# Oregon's Health System Transformation: CCO Metrics 2015 Mid-Year Update

January 2016

Oregon Health Authority

MEASUREMENT PERIOD:
July 2014 - June 2015

JANUARY 20, 2016

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## Metrics, continued

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## Appendices



Mid-year data are not available for the following annual metrics

- Access to care (CAHPS)*
- Colorectal cancer screening*
- Controlling high blood pressure*
- Depression screening and follow-up plan*
- Diabetes HbA1c poor control*
- Early elective delivery
- Health status (CAHPS)
- Medical assistance with smoking and tobacco use cessation
- Obesity prevalence
- Prenatal and postpartum care: timeliness of prenatal care*
- Prenatal and postpartum care: postpartum care rate
- Provider access questions from the Physician Workforce Survey
- Satisfaction with care (CAHPS)*
- Tobacco use prevalence (CAHPS)

Calendar year 2015 results for these measures will be published in June 2016. Calendar year 2014 results are available online at: www.oregon.gov/oha/Metrics

*denotes 2015 CCO Incentive Metric

# METRIC QUICK GUIDE

## 2015 CCO Incentive Metrics



## State Performance Metrics

# METRIC QUICK GUIDE

## State Performance Metrics, continued



## Core Metrics

# METRIC QUICK GUIDE

## Core Metrics, continued

# EXECUTIVE SUMMARY

This mid-year report lays out the progress of Oregon's coordinated care organizations (CCOs) on quality measures from July 1, 2014 through June 30, 2015.

This report indicates that through the coordinated care model, there have been improvements in a number of areas, such as reductions in emergency department visits, and increases in developmental screening, screening for alcohol and other substance use, and enrollment in patient-centered primary care homes (PCPCHs). This is also the first report to show results on a subset of measures for Oregonians enrolled in the Oregon Health Plan with disabilities, or with severe and persistent mental illness.

The coordinated care model continues to show large improvements in the following areas for Oregon Health Plan members:

- **Decreased emergency department visits**. Emergency department visits by people served by CCOs have decreased 23 percent since 2011 baseline data. While some of the improvements seen may be due to national trends, CCOs have implemented a number of best practices for reducing emergency department utilization rates, such as the use of emergency department navigators.
- **Decreased hospital admissions for short-term complications from diabetes**. The rate of adult patients (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease dropped by 32 percent since 2011 baseline data.
- **Decreased rate of hospital admissions for chronic obstructive pulmonary disease**. The rate of adult patients (ages 40 and older) who had a hospital stay because of chronic obstructive pulmonary disease or asthma decreased by 68 percent since 2011 baseline data.
- **Patient-Centered Primary Care Home (PCPCH) enrollment continues to increase**. Coordinated care organizations continue to increase the proportion of members enrolled in patient-centered primary care homes – indicating continued momentum even with the increase in members added since January 1, 2014. PCPCH enrollment has increased 61 percent since 2012.

This report includes new measures that were added as CCO incentive measures for 2015:

1. Effective contraceptive use – this incentive measure looks at the percentage of women ages 18-50 who are using one of the most or moderately effective forms of contraception. Mid-year results are promising compared to calendar year 2014 baseline.
2. Dental sealants on permanent molars for children – this is the first oral health incentive measure, looking at the percentage of children ages 6-9 and 10-14 who received a sealant on a permanent molar. While the benchmark is low (20 percent), there is still room for improvement.

Another measure in this report that highlights room for improvement is assessments for children in foster care. This measure now includes mental, physical, and dental health assessments for children entering foster care (previous reports only included mental and physical health assessments).

# EXECUTIVE SUMMARY

The addition of dental health assessments resulted in lower rates of children receiving all three assessments within 60 days.

In addition to the modification to the assessments for children in foster care measure, this report also provides new data for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) measure, which now includes adolescents ages 12-17. Early results show promising improvement as pediatric and family practices focus on providing these alcohol and substance use screenings to their patients.

This report does not include detailed cost and utilization data, as OHA is in the process of implementing new software to support this reporting. Cost and utilization data will be available in the June 2016 Health System Transformation Performance Report. However, financial data indicate that coordinated care organizations are continuing to hold down costs. Oregon is staying within the budget that meets its commitment to the Centers for Medicare and Medicaid Services to reduce the growth in spending by two percentage points per member, per year.

Oregon is continuing its efforts to transform the health delivery system. By measuring our progress, sharing it publicly, and learning from our successes and challenges, we can see clearly where we started, where we are, and where we need to go next.

## New in This Report

This report includes information on several new measures, as well as modifications to several existing measures.

**New Measures**

- Dental sealants on permanent molars for children – this measure is reported for children ages 6-9, 10-14, and combined (ages 6-14).
- Effective contraceptive use – this measure is reported for adolescents (ages 15-17), adults (ages 18-50), and combined (ages 15-50).
- Prevention Quality Indicator (PQI) 90 - Prevention quality overall composite
- PQI 91: Prevention quality acute composite
- PQI 92: Prevention quality chronic composite

**Modified Measures**

- Screening, Brief Intervention, and Referral to Treatment (SBIRT) is now reported for adolescents (ages 12-17), adults (ages 18+), and combined (the combined age range is incentivized).
- Assessments for children in DHS custody. Previously, this measure only looked for mental and physical health assessments within 60 days for children in foster care. With the incorporation of dental services into CCOs in July 2014, the measure now looks for mental, physical, and dental

health assessments to occur within 60 days. Calendar year 2014 data have been recalculated to include dental health assessments and data in this report differ from results previously published.

- Follow-up after hospitalization for mental illness. Previously, this measure did not include follow-up services that occurred on the same day as the hospital discharge. The measure specifications have been adjusted and the data presented in this report now incorporate same-day follow up. Because of this measure's modification, data in this report cannot be compared to prior years.

**Additional Measure Stratification**

This report provides a subset of measures reported for Oregon Health Plan members with disability, and with severe and persistent mental illness (adults) or broad mental health conditions (children/adolescents). A new section of the report (pages 92-104) provides more details on these definitions and presents measure results for these members.

**Reporting Period**

This report lays out the progress of Oregon's CCOs from July 1, 2014 through June 30, 2015. New data included in this report reflects a full twelve month measurement period and most measures are directly comparable to previous years. Future reports will continue to include a full twelve months of data.

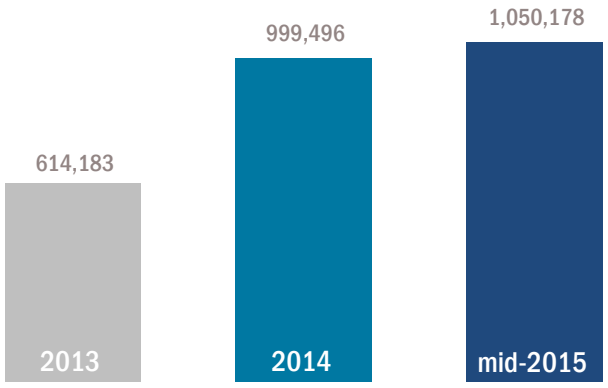
# OREGON HEALTH PLAN POPULATION

## Medicaid demographics

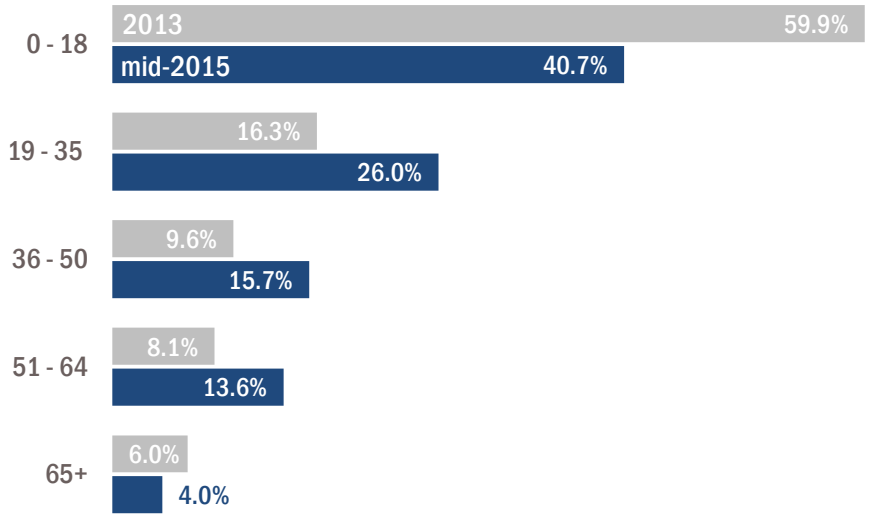
With the Affordable Care Act (ACA) coverage expansion, an increasing number of Oregonians receive health insurance through the Oregon Health Plan (Medicaid). More than 385,313 Oregonians gained covererage in 2014. Enrollment has continued to increase since then, with an additional 50,682 members enrolled in the first six months of 2015, for a total 1,050,178 members.

Despite this influx of new members, the racial and ethnic makeup of the Medicaid population has remained largely consistent. However, the age distribution has shifted: in 2013 and earlier, the majority of the population were children and adolescents; with the enrollment expansion in 2014, more adults were eligible for Medicaid and the proportion of members ages 19-64 increased, with the greatest increase being members ages 19-35.

### Total Medicaid enrollment increased 71% between 2013 and mid-2015.

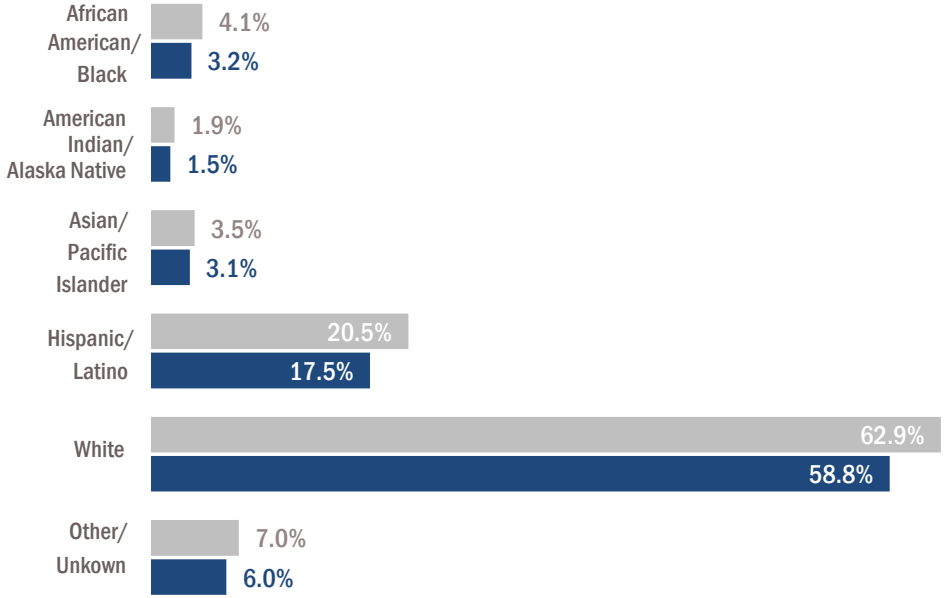



### Age distribution of Medicaid population in 2013 and mid-2015.




### Racial and ethnic distribution of Medicaid members in 2013 and mid-2015.

Data missing for 10% of respondents



# HOW TO READ THESE GRAPHS

## Icons

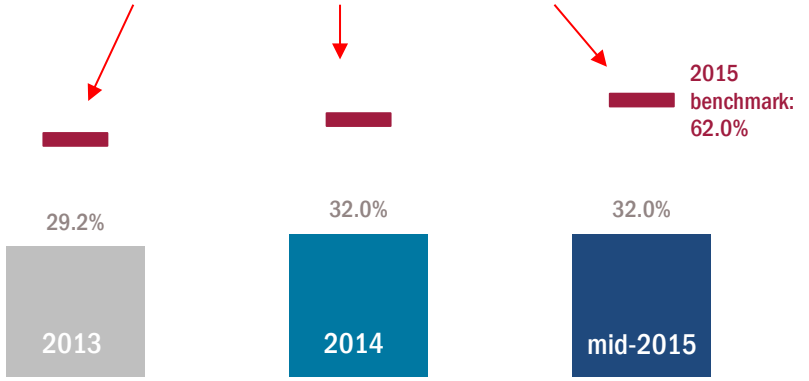
To help readers identify which metrics belong in which measure set, each metric is accompanied by up to three icons that denote the measure set:

This icon indicates the measure is one of the 17 CCO incentive metrics. CCOs receive quality pool funding based on their 2015 performance on these measures.

This icon indicates the measure is one of the 33 state performance metrics (also known as quality and access metrics). OHA is accountable to the Center for Medicare and Medicaid Services (CMS) for statewide performance on these metrics.

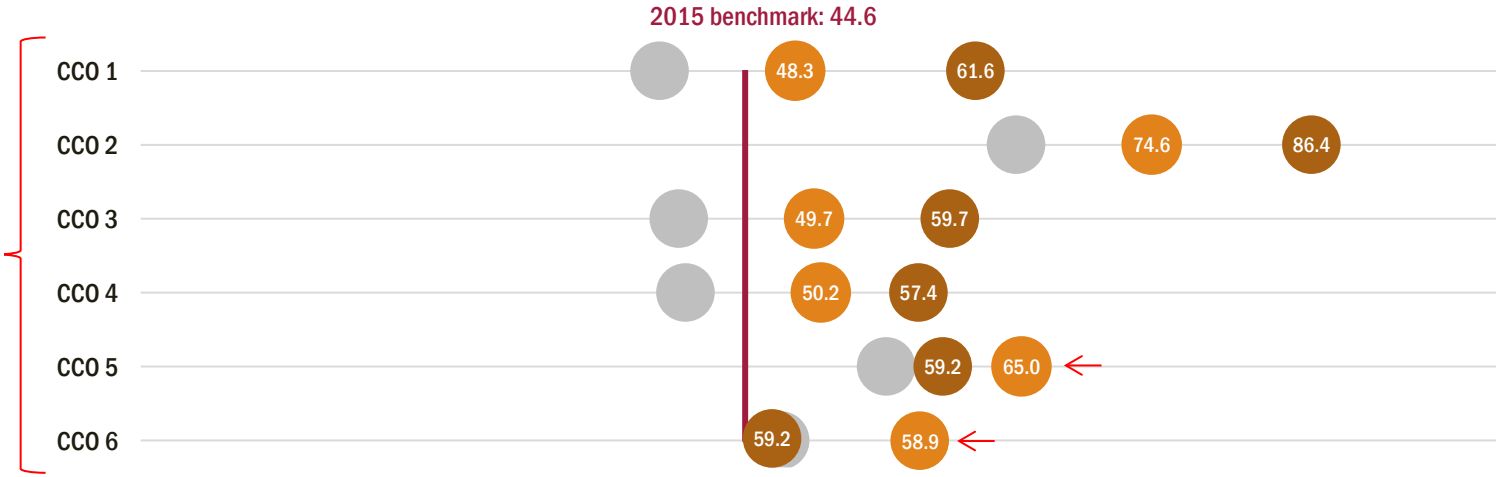
This icon indicates the measure is one of the core performance metrics. There are no financial incentives or penalties for performance on these measures.

Note that statewide graphs also show benchmarks for previous years. In some cases, benchmarks change from year to year; 2013 and 2014 benchmark values can be found in annual reports available online at www.oregon.gov/oha/metrics




**[Descriptive title] between 2014 & mid-2015.**

Categories are sorted by amount of change between 2014 and mid-2015. That is the CCOs or racial/ethnic groups with the **most improvement*** in mid-2015 are listed first.




Arrows highlight negative change* (away from the benchmark)

*Please note that changes between years have not been measured for statistical signifance.

# ADOLESCENT WELL-CARE VISITS

## Adolescent well-care visits

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

**Purpose:** Youth who can easily access preventive health services are more likely to be healthy and able to reach milestones such as high school graduation and entry into the work force, higher education, or military service.

## mid-2015 data

Statewide change since 2014: **0%**

Number of CCOs that improved: **10**

Racial and ethnic groups experiencing improvement:

- ✓ White
- ✓ African American / Black

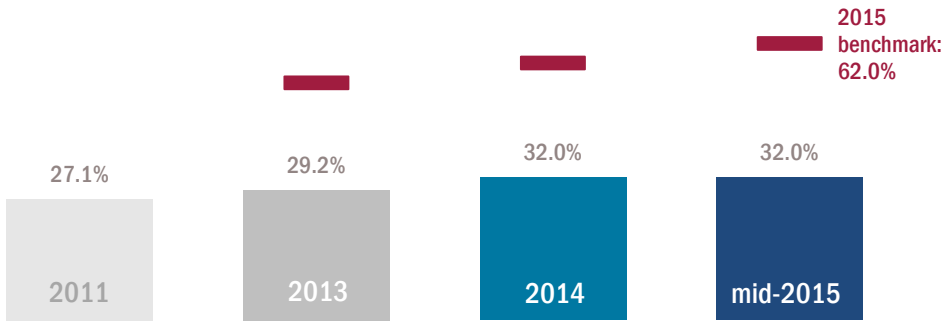
Statewide, the percentage of adolescents who had at least one well-care visit remains well below the benchmark. Barriers to improvement may include providers performing acute care visits when a patient would benefit from comprehensive well care; changes in recommendations for clinical care; and concerns about confidentiality for sensitive services.

See pages 96 and 102 for results stratified by members with- and without disability and mental health diagnoses.

### About these data:

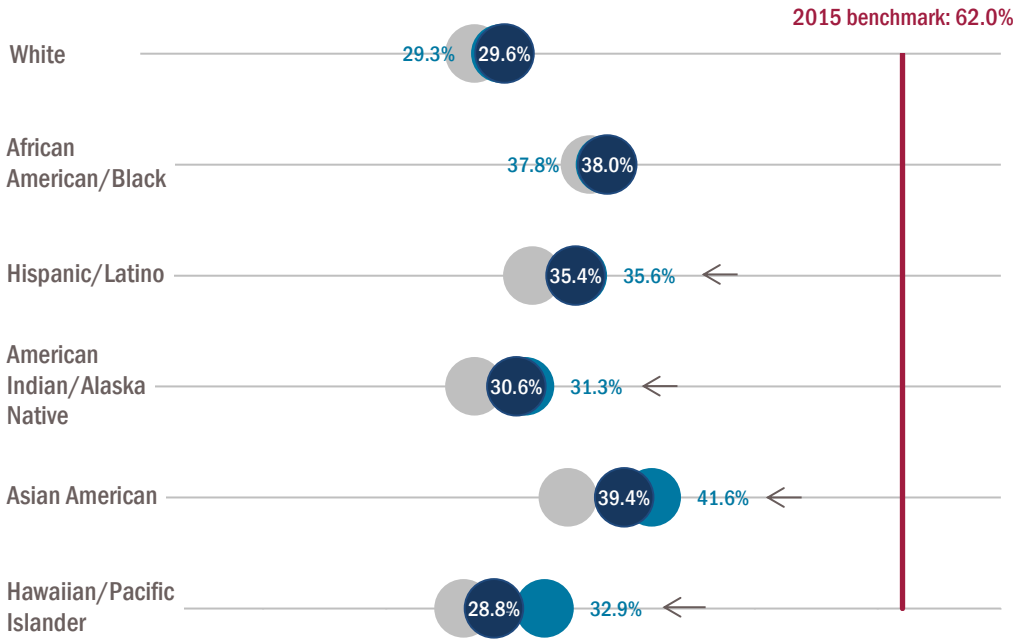
- N=139,369
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 75th percentile (administrative data only)
- Race and ethnicity data missing for 11.9% of respondents
- Each race category excludes Hispanic/Latino

### Statewide, the percentage of adolescents receiving well-care visits remained steady between 2014 and mid-2015.




### The percentage of Hawaiian / Pacific Islander adolescents receiving well-care visits declined between 2014 and mid-2015.

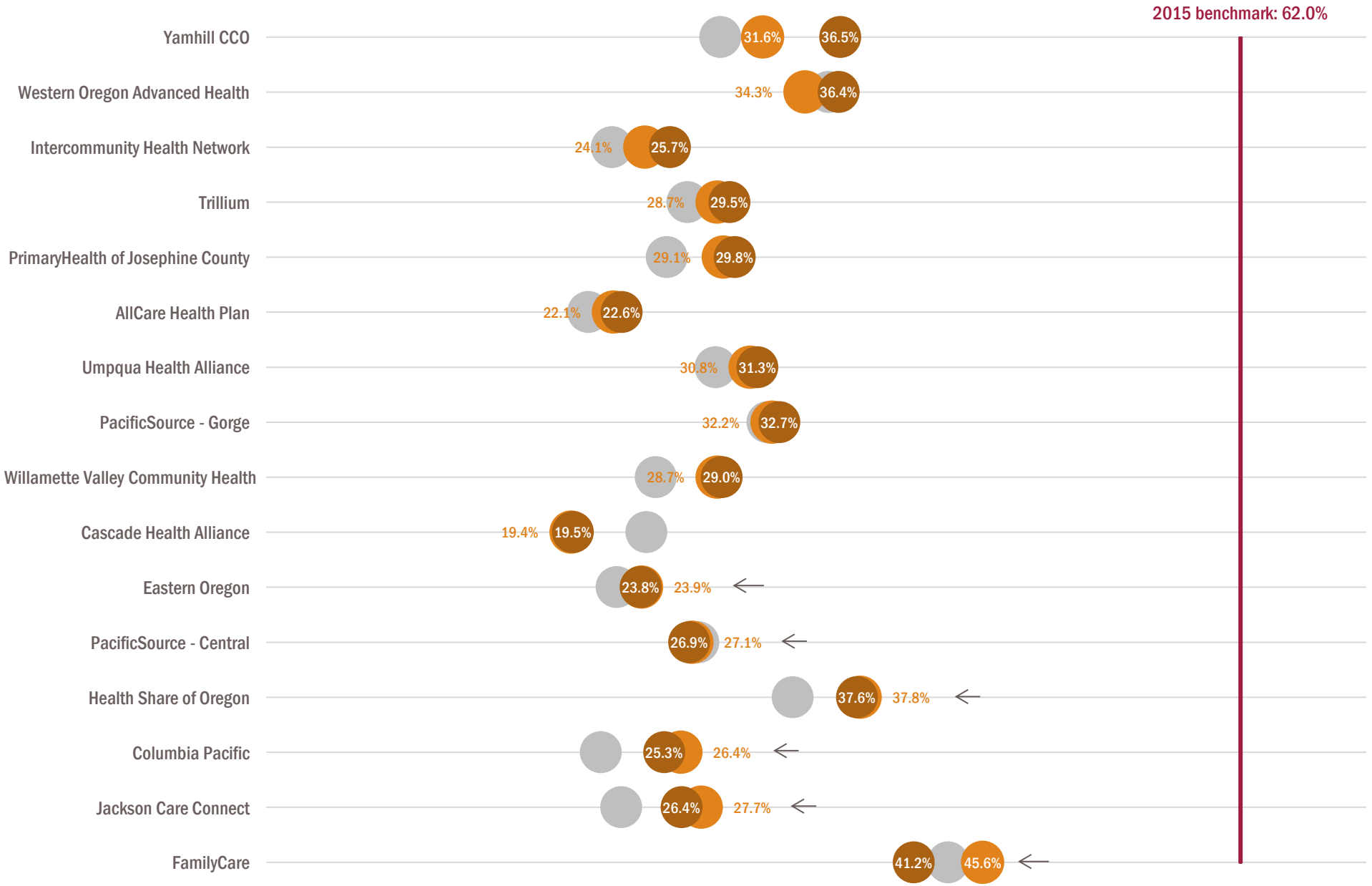
Gray dots represent 2013.



# ADOLESCENT WELL-CARE VISITS

## CCO performance on adolescent well-care visits was mixed between 2014 & mid-2015.

Gray dots represent 2013.



# ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ALL AGES)

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

**Measure description:** The SBIRT measure, or Screening, Brief Intervention, and Referral to Treatment, measures the percentage of members (ages 12 and older) who had appropriate screening and intervention for alcohol or other substance abuse.

**Purpose:** By offering a simple but effective screening for alcohol or drug abuse during an office visit, providers can help patients get the care and information they need to stay healthy. If risky drinking or drug use is detected, a brief intervention, and in some cases referral to additional treatment, helps the patient recover more quickly and avoid serious health problems.

## mid-2015 data

Statewide change since 2014: **+31%**

Number of CCOs that improved: **13**

**All** racial and ethnic groups experienced improvement.

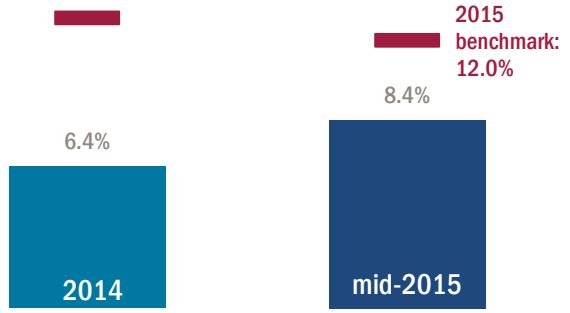
Adolescents age 12-17 were added to the SBIRT measure in 2015. Results are stratified by age groups for reporting and monitoring purposes (see pages 10-13). Incentive payments are based on all ages combined.

See pages 94, 100, and 104 for results stratified by members with- and without disability, mental health diagnoses, and severe and persistent mental illness.

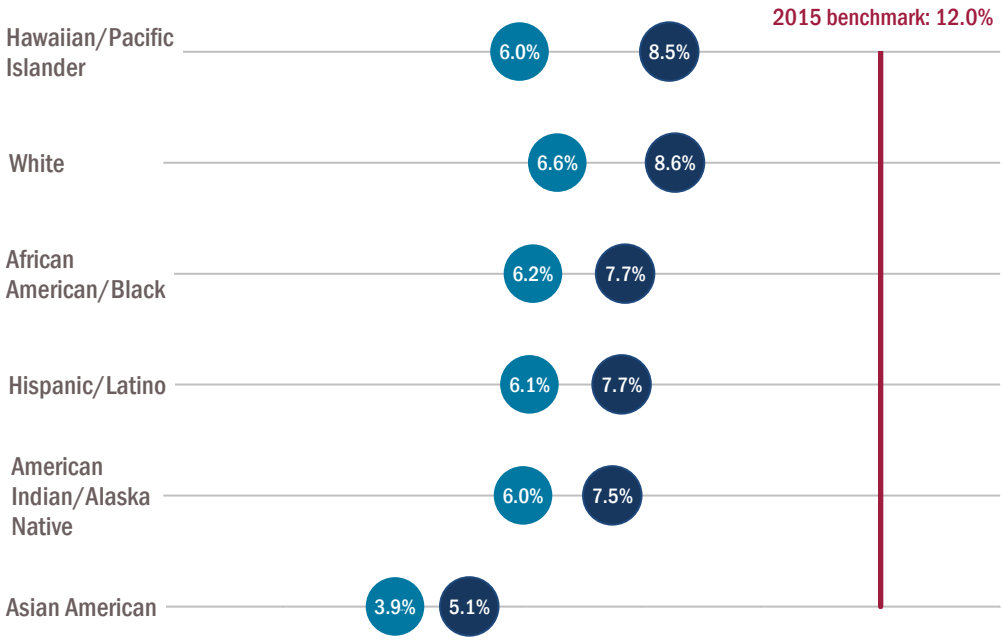
### About these data:

- N=500,524
- Data source: Administrative (billing) claims
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 11.5% of respondents
- Each race category excludes Hispanic/Latino
- 2014 results have been recalculated to include adolescents and will differ from previously published 2014 results. 2011 and 2013 have not been recalculated; results published in earlier reports are not comparable.

## Statewide, screening for alcohol or other substance misuse for all ages has increased.




## SBIRT for all ages between 2014 & mid-2015, by race and ethnicity.



# ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ALL AGES)

SBIRT for all ages improved in 13 of 16 CCOs between 2014 & mid-2015.

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

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

**Measure description:** The SBIRT measure, or Screening, Brief Intervention, and Referral to Treatment, measures the percentage of members (ages 12 and older) who had appropriate screening and intervention for alcohol or other substance abuse. The SBIRT measure is stratified by adolescents and adults for reporting and monitoring; this page shows results for adolescents (ages 12-17).

**Purpose:** See page 8.

## mid-2015 data

Statewide change since 2014: **+121%**

Number of CCOs that improved: **all 16**

**All** racial and ethnic groups experienced improvement.

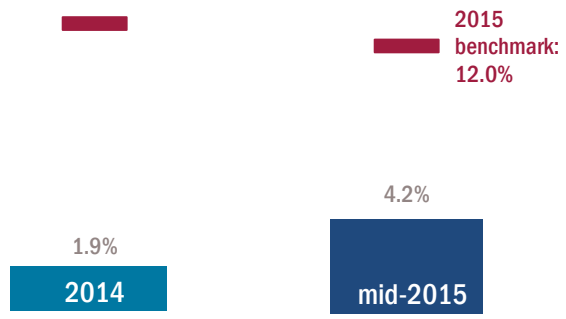
Adolescents ages 12-17 were added to the SBIRT measure in 2015. Incentive payments are based on all ages combined (see pages 8-9).

See pages 94, 100, and 104 for results stratified by members with– and without disability and mental health diagnoses.

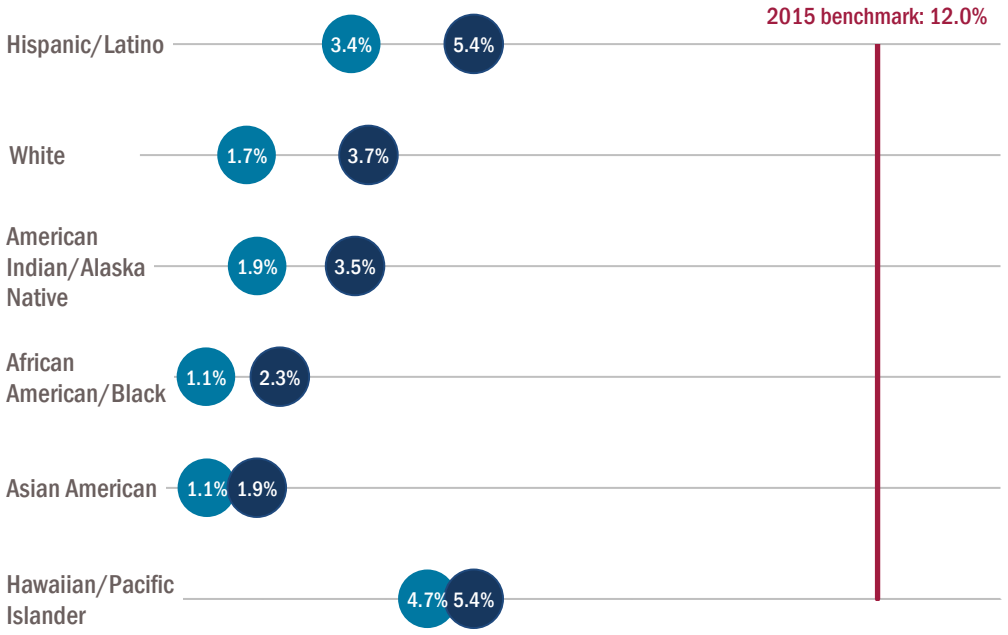
### About these data:

- N= 83,220
- Data source: Administrative (billing) claims
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 11.9% of respondents
- Each race category excludes Hispanic/Latino
- 2014 results have been recalculated to include adolescents and will differ from previously published 2014 results. 2011 and 2013 have not been recalculated; results published in earlier reports are not comparable.

### Statewide, SBIRT among adolescents (ages 12-17) more than doubled between 2014 and mid-2015, but remains below the benchmark.

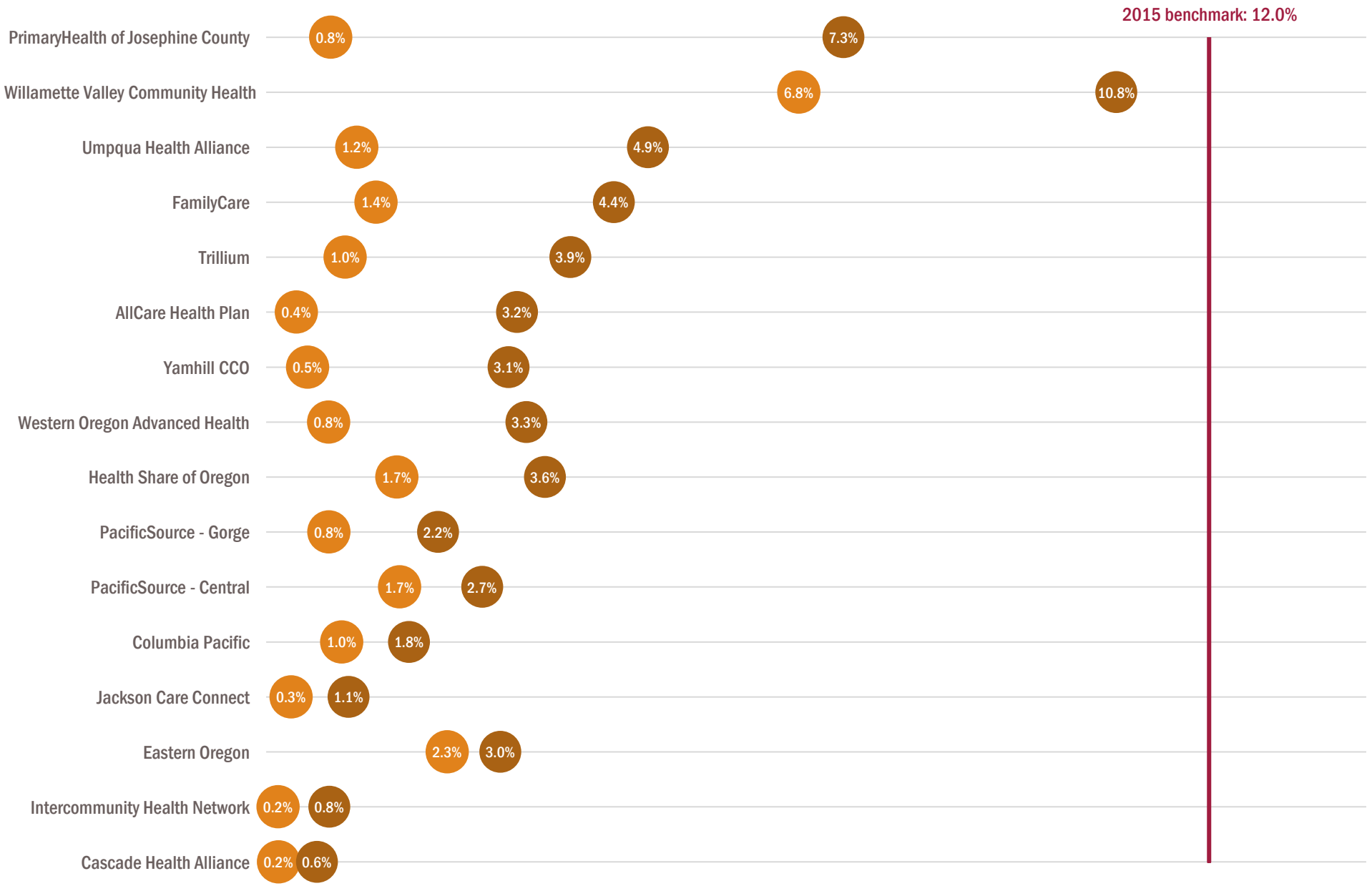



### SBIRT among adolescents between 2014 & mid-2015, by race and ethnicity.



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

All 16 CCOs improved SBIRT for adolescents between 2014 & mid-2015.



# ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (AGES 18+)

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

**Measure description:** The SBIRT measure, or Screening, Brief Intervention, and Referral to Treatment, measures the percentage of members (ages 12 and older) who had appropriate screening and intervention for alcohol or other substance abuse. The SBIRT measure is stratified by adolescents and adults for reporting and monitoring; this page shows results for adults (ages 18 and older).

**Purpose:** See page 8.

## mid-2015 data

Statewide change since 2014: **+27%**

Number of CCOs that improved: **13**

**All** racial and ethnic groups experienced improvement.

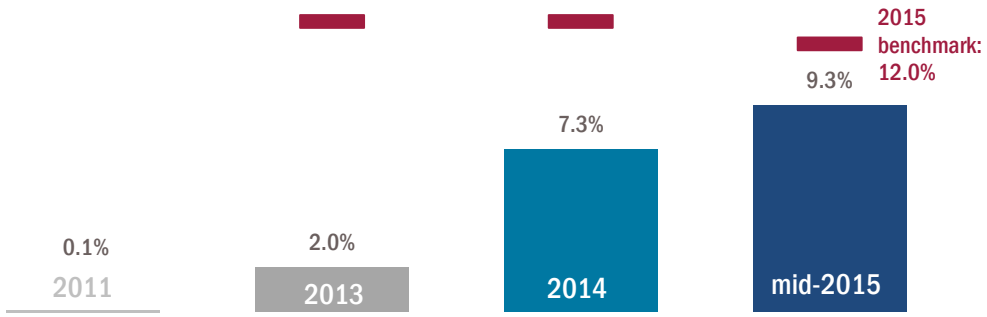
Adolescents ages 12-17 were added to the SBIRT measure beginning in 2015. Results are stratified by age for reporting and monitoring only; incentive payments are based on all ages combined (see pages 8-9).

See pages 94, 100, and 104 for results stratified by members with- and without disability and mental health diagnoses.

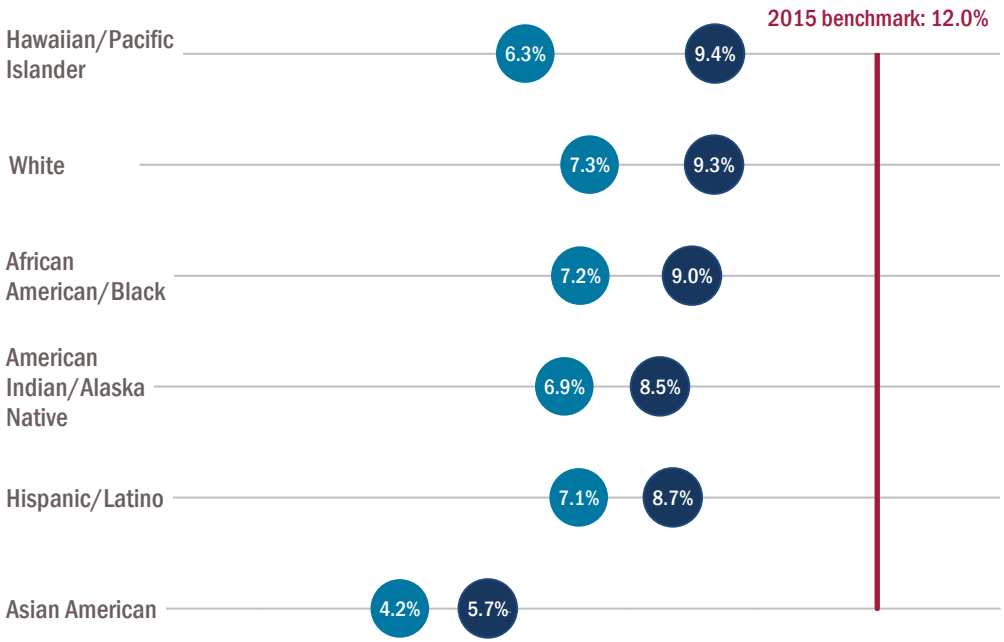
### About these data:

- N=417,204
- Data source: Administrative (billing) claims
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 11.4% of respondents
- Each race category excludes Hispanic/Latino
- 2014 results have been recalculated and will differ from previously published 2014 results.

## Statewide, SBIRT among adults continues to improve.

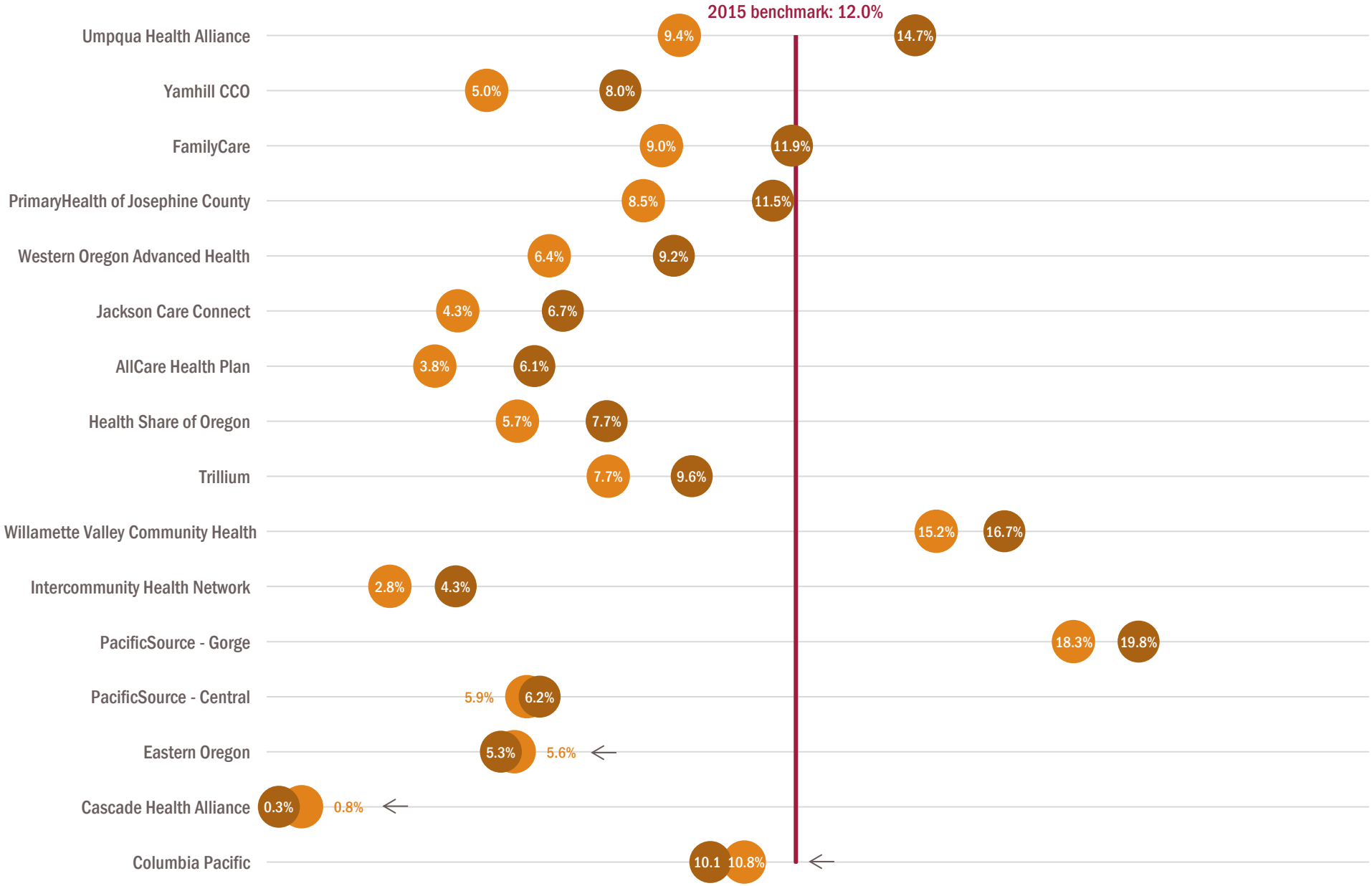



## SBIRT among adults between 2014 & mid-2015, by race and ethnicity.



# ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (AGES 18+)

SBIRT for adults increased in all but three CCOs between 2014 & mid-2015.



