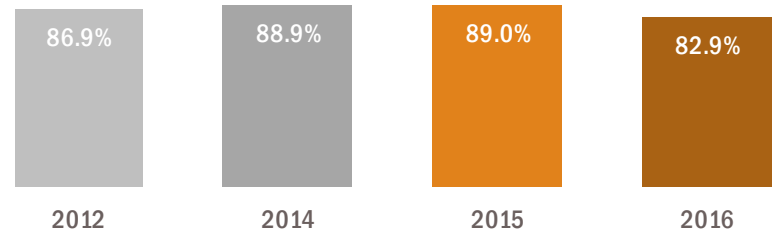
Component 2: Extent to which providers currently see Medicaid patients.

Percentage of providers who currently care for Medicaid / Oregon Health Plan members. This information does not include “don’t know” or missing survey responses.

Statewide change since 2015: **-7%**

Providers **currently seeing** Medicaid patients.

Data source: Physician Workforce Survey



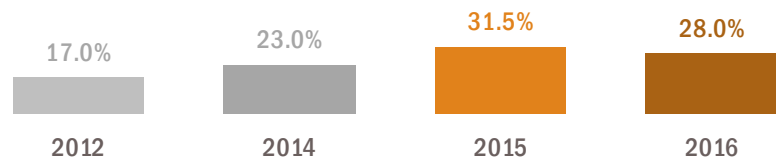
Component 3: Current payer mix.

Percentage of Medicaid payers at practice.

Statewide change since 2015: **-11%**

Medicaid **share of provider payer mix.**

Data source: Physician Workforce Survey



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TOBACCO USE PREVALENCE (CAHPS SURVEY)

Tobacco use prevalence

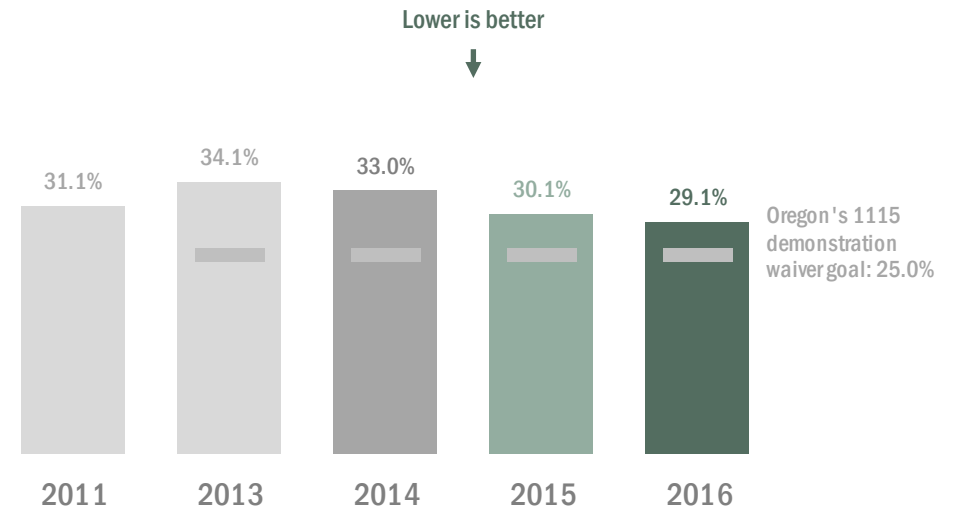
Percentage of adult Medicaid members (ages 18 and older) who currently smoke cigarettes or use other tobacco products.

2016 data

- Statewide change since 2015: **-3.3%** (lower is better)
- Number of CCOs that improved: **11**