# ALL-CAUSE READMISSION

## All-cause readmission

**Measure description:** 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.

**Purpose:** Some patients who leave the hospital end up being admitted again shortly thereafter. Often times, these costly and burdensome readmissions are avoidable. Reducing the preventable problems that send patients back to the hospital is the best way to keep patients at home and healthy.

## mid-2015 data

Statewide change since 2014: **-13%** (lower is better)

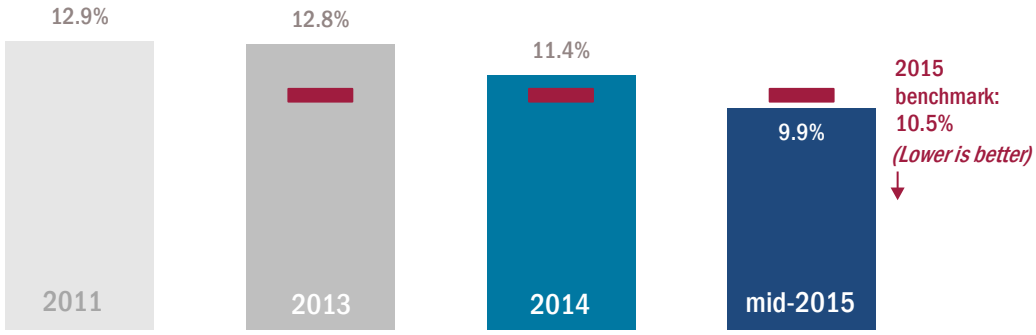
Number of CCOs that improved: **10**

**All** racial and ethnic groups experienced improvement.

### About these data:

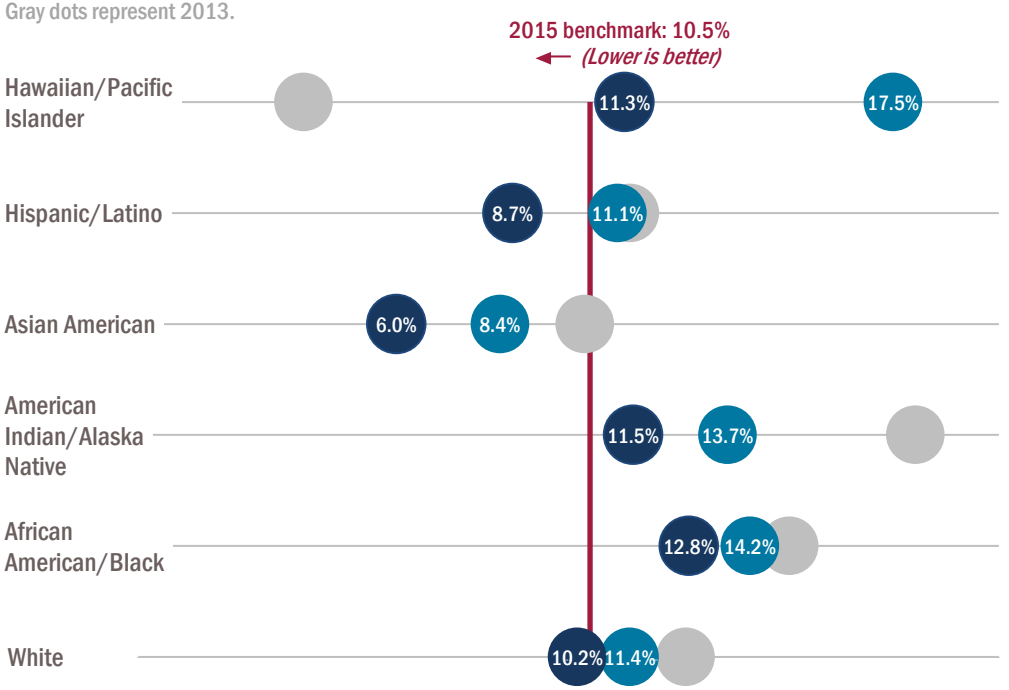
- N=31,322
- Data source: Administrative (billing) claims
- Benchmark source: Average of the 2013 commercial and Medicare 75th percentiles
- Race and ethnicity data missing for 7.2% of respondents
- Each race category excludes Hispanic/Latino

## Statewide, all-cause readmissions met the benchmark for the first time in mid-2015.




## Hawaiian/Pacific Islander members experienced the greatest improvement in readmission rates between 2014 & mid-2015.

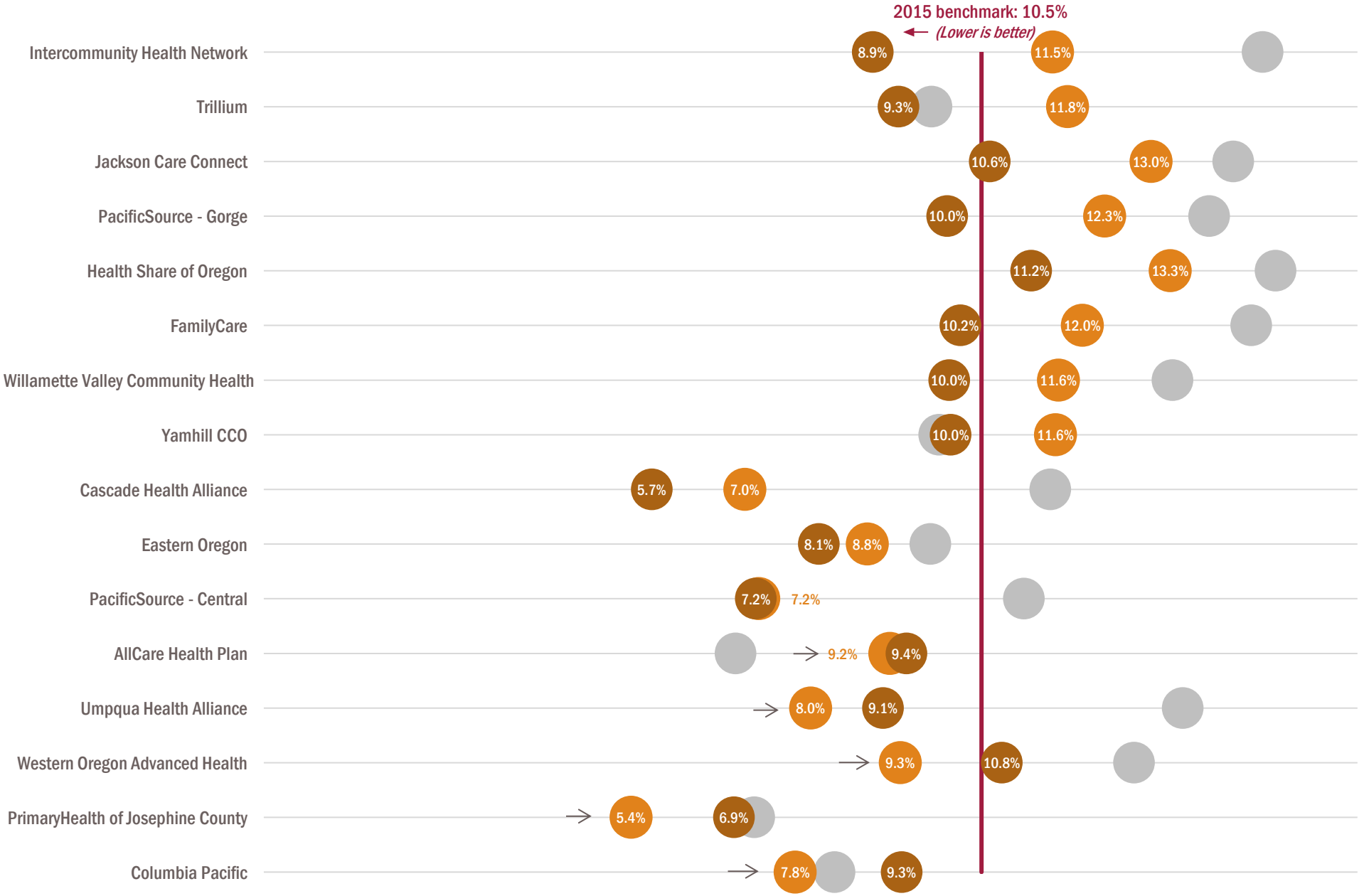
Gray dots represent 2013.



# ALL-CAUSE READMISSION

## Readmissions improved in ten of 16 CCOs between 2014 & mid-2015.

Gray dots represent 2013.



# AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

## Ambulatory care: emergency department utilization

**Measure description:** 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 this care.

**Purpose:** Emergency departments are sometimes used for problems that could have been treated at a doctor's office or urgent care clinic. Reducing inappropriate emergency department use can help to save costs and improve the health care experience for patients

## mid-2015 data

Statewide change since 2014: **-0.6%** (lower is better)

Number of CCOs that improved: **9**

Racial and ethnic groups experiencing improvement:

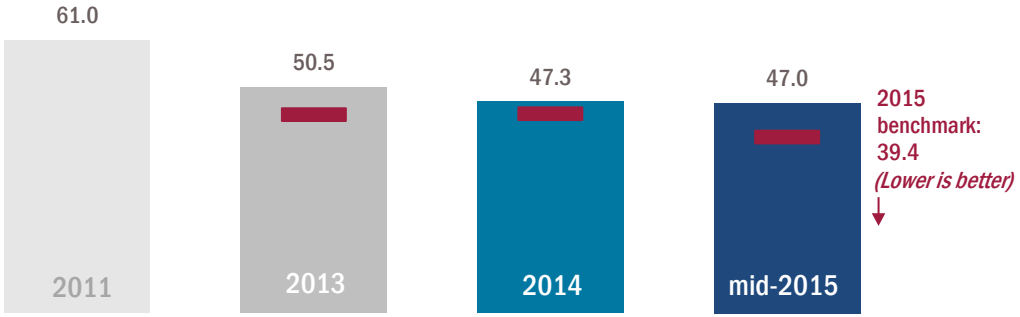
- ✓ African American / Black
- ✓ White

See pages 93, 98, and 103 for results stratified by members with- and without disability and mental health diagnoses.

### About these data:

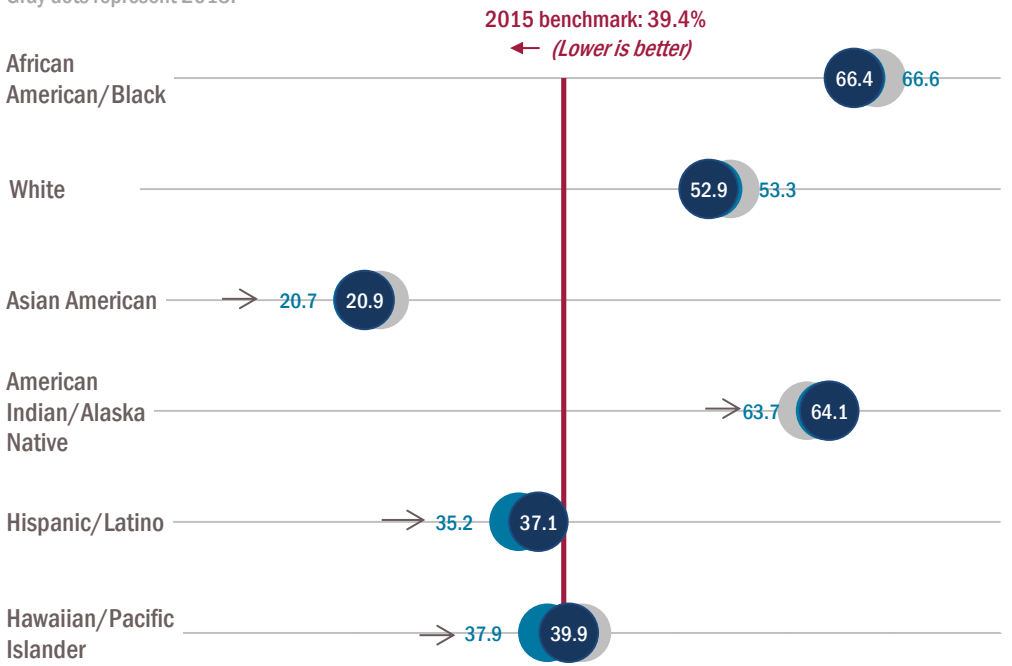
- N= 10,644,736 member months
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 90th percencentile
- Race and ethnicity data missing for 12.6% of respondents
- Each race category excludes Hispanic/Latino

## Statewide, emergency department utilization remained steady between 2014 and mid-2015.




## Emergency department utilization was lowest among Asian American members in both 2014 & mid-2015.

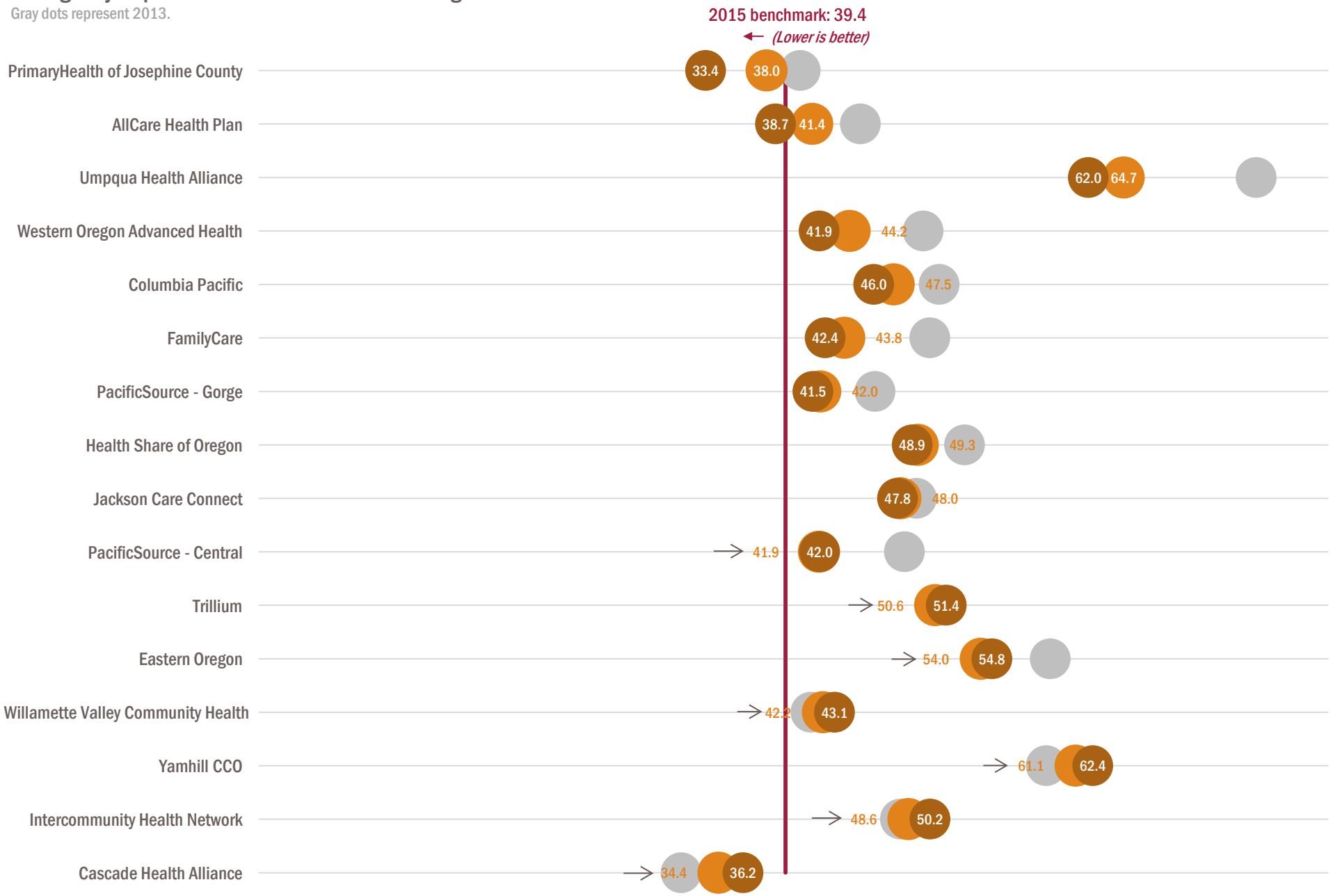
Gray dots represent 2013.



# AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

## Emergency department utilization varied among CCOs in 2014 & mid-2015.

Gray dots represent 2013.



# AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

## Avoidable emergency department utilization

**Measure description:** 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.

**Purpose:** Many patients use emergency departments for conditions that could be treated or prevented in a different care setting. Reducing avoidable emergency department utilization is an opportunity to improve care coordination, address high utilization, and explore innovative programs such as health navigators.

## mid-2015 data

Statewide change since 2014: **-3%** (lower is better)

Number of CCOs that improved: **12**

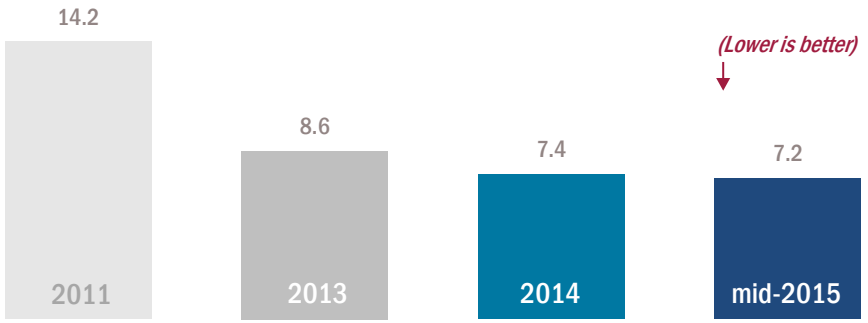
Racial and ethnic groups experiencing improvement:

- ✓ African American / Black
- ✓ American Indian / Alaska Native
- ✓ White
- ✓ Hawaiian / Pacific Islander

### About these data:

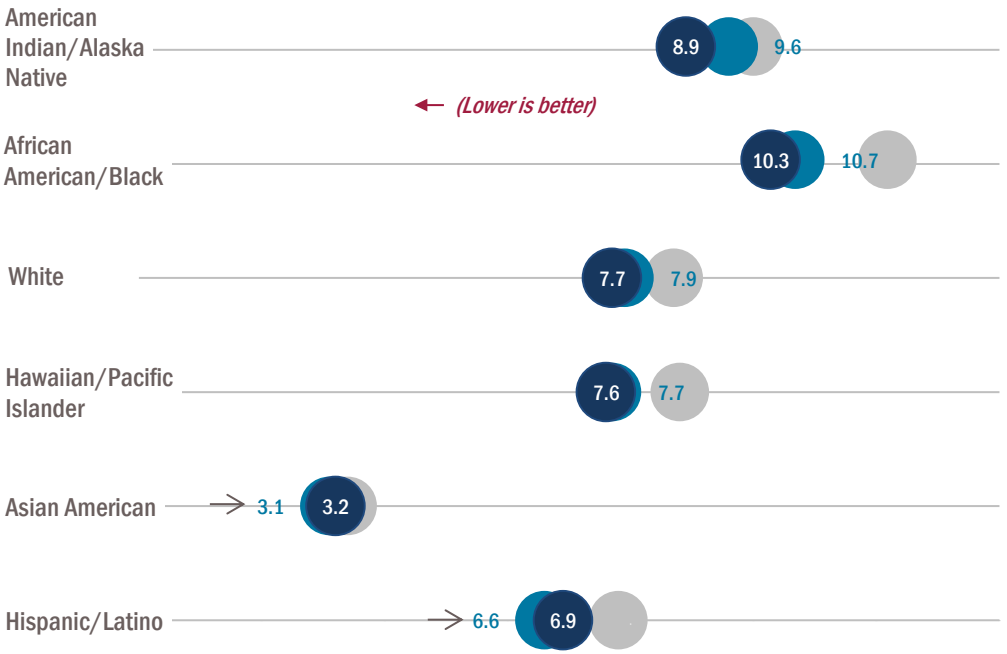
- N=10,660,459 member months
- Data source: Administrative (billing) claims
- Benchmark source: No benchmark. Lower is better.
- Race and ethnicity data missing for 12.5% of respondents
- Each race category excludes Hispanic/Latino

## Statewide, avoidable emergency department utilization remained steady between 2014 and mid-2015.




## Avoidable emergency department utilization was lowest among Asian American members in both 2014 & mid-2015.

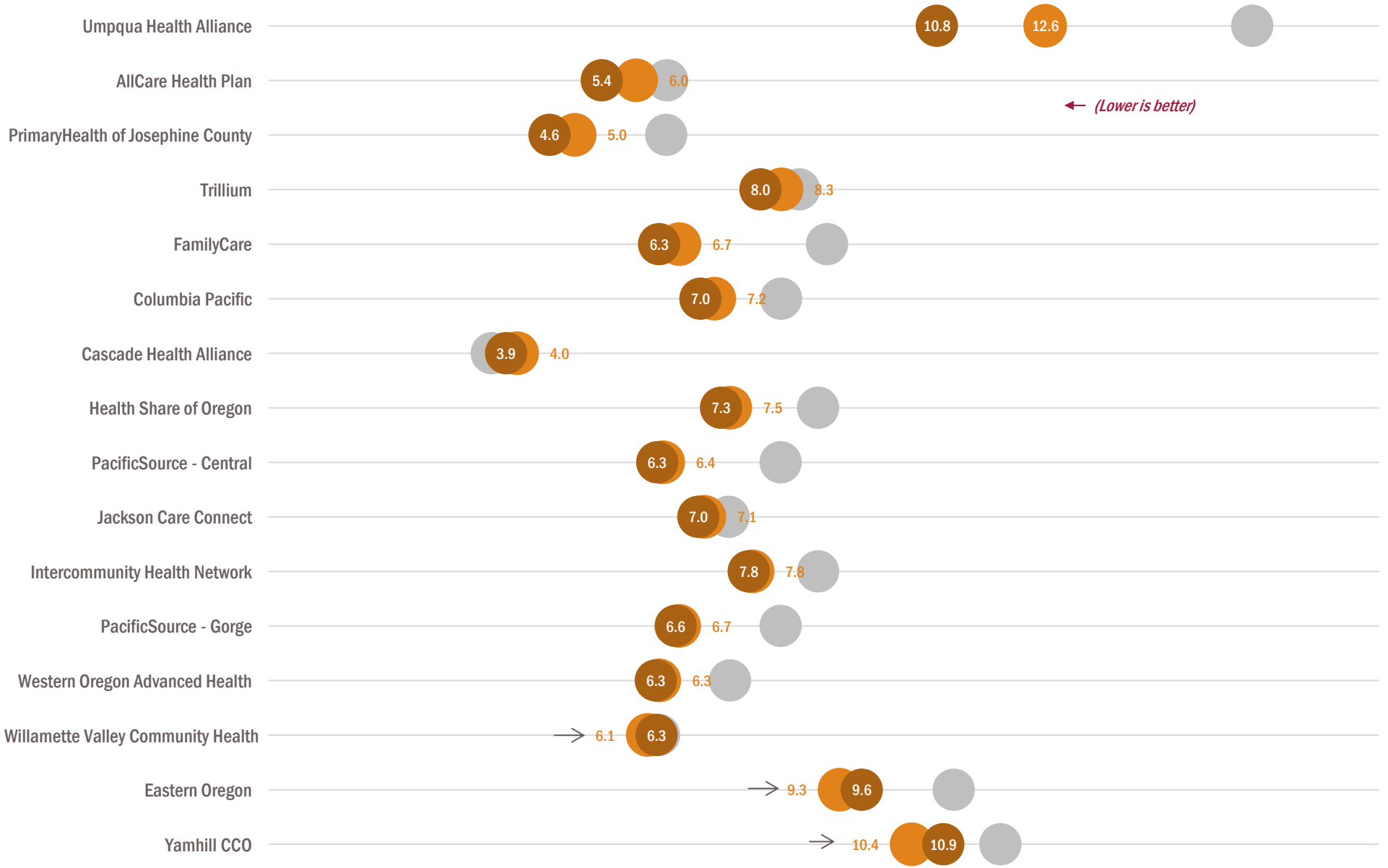
Gray dots represent 2013.



# AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

## Avoidable emergency dpeartment utilization continued to improve in many CCOs between 2014 & mid-2015.

Gray dots represent 2013.



# AMBULATORY CARE: OUTPATIENT UTILIZATION

## Outpatient utilization

**Measure description:** 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.

**Purpose:** Promoting the use of outpatient settings such as a doctor's office or urgent care clinic is part of Oregon's goal of making sure patients are getting the right care in the right places and at the right times. Outpatient care helps improve health and lower costs by promoting prevention and keeping down rates of unnecessary emergency department use.

## mid-2015 data

Statewide change since 2014: **-3%**

Number of CCOs that increased: **5**

Racial and ethnic groups experiencing increase:

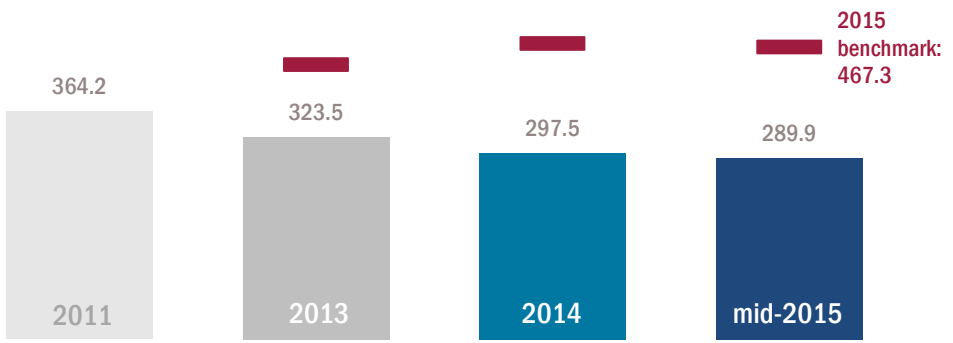
- ✓ American Indian / Alaska Native

### About these data:

- N=10,635,959 member months
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 90th percentile
- Race and ethnicity data missing for 12.5% of respondents
- Each race category excludes Hispanic/Latino

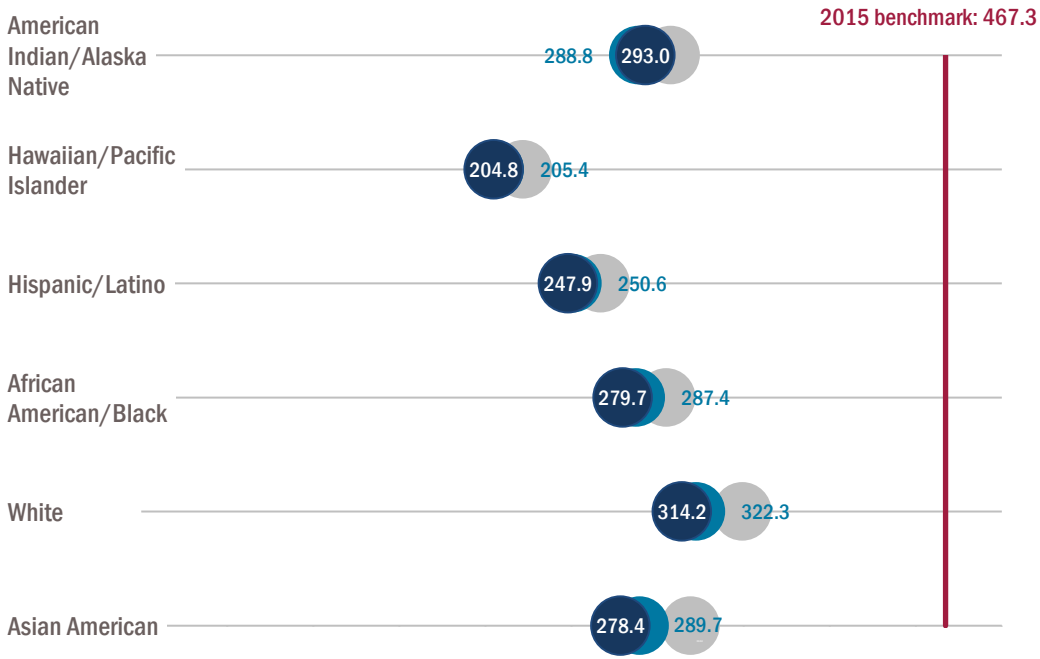
## Statewide, outpatient utilization declined slightly between 2014 and mid-2015.

Per 1,000 member months




## Outpatient utilization declined among all races and ethnicities but American Indian / Alaska Native between 2014 & mid-2015.

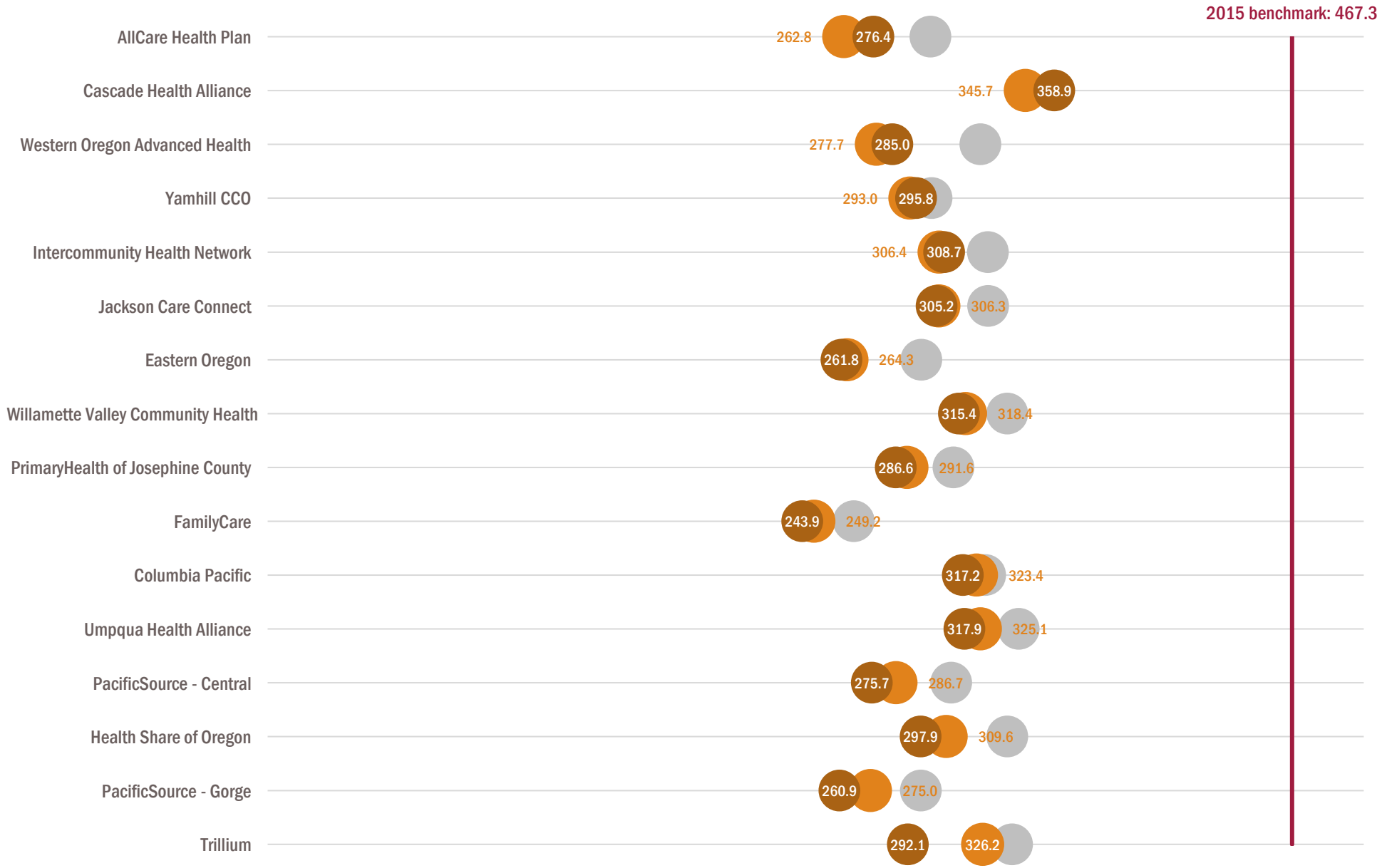
Per 1,000 member months
Gray dots represent 2013.



# AMBULATORY CARE: OUTPATIENT UTILIZATION

## Outpatient utilization rates between 2014 & mid-2015, by CCO.

Gray dots represent 2013.



# APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

## Appropriate testing for children with pharyngitis

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

**Purpose:** A strep test helps determine whether or not a child will benefit from antibiotics for a sore throat (pharyngitis). This test can help reduce the overuse of antibiotics, which can improve care quality and ensure that antibiotics continue to work when they are needed.

## mid-2015 data

Statewide change since 2014: **+2%**

Number of CCOs that improved: **13**

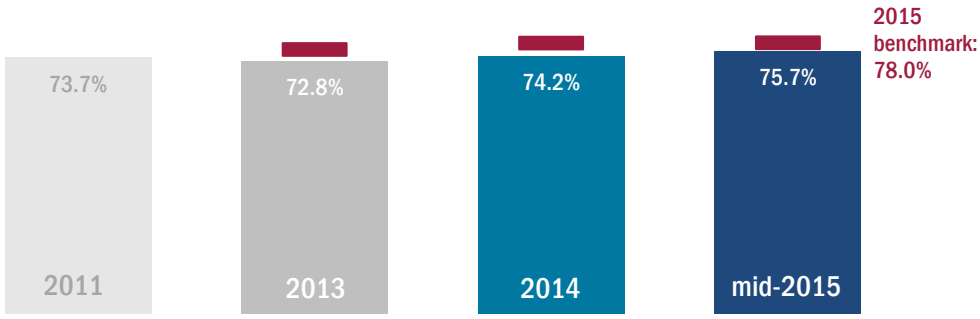
Racial and ethnic groups experiencing improvement:

- ✓ Asian American
- ✓ African American / Black
- ✓ White

### About these data:

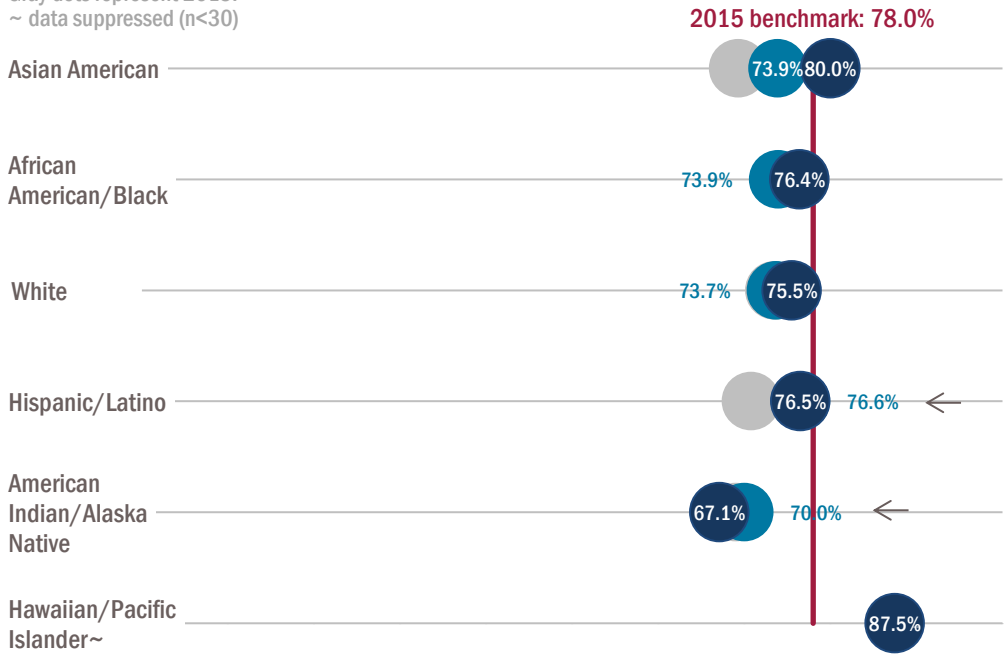
- N=8.581
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 75th percentile
- Race and ethnicity data missing for 11.3% of respondents
- Each race category excludes Hispanic/Latino

## Statewide, the percentage of children with pharyngitis who were appropriately tested is near the benchmark.




## Appropriate testing for children with pharyngitis in 2014 & mid-2015, by race and ethnicity.

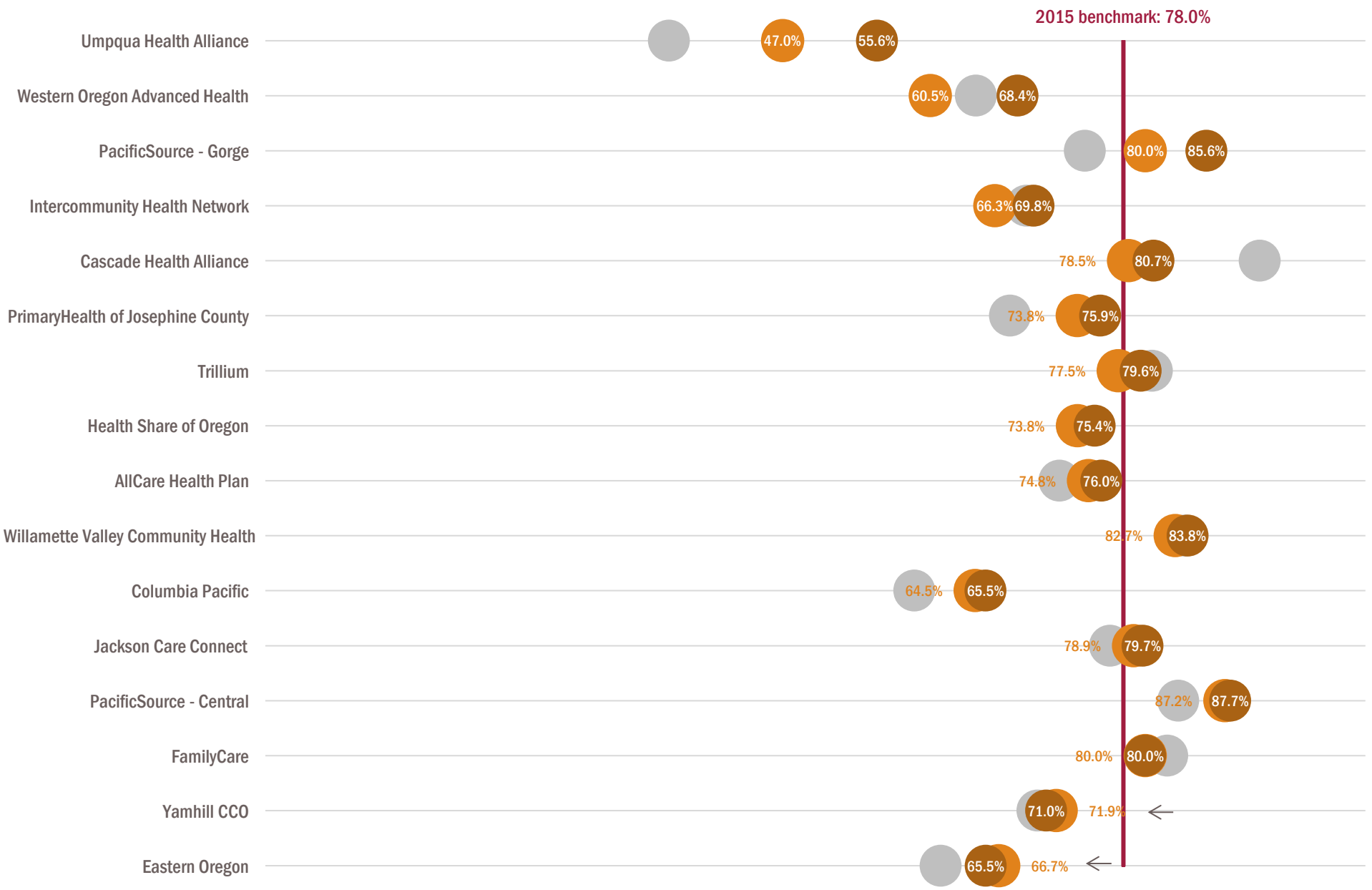
Gray dots represent 2013.
~ data suppressed (n<30)



# APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

## Appropriate testing for children with pharyngitis was varied among CCOs in 2014 & mid-2015.

Gray dots represent 2013.



# CERVICAL CANCER SCREENING

## Cervical cancer screening

**Measure description:** Percentage of women (ages 24 to 64) who received one or more Pap tests for cervical cancer during the past three years.

**Purpose:** A Pap test helps find early signs of cancer in the cervix when the disease is easier and less costly to treat. Treating cervical cancer in its earliest stages also increases the five-year survival rate to 92 percent, according to the American Cancer Society.

## mid-2015 data

Statewide change since 2014: **-2%**

Number of CCOs that improved: **4**

Racial and ethnic groups experiencing improvement:

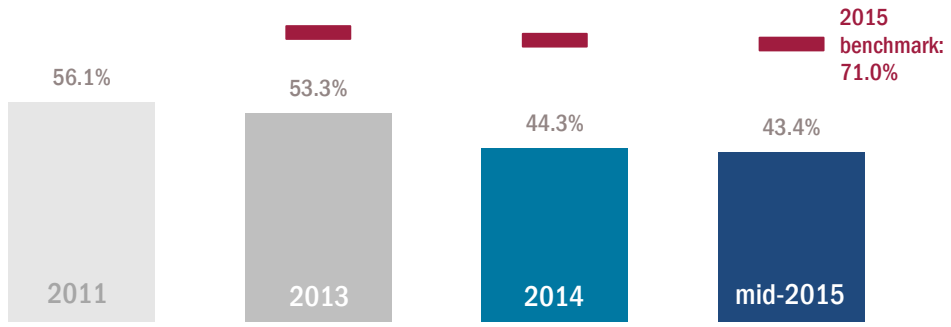
- ✓ Hispanic / Latino
- ✓ American Indian / Alaska Native

The decreased cervical cancer screening may be due to a number of factors, including changes in national guidelines reported in 2012, which recommend women wait three to five years between Pap tests (this report only looks at tests within a three-year period). Decreased screening also may be due to new members who gained coverage in 2014 and have not yet been screened.

### About these data:

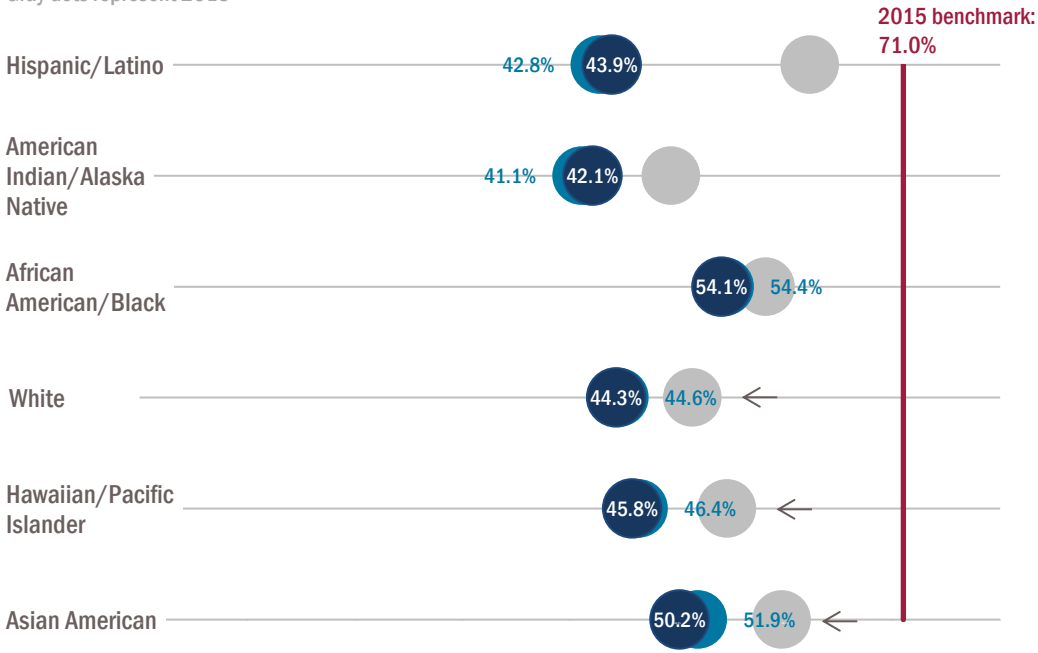
- N=159,927
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 75th percentile
- Race and ethnicity data missing for 12.8% of respondents
- Each race category excludes Hispanic/Latino

### Percentage of women who were screened for cervical cancer in the last three years, statewide.




### Percentage of women who were screened for cervical cancer in the last three years in 2014 & mid-2015, by race and ethnicity.

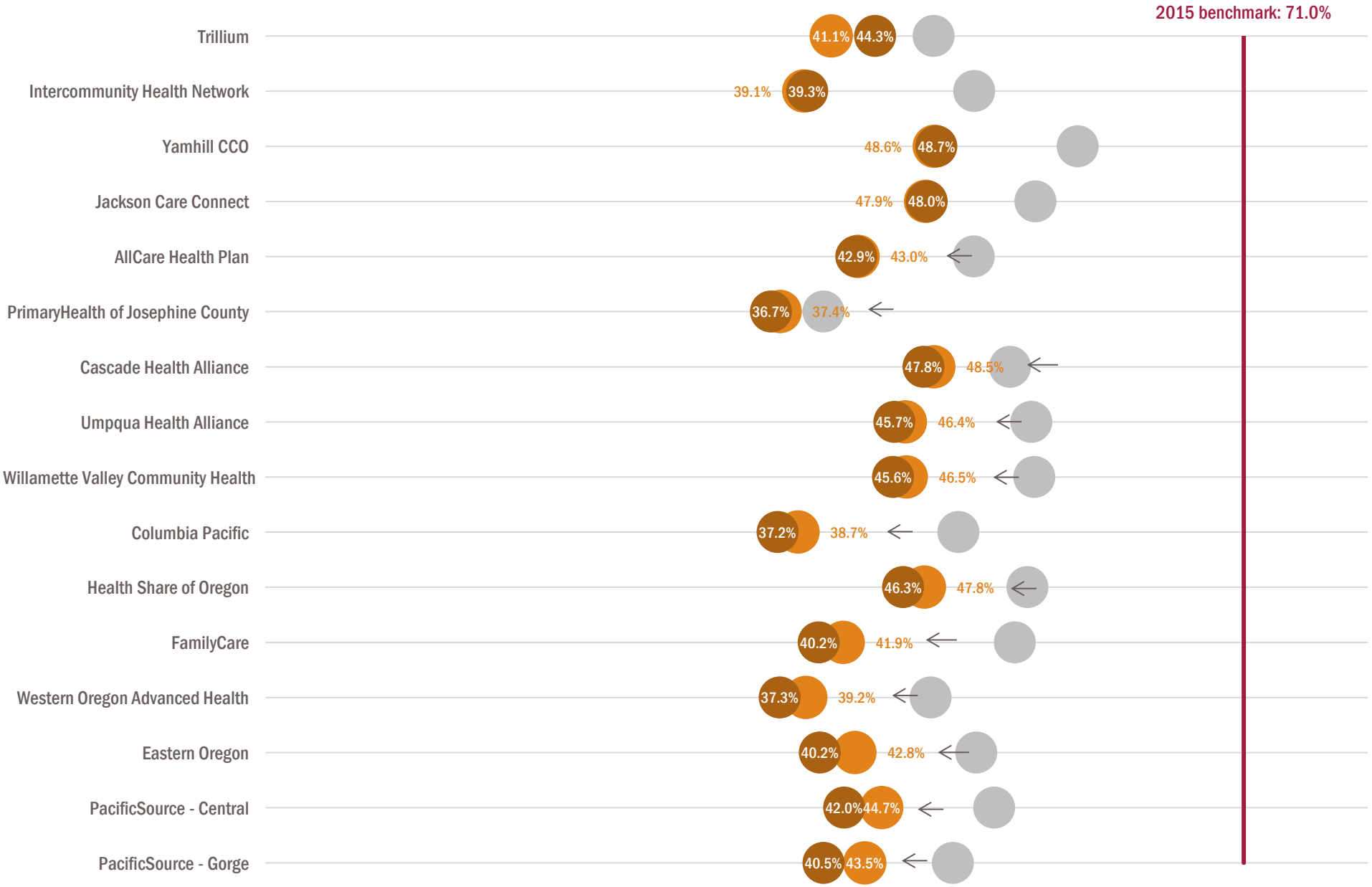
Gray dots represent 2013



# CERVICAL CANCER SCREENING

## Cervical cancer screening continued to decline in many CCOs between 2014 & mid-2015.

Gray dots represent 2013.



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

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

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

**Purpose:** Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider ensures youth are receiving necessary services to support their development and health.

## mid-2015 data

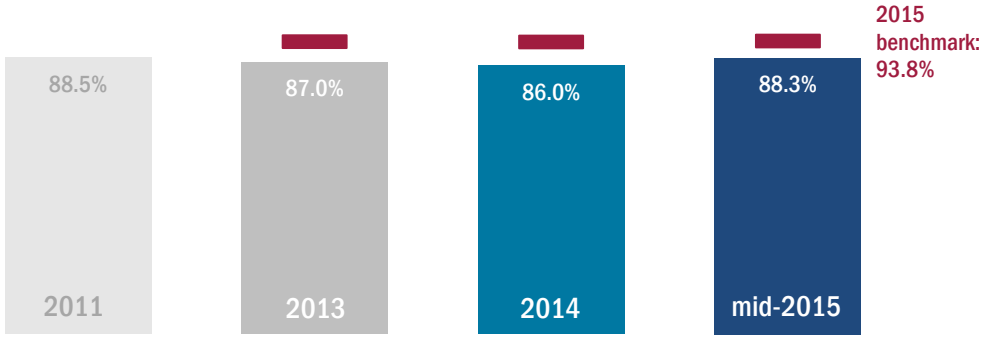
Statewide change since 2014: **+3%**

**All** racial and ethnic groups experienced improvement.

### About these data:

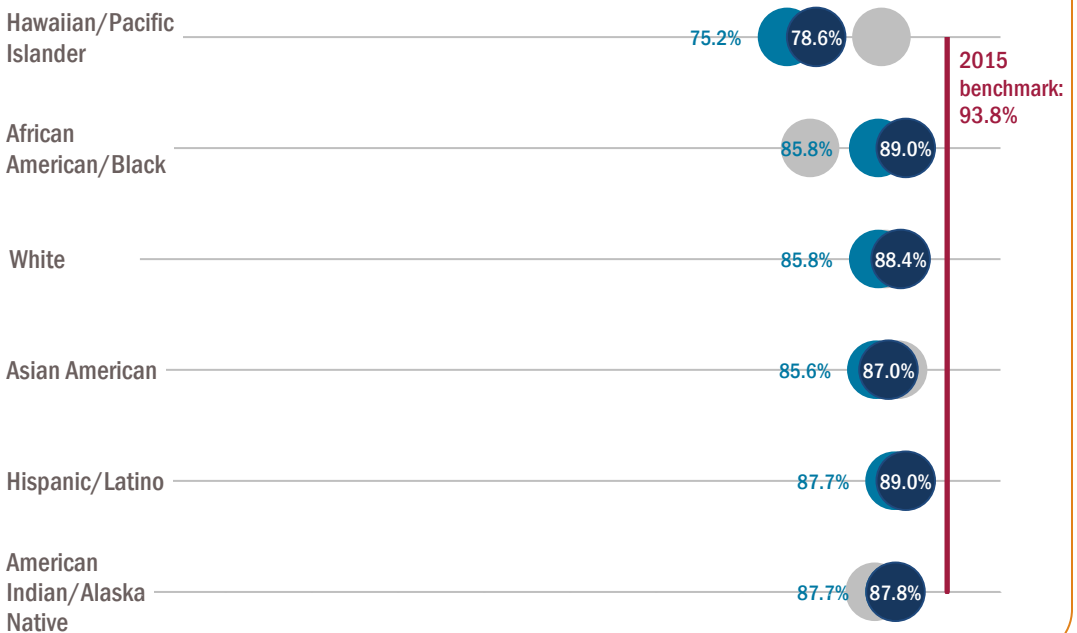
- N=252,606
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 75th percentile
- Race and ethnicity data missing for 10.9% of respondents
- Each race category excludes Hispanic/Latino
- 2011-2014 data for this measure are not available by CCO.

## Statewide, childhood and adolescent access to primary care increased slightly between 2014 and mid-2015.




## Access improved the most for Hawaiian / Pacific Islander members between 2014 & mid-2015, but remains lower than other races and ethnicities.

Gray dots represent 2013



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

Access to primary care providers among children and adolescents (all ages) in mid-2015, by CCO.

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

## Childhood and adolescent access to primary care providers (12—24 months)

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

**Purpose:** See page 26.

## mid-2015 data

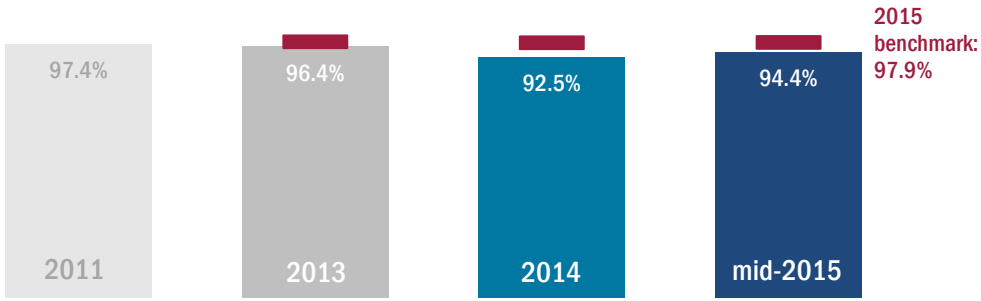
Statewide change since 2014: **+2%**

**All** racial and ethnic groups in this age category experienced improvement.

### About these data:

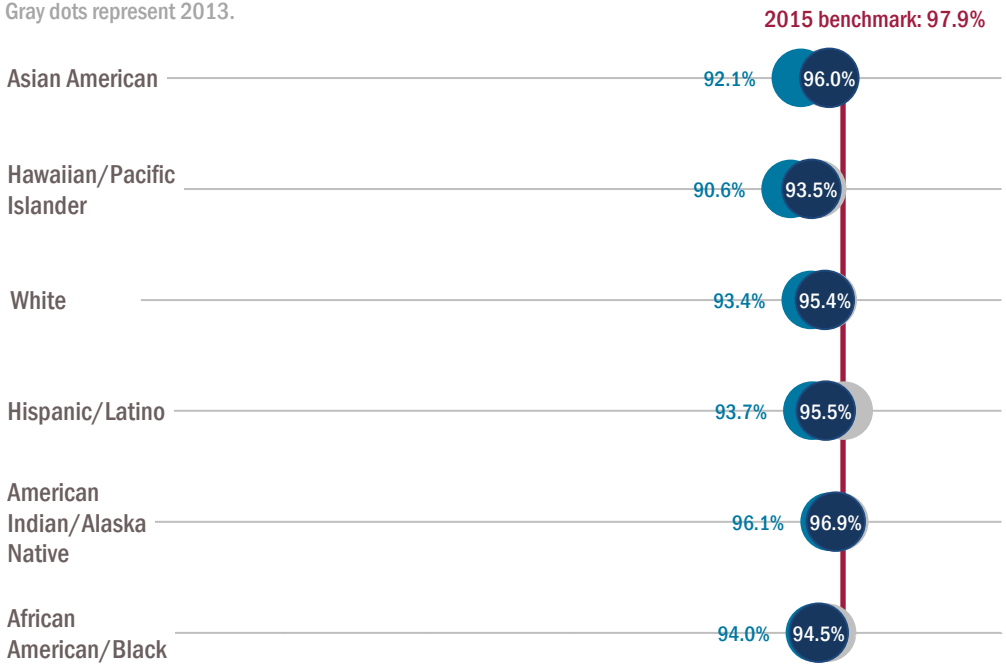
- N=18,689
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 75th percentile
- Race and ethnicity data missing for 16.5% of respondents
- Each race category excludes Hispanic/Latino
- 2011-2014 data for this measure are not available by CCO.

### Access to primary care providers among children ages 12-24 months, statewide.




### Access to primary care providers among children ages 12-24 months between 2014 & mid-2015, by race and ethnicity.

Gray dots represent 2013.



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

Access to primary care providers among children ages 12-24 months in mid-2015, by CCO.

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

## Childhood and adolescent access to primary care providers (25 months—6 years)

**Measure description:** Percentage of children and adolescents (ages 25 months - 6 years) who had a visit with a primary care provider.

**Purpose:** See page 26.

## mid-2015 data

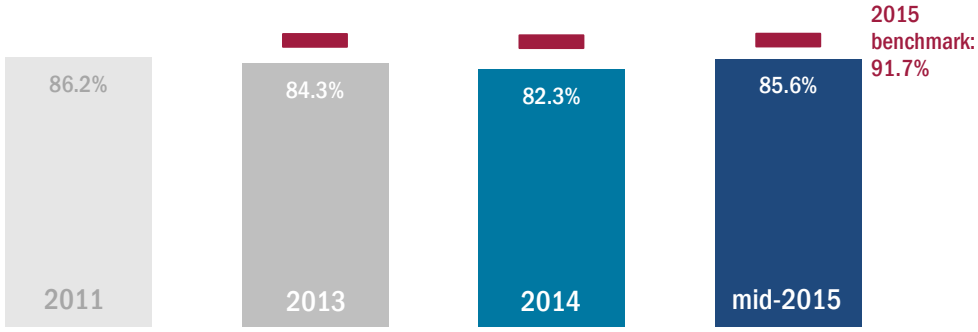
Statewide change since 2014: **+4%**

**All** racial and ethnic groups in this age category experienced improvement.

### About these data:

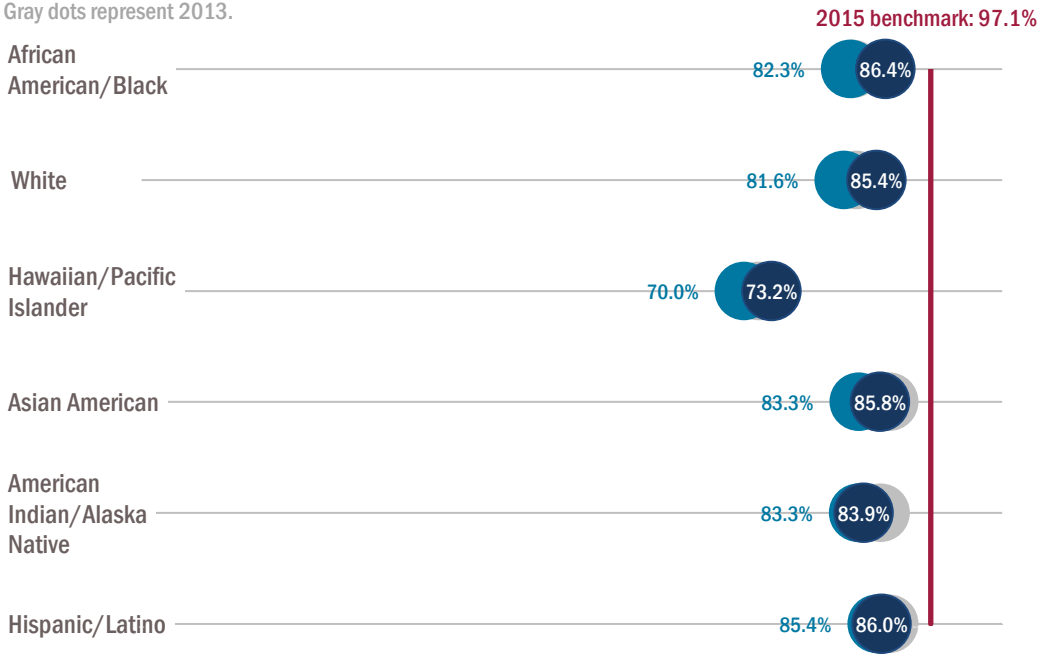
- N=85,299
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 75th percentile
- Race and ethnicity data missing for 12.3% of respondents
- Each race category excludes Hispanic/Latino
- 2011-2014 data for this measure are not available by CCO.

## Access to primary care providers among children ages 25 months-6 years, statewide.




## Access to primary care providers among children ages 25 months-6 years between 2014 & mid-2015, by race and ethnicity.

Gray dots represent 2013.



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

Access to primary care providers among children ages 25 months - 6 years in mid-2015, by CCO.

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

## Childhood and adolescent access to primary care providers (7—11 years)

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

**Purpose:** See page 26.

## mid-2015 data

Statewide change since 2014: **+2%**

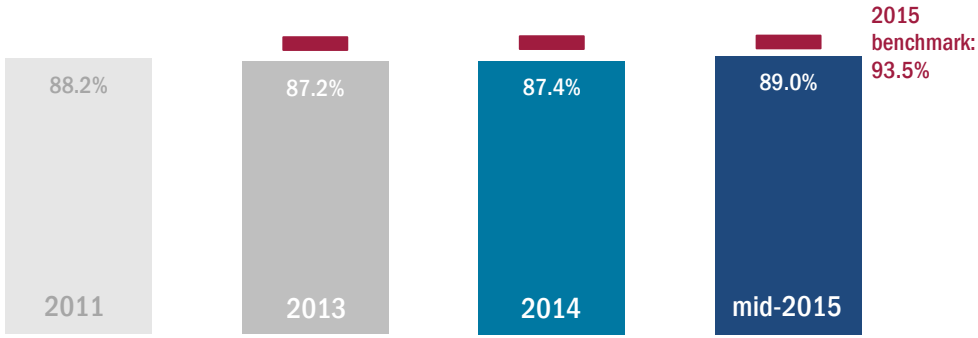
Racial and ethnic groups experiencing improvement:

- ✓ Hawaiian / Pacific Islander
- ✓ African American / Black
- ✓ White
- ✓ Hispanic / Latino
- ✓ Asian American

### About these data:

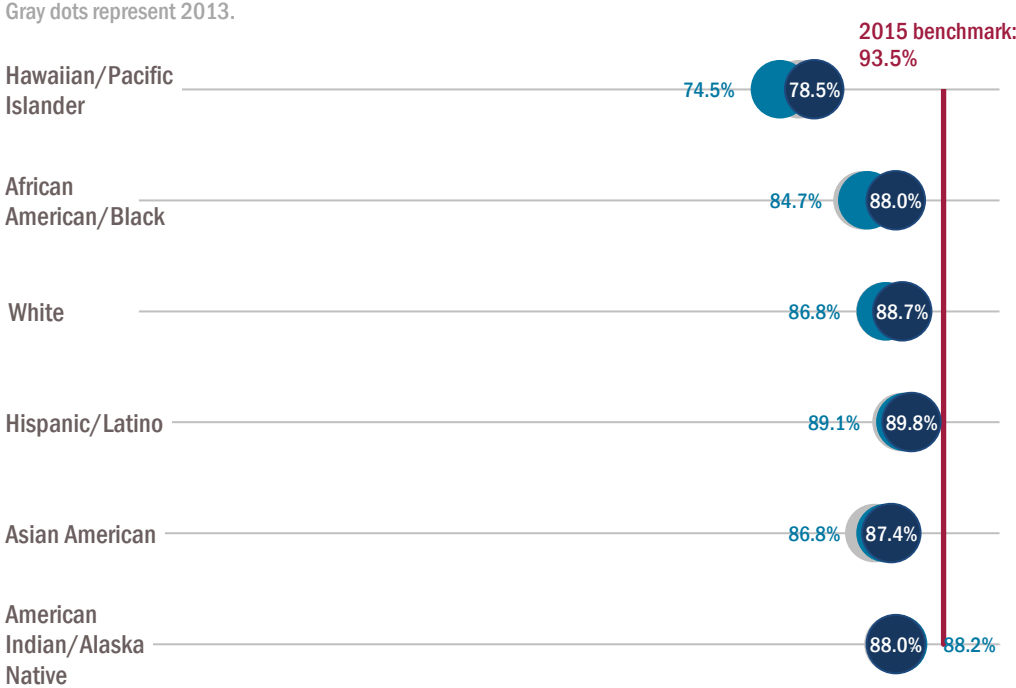
- N=66,473
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 75th percentile
- Race and ethnicity data missing for 10.6% of respondents
- Each race category excludes Hispanic/Latino
- 2011-2014 data for this measure are not available by CCO.

### Access to primary care providers among children ages 7-11 years, statewide.




### Access to primary care providers among children ages 7-11 years between 2014 & mid-2015, by race and ethnicity.

Gray dots represent 2013.



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

Access to primary care providers among children ages 7-11 years in mid-2015, by CCO.

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

## Childhood and adolescent access to primary care providers (12—19 years)

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

**Purpose:** See page 26.

## mid-2015 data

Statewide change since 2014: **+2%**

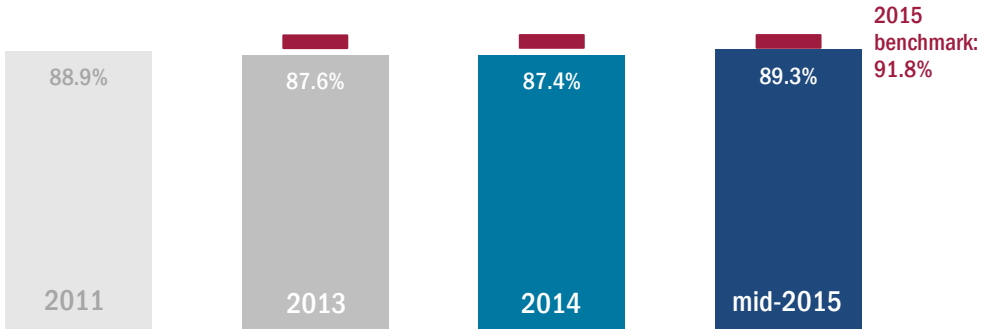
Racial and ethnic groups experiencing improvement:

- ✓ Hawaiian / Pacific Islander
- ✓ African American / Black
- ✓ White
- ✓ Hispanic / Latino
- ✓ Asian American

### About these data:

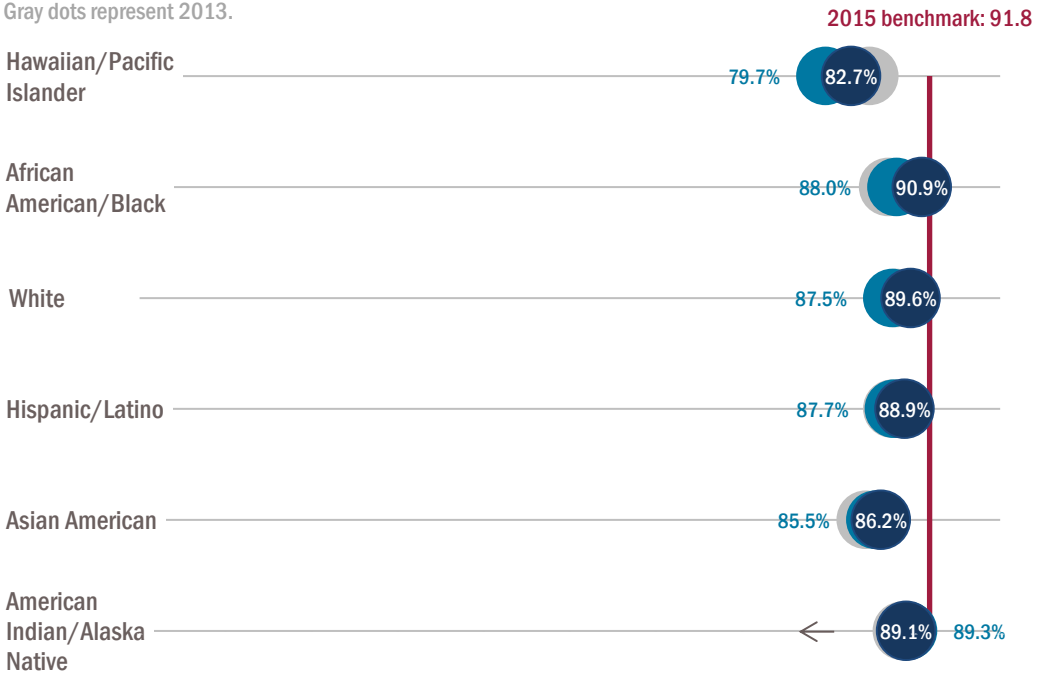
- N=82,181
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 75th percentile
- Race and ethnicity data missing for 9.6% of respondents
- Each race category excludes Hispanic/Latino
- 2011-2014 data for this measure are not available by CCO.

### Access to primary care providers among adolescents ages 12-19 years, statewide.




### Access to primary care providers among adolescents ages 12-19 years between 2014 & mid-2015, by race and ethnicity.

Gray dots represent 2013.



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

Access to primary care providers among adolescents ages 12-19 years in mid-2015, by CCO.

# CHILDHOOD IMMUNIZATION STATUS

## Childhood immunization status

**Measure description:** Percentage of children who received recommended vaccines (series 4:3:1:3:3:1:4) before their second birthday.

**Purpose:** Vaccines are one of the safest, easiest and most effective ways to protect children from potentially serious diseases. Vaccines are also cost-effective tools which help to prevent the spread of serious diseases which can sometimes lead to widespread public health threats.

## mid-2015 data

Statewide change since 2014: **+3%**

Number of CCOs that improved: **14**

Racial and ethnic groups experiencing improvement:

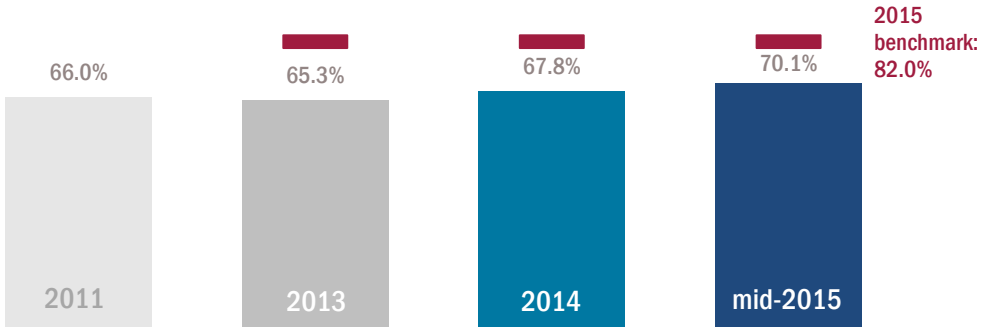
- ✓ American Indian / Alaska Native
- ✓ Asian American
- ✓ White
- ✓ African American / Black

Childhood immunization status will be a CCO incentive measure beginning in 2016.

### About these data:

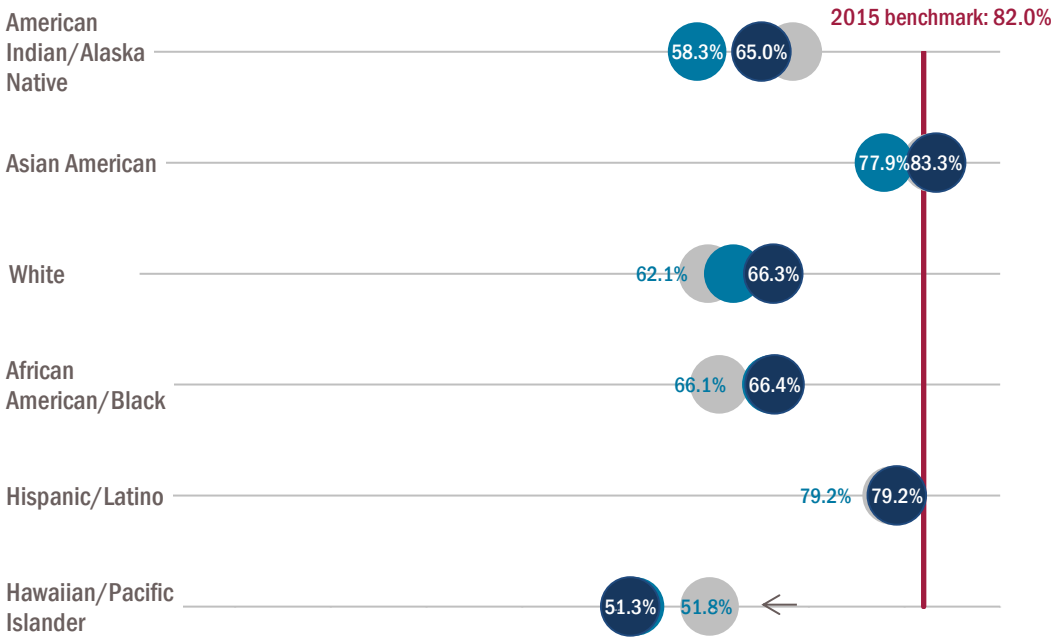
- N=16,253
- Data source: Administrative (billing) claims and ALERT immunization information system
- Benchmark source: 2014 national Medicaid 75th percentile
- Race and ethnicity data missing for 11.6% of respondents
- Each race category excludes Hispanic/Latino

## Statewide, the percentage of children who received recommended vaccines before their second birthday continues to improve.




## Hawaiian / Pacific Islander children received recommended immunizations less often than other races and ethnicities in both 2014 & mid-2015.

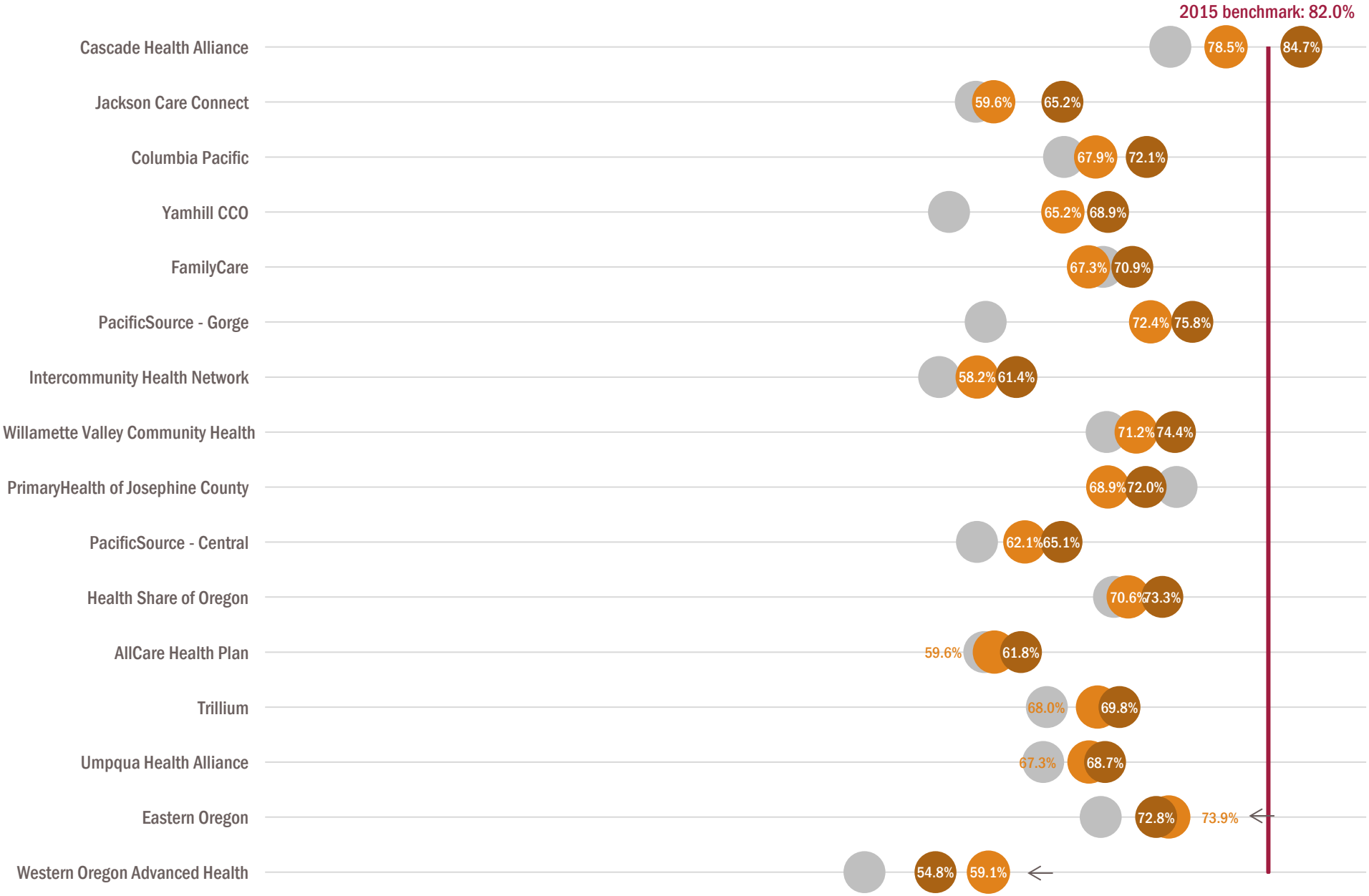
Gray dots represent 2013.



# CHILDHOOD IMMUNIZATION STATUS

## Childhood immunizations increased in 14 of 16 CCOs between 2014 & mid-2015.

Gray dots represent 2013.



# CHLAMYDIA SCREENING IN WOMEN AGES 16-24

## Chlamydia screening

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

**Purpose:** Chlamydia is the one of the most common reportable illness in Oregon. Since there are usually no symptoms, routine screening is important to find the disease early so that it can be treated and cured with antibiotics. If chlamydia is not found and treated early, it can lead to pelvic inflammatory disease, which can cause infertility.

## mid-2015 data

Statewide change since 2014: **+5%**

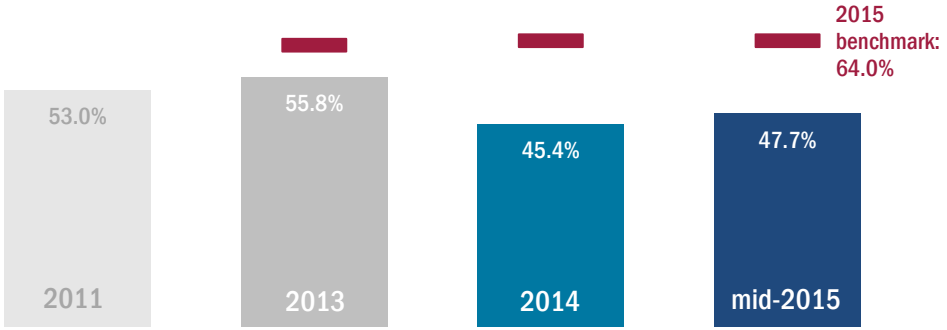
Number of CCOs that improved: **13**

**All** racial and ethnic groups experienced improvement.

### About these data:

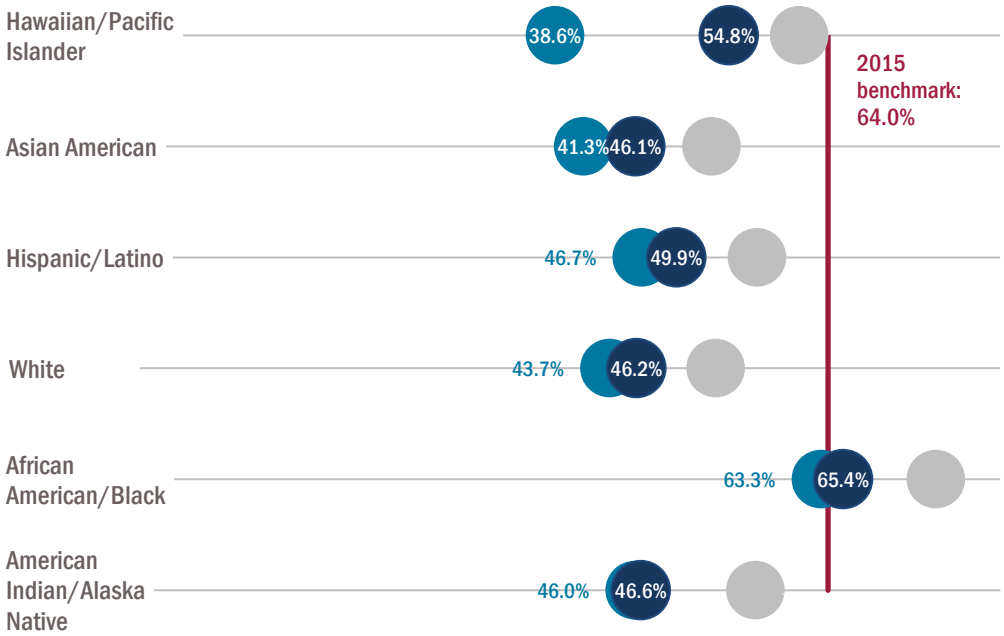
- N=27,209
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 75th percentile
- Race and ethnicity data missing for 10.0% of respondents
- Each race category excludes Hispanic/Latino

## Statewide, chlamydia screening improved slightly between 2014 and mid-2015, but remains below the benchmark.




## Chlamydia screening between 2014 & mid-2015, by race and ethnicity.

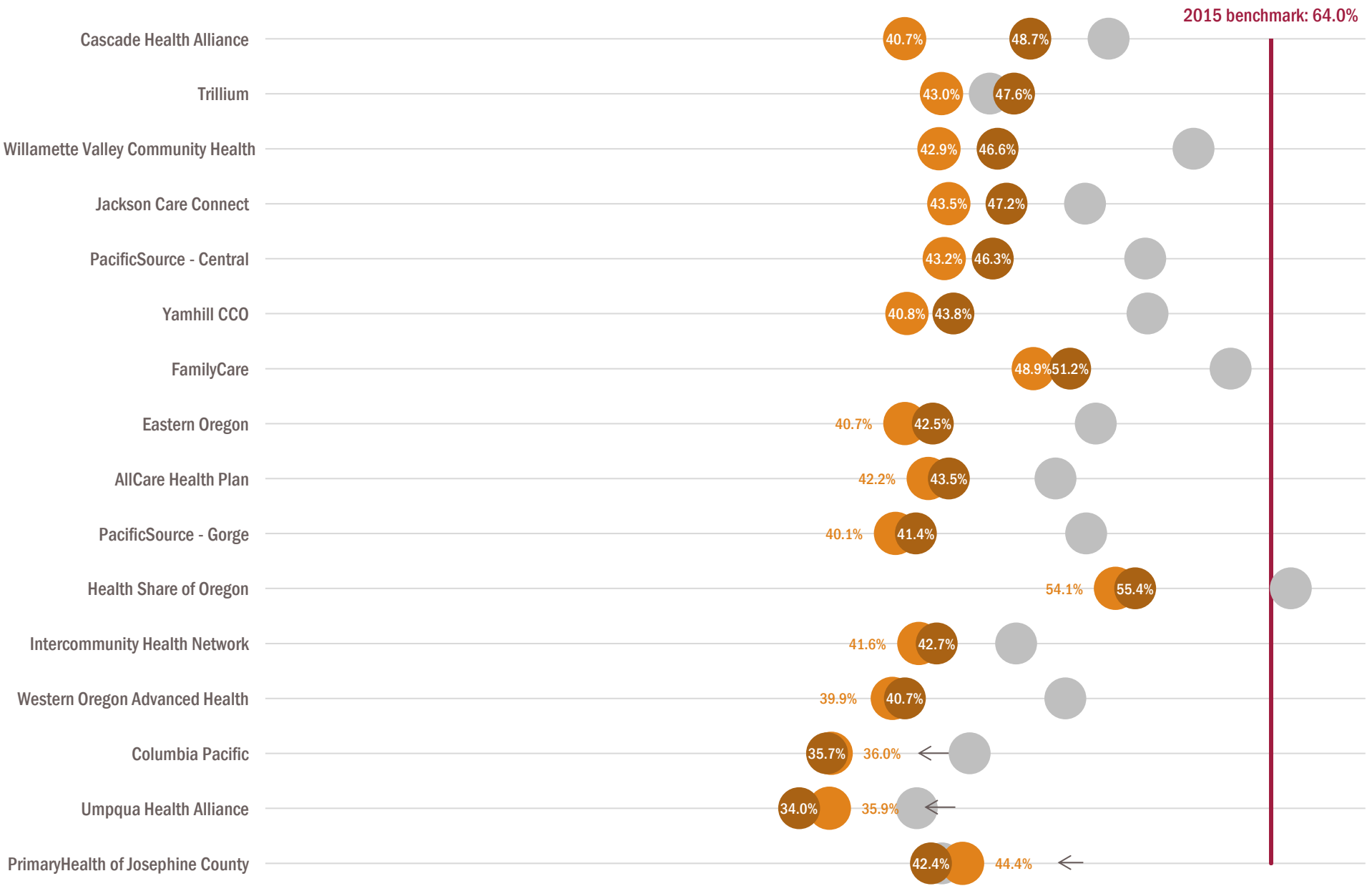
Grey dots represent 2013.