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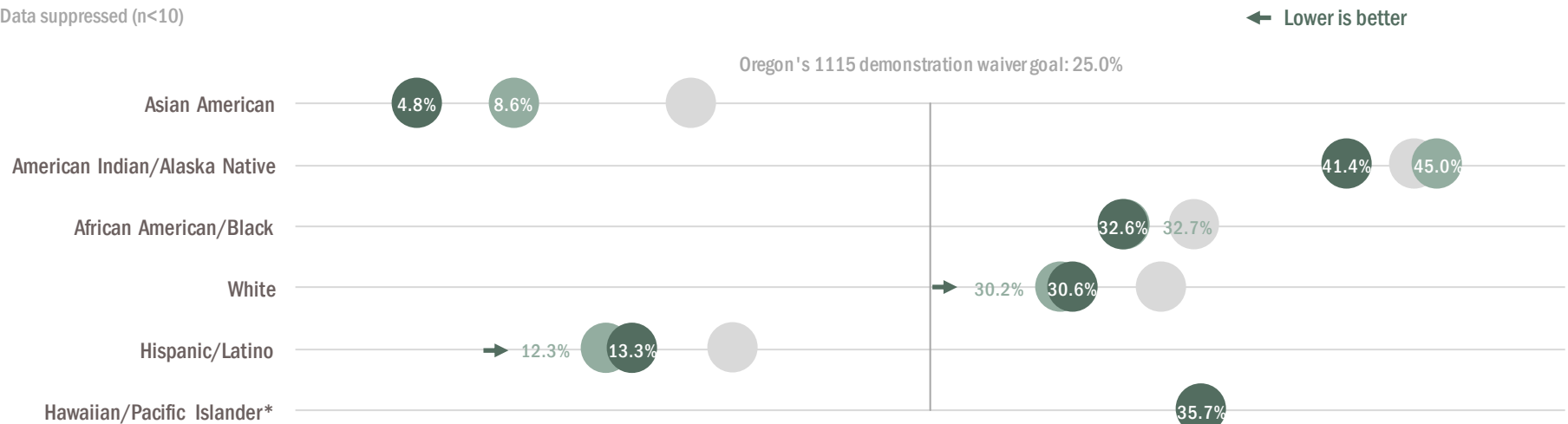
Tobacco use prevalence, statewide.



Tobacco use prevalence in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Each race category excludes Hispanic/Latino

*Data suppressed (n<10)





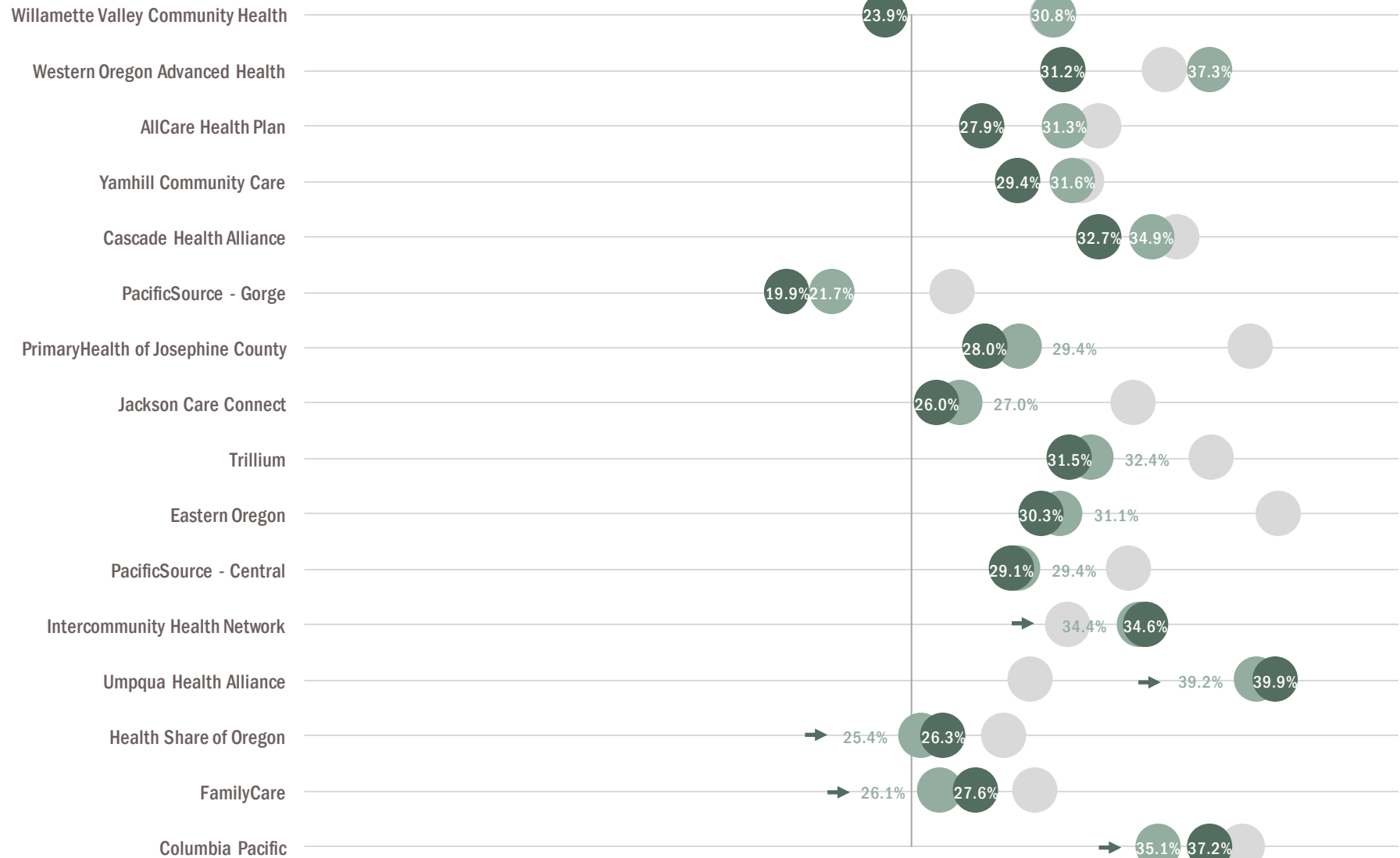
TOBACCO USE PREVALENCE (CAHPS SURVEY)