# CHLAMYDIA SCREENING IN WOMEN AGES 16-24

Percentage of women who had a screening for chlamydia infection in 2014 & mid-2015.

Gray dots represent 2013.



# COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

## Comprehensive diabetes care: HbA1c testing

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

**Purpose:** Controlling blood sugar levels is important to help people with diabetes manage their disease. It is also a key way to assess the overall effectiveness of diabetes care in Oregon. By improving the quality of care for diabetes, Oregon can help members avoid complications and hospitalizations that lead to poor health and high costs.

## mid-2015 data

Statewide change since 2014: **+1%**

Number of CCOs that improved: **10**

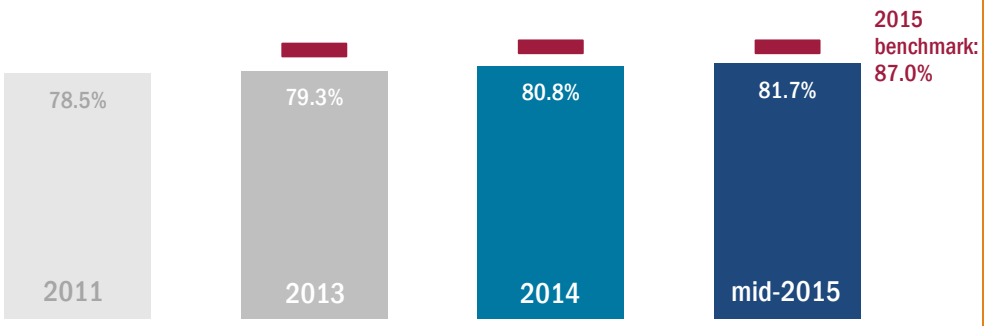
Racial and ethnic groups experiencing improvement:

- ✓ Hawaiian / Pacific Islander
- ✓ Asian American
- ✓ Hispanic / Latino
- ✓ African American / Black
- ✓ White

### About these data:

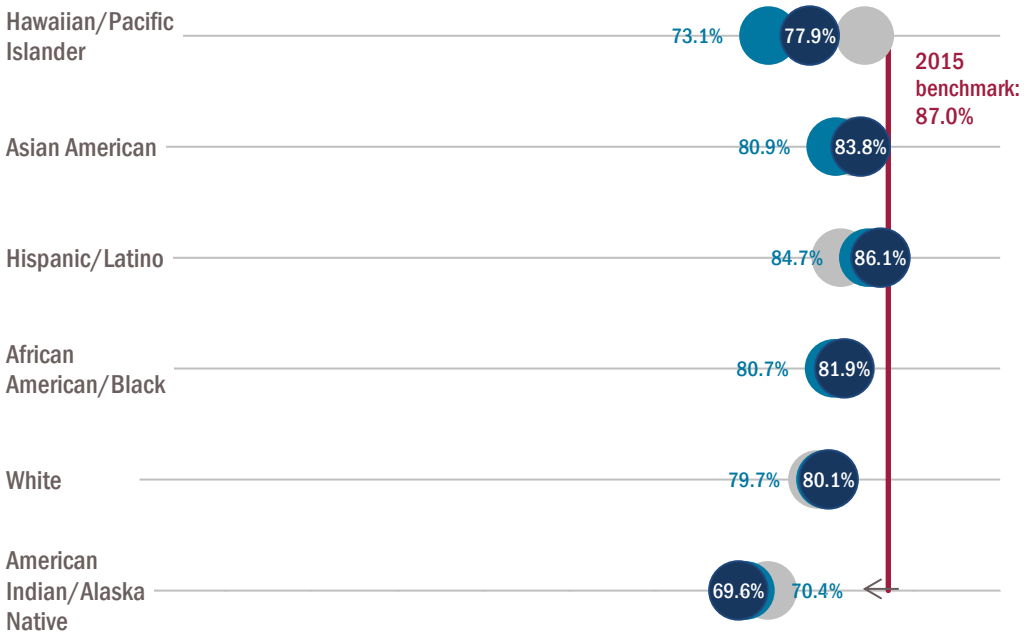
- N=33,273
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 75th percentile
- Race and ethnicity data missing for 8.2% of respondents
- Each race category excludes Hispanic/Latino

## Statewide, the percentage of adults with diabetes who received an A1c blood sugar test continues to improve.




## Percentage of adults with diabetes who received an A1c blood sugar test in 2014 & mid-2015, by race and ethnicity.

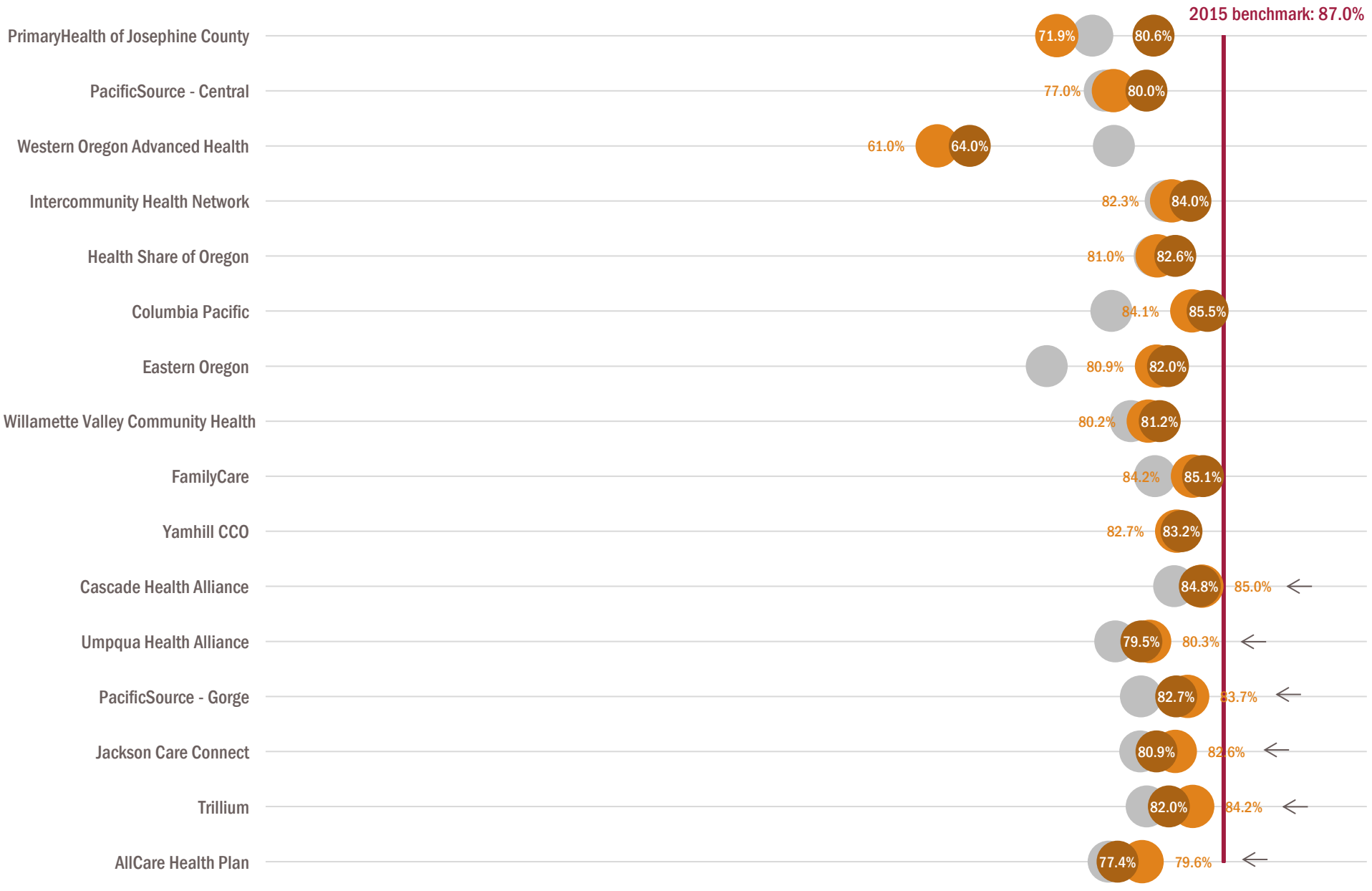
Gray dots represent 2013.



# COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

## Percentage of adults with diabetes who received an A1c blood sugar test in 2014 & mid-2015, by CCO.

Gray dots represent 2013.



# COMPHREHENSIVE DIABETES CARE: LDL-C SCREENING

## Comprehensive diabetes care: LDL-C screening

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

**Purpose:** This test helps people with diabetes manage their condition by measuring the level of "bad" cholesterol (LDL-C) in the blood. Managing cholesterol levels can help people with diabetes avoid problems such as heart disease and stroke.

## mid-2015 data

Statewide change since 2014: **-3%**

Number of CCOs that improved: **2**

Racial and ethnic groups experiencing improvement:

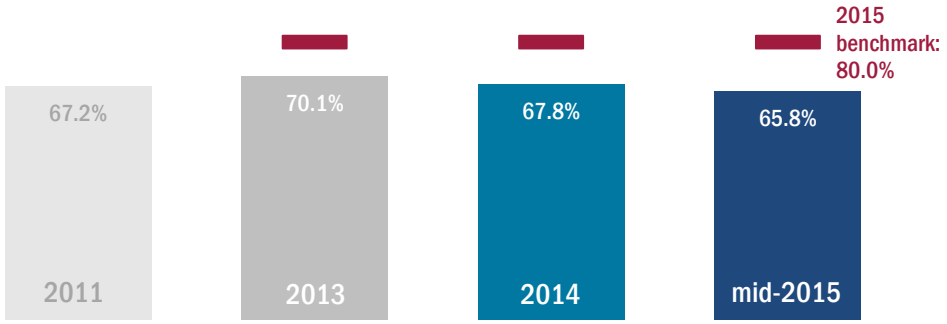
- ✓ Asian American

LDL-C (cholesterol) testing among members with diabetes declined slightly in mid-2015, while HbA1c blood sugar testing among the same population increased. This may be because the American College of Cardiology / American Heart Assocation released updated guidelines in 2013 which 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.

### About these data:

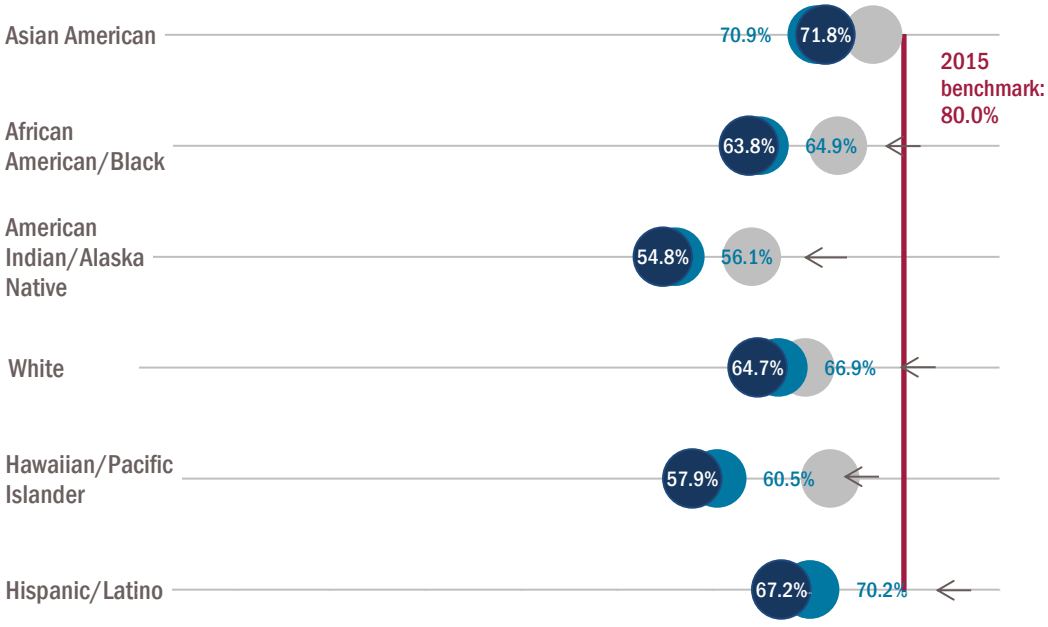
- N=33,273
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 75th percentile
- Race and ethnicity data missing for 8.2% of respondents
- Each race category excludes Hispanic/Latino

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




## Percentage of adults with diabetes who received an LDL-C test in 2014 & mid-2015, by race and ethnicity.

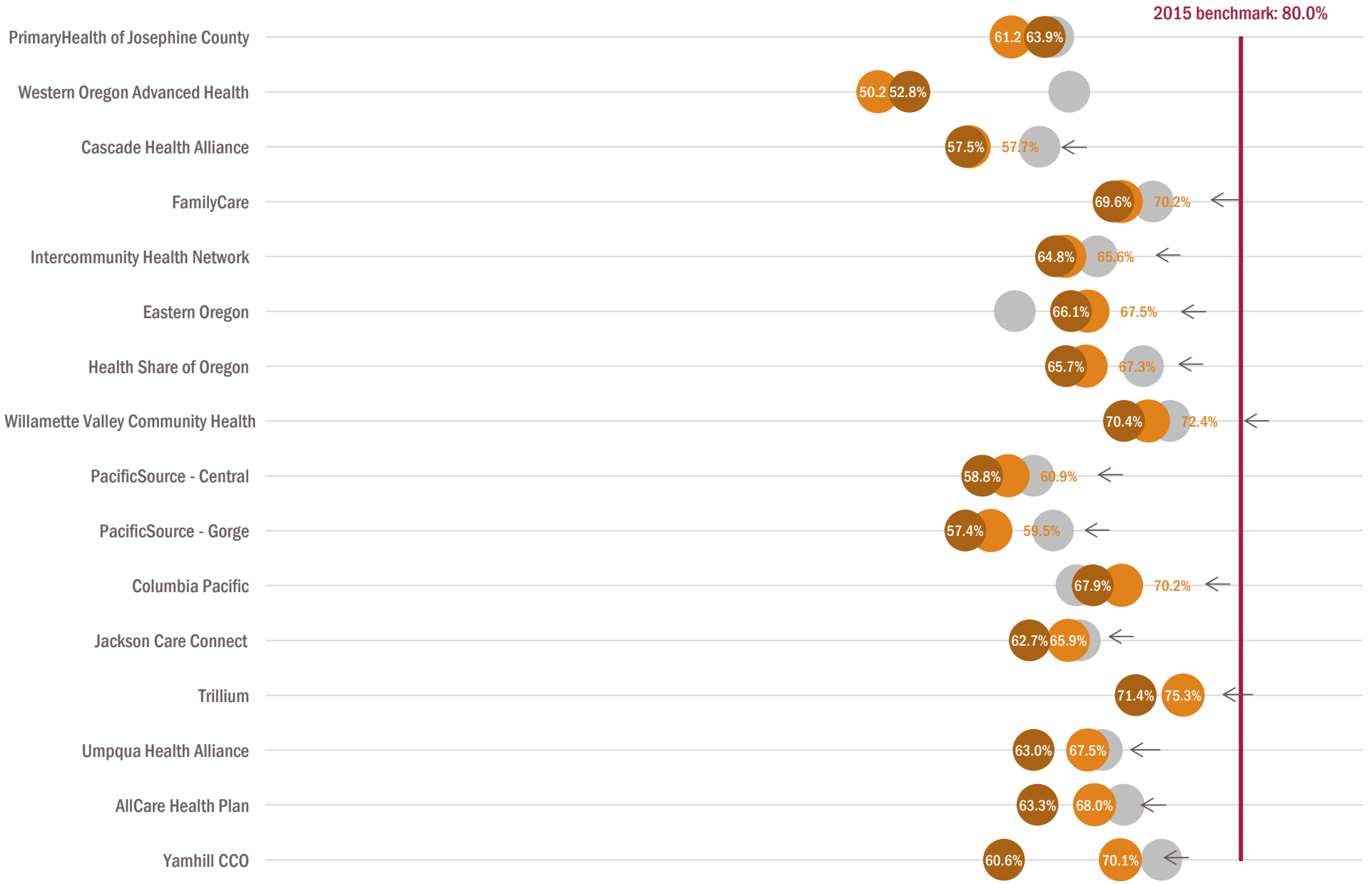
Gray dots represent 2013



# COMPHREHENSIVE DIABETES CARE: LDL-C SCREENING

Percentage of adults with diabetes who received an LDL-C (cholesterol) test in 2014 & mid-2015, by CCO.

Gray dots represent 2013.



# DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN - ALL AGES (6-14)

## Dental sealants on permanent molars for children (all ages)

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

**Purpose:** Dental sealants are a widely recognized tool used to prevent tooth decay. Childhood tooth decay causes needless pain and infection, and can affect a child's nutrition and academic performance.

### mid-2015 data

Statewide change since 2014: **+28%**

Number of CCOs that improved: **all 16**

**All** racial and ethnic groups experienced improvement.

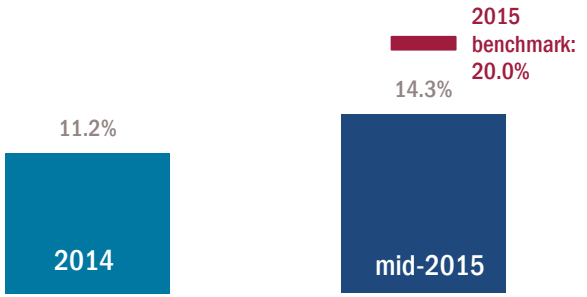
Dental sealants is a new incentive measure beginning in 2015. Results are stratified by age groups (see pages 46-49) for reporting and monitoring purposes only. Incentive payments are based on all ages combined.

See pages 95 and 101 for results stratified by members with- and without disability and mental health diagnoses.

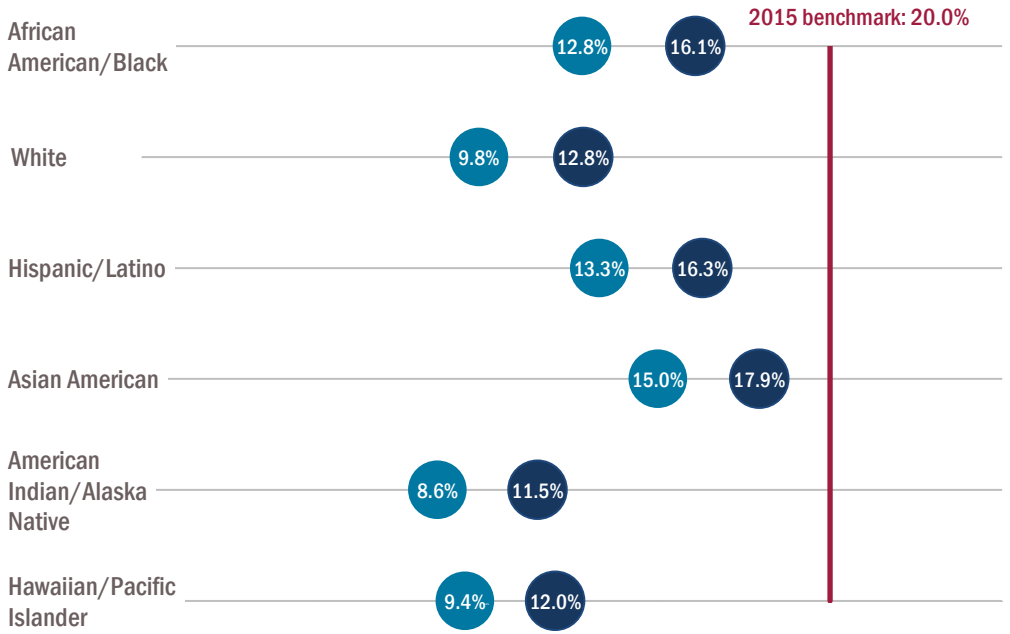
### About these data:

- N=149,048
- Data source: Administrative (billing) claims
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 10.3% of respondents
- Each race category excludes Hispanic/Latino
- 2011 and 2013 results are not available for this measure

## Statewide, the percentage of children ages 6-14 who received dental sealants has increased.

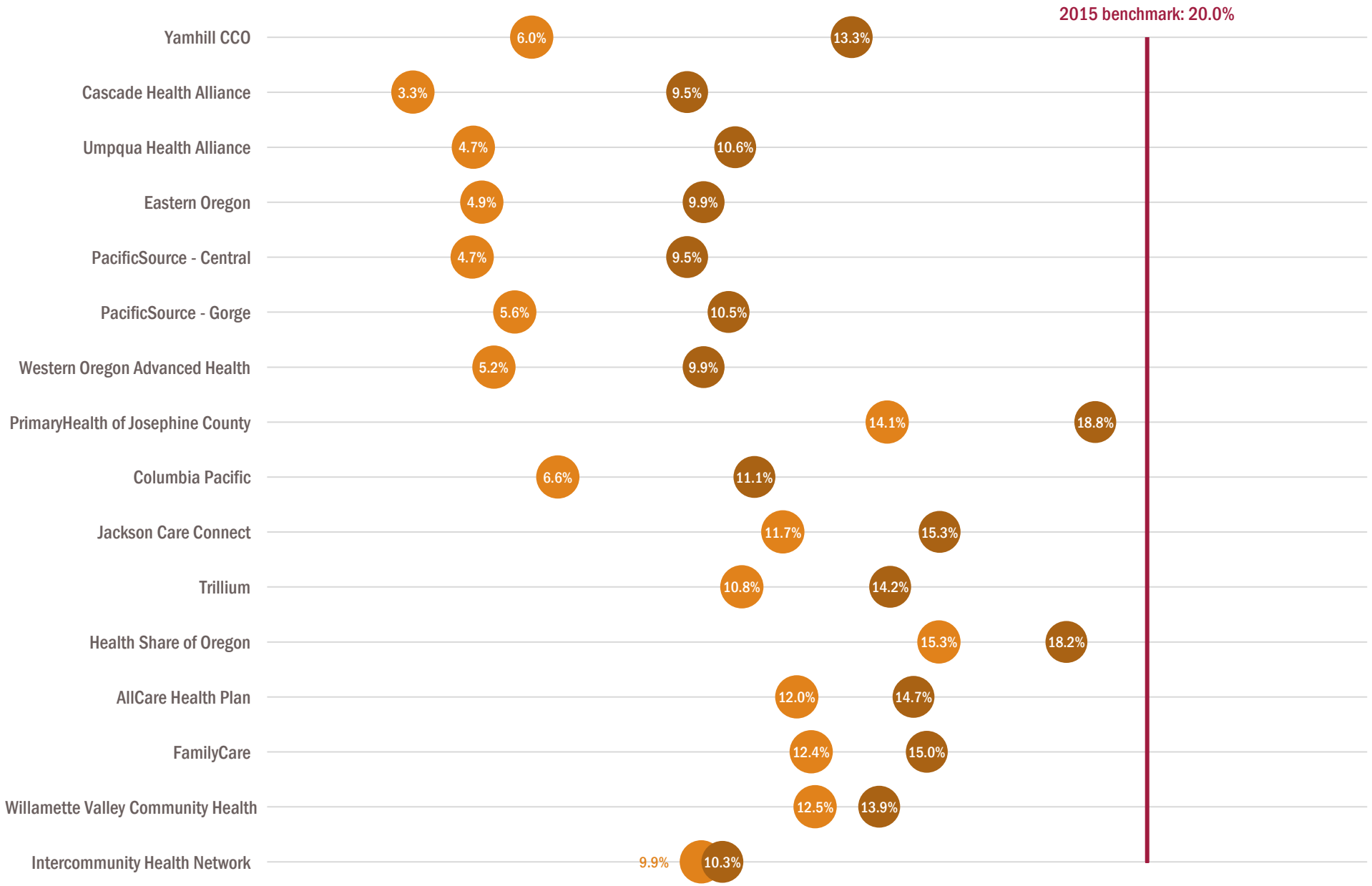



## Asian American children ages 6-14 received dental sealants more frequently than other races and ethnicities in both 2014 & mid-2015.



# DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN - ALL AGES (6-14)

CCOs improved considerably on dental sealants for children (all ages) between 2014 & mid-2015.



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

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

**Measure description:** Percentage of children ages 6-14 who received a dental sealant during the measurement year. Results are stratified by age for reporting and monitoring purposes only; data shown here are for children ages 6-9.

**Purpose:** See page 44.

## mid-2015 data

Statewide change since 2014: **+25%**

Number of CCOs that improved: **15**

**All** racial and ethnic groups experienced improvement.

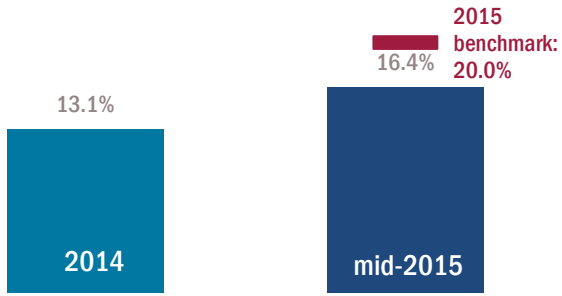
Dental sealants is a new incentive measure beginning in 2015. Results are stratified by age range (6-9 and 10-14) for reporting and monitoring purposes only. Incentive payments are based on all ages combined (see pages 44-45).

See pages 95 and 101 for results stratified by members with- and without disability and mental health diagnoses.

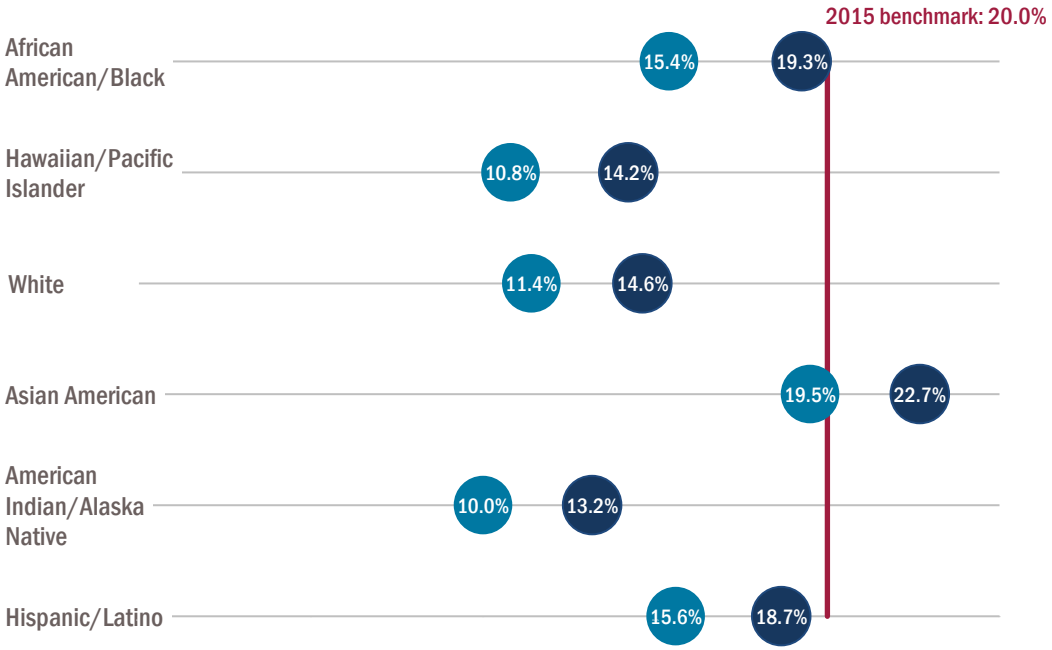
### About these data:

- N=71,826
- Data source: Administrative (billing) claims
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 10.6% of respondents
- Each race category excludes Hispanic/Latino
- 2011 and 2013 results are not available for this measure

### Statewide, the percentage of children ages 6-9 who received dental sealants increased between 2014 and mid-2015.

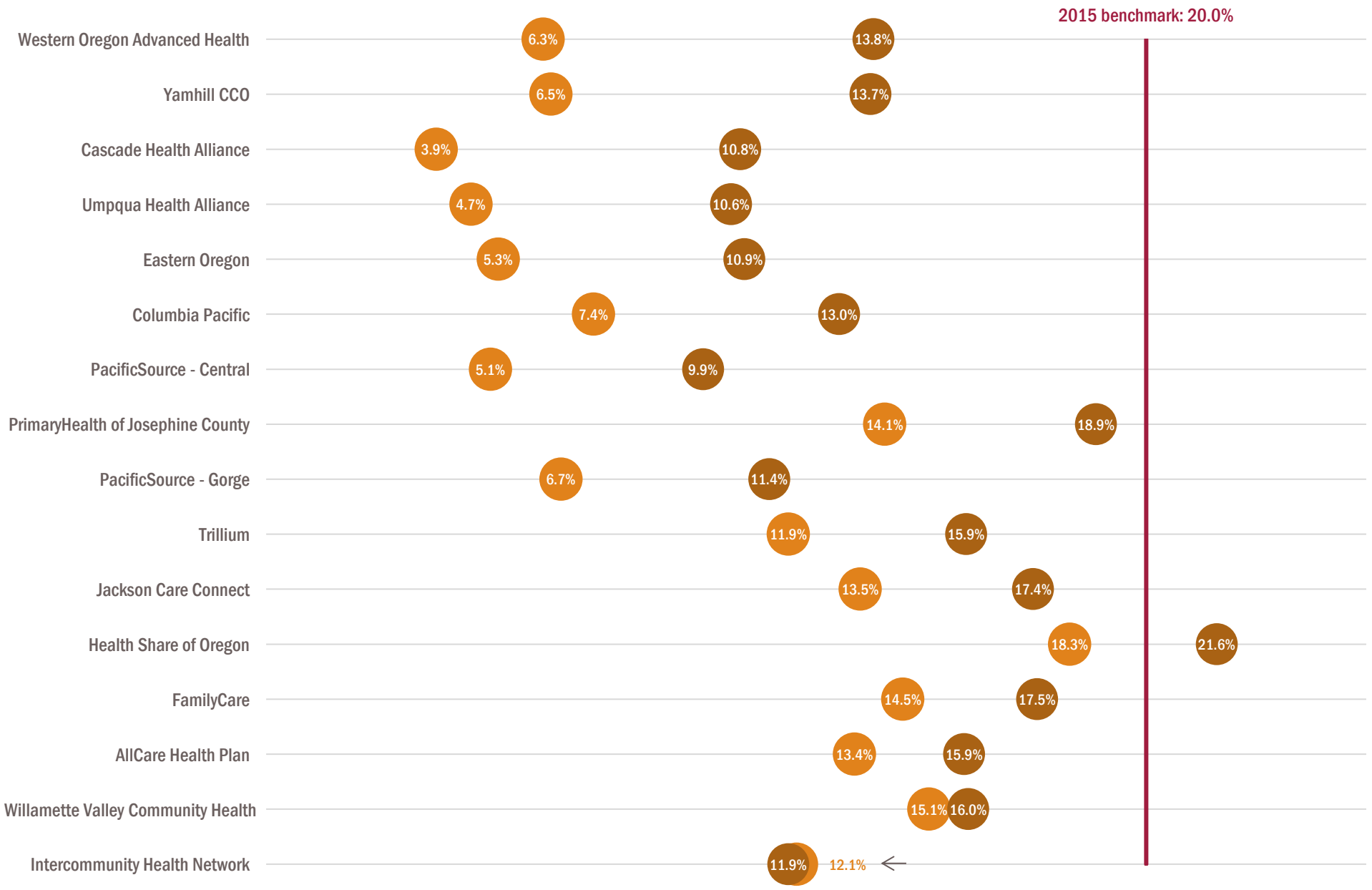



### American Indian / Alaska Native children ages 6-9 received dental sealants less frequently than other races and ethnicities in both 2014 & mid-2015.



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

Overall, CCOs showed considerable improvement on dental sealants for children ages 6-9 between 2014 & mid-2015.



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

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

**Measure description:** Percentage of children ages 6-14 who received a dental sealant during the measurement year. Results are stratitified by age for reporting and monitoring purposes only; data shown here are for children ages 10-14

**Purpose:** See page 44.

## mid-2015 data:

Statewide change since 2014: **+23%**

Number of CCOs that improved: **all 16**

**All** racial and ethnic groups experienced improvement.

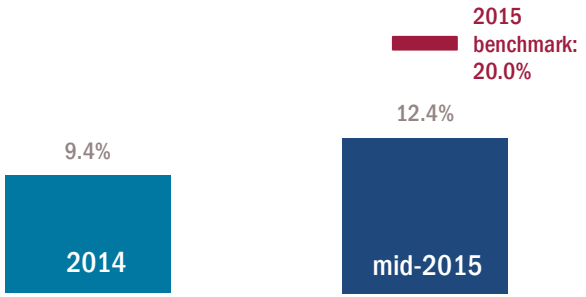
Dental sealants is a new incentive meaure beginning in 2015. Results are stratified by age range (6-9 and 10-14) for reporting and monitoring purposes only. Incentive payments are based on all ages combined (see pages 44-45).

See pages 95 and 101 for results stratified by members with- and without disability and mental health diagnoses.

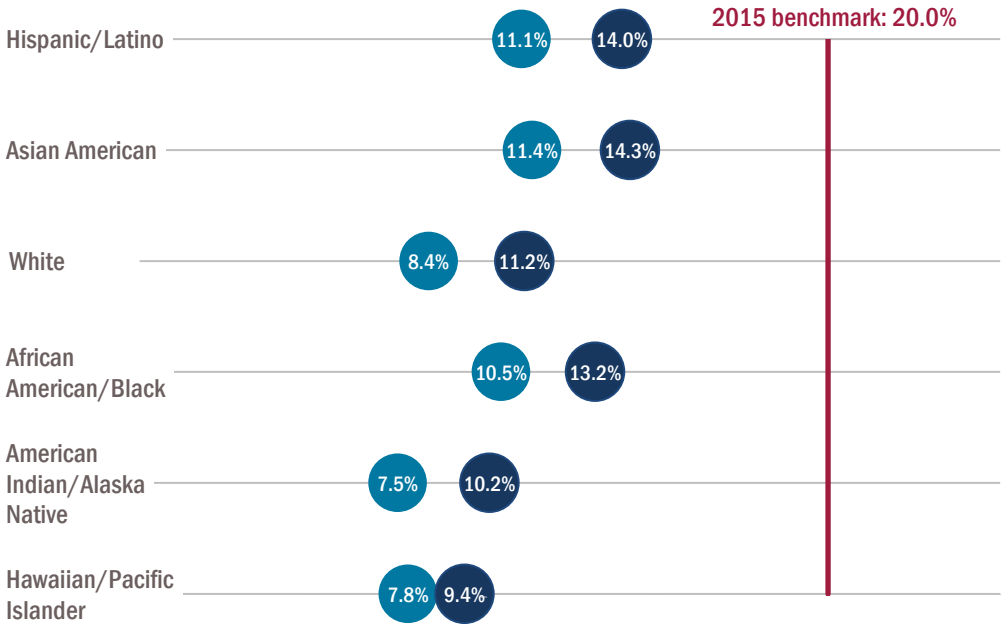
### About these data:

- N = 77,222
- Data source: Administrative (billing) claims
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 10.0% of respondents
- Each race category excludes Hispanic/Latino
- 2011 and 2013 results are not available for this measure

## Statewide, the percentage of children ages 10-14 who received dental sealants has increased.

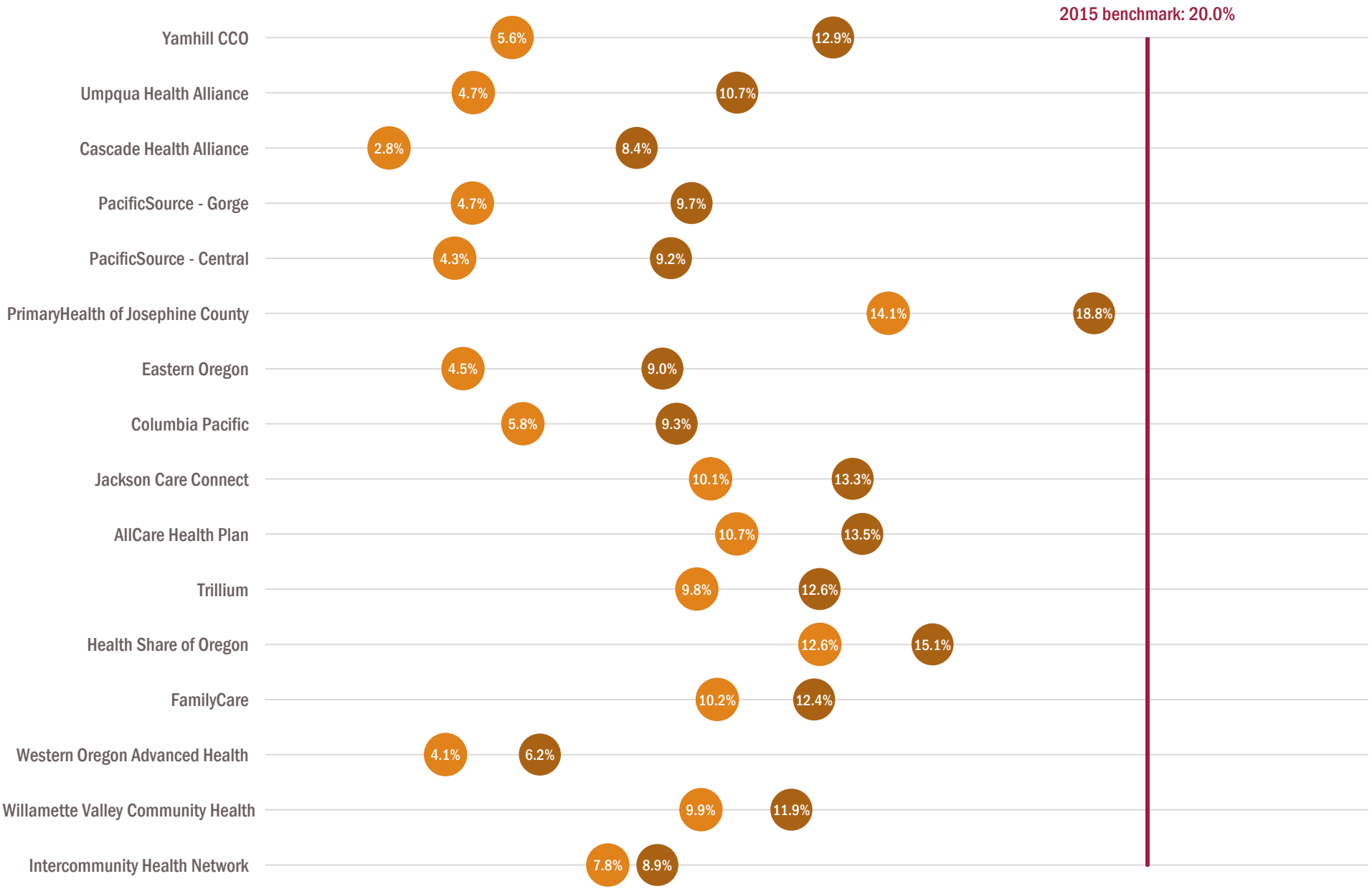



## Hispanic/Latino children ages 10-14 experienced the greatest improvement in dental sealant application between 2014 & mid-2015.



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

All 16 CCOs improved dental sealants for children ages 10-14 between 2014 & mid-2015.



# DEVELOPMENTAL SCREENING IN THE FIRST 36 MONTHS OF LIFE

## Developmental screening in the first 36 months of life

**Measure description:** 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.

**Purpose:** Early childhood screening helps find delays in development as early as possible, which leads to better health outcomes and reduced costs. Early developmental screening provides an opportunity to refer children to the appropriate specialty care before problems worsen. Often, developmental delays are not found until kindergarten or later -- well beyond the time when treatments are most helpful.

## mid-2015 data

Statewide change since 2014: **+16%**

Number of CCOs that improved: **all 16**

**All** racial and ethnic groups experienced improvement.

Developmental screenings have improved each year, and more than doubled since 2011.

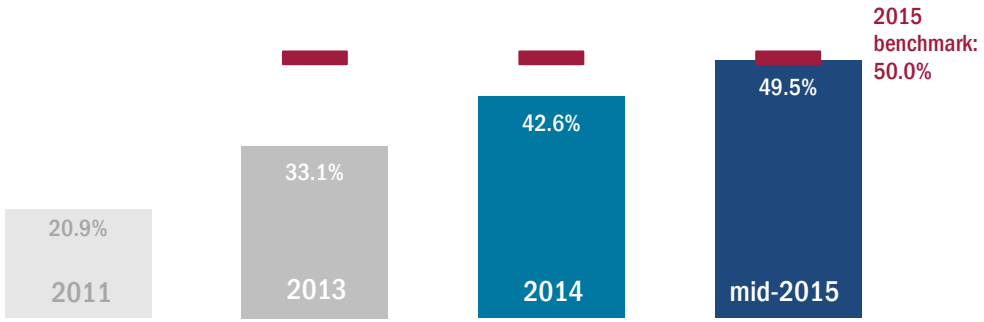
Examples of interventions CCOs have taken to improve developmental screening include provider training, collaborating with early learning hubs, and developing alternate payment methodologies for providers to incentivize increased screening.

See pages 92 and 97 for results stratified by members with- and without disability and mental health diagnoses.

### About these data:

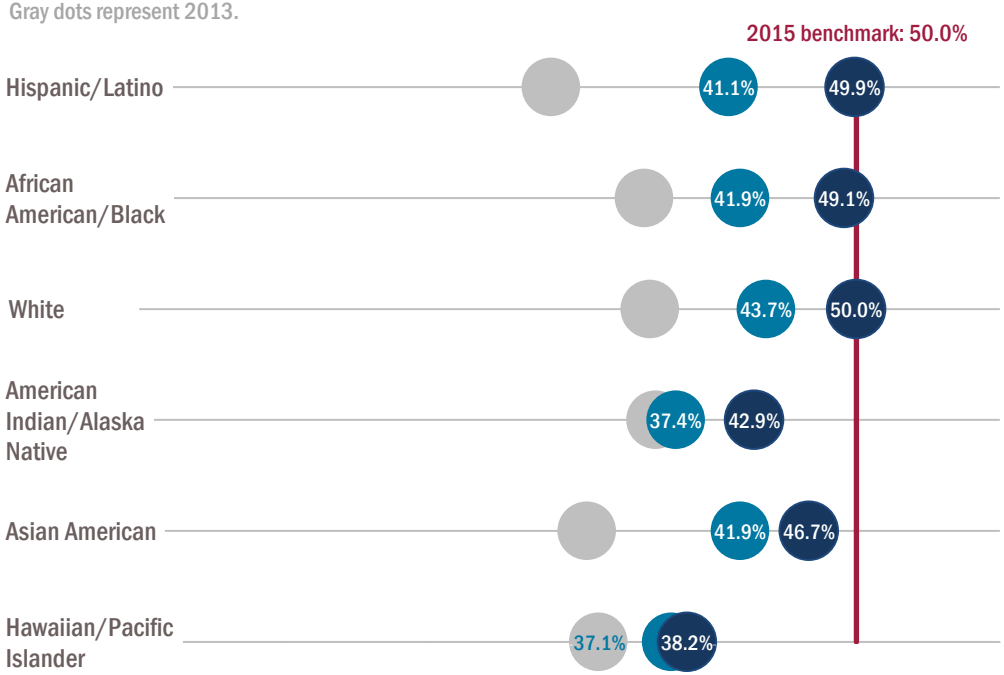
- N= 54,190
- Data source: Administrative (billing) claims
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 11.5% of respondents
- Each race category excludes Hispanic/Latino

## Statewide, developmental screening continues to improve and is near the benchmark as of mid-2015.




## Developmental screening improved for all races and ethnicities between 2014 & mid-2015.

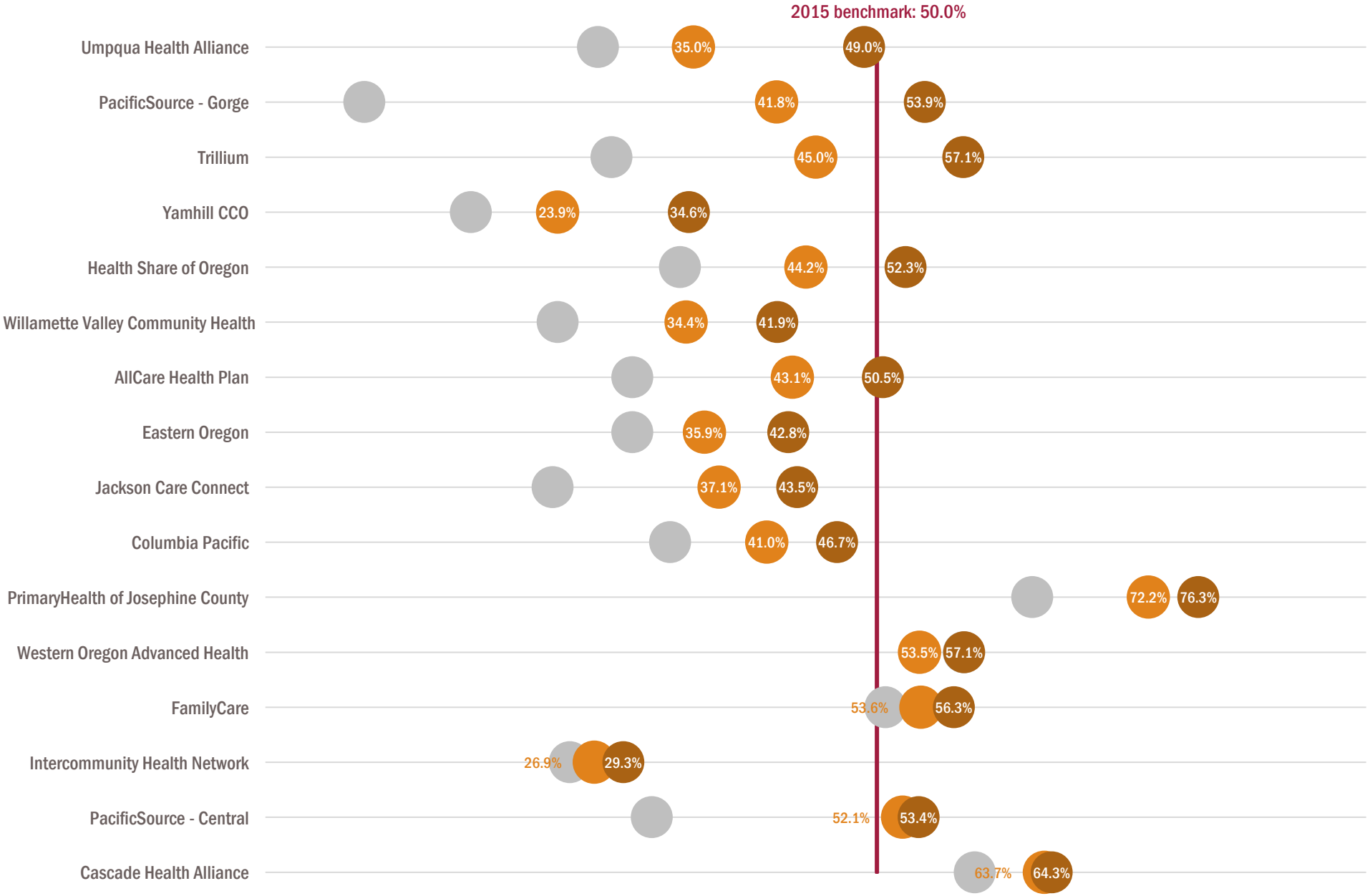
Gray dots represent 2013.



# DEVELOPMENTAL SCREENING IN THE FIRST 36 MONTHS OF LIFE

## All 16 CCOs improved developmental screenings between 2014 & mid-2015, and nine exceeded the benchmark.

Gray dots represent 2013.



# 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)

**Measure description:** Percentage of adult 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.

**Purpose:** Almost 50 percent of pregnancies in Oregon are unintended. Among women with an unintended pregnancy, 43 percent reported using contraception, but they were using it incorrectly or inconsistently.

## mid-2015 data

Statewide change since 2014: **+2%**

Number of CCOs that improved: **12**

Racial and ethnic groups experiencing improvement:

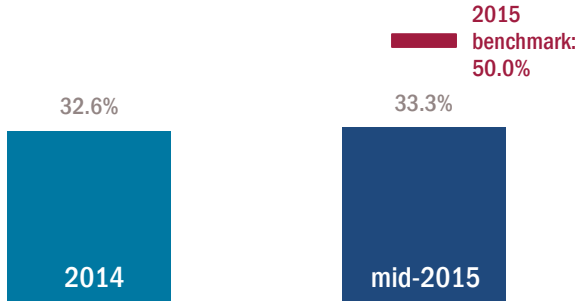
- ✓ Hawaiian / Pacific Islander
- ✓ Asian American
- ✓ Hispanic / Latino
- ✓ African American / Black
- ✓ White

Effective contraceptive use among women at risk of unintended pregnancy is a new incentive meaure beginning in 2015. Results are stratified by adolescents (ages 15-17), adults (ages 18-50), and all ages combined. Incentive payments are based on adults only (see pages 56-57).

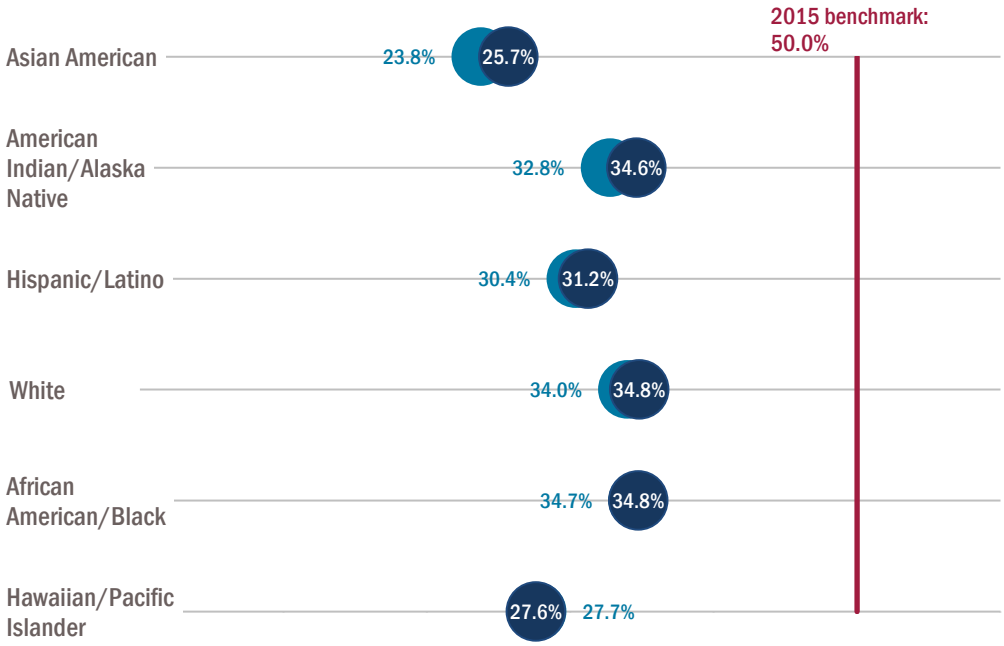
### About these data:

- N=151,996
- Data source: administrative (billing) claims
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 12.5% of respondents.
- Each race category excludes Hispanic/Latino
- 2011 and 2013 results are not available for this measure

## Statewide, effective contraceptive use among women at risk of unintended pregnancy remained fairly steady between 2014 and mid-2015.

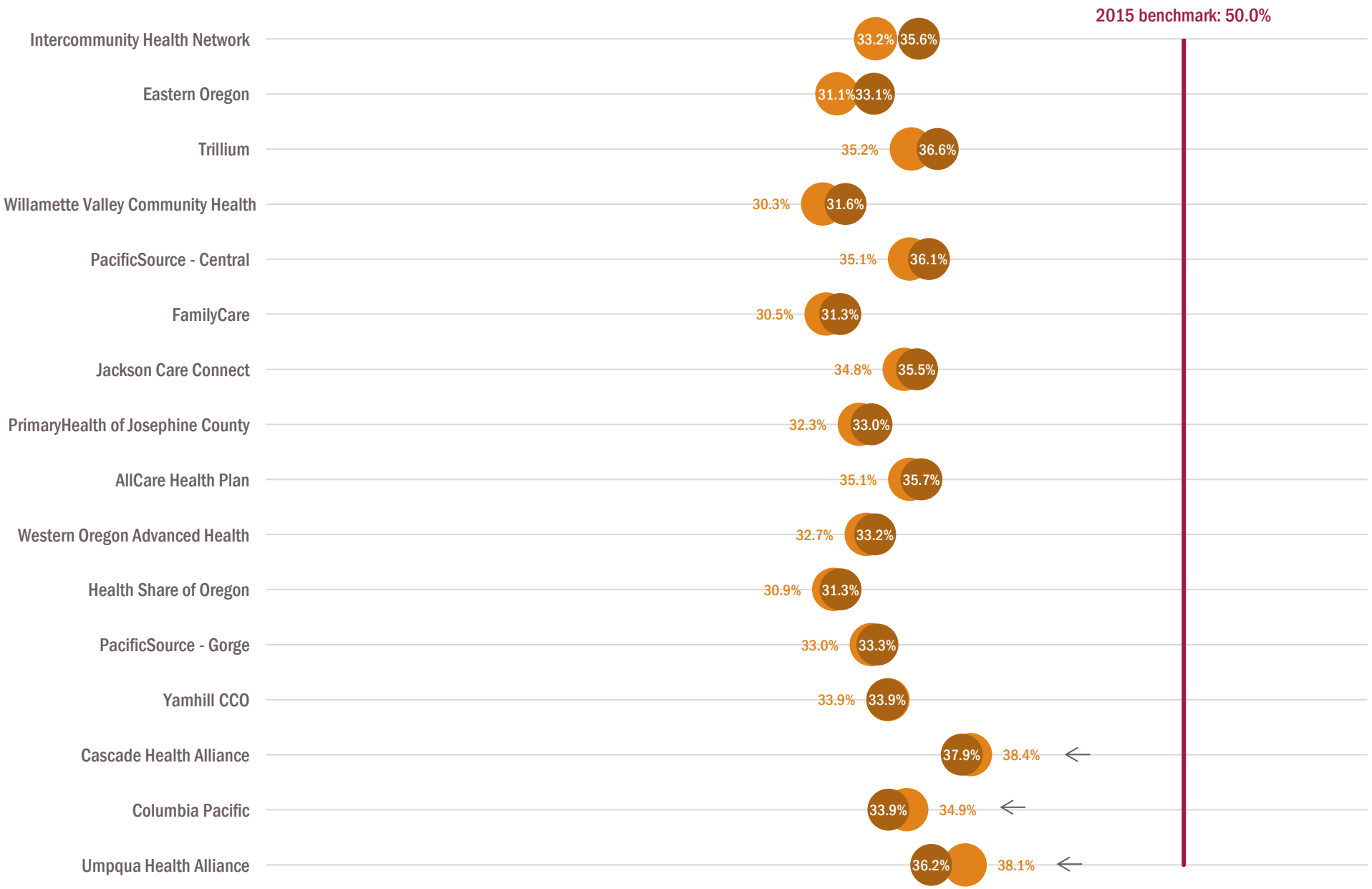



## Effective contraceptive use increased across all races and ethnicities between 2014 & mid-2015.



# EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY - ALL AGES (15-50)

The percentage of women at risk of unintended pregnancy who used effective contraceptives was similar across CCOs in 2014 & mid-2015.



# 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)

**Measure description:** 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.

**Purpose:** See page 52.

## mid-2015 data

Statewide change since 2014: **+3%**

Number of CCOs that improved: **11**

Racial and ethnic groups experiencing improvement:

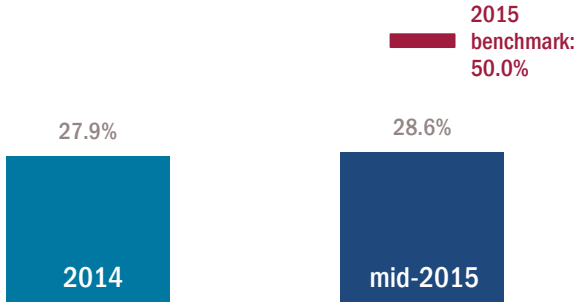
- ✓ White
- ✓ American Indian / Alaska Native
- ✓ Hispanic / Latino
- ✓ African American / Black

Adolescent results are for reporting and monitoring purposes only. Incentive payments are based on adults only (see pages 56-57).

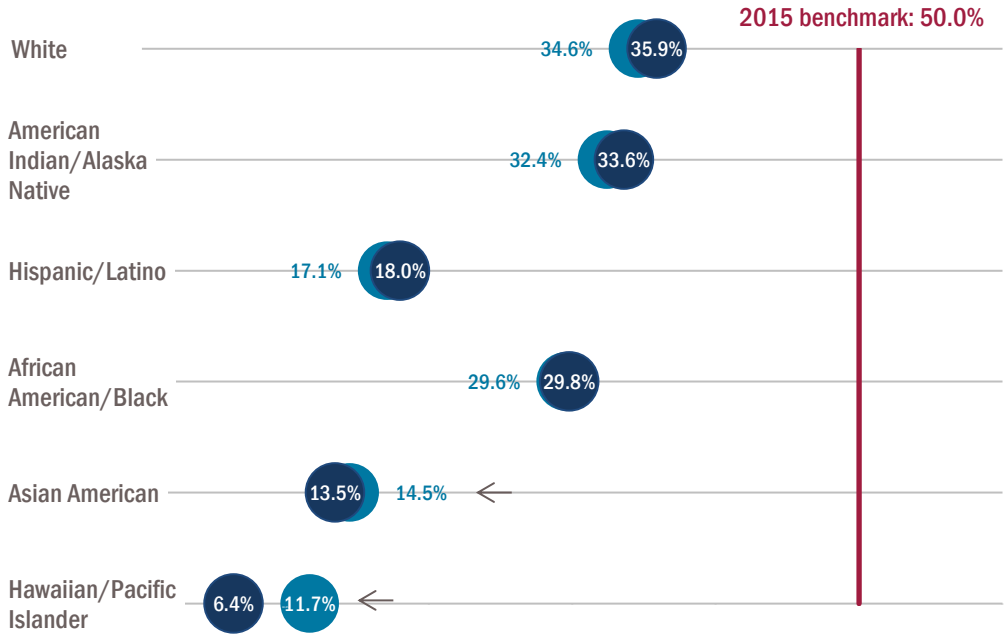
### About these data:

- N=20,174
- Data source: Administrative (billing) claims
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 12.0% of respondents
- Each race category excludes Hispanic/Latino
- 2011 and 2013 results are not available for this measure

## Effective contraceptive use among adolescents (ages 15-17) at risk of unintended pregnancy, statewide.

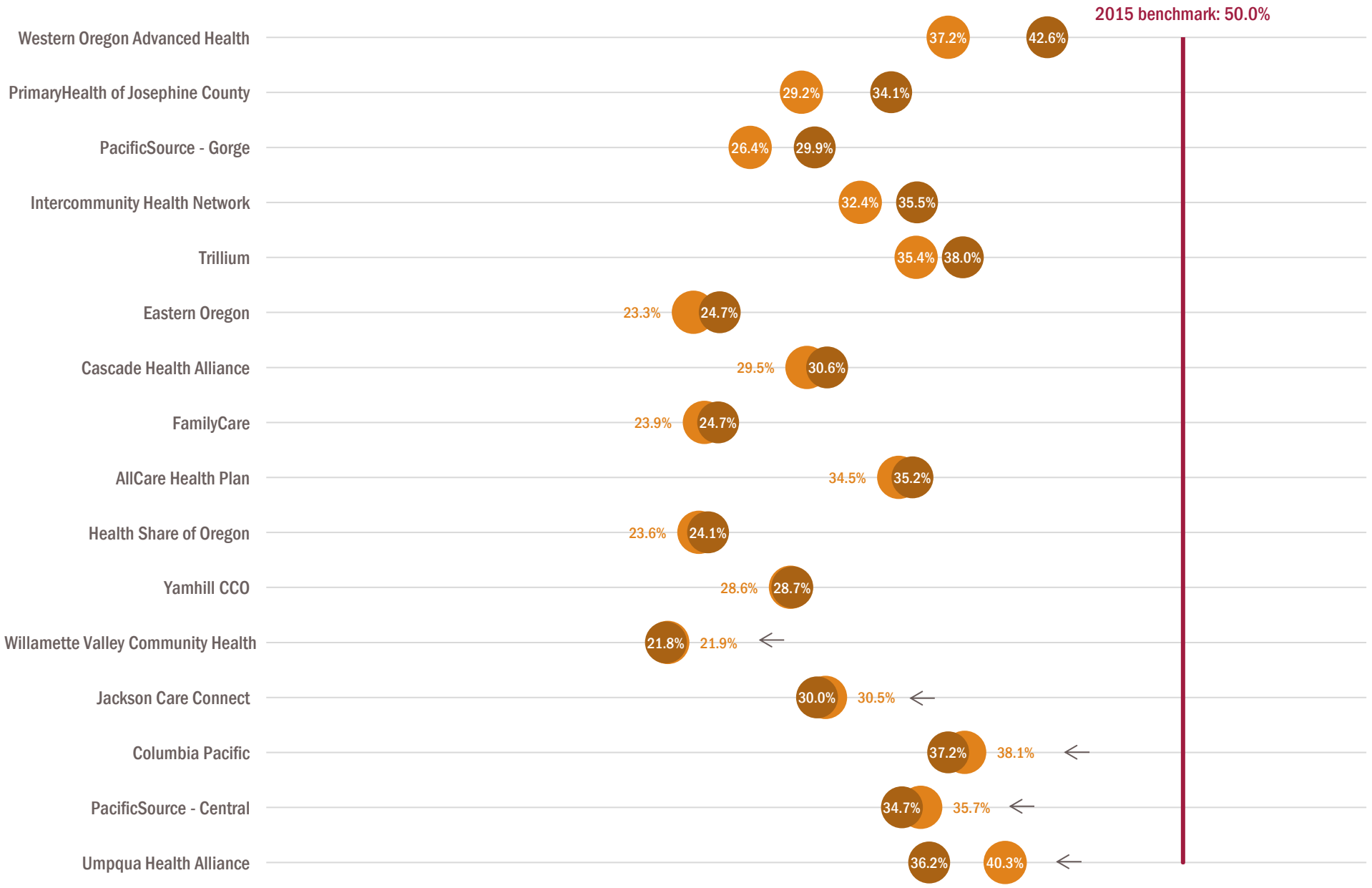



## Fewer Hawaiian / Pacific Islander adolescents used effective contraceptives in both 2014 & mid-2015.



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

Effective contraceptive use among adolescents varied among CCOs in 2014 & mid-2015.



# 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)

**Measure description:** Percentage of adolescent (ages 15-17) and adult (15-17) women 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.

**Purpose:** See page 52.

## mid-2015 data

Statewide change since 2014: **+2%**

Number of CCOs that improved: **9**

Racial and ethnic groups experiencing improvement:

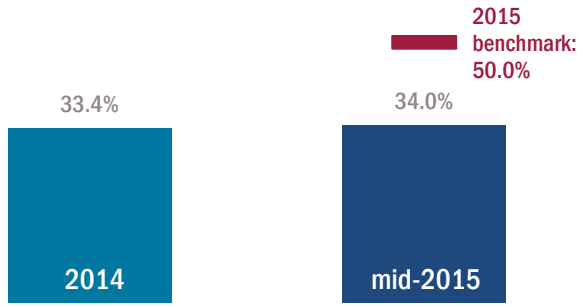
- ✓ Asian American
- ✓ American Indian / Alaska Native
- ✓ Hawaiian / Pacific Islander
- ✓ White
- ✓ Hispanic / Latino

Effective contraceptive use among women at risk of unintended pregnancy is a new incentive measure beginning in 2015.

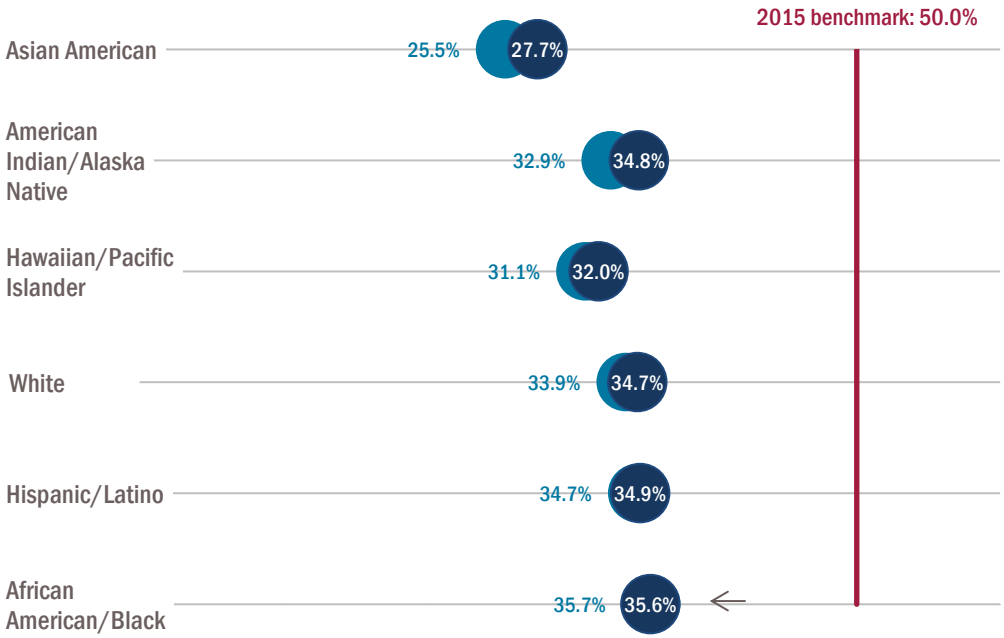
### About these data:

- N=131,822
- Data source: Administrative (billing) claims
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 12.6% of respondents
- Each race category excludes Hispanic/Latino
- 2011 and 2013 results are not available for this measure

## Statewide, effective contraceptive use among adults remained fairly steady between 2014 and mid-2015.

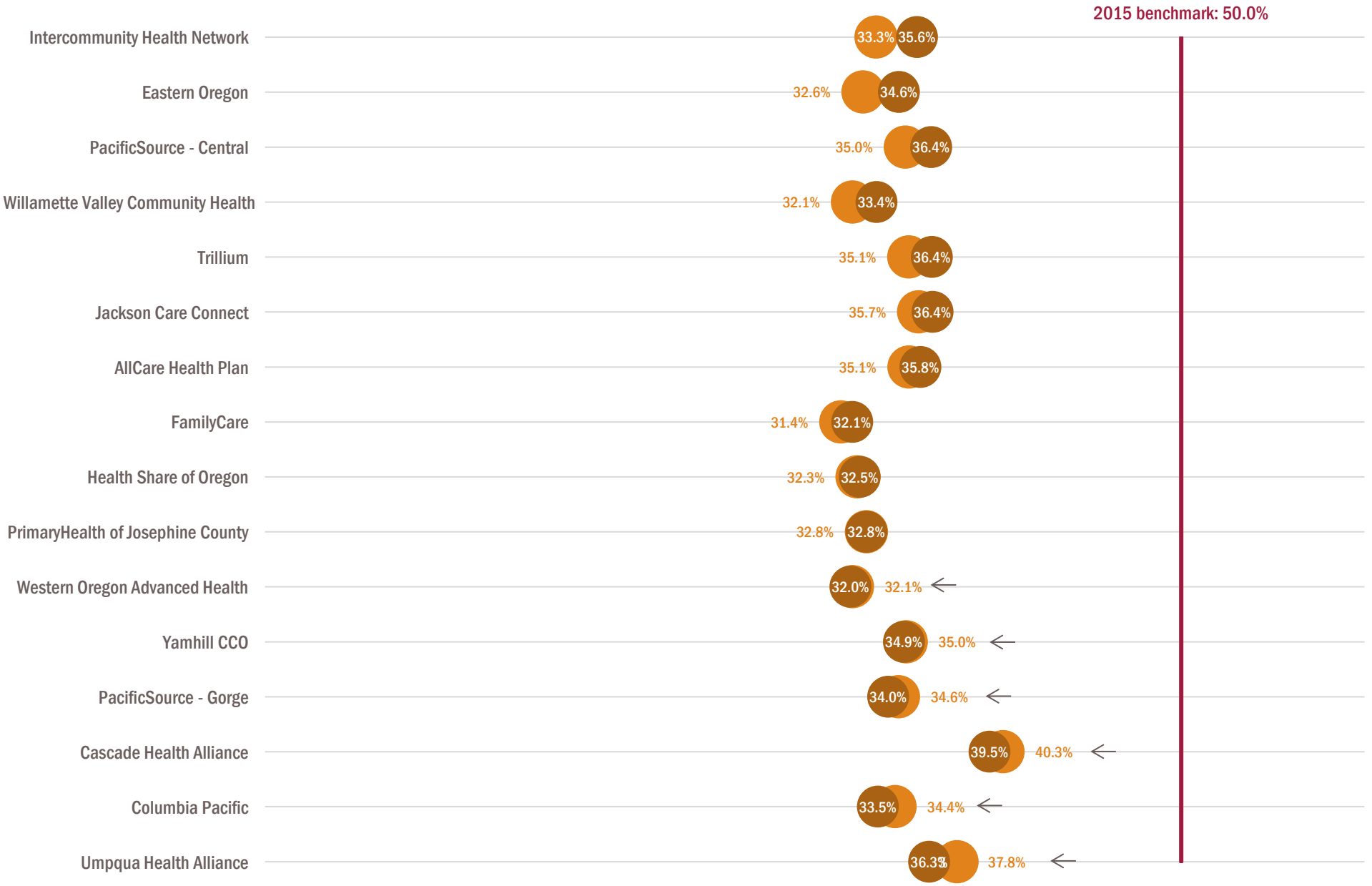



## Effective contraceptive use increased among Asian Americans adults between 2014 & mid-2015, but remains lower than other groups.



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

Effective contraceptive among adults age 18-50 in 2014 & mid-2015, by CCO.



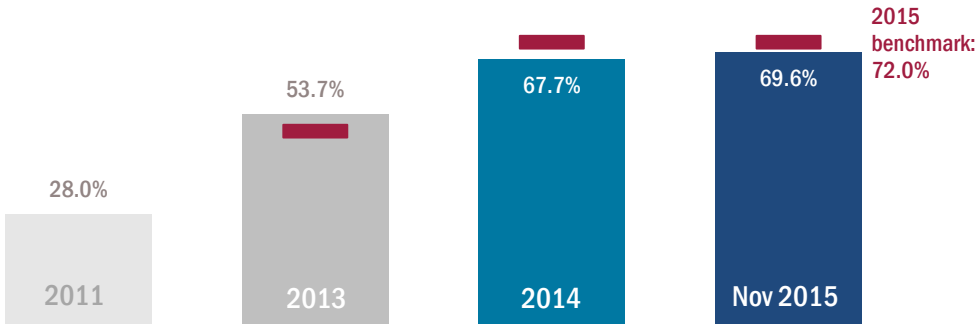
# ELECTRONIC HEALTH RECORD ADOPTION

## Electronic Health Record Adoption

**Measure description:** 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.

**Purpose:** Electronic health records have the potential to improve coordination of care, increase patient safety, reduce medical error, and contain health care costs by reducing costly, duplicative tests. Physicians who use electronic health records use information available to make the most appropriate clinical decisions.

## Statewide, electronic health record adoption continues to improve.




## November 2015 data

Statewide change since 2014: **+3%**

Number of CCOs that improved: **8**

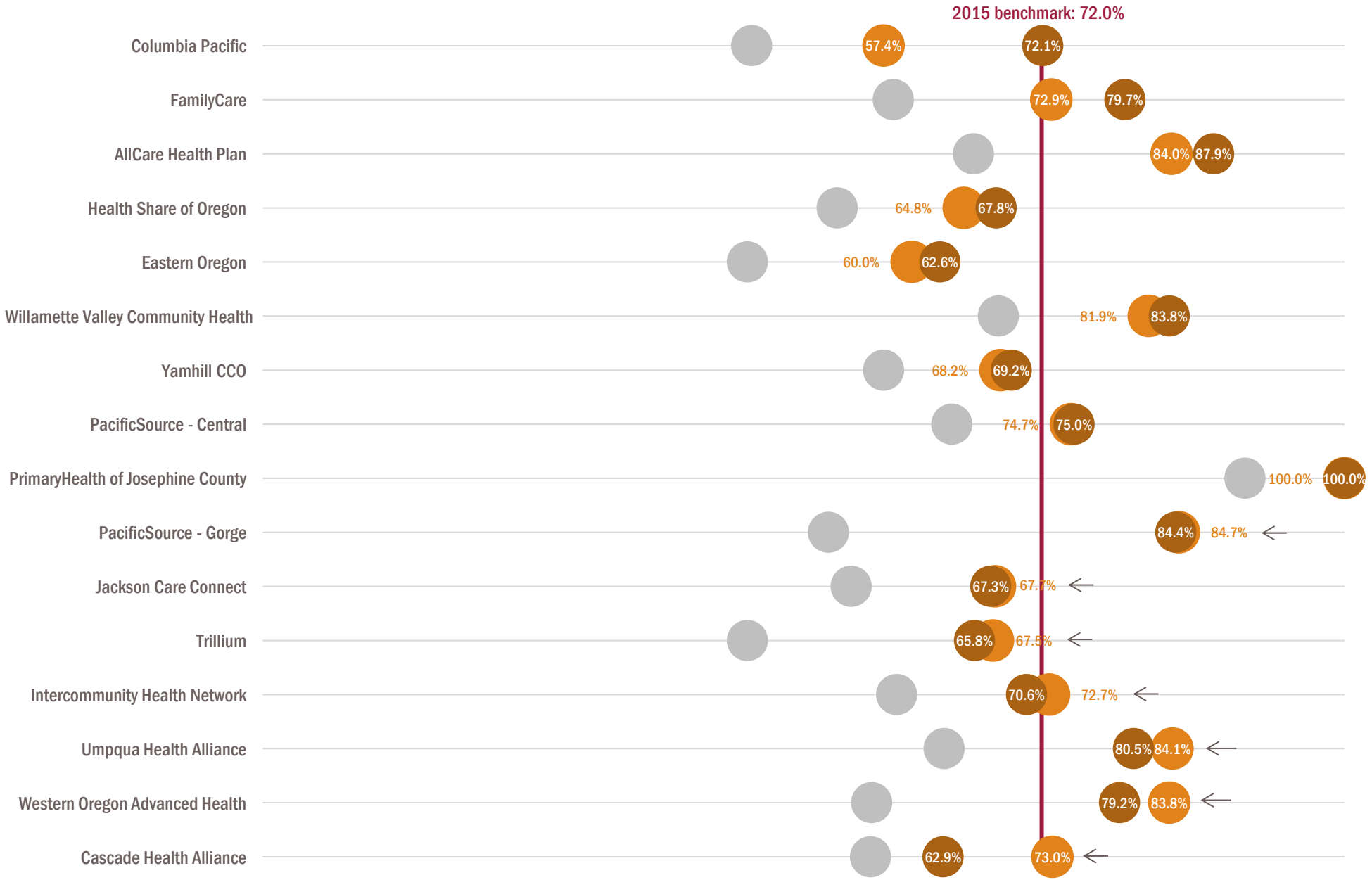
### About these data:

- N=9,136 (total number of eligible providers).
- Data source: State and federal EHR incentive programs
- Benchmark source: Metrics and Scoring Committee consensus, based on highest performing CCO in July 2013.
- Race and ethnicity data are not available for this measure.

# ELECTRONIC HEALTH RECORD ADOPTION

## Electronic health record adoption between 2014 & mid-2015, by CCO.

Gray dots represent 2013.



# FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

## Follow-up after hospitalization for mental illness

**Measure descripton:** 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 the hospital for mental illness.

**Purpose:** Follow-up care is important to help members make progress and feel better after being in the hospital for mental illness. Additionally, research shows that follow-up care helps keep members from returning to the hospital, providing an important opportunity to reduce health care costs and improve health.

## mid-2015 data

Statewide change since 2014: **+3%**

Number of CCOs that improved: **8** of 13 reported

Racial and ethnic groups experiencing improvement:

- ✓ African American / Black
- ✓ Asian American
- ✓ White

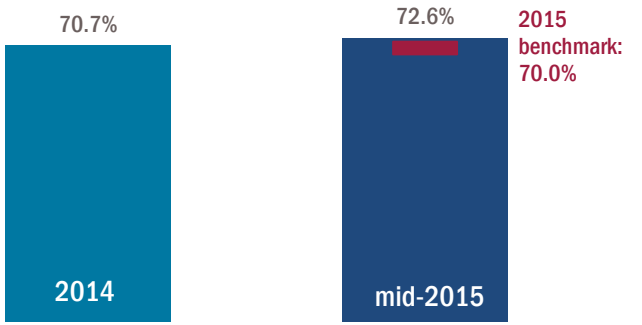
Beginning in 2015, follow-up visits on the day of discharge are included in this measure.

See pages 93 and 99 for results stratified by members with- and without disability and mental health diagnoses.

### About these data:

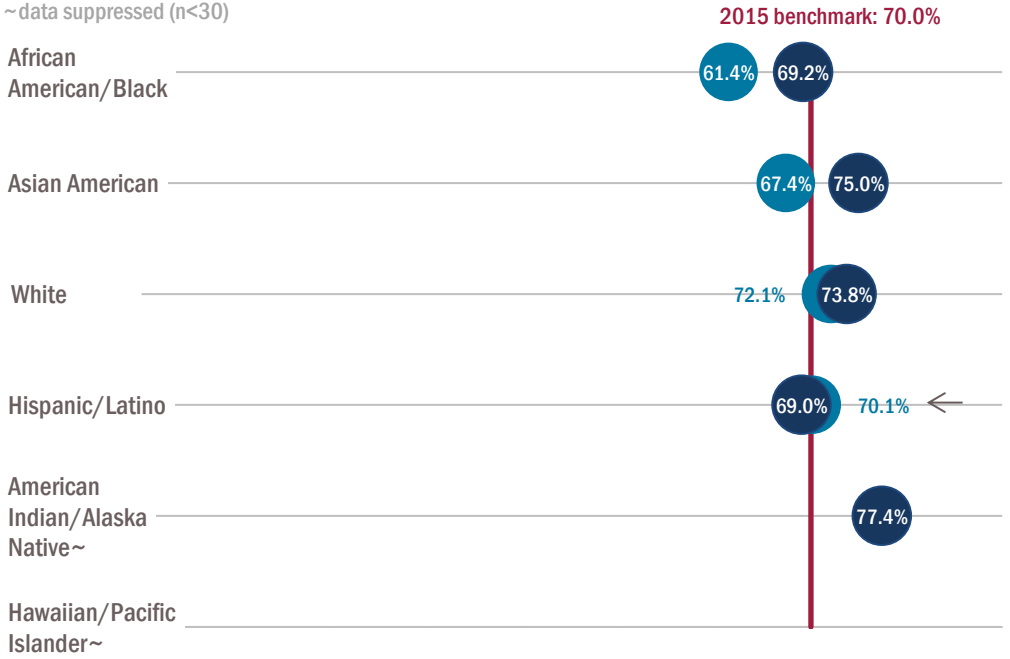
- N = 3,043
- Data source: Administrative (billing) claims
- Benchmark source: national Medicaid 90th percentile
- Race and ethnicity data missing for 7.5% of respondents
- Each race category excludes Hispanic/Latino
- 2014 results have been updated to include same-day follow-up and thus will differ from previously published reports. Prior years are not comparable.

## Statewide, follow-up after hospitalization for mental illness has increased slightly, and exceeds the benchmark.




## African American/Black and Asian American members experienced the greatest improvement in follow-up care between 2014 & mid-2015.

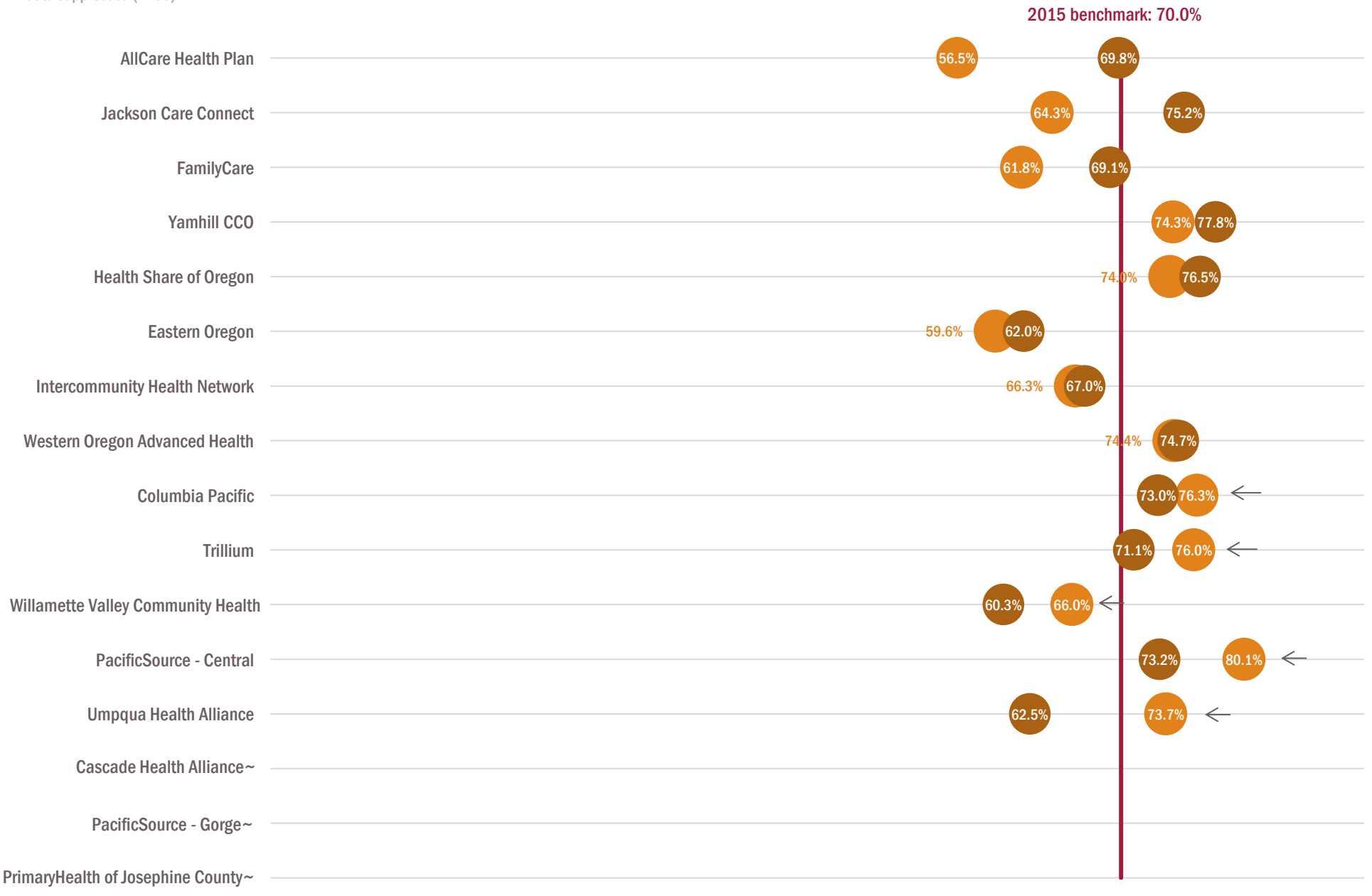
Grey dots represent 2013.
~data suppressed (n<30)



# FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

CCO performance on follow-up after hospitalization was mixed between 2014 & mid-2015.

~ data suppressed (n<30)



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

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

**Measure description:** Percentage of children (ages 6-12) who had at least one follow-up visit with a provider during the 30 days after receiving a new prescription for attention deficit hyperactivity disorder (ADHD).

**Purpose:** Children with attention deficit hyperactivity disorder can be greatly helped by ADHD medication. One critical component of care is that children have follow-up visits once they are on medication. After a child receives ADHD medication, a primary care provider should continue to assess learning and behavior and help manage the condition.

## mid-2015 data

Statewide change since 2014: **+3%**

Number of CCOs that improved: **13** of 15 reported

Racial and ethnic groups experiencing improvement:

- ✓ White
- ✓ African American / Black

This measure was retired as a CCO incentive measure beginning in 2015, although Oregon will continue monitoring and reporting on it.