Tobacco use prevalence in 2015 and 2016, by CCO.

Grey dots represent 2014

Oregon's 1115 demonstration waiver goal: 25.0%

← Lower is better





WELL-CHILD VISITS IN THE FIRST 36 MONTHS OF LIFE

Well-child visits in the first 15 months of life

Percentage of children who had six visits with their health care provider prior to reaching 15 months of age.

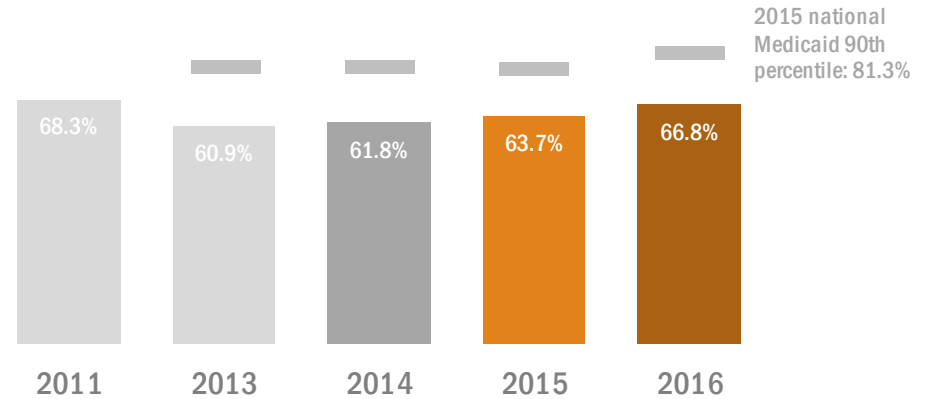
2016 data (n=16,659)

- Statewide change since 2015: **+4.9%**
- Number of CCOs that improved: **14**

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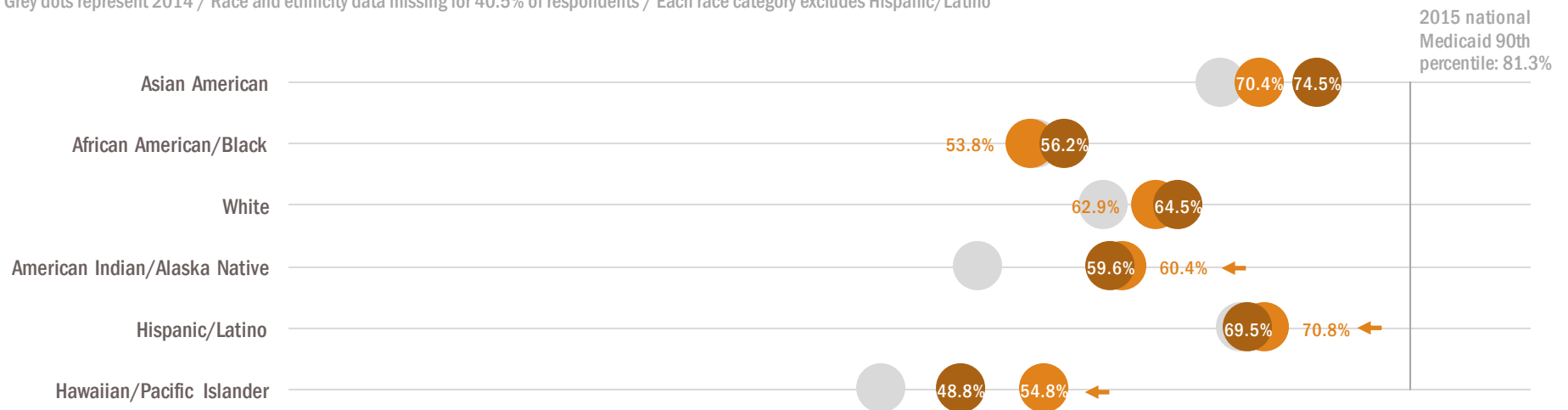
Well-child visits in the first 15 months of life, statewide.