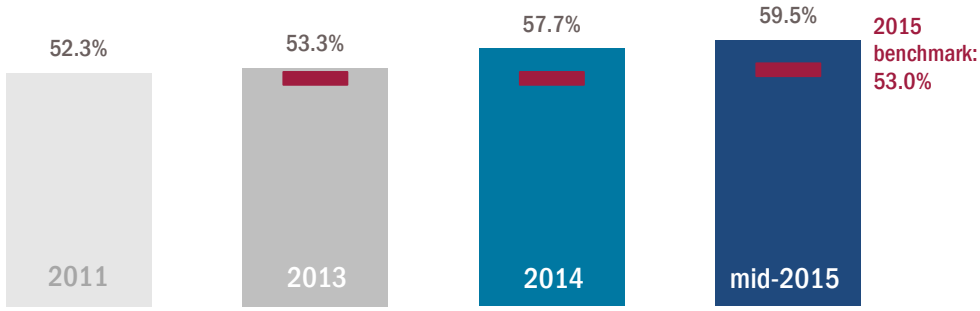
See pages 96 and 102 for results stratified by members with- and without disability and mental health diagnoses.

### About these data:

- N=2,380
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 90th percentile
- Race and ethnicity data missing for 9.5% of respondents
- Each race category excludes Hispanic/Latno

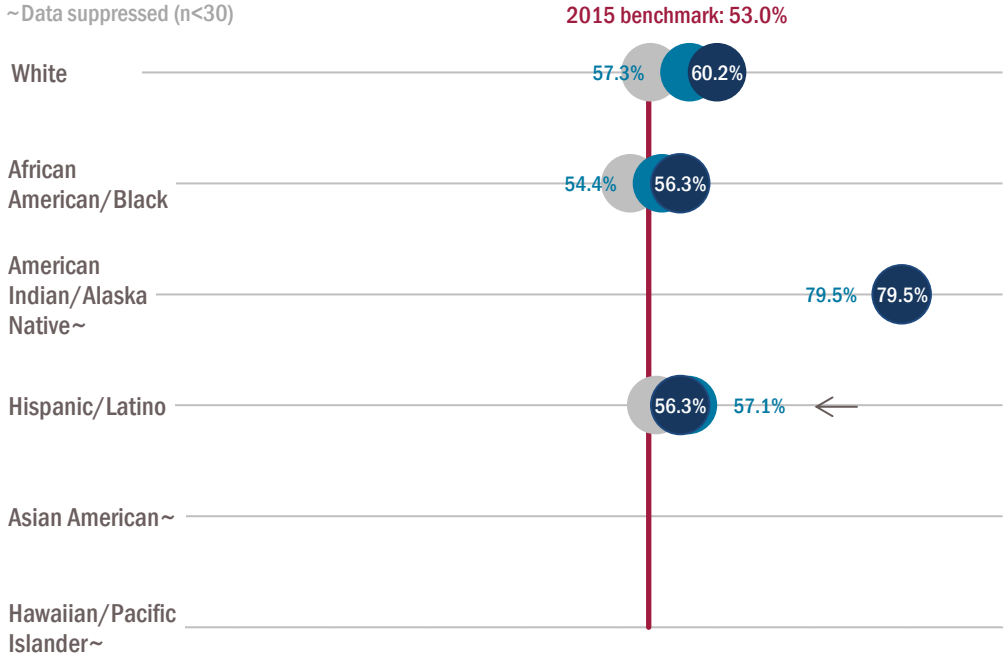
## Statewide, initiation of follow-up care for children prescribed ADHD medication continues to improve.

Gray dots represent 2013.




## Follow-up for ADHD medication was above the benchmark for all reportable races and ethnicities in both 2014 & mid-2015.

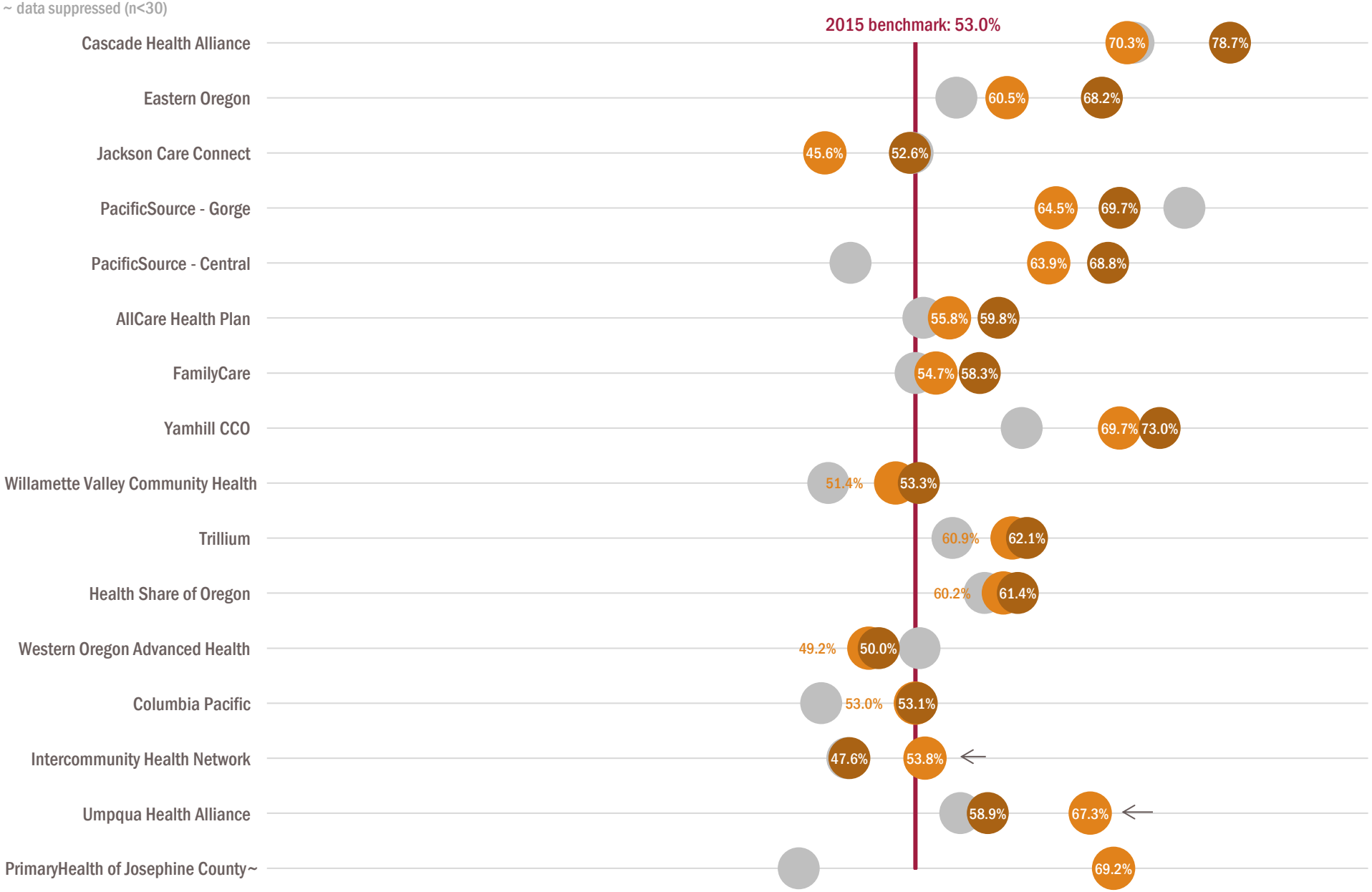
Gray dots represent 2013.
~Data suppressed (n<30)



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

## Overall, CCOs performed well on follow-up care for children presribed ADHD medication in 2014 & mid-2015.

Gray dots represent 2013.
~ data suppressed (n<30)



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

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

**Measure description:** 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 62-63).

**Purpose:** Children with attention deficit hyperactivity disorder can be greatly helped by ADHD medication. One critical component of care is that children have follow-up visits once they are on the medication. After a child receives ADHD medication, a primary care provider should continue to assess learning and behavior and help manage the condition.

## mid-2015 data

Statewide change since 2014: **+12%**

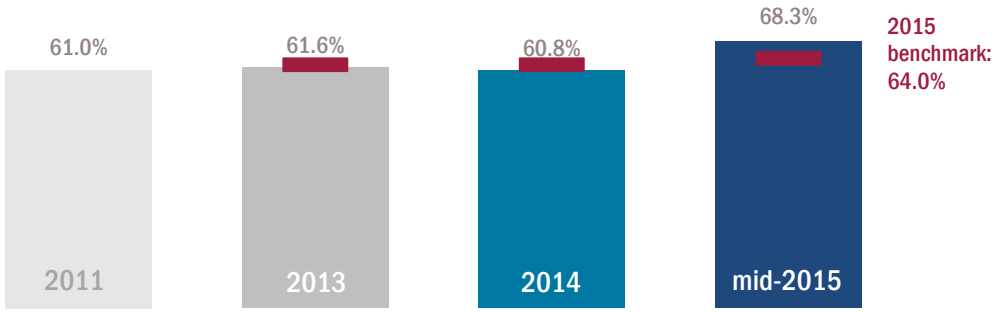
Racial and ethnic groups experiencing improvement:

- ✓ Hispanic / Latino
- ✓ White

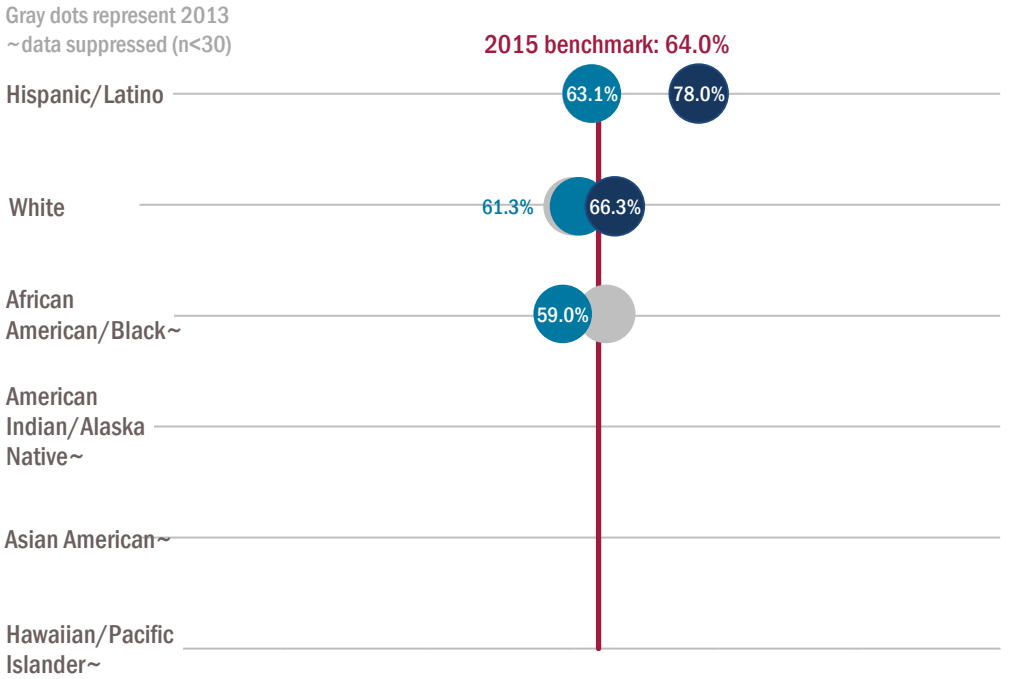
### About these data:

- N=856
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 90th percentile
- Race and ethnicity data missing for 11.3% of respondents
- Each race category excludes Hispanic/Latino
- 2011-2014 results are not available for this measure by CCO

## Statewide, ongoing follow-up care for children prescribed ADHD medication met the benchmark for the first time in mid-2015.

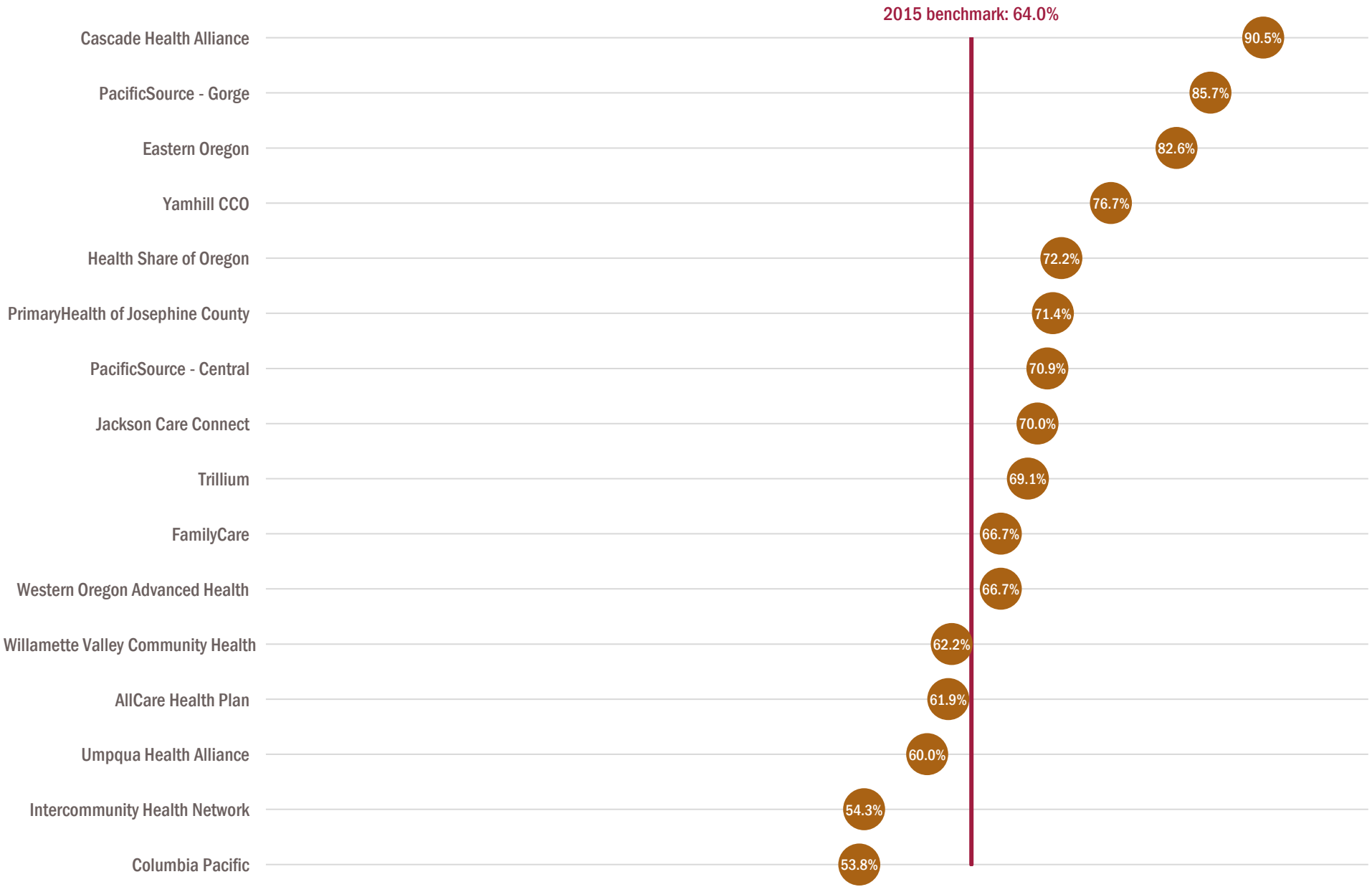



## Ongoing follow-up care for children prescribed ADHD medication between 2014 & mid-2015, by race and ethnicity.



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

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



# IMMUNIZATION FOR ADOLESCENTS

## Immunization for adolescents

**Measure description:** Percentage of adolescents who received recommended vaccines (Meningococcal and Tdap/TD) before their 13th birthday.

**Purpose:** Like young children, adolescents also benefit from immunizations. Vaccines are a safe, easy and cost-effective way to prevent serious disease. Vaccines are also cost-effective tools that help prevent the spread of serious and sometimes fatal diseases.

## mid-2015 data

Statewide change since 2014: **+22%**

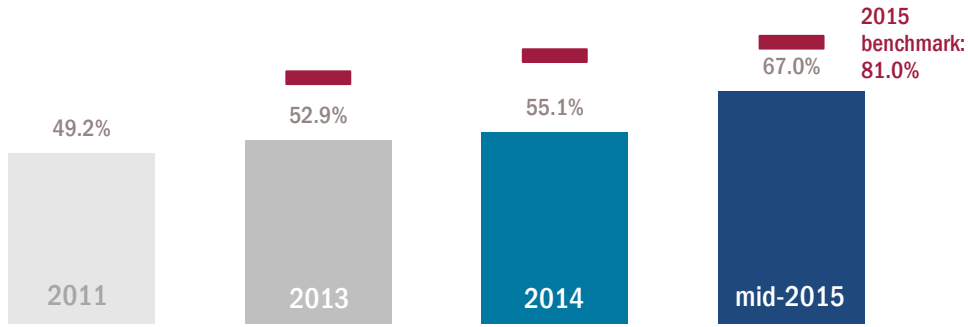
Number of CCOs that improved: **all 16**

**All** racial and ethnic groups experienced improvement.

### About these data:

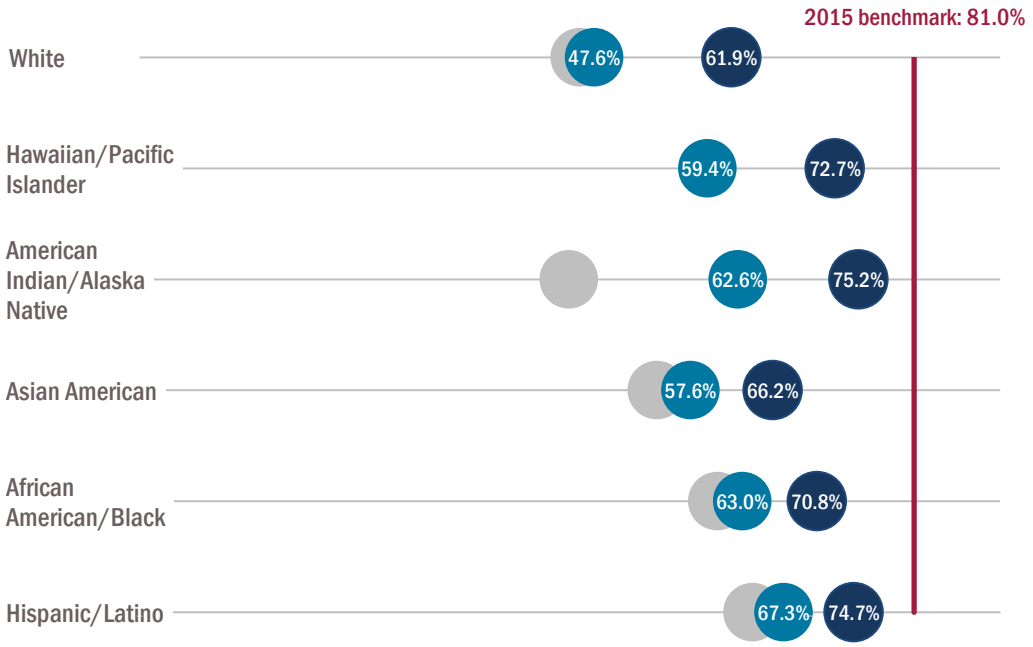
- N=12,305
- Data source: Administrative (billing) claims and ALERT Immunization Information System
- Benchmark source: 2014 national Medicaid 75th percentile
- Race and ethnicity data missing for 10.3% of respondents
- Each race category excludes Hispanic/Latino

## Statewide, the percentage of adolescents receiving immunizations has increased.




## Adolescent immunizations between 2014 & mid-2015, by race and ethnicity.

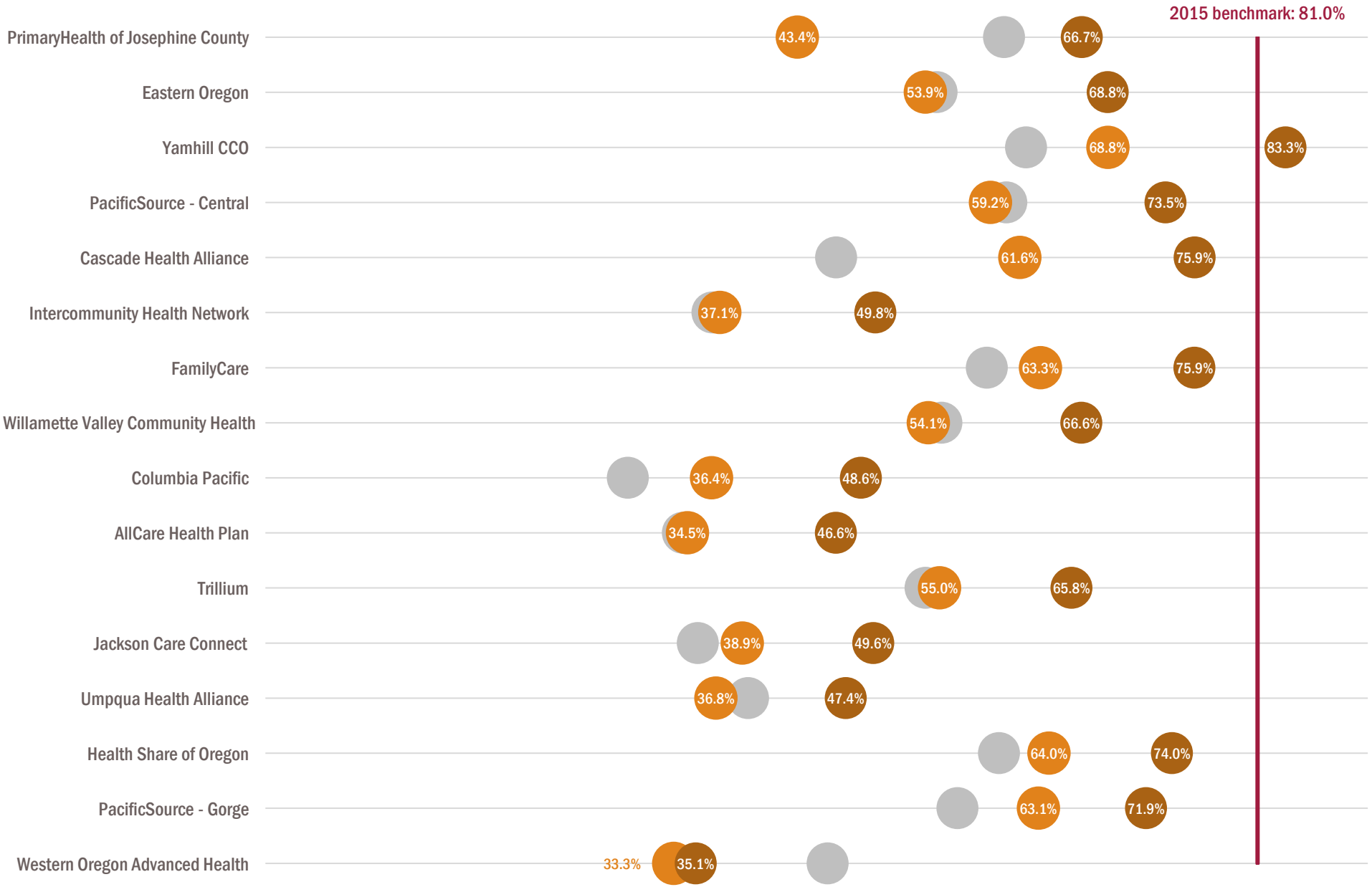
Gray dots represent 2013.



# IMMUNIZATION FOR ADOLESCENTS

## Immunizations for adolescents increased in all CCOs between 2014 & mid-2015.

Gray dots represent 2013.



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

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

**Measure description:** 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.

**Purpose:** There are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition.

Deliberate efforts to reach those with alcohol or other drug dependence and keep them engaged in treatment can improve health outcomes and save on health care costs.

## mid-2015 data

Statewide change since 2014: **0%**

Number of CCOs that improved: **7**

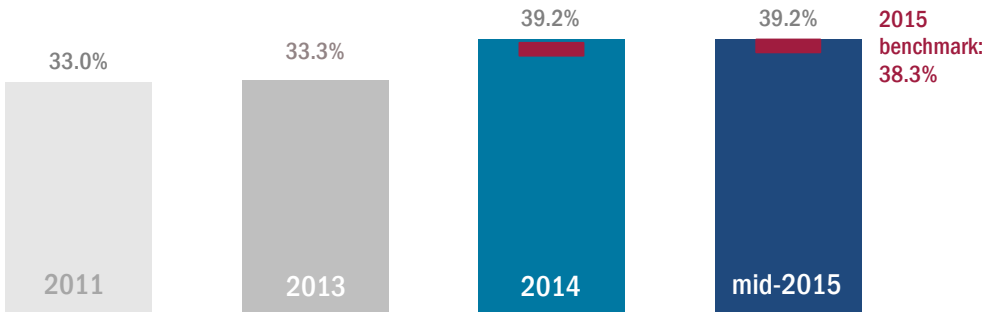
Racial and ethnic groups experiencing improvement:

- ✓ American Indian / Alaska Native
- ✓ African American / Black
- ✓ White

### About these data:

- N=15,806
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid median
- Race and ethnicity data missing for 10.4% of respondents
- Each race category excludes Hispanic/Latino

## Statewide, initiation of treatment for members diagnosed with alcohol or other drug dependence remains above the benchmark.




## Initiation of treatment improved among American Indian / Alaska Native members between 2014 & mid-2015, but remains lower than other groups.

Gray dots represent 2013
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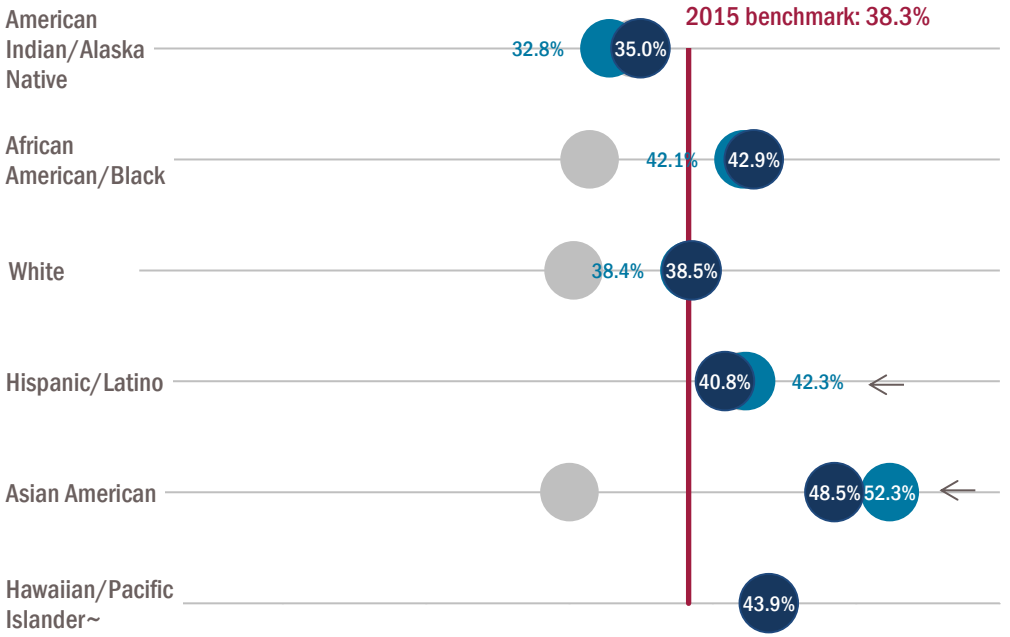
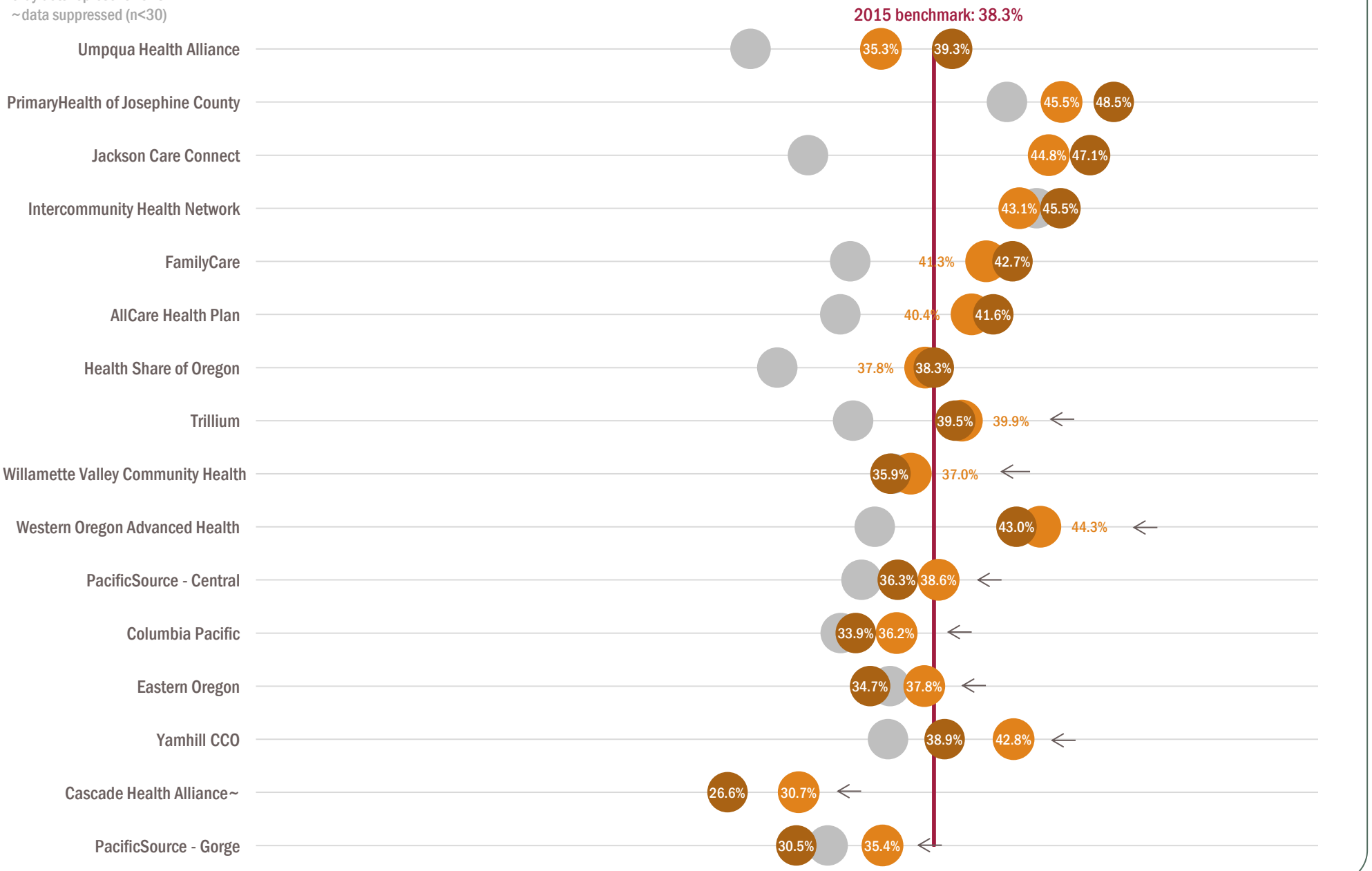


# INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (INITIATION PHASE)

## Initiation of alcohol or other drug treatment between 2014 & mid-2015, by CCO.

Gray dots represent 2013
~data suppressed (n<30)



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

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

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

**Purpose:** Many individuals with alcohol and other drug disorders leave treatment prematurely, even though individuals who remain in treatment longer have better outcomes. Ongoing engagement is an important step between the first visit and completing a full treatment. Deliberate efforts to reach those with alcohol or other drug dependence and keep them engaged in treatment can improve health outcomes and save on health care costs.

## mid-2015 data

Statewide change since 2014: **-7%**

Number of CCOs that improved: **4**

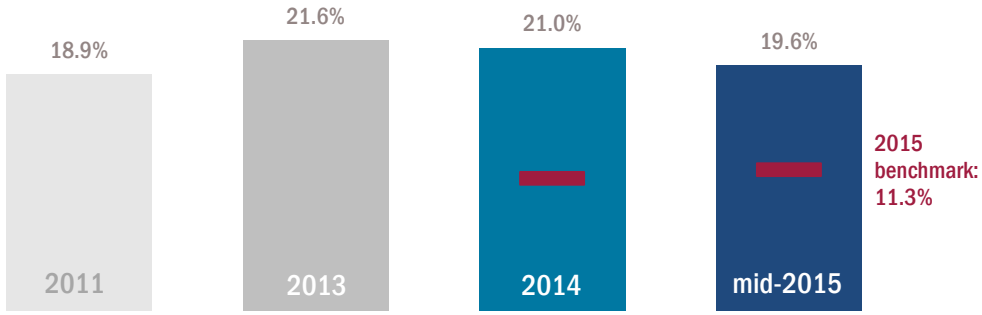
Racial and ethnic groups experiencing improvement:

- ✓ African American / Black

### About these data:

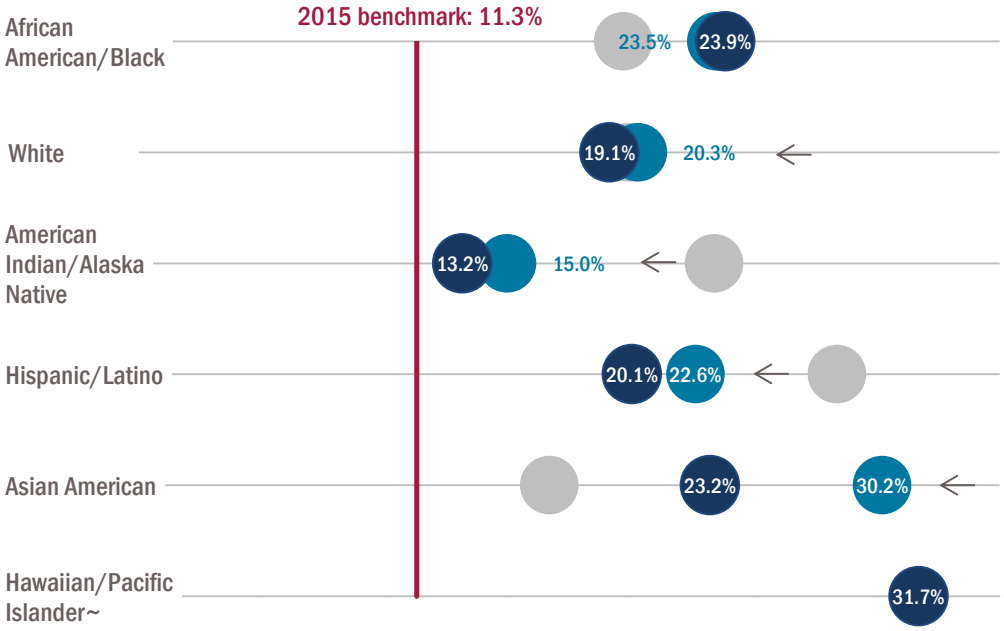
- N=15,806
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid median
- Race and ethnicity data missing for 10.4% of respondents
- Each race category excludes Hispanic/Latino

## Statewide, engagement of alcohol or other drug treatment decreased, but remains well above the benchmark.




## Engagement of alcohol or other drug treatment decreased among Asian American members between 2014 & mid-2015.

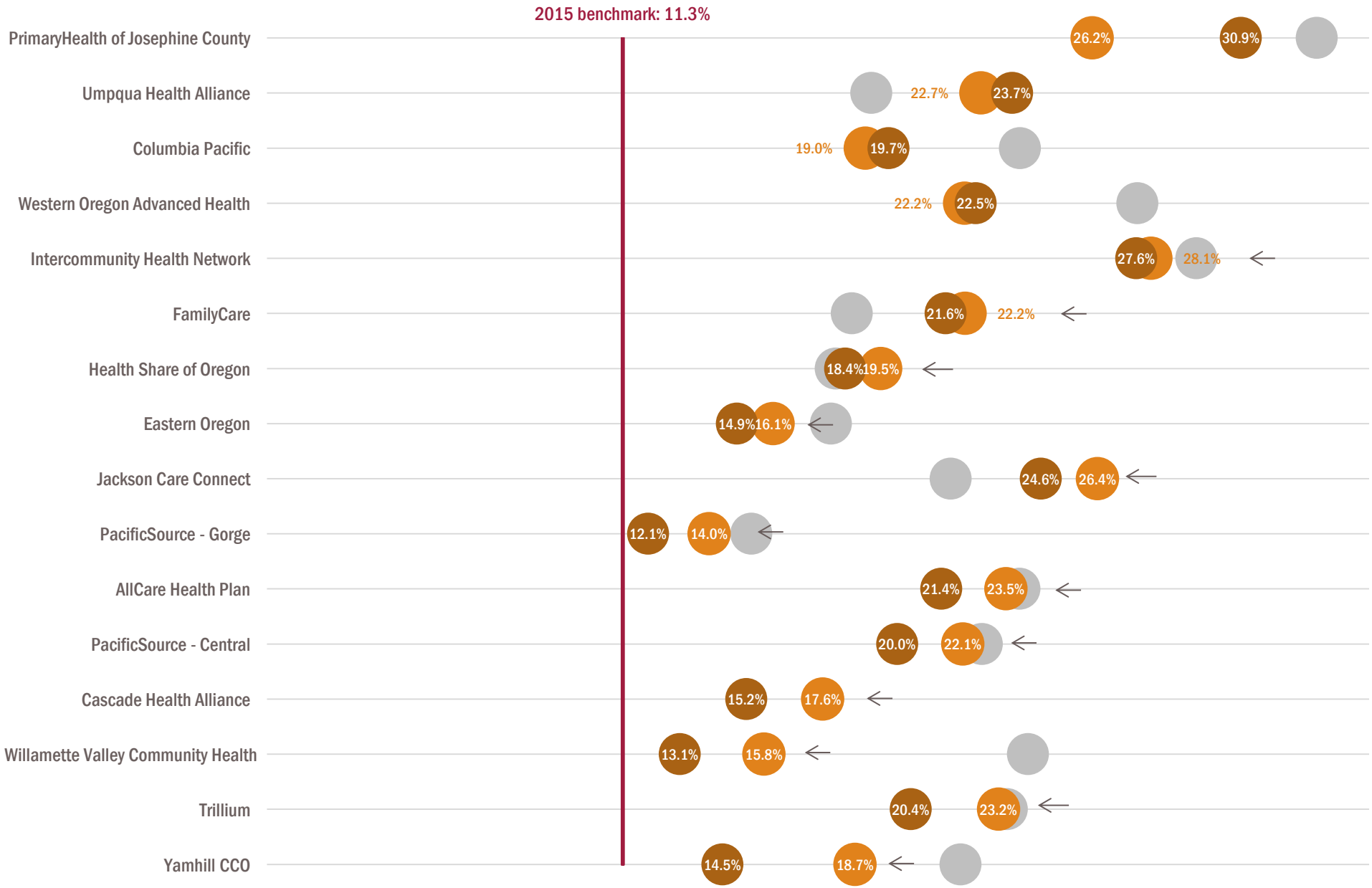
Gray dots represent 2013.
~ data supressed (n<30)



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

## Engagement of alcohol or other drug treatment declined in 12 CCOs between 2014 & mid-2015, although all 16 were above the benchmark.

Gray dots represent 2013.



# MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

## Mental, physical, and dental health assessments within 60 days for children in DHS custody

**Measure description:** 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.

**Purpose:** Children who have been placed in foster care should have their mental, physical, and dental health checked so that an appropriate care plan can be developed. Health assessments are a requirement for the foster program because of their importance to improving the health and well-being of a child in a trying situation.

### mid-2015 data

Statewide change since 2014: **+33%**

Number of CCOs that improved: **11** of 12 reported

**All** racial and ethnic groups for whom data are reported experienced improvement.

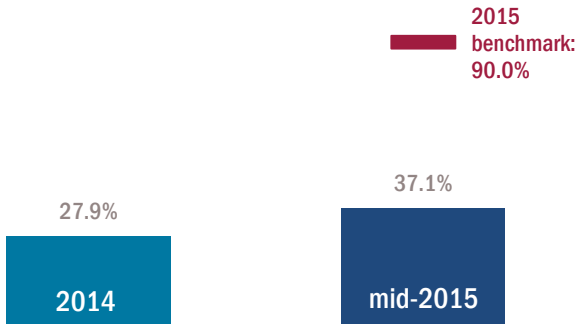
Dental health assessments have been added to this measure beginning in 2015. 2014 results have also been updated to reflect this change, and thus differ from previously published reports.

See pages 92 and 97 for results by members with- and without disability and mental health diagnoses.

### About these data:

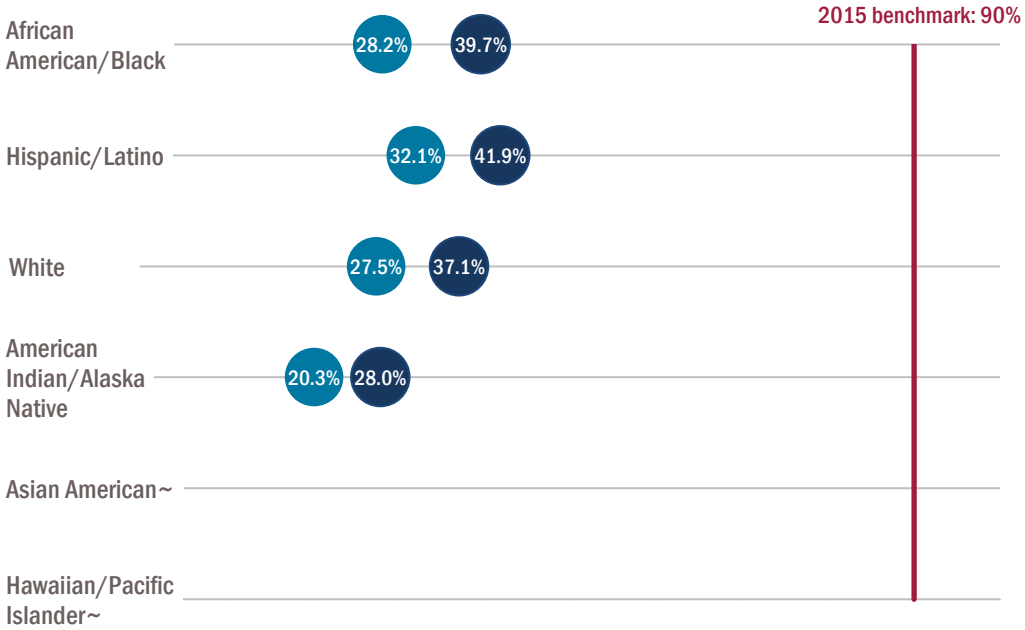
- N=1,574
- Data source: Administrative (billing) claims + ORKids
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 3.4% of respondents
- Each race category excludes Hispanic/Latino

### Statewide, health assessments for children in DHS custody improved considerably between 2014 and mid-2015, but remain well below the benchmark.




### Health assessments for children in DHS custody between 2014 & mid-2015, by race and ethnicity.

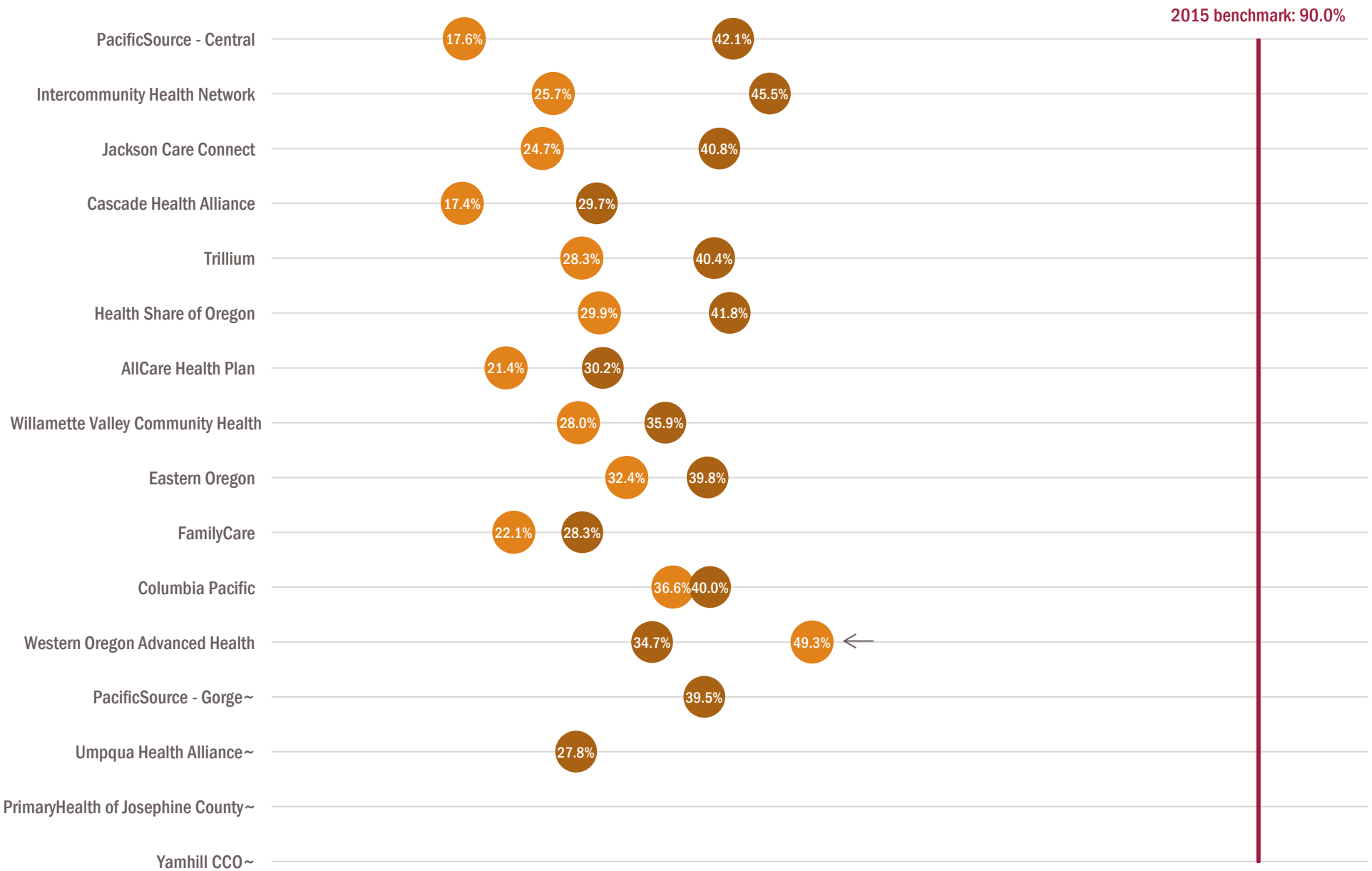
~ data suppressed (n<30)



# MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

## Overall, CCOs improved on this measure between 2014 & mid-2015, but remain well below the benchmark.

~ data suppressed (n<30)



# PATIENT-CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT

## Patient-centered primary care home enrollment

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

**Purpose:** Patient-centered primary care homes are clinics that have been recognized for their commitment to quality, patient-centered, coordinated care. Patient-centered primary care homes help improve a patient's health care experience and overall health.

## September 2015 data

Statewide change since 2014: **+3%**

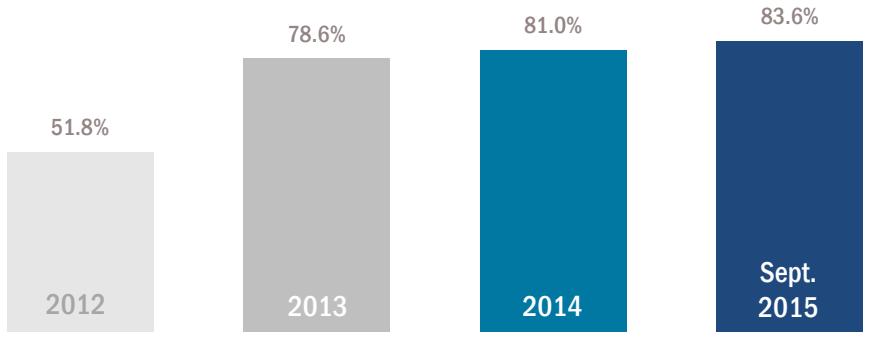
Number of CCOs that improved: **12**

Enrollment in patient-centered primary care homes increased by 61 percent since 2012, the baseline year for this metric. This improvement is impressive considering that CCO enrollment increased more than 70 percent due to Medicaid expansion (see graph at right).

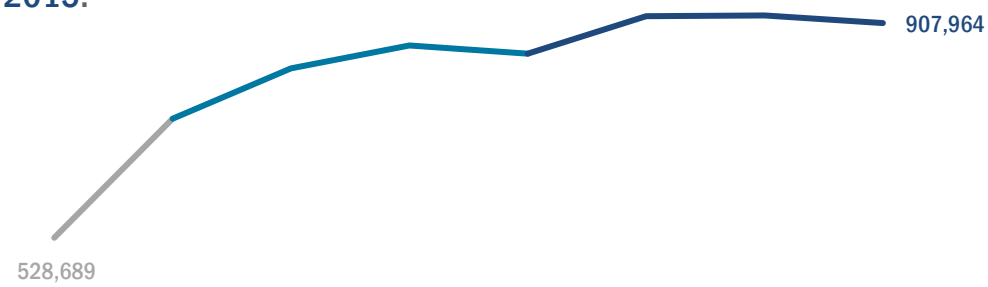
### About these data:

- Data source: CCO quarterly reporting
- Benchmark: CCOs must have 60 percent of members enrolled in patient-centered primary care homes to earn incentive money.

### Statewide, patient-centered primary care home enrollment continues to increase.



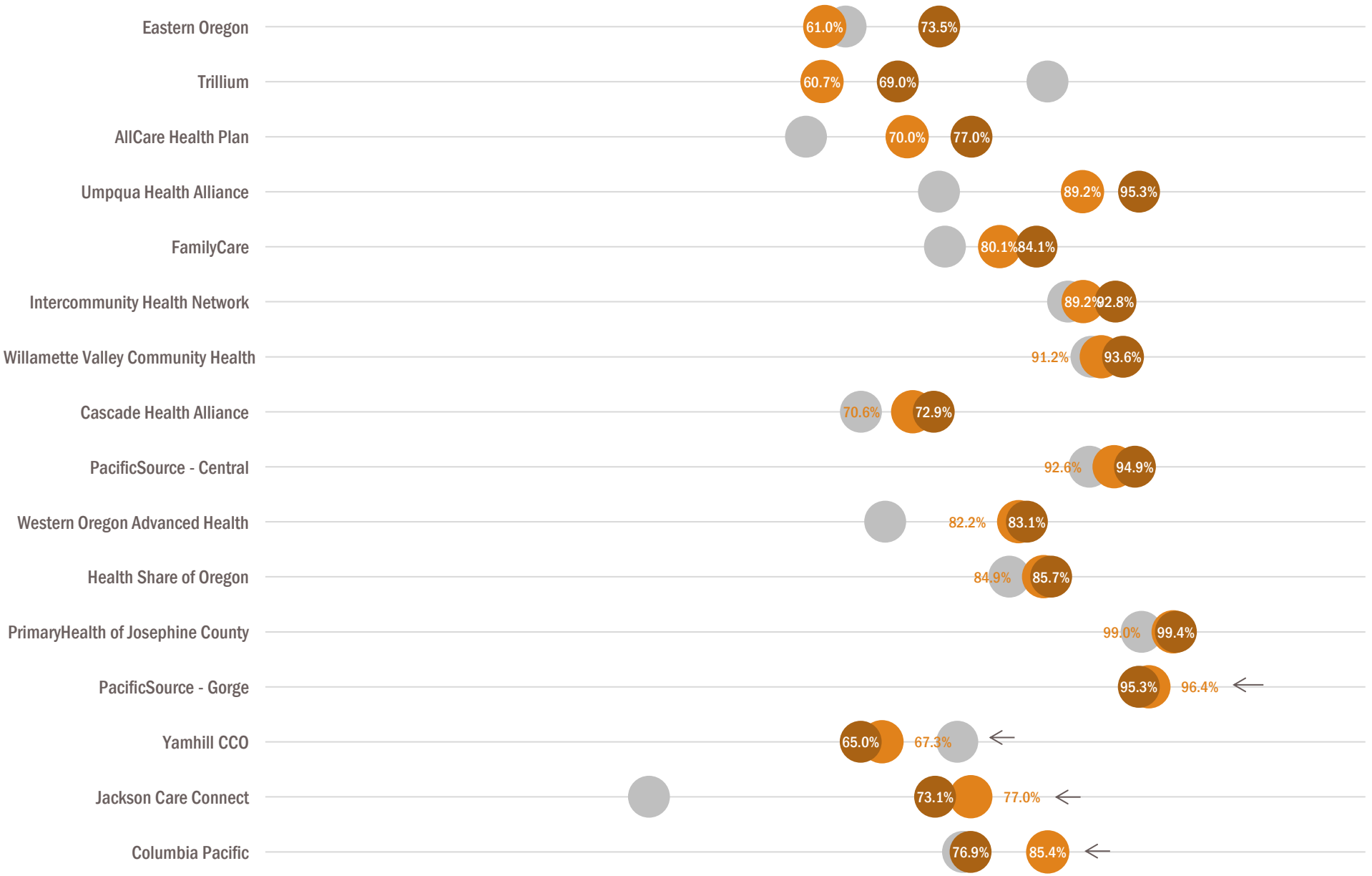

### Total CCO enrollment increased 72 percent between 2013 & September 2015.




# PATIENT-CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT

## Patient-centered primary care home enrollment in 2014 & September 2015, by CCO.

Gray dots represent 2013.



# PQI 01: DIABETES SHORT-TERM COMPLICATION ADMISSION RATE

## Diabetes short-term complications admission rate

**Measure description:** 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.

**Purpose of Prevention Quality Indicators:** Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce the costs of health care.

## mid-2015 data

Statewide change since 2014: **-7%** (lower is better)

Number of CCOs that improved: **10**

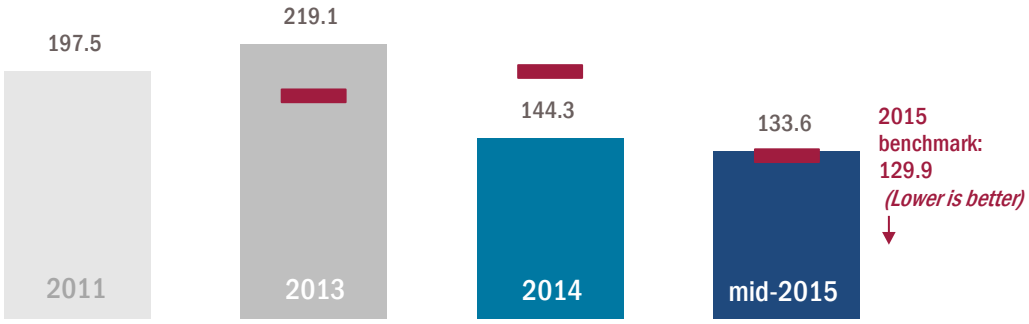
Racial and ethnic groups experiencing improvement:

- ✓ White
- ✓ Hispanic / Latino
- ✓ African American / Black
- ✓ American Indian / Alaska Native

### About these data:

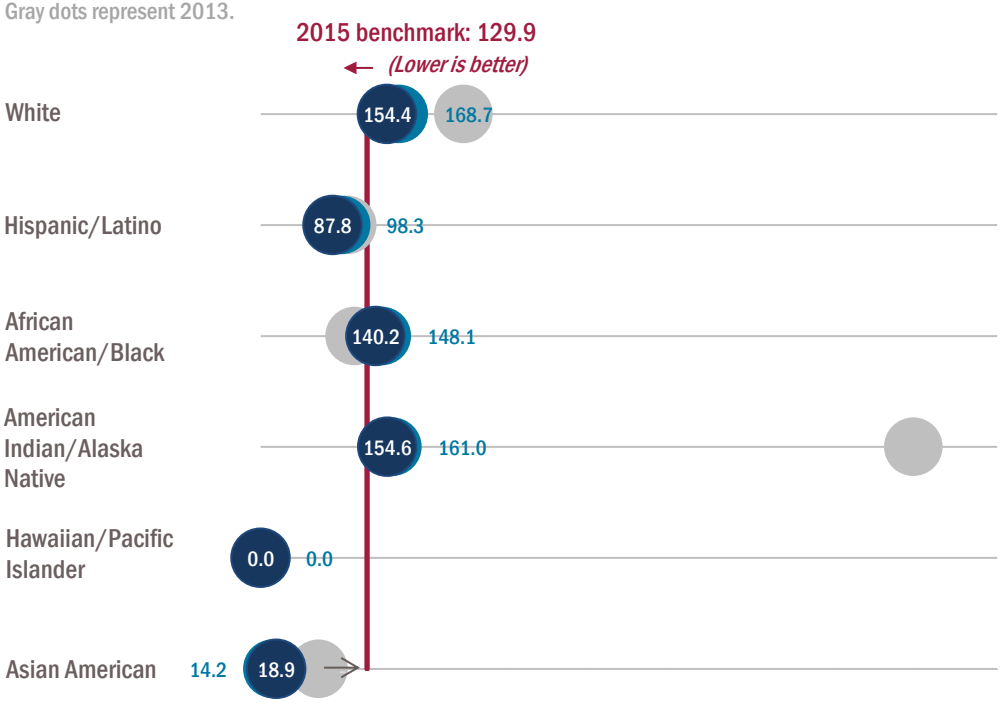
- N=6,294,904 member months
- Data source: Administrative (billing) claims
- Benchmark source: 10% reduction from previous year's statewide rate
- Race and ethnicity data missing for 12.7% of respondents
- Each race category excludes Hispanic/Latino

## Statewide, the diabetes short-term complications admission rate continued to improve.




## Admission rates for short-term complications of diabetes improved slightly for most races and ethnicities between 2014 & mid-2015.

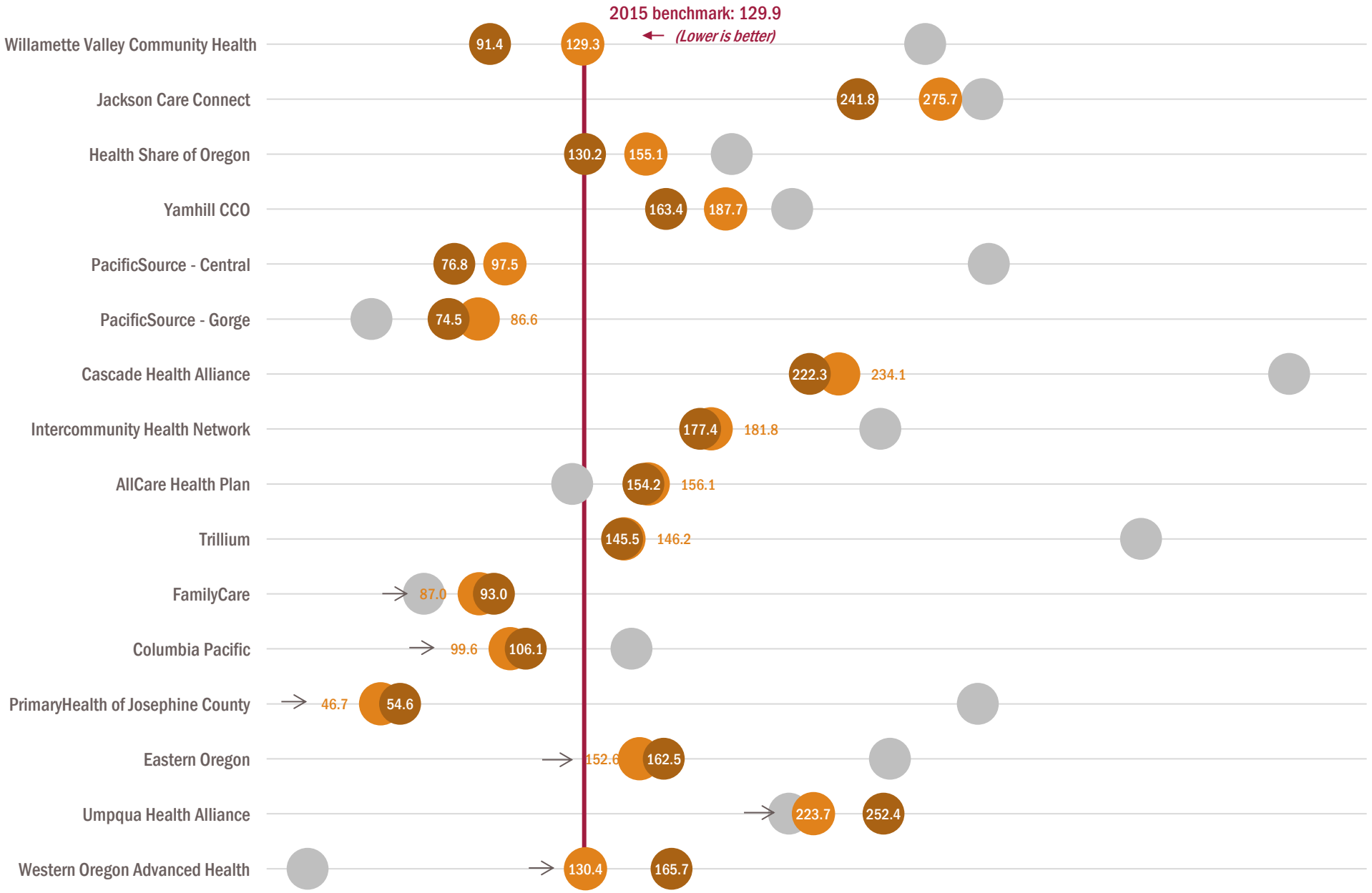
Gray dots represent 2013.



# PQI 01: DIABETES SHORT-TERM COMPLICATION ADMISSION RATE

## Diabetes short-term complication admission rates varied among CCOs in 2014 & mid-2015.

Gray dots represent 2013.



# PQI 05: CHRONIC OBSTRUCTIVE PULMONARY DISEASE OR ASTHMA ADMISSION RATE

## Chronic obstructive pulmonary disease or asthma admission rate

**Measure description:** 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.

**Purpose:** See page 76.

### mid-2015 data

Statewide change since 2014: **-19%** (lower is better)

Number of CCOs who have improved: **12**

Racial and ethnic groups experiencing improvement:

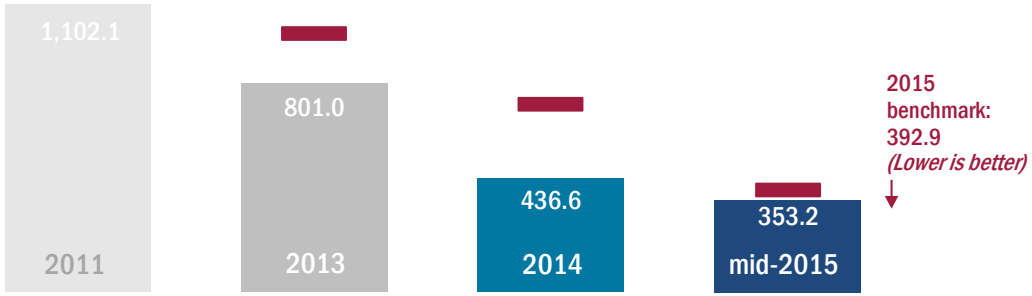
- ✓ African American / Black
- ✓ Asian American
- ✓ White
- ✓ Hispanic / Latino
- ✓ American Indian / Alaska Native

Although admission rates improved the most for African American members, rates remain higher than any other racial or ethnic group.

### About these data:

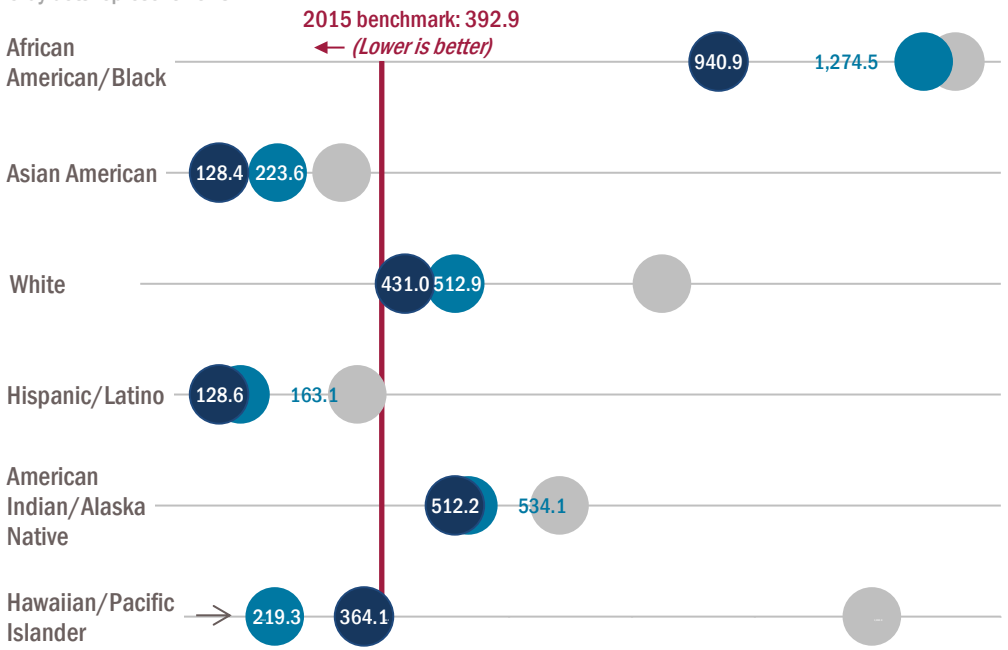
- N=2,918,279 member months
- Data source: Administrative (billing) claims
- Benchmark source: 10% reduction from previous year's statewide rate
- Race and ethnicity data missing for 12.5% of respondents
- Each race category excludes Hispanic/Latino

## Statewide, the COPD or asthma admission rate continues to improve, and remains below the benchmark.




## Admission rates for COPD/asthma varied widely but improved for most races and ethnicities between 2014 & mid-2015.

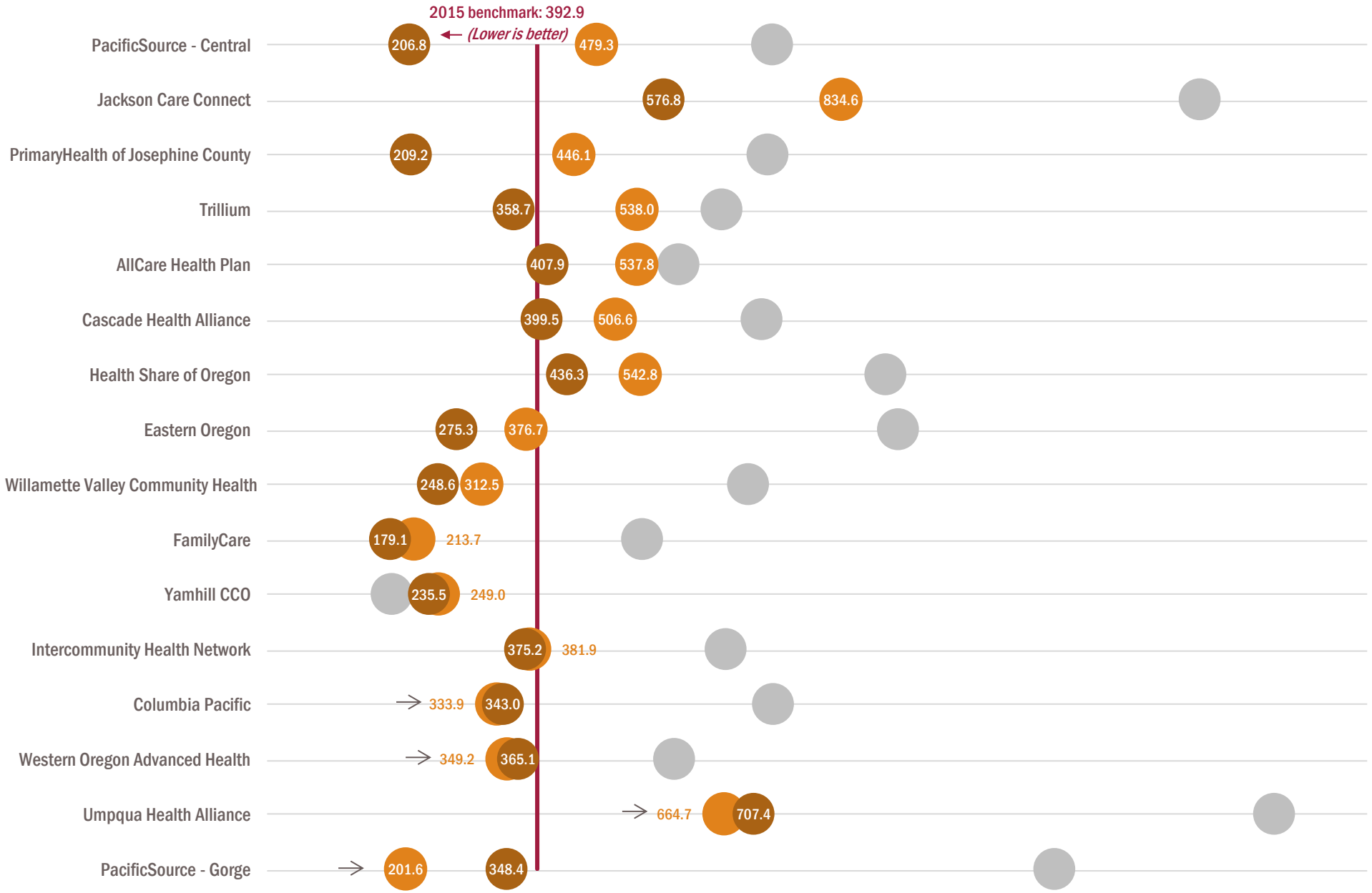
Gray dots represent 2013.



# PQI 05: CHRONIC OBSTRUCTIVE PULMONARY DISEASE OR ASTHMA ADMISSION RATE

## Overall, CCOs continued to improve admission rates for COPD or asthma between 2014 & mid-2015.

Gray dots represent 2013.



# PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

## Congestive heart failure admission rate

**Measure description:** 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.

**Purpose:** See page 76.

## mid-2015 data

Statewide change since 2014: **-3%** (lower is better)

Number of CCOs who have improved: **9**

Racial and ethnic groups experiencing improvement:

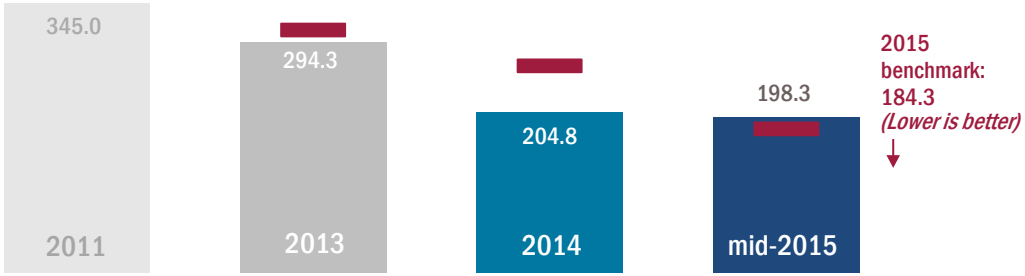
- ✓ African American / Black
- ✓ White
- ✓ Asian American

Although admission rates improved the most for African American members, rates remain higher than any other racial or ethnic group.

### About these data:

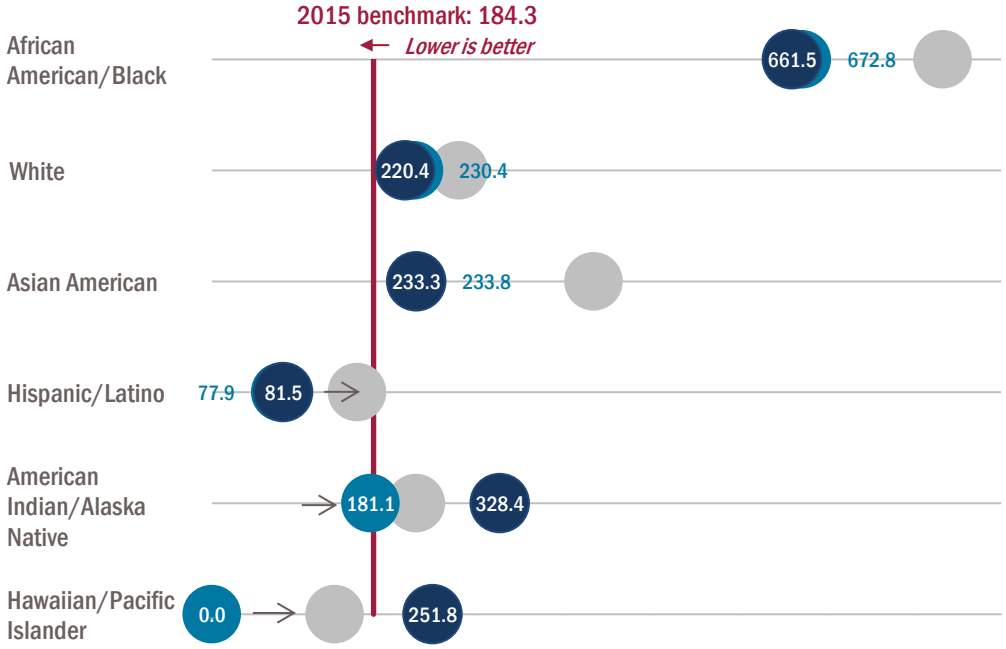
- N=6,294,904 member months
- Data source: Administrative (billing) claims
- Benchmark source: 10% reduction from previous year's statewide rate
- Race and ethnicity data missing for 12.7% of respondents
- Each race category excludes Hispanic/Latino

## Statewide, the congestive heart failure admission rate improved slightly in mid-2015.




## Congestive heart failure admission rates varied among races and ethnicities between 2014 & mid-2015.

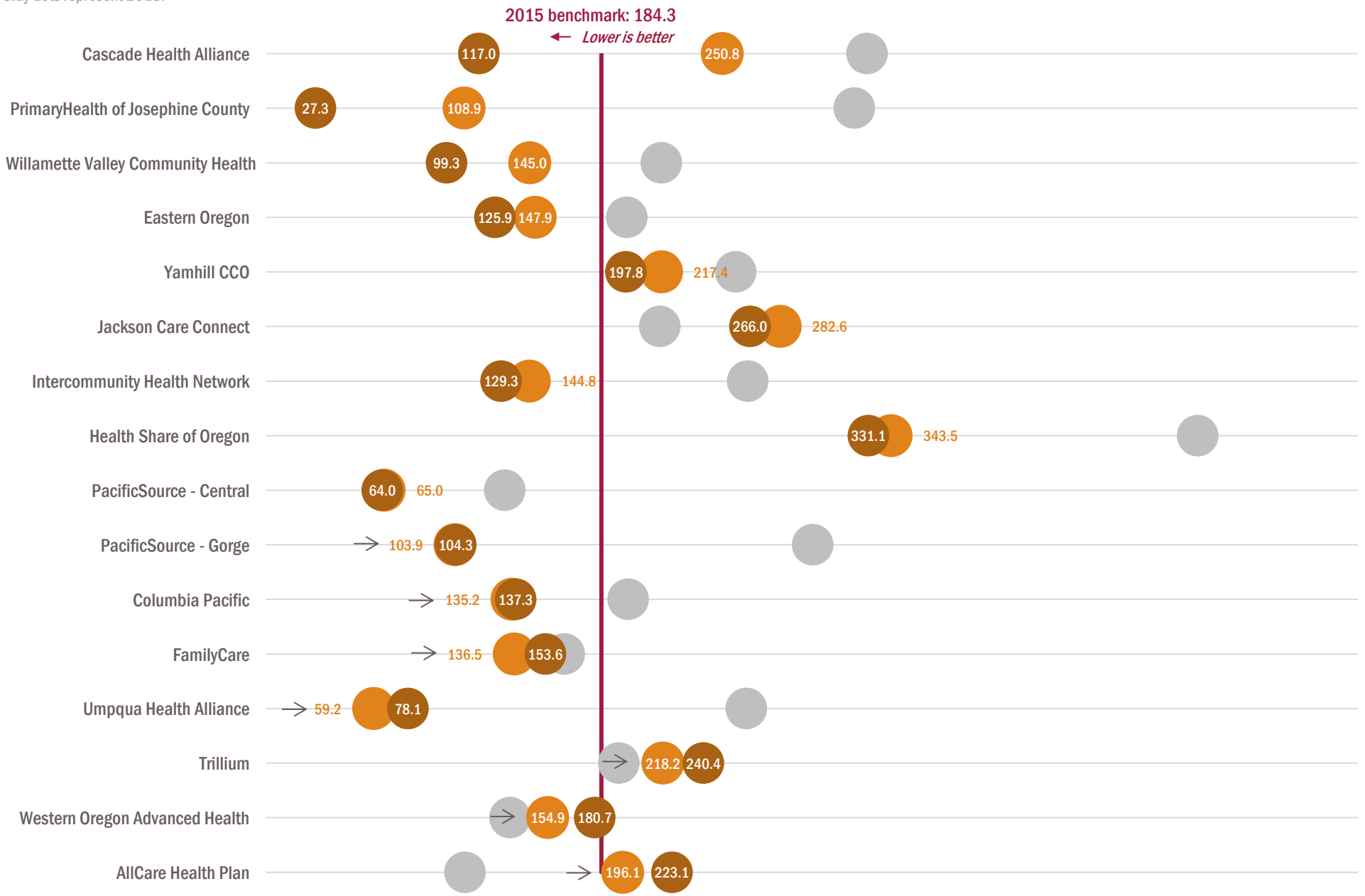
Gray dots represent 2013.



# PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

More than half of CCOs improved admission rates for congestive heart failure between 2014 & mid-2015.

Gray dots represent 2013.



# PQI 15: ADULT ASTHMA ADMISSION RATE

## Adult asthma admission rate

**Measure description:** 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.

**Purpose:** See page 76.

## mid-2015 data

Statewide change since 2014: **-5%** (lower is better)

Number of CCOs who have improved: **8**

Racial and ethnic groups experiencing improvement

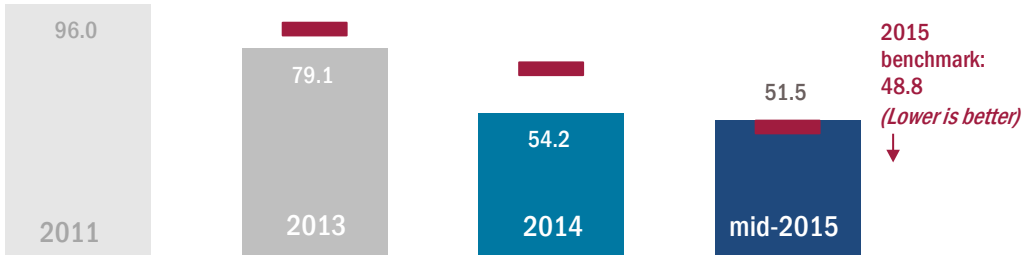
- ✓ African American / Black
- ✓ White
- ✓ Asian American

Although admission rates improved the most for American Indian / Alaska Native members, rates remain higher than any other racial or ethnic group.

### About these data:

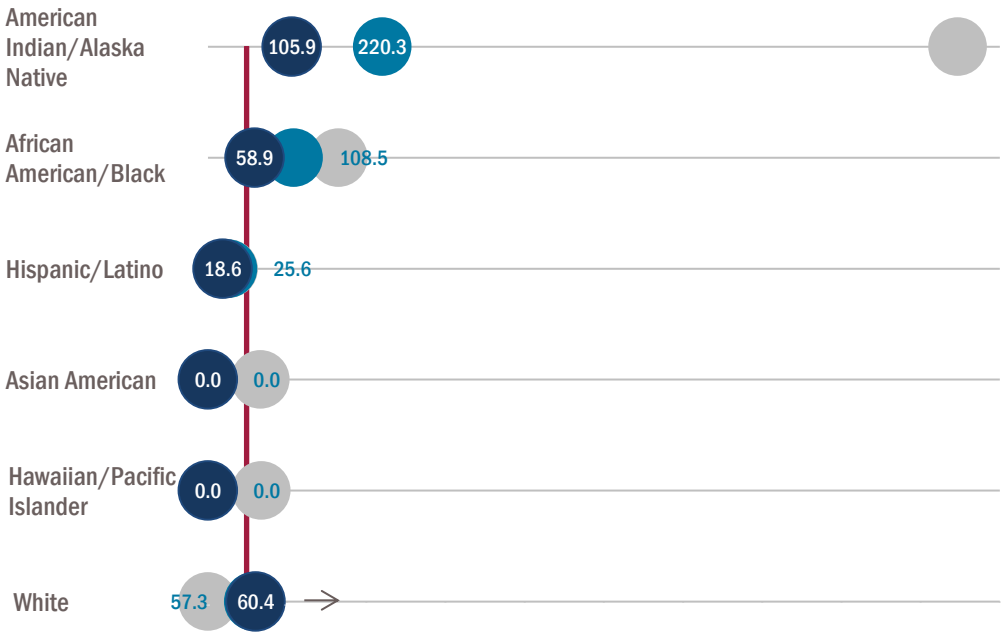
- N=3,376,625 member months
- Data source: Administrative (billing) claims
- Benchmark source: 10% reduction from previous year's statewide rate
- Race and ethnicity data missing for 13.2% of respondents
- Each race category excludes Hispanic/Latino

## Statewide, adult asthma admission rates continue to improve.




## Adult asthma admission rates between 2014 and mid-2015, by race and ethnicity.

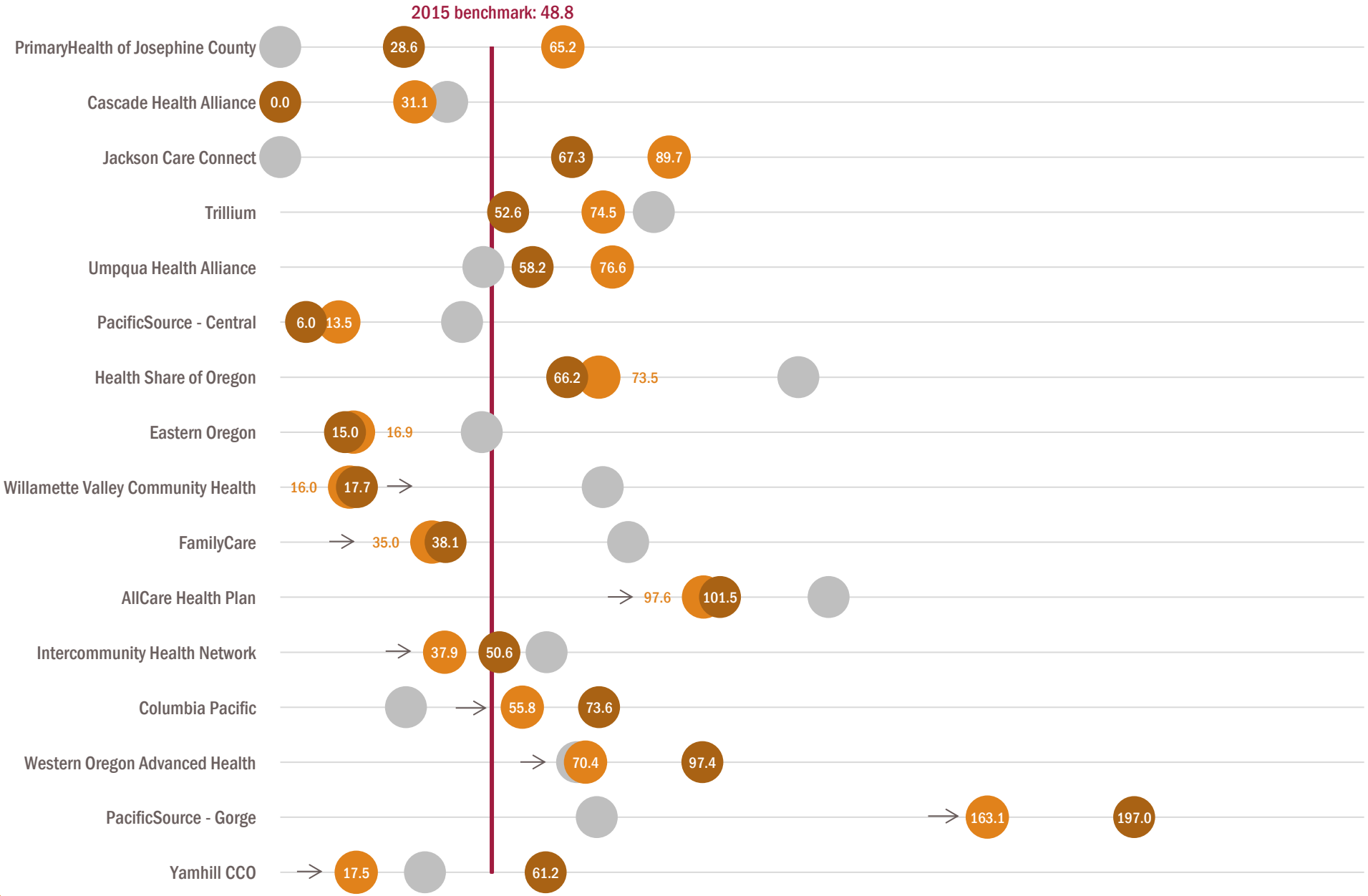
Gray dots represent 2013.



# PQI 15: ADULT ASTHMA ADMISSION RATE

Adult asthma admission rates between 2014 & mid-2015, by CCO.

Gray dots represent 2013.