Data source: Administrative (billing) claims



Well-child visits in the first 15 months of life in 2015 and 2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 40.5% of respondents / Each race category excludes Hispanic/Latino

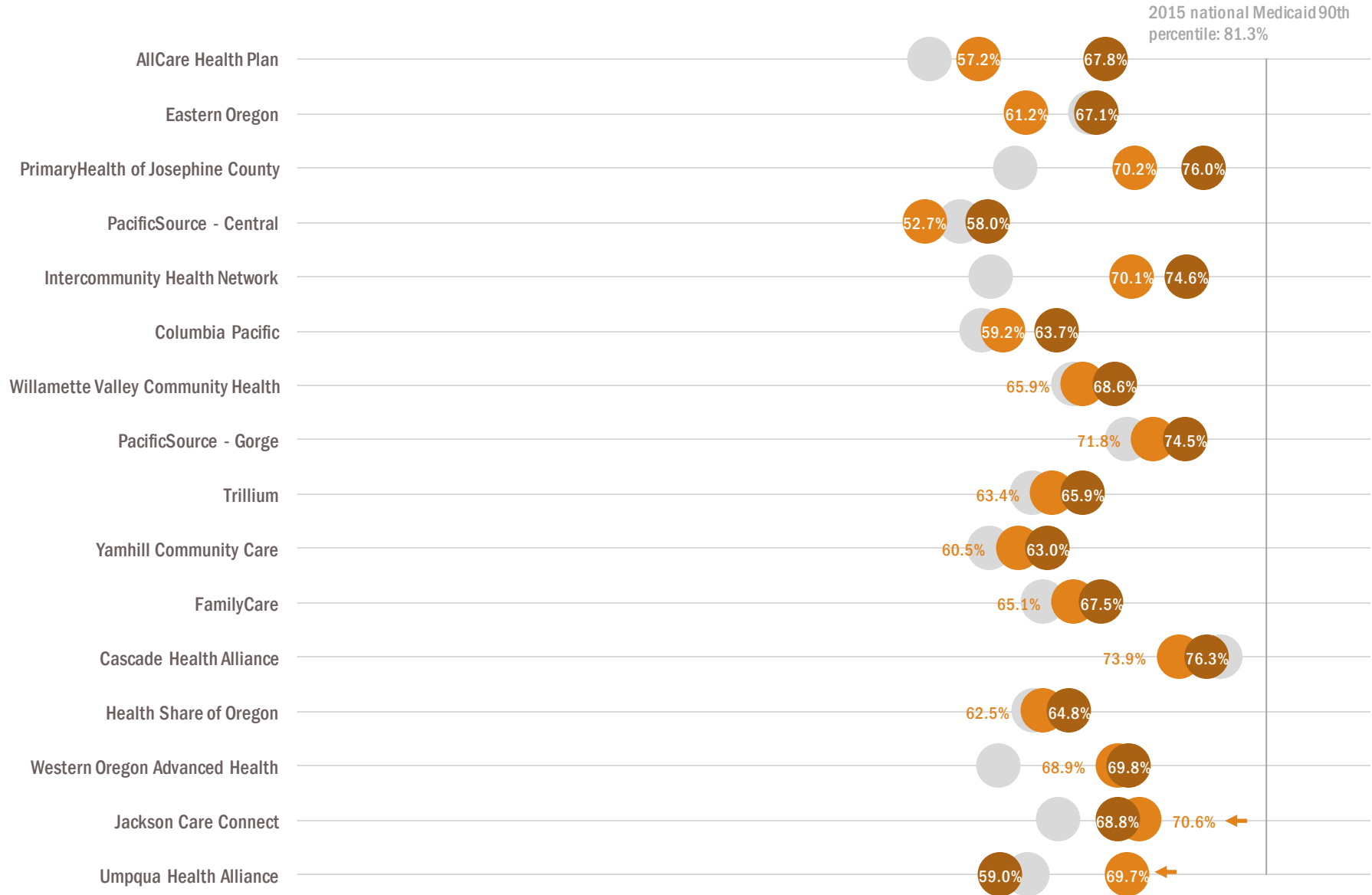




WELL-CHILD VISITS IN THE FIRST 36 MONTHS OF LIFE

Well-child visits in the first 15 months of life in 2015 and 2016, by COO.

Grey dots represent 2014





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