# PQI 90: PREVENTION QUALITY OVERALL COMPOSITE

## PQI 91: Prevention quality overall composite

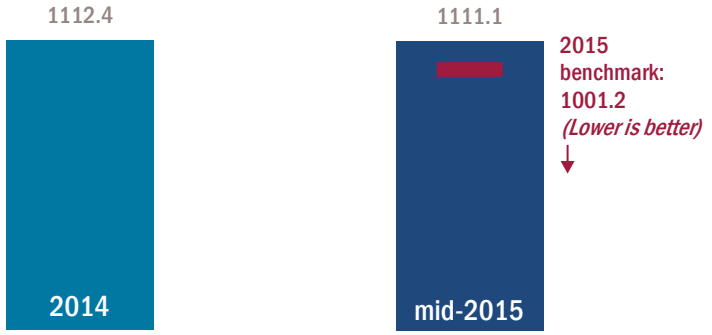
**Measure description:** Composite rate of adult members who were admitted to a hospital for any of the following preventable conditions:

- Diabetes with short-term complications (PQI 1, see page 76)
- Diabetes with long-term complications
- Uncontrolled diabetes without complications
- Diabetes with lower-extremity amputation
- COPD (PQI 5, see page 78)
- Asthma (PQI 15, see page 82)
- Hypertension
- Heart failure (PQI 8, see page 80)
- 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 Indicators, which is a set of indicators developed by the Agency for Healthcare Research and Quality (AHRQ) to track avoidable hospital admissions.

**Purpose**: see page 76.

## Statewide, the overall rate of hospitalizations for preventable conditions remained steady.




## mid-2015 data

Statewide change since 2014: **-0.1%** (lower is better)

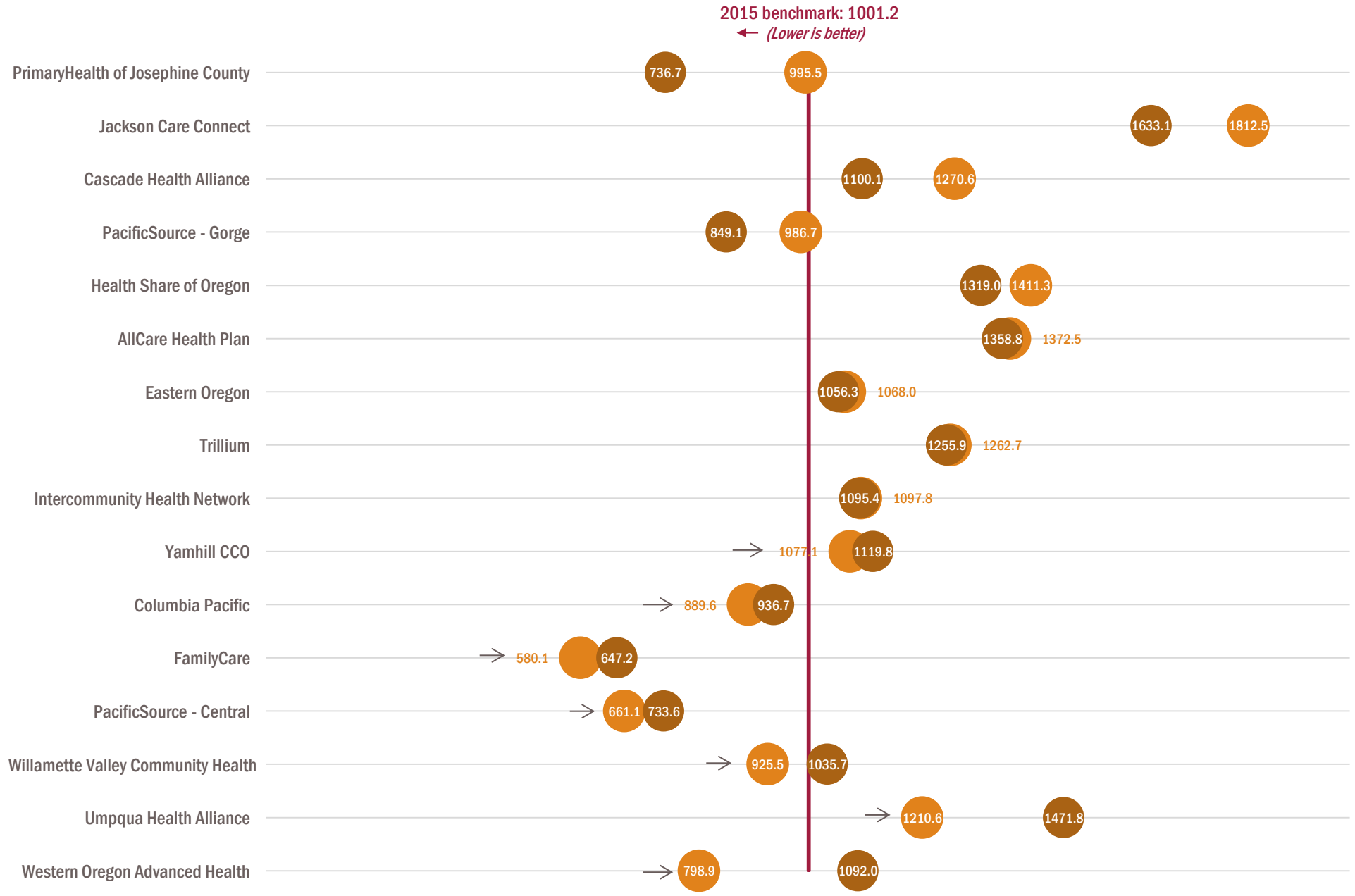
Number of CCOs that improved: **9**

### About these data:

- N=6,290,959 member months
- Data source: Administrative (billing) claims
- Benchmark source: 10% reduction from previous year's statewide rate
- 2011 and 2013 data are not available for this measure
- Race and ethnicity data are not available for this measure

# PQI 90: PREVENTION QUALITY OVERALL COMPOSITE

The overall rate of hospitalizations for preventable conditions varied widely among CCOs between 2014 & mid-2015.



# PQI 91: PREVENTION QUALITY ACUTE COMPOSITE

## PQI 91: Prevention quality acute composite

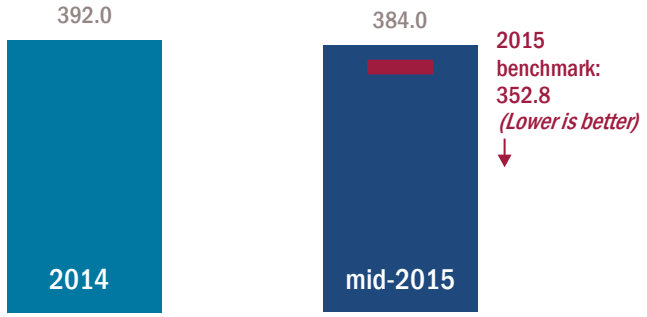
**Measure description**: Composite rate of adult members who were admitted to a hospital for any of the following acute conditions:

- Dehydration
- Bacterial pneumonia
- Urinary tract infection

Rates are reported per 100,000 member years and 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 (AHRQ) to track avoidable hospital admissions.

**Purpose:** See page 76.

## Statewide, admissions for acute conditions decreased slightly between 2014 and mid-2015.




## mid-2015 data

Statewide change since 2014: **-2%** (lower is better)

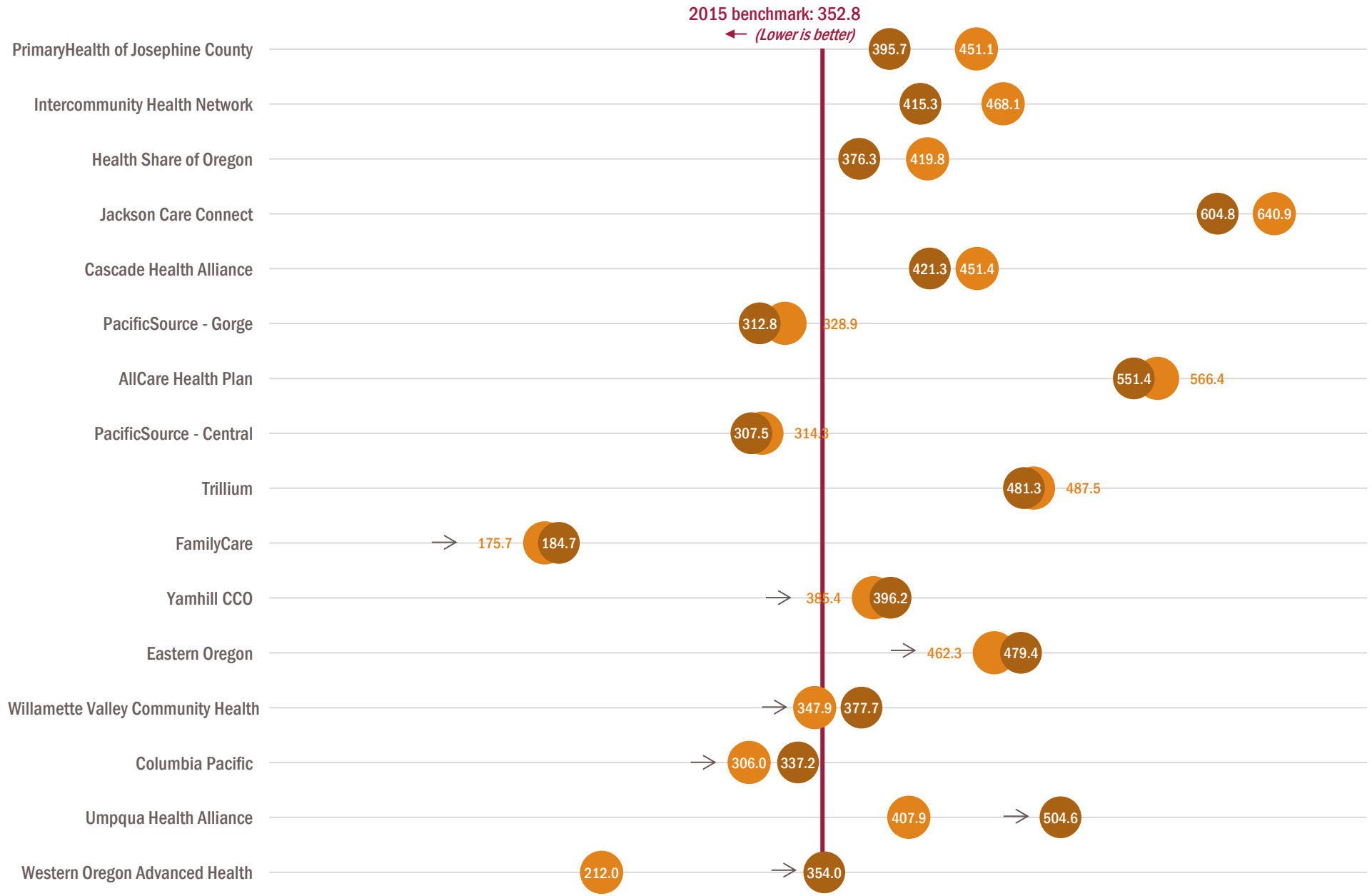
Number of CCOs that improved: **9**

### About these data:

- N=6,290,959 member months
- Data source: Administrative (billing) claims
- Benchmark source: 10% reduction from previous year's statewide rate
- 2011 and 2013 data are not available for this measure
- Race and ethnicity data are not available for this measure

# PQI 91: PREVENTION QUALITY ACUTE COMPOSITE

Admissions for acute conditions varied widely between CCOs in 2014 & mid-2015.



# PQI 92: PREVENTION QUALITY CHRONIC COMPOSITE

## PQI 92: Prevention quality chronic composite

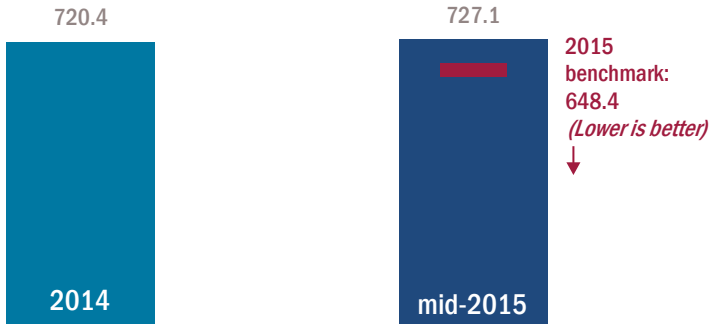
**Measure description**: Composite rate of adult members who were admitted to a hospital for any of the following chronic conditions:

- Diabetes with short-term complications (PQI 1, see page 76)
- Diabetes with short– or long-term complications
- Uncontrolled diabetes without complications
- Diabetes with lower-extremity amputation
- COPD ( PQI 5, see page 78)
- Asthma (PQI 15, see page 82)
- Hypertension
- Heart failure (PQI 8, see page 80)
- Angina

Rates are reported per 100,000 member years and 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 (AHRQ) to track avoidable hospital admissions.

**Purpose:** See page 76.

## Statewide, admissions for chronic conditions remained fairly steady between 2014 and mid-2015.




## mid-2015 data

Statewide change since 2014: **+1%** (lower is better)

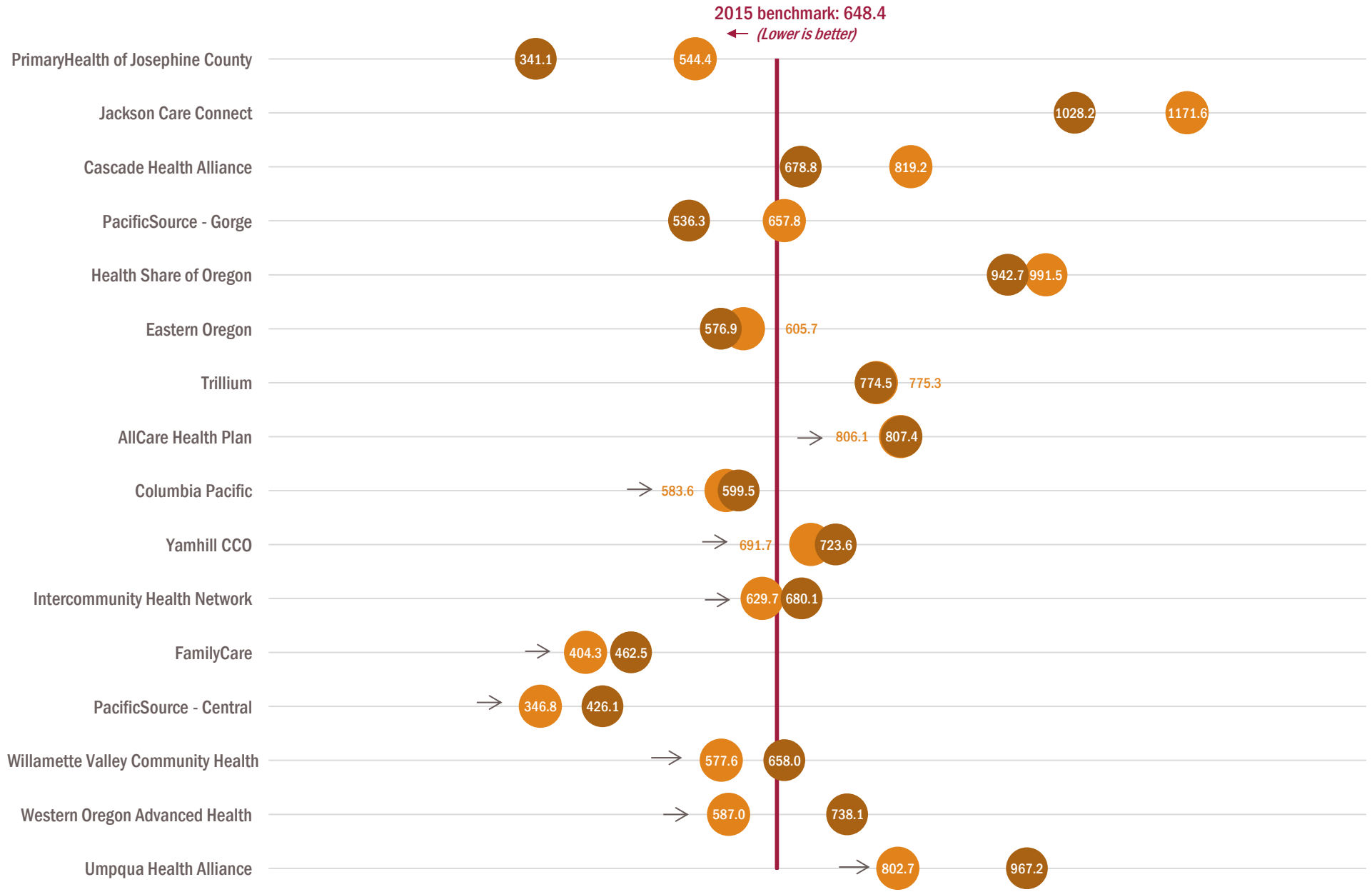
Number of CCOs that improved: **7**

### About these data:

- N=6,290,959 member months
- Data source: Administrative (billing) claims
- Benchmark source: 10% reduction from previous year's statewide rate
- 2011 and 2013 data are not available for this measure
- Race and ethnicity data are not available for this measure

# PQI 92: PREVENTION QUALITY CHRONIC COMPOSITE

Admissions for chronic conditions varied widely between CCOs in 2014 & mid-2015.



# WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

## Well-child visits in the first 15 months of life

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

**Purpose:** Regular well-child visits are one of the best ways to detect physical, developmental, behavioral and emotional problems in infants. They are also an opportunity for providers to offer guidance and counseling to parents.

## mid-2015 data

Statewide change since 2014: **+1%**

Number of CCOs that improved: **10**

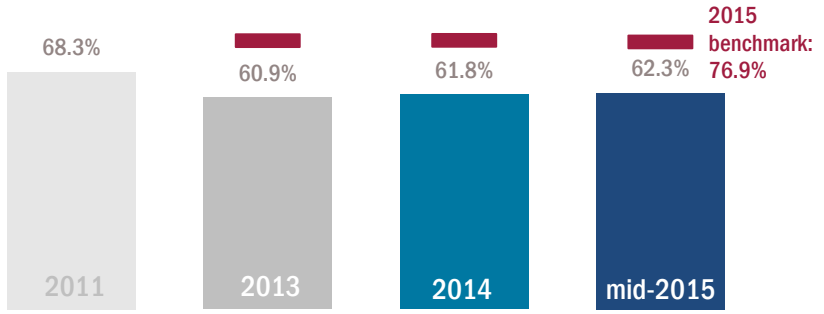
Racial and ethnic groups experiencing improvement:

- ✓ American Indian / Alaska Native
- ✓ Hawaiian / Pacific Islander
- ✓ Asian American
- ✓ White
- ✓ African American / Black

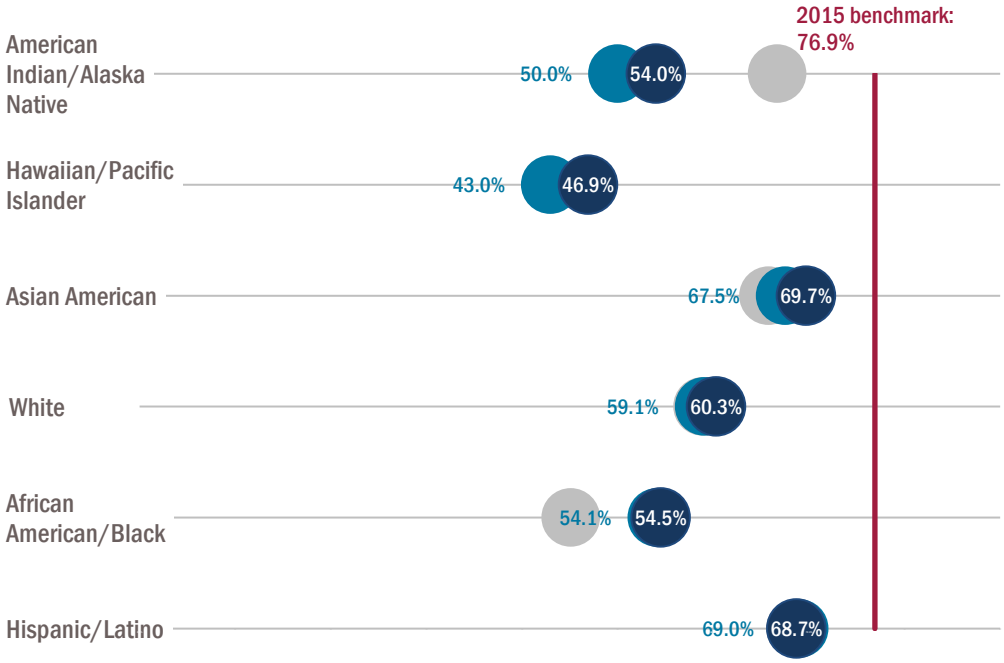
### About these data:

- N=17,438
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 90th percentile
- Race and ethnicity data missing for 11.6% of respondents
- Each race category excludes Hispanic/Latino
- 2014 results have been updated and may differ from previously published reports

## Statewide, the percentage of children receiving six or more well-child visits before reaching 15 months of age remained steady between 2014 and mid-2015.

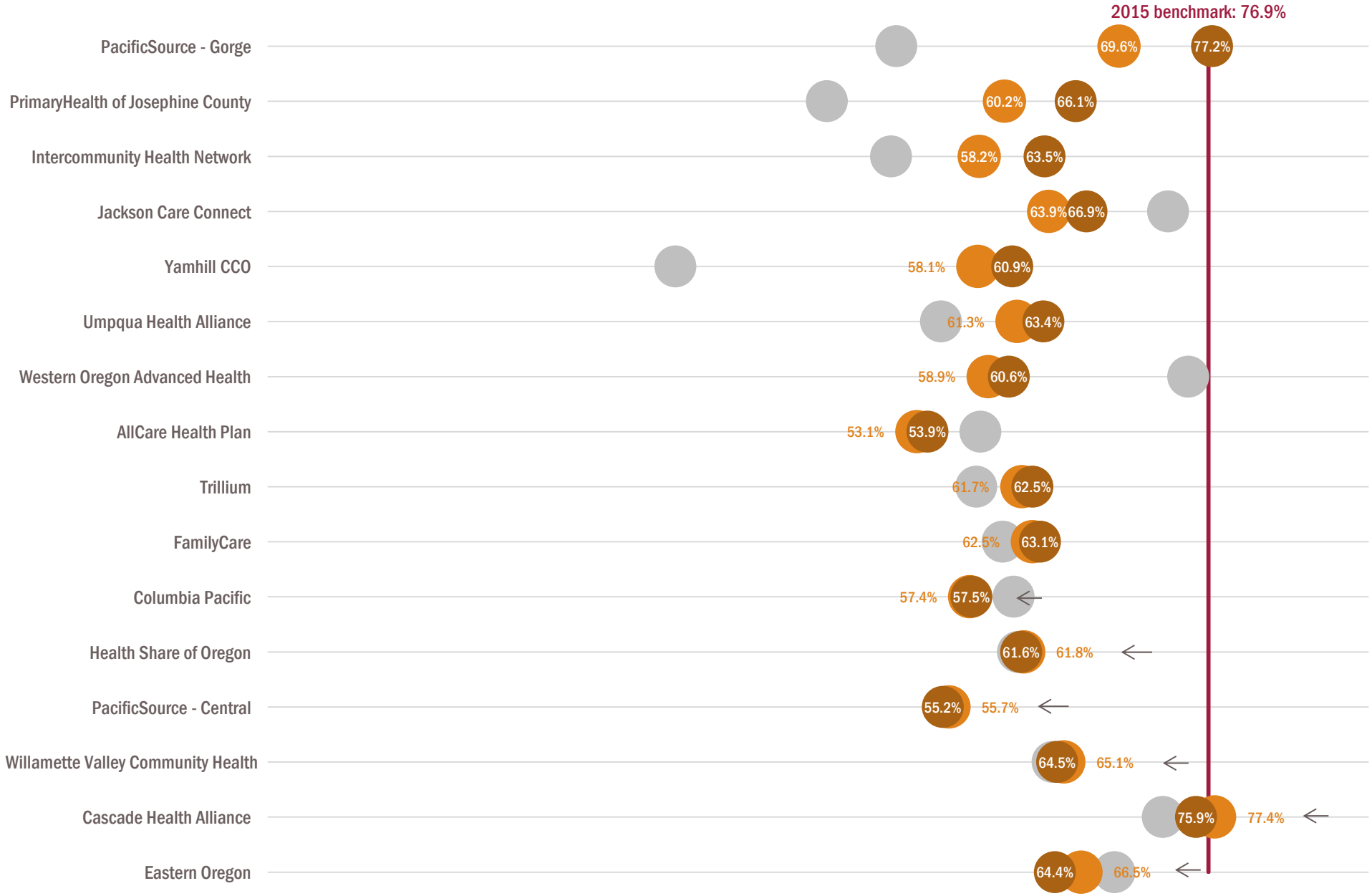



## Well-child visits in 2014 & mid-2015, by race and ethnicity.



# WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

The percentage of children receiving six or more well-care visits before 15 months of age increased in many CCOs between 2014 & mid-2015.



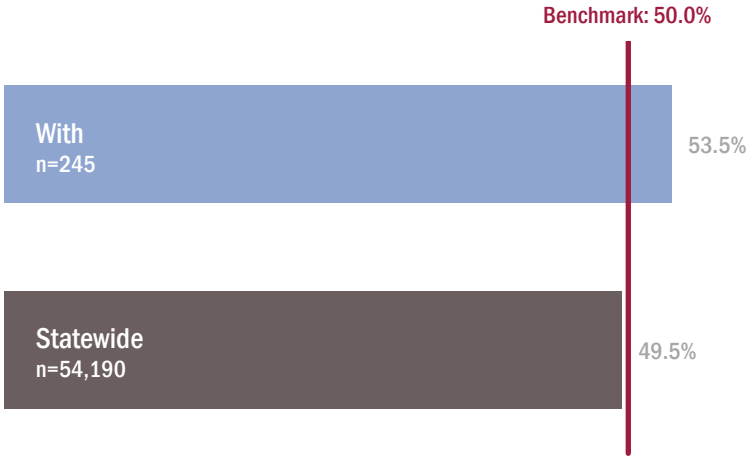
# MEASURES BY DISABILITY

## Introduction

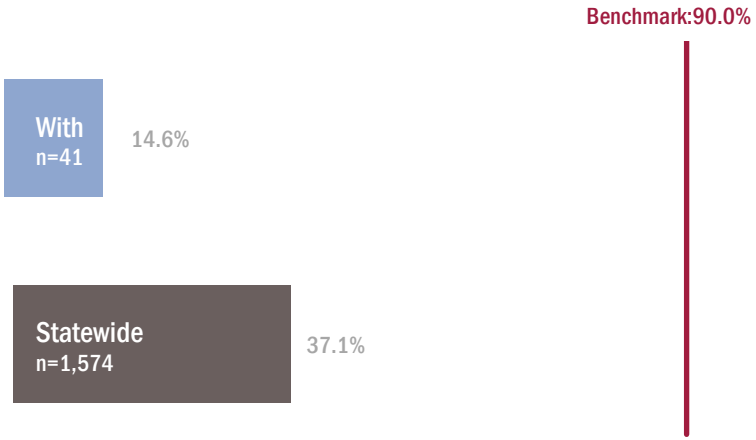
This section shows 2015 mid-year data (July 2014 – June 2015) for 12 measures, reported for CCO members with disability, compared to statewide. Additional measures will be included in the 2015 Final Report (published in June 2016).

**With disability** means people who qualify for Medicaid based on an impairment that has prevented them from performing substantial gainful activity for at least one year, or is expected to prevent them from performing substantial gainful activity for at least one year. This may include physical, mental, emotional, learning, developmental or other disabilities. These individuals may or may not also be qualified for Medicare. Eligibility codes include: 3, 4, B3, and D4.

### Children with disability received development screenings during the first 36 months of life more frequently than statewide.




### Children in DHS custody (foster care) with disability received mental, physical, and dental health assessments less frequently than statewide.



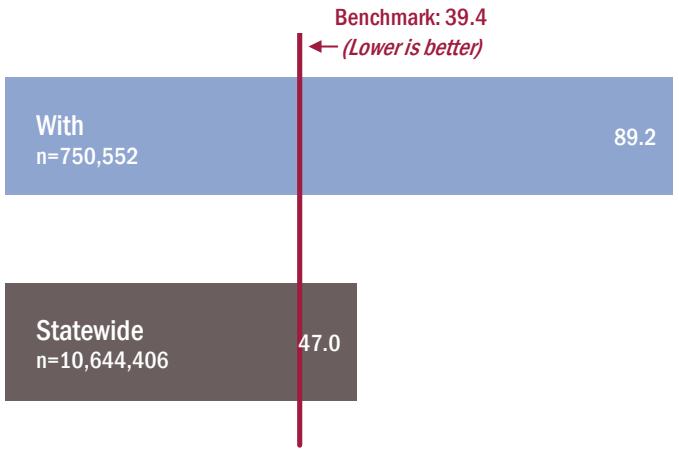

## Mid-2015 data

Children with disability have higher rates of developmental screening during the first three years of life, which may reflect a higher engagement with the health system. These children may be more likely to see a provider for reasons related to their disability, which creates more opportunities for them to also receive their developmental screening. It may also be that the developmental screening was what first identified their disability.

However, children with disability in DHS custody had much lower rates of mental, physical, and dental health assessments upon entering foster care, which may reflect even greater challenges with care coordination for this population.

# MEASURES BY DISABILITY

## Emergency department utilization among members with disability compared with statewide.




## Follow-up after hospitalization for mental illness for members with disability compared with statewide.

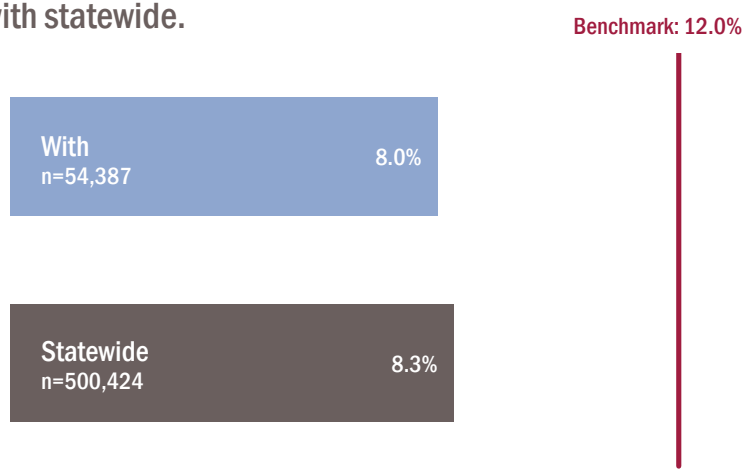

## Mid-2015 data

Members with disability have higher rates of emergency department utilization, which mirrors national data (lower rates are better).

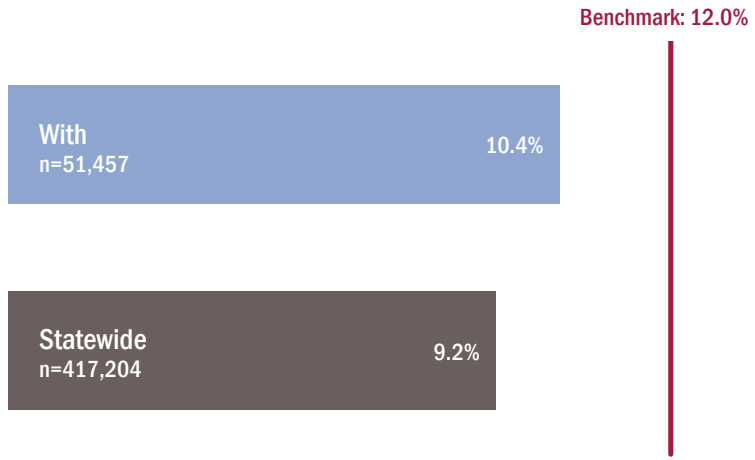
Members with disability are more likely to receive timely follow-up (within 7 days) after hospitalization for mental illness than statewide. Timely follow-up after hospitalization can reduce the duration of disability and, for certain conditions, the likelihood of re-hospitalization.

# MEASURES BY DISABILITY

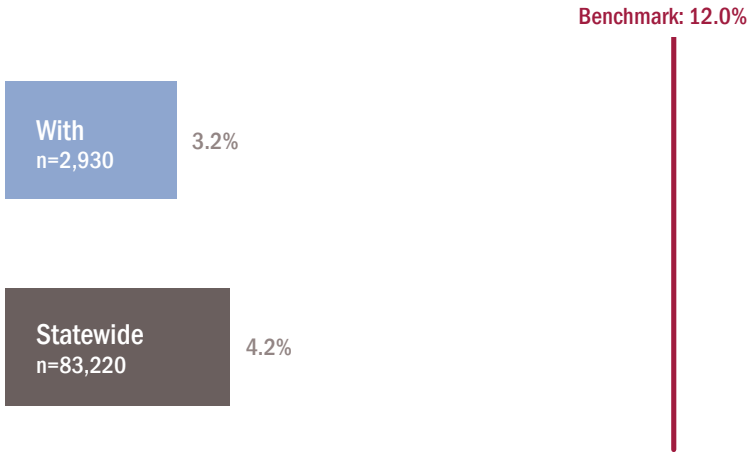
Screening, brief intervention, and referral to treatment (SBIRT) for members (ages 12+) with disability compared with statewide.




SBIRT for members (ages 18+) with disability compared with statewide.




SBIRT for members (ages 12-17) with disability compared with statewide.

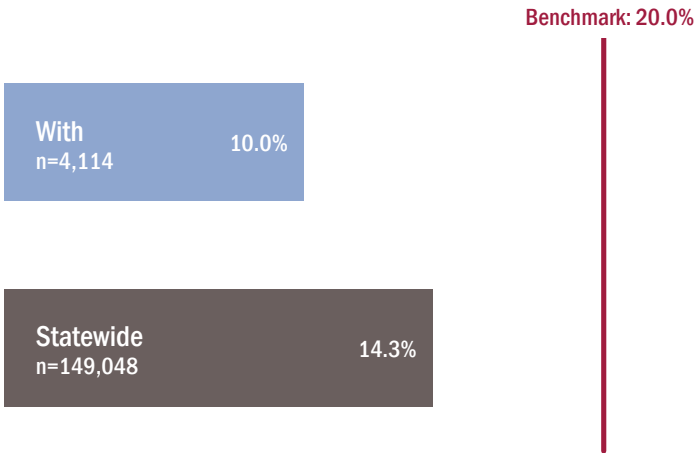



## Mid-2015 data

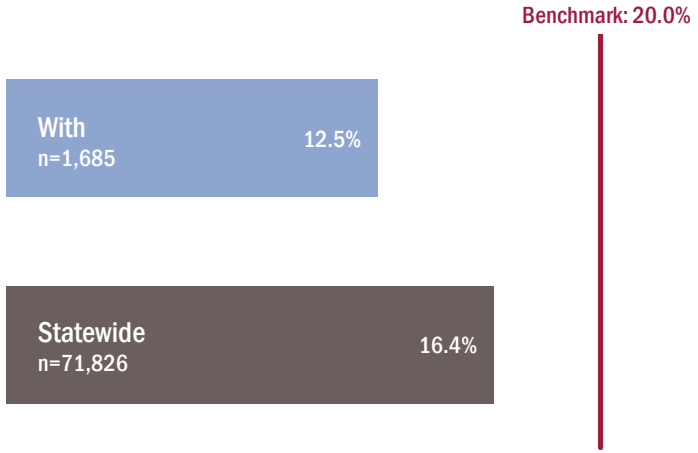
Screening, brief intervention, and referral to treatment (SBIRT) for alcohol or substance abuse is similar for Medicaid members ages 12+ with disability, compared to statewide, although SBIRT is slightly lower for adolescents (ages 12-17) with disability, and slightly higher for adults (ages 18+) with disability.

# MEASURES BY DISABILITY

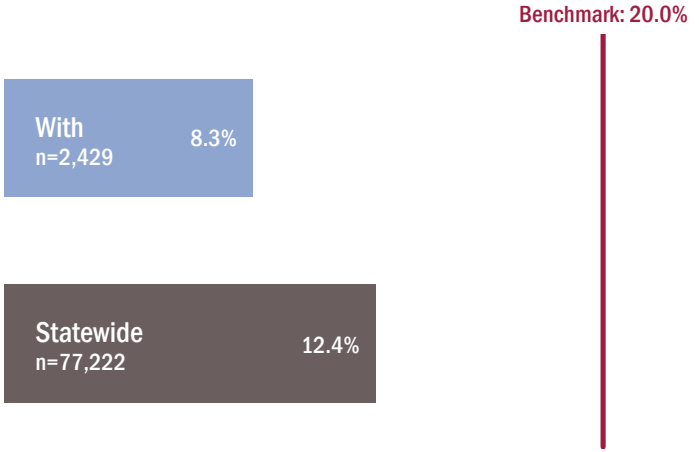
## Dental sealants on permanent molars for children all ages (6-14) with disability compared with statewide.




## Dental sealants on permanent molars for children (ages 6-9) with disability compared with statewide.




## Dental sealants on permanent molars for children (ages 10-14) with disability compared with statewide.



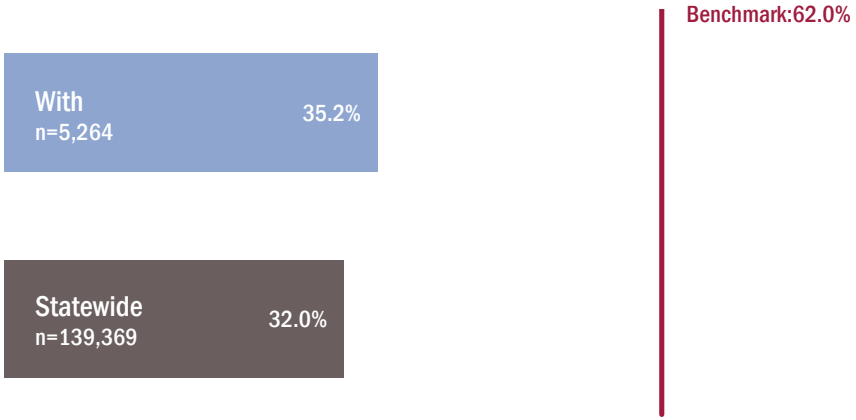

## Mid-2015 data

Dental sealants on permanent molars for children with disability are lower than statewide performance in all age breakouts. National data have found no difference in dental sealants for children with and without disabilitiy, indicating a disparity in care for children in Oregon.

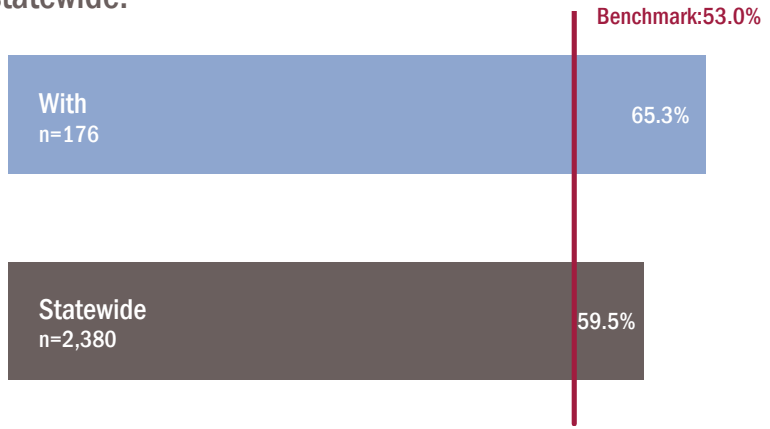
As children with disability are more likely to have oral health problems than children without disability, and parents may have difficulty finding dental care for their children with special needs, these results indicate a need to ensure children with disability receive these preventive oral health services.

# MEASURES BY DISABILITY

Adolescent well-care visits were higher among members with disability compared with statewide.




Initiation of follow-up for children newly prescribed ADHD medication was higher among members with disability than statewide.




## Mid-2015 data

Adolescent well-care visits and initiation of follow-up care for children newly prescribed ADHD medications were higher for individuals with disability than average statewide performance. However, only a third of adolescents on Medicaid receive an annual well-care visit, well below the benchmark of 62 percent.

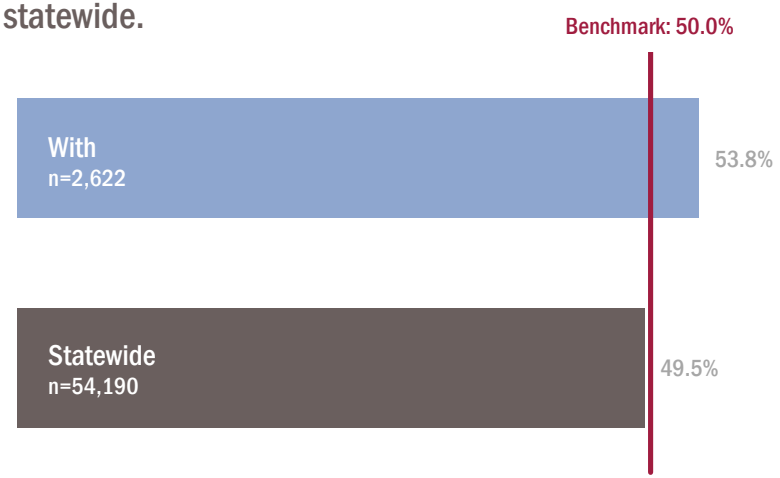
# MEASURES BY MENTAL HEALTH DIAGNOSES

## Introduction

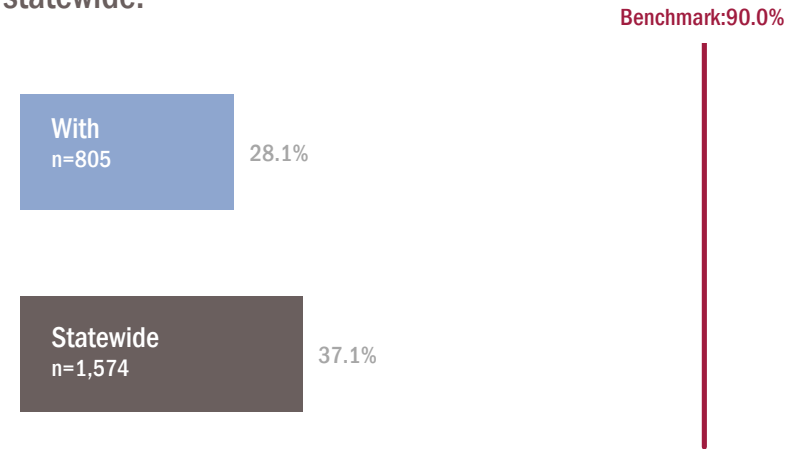
This section shows 2015 mid-year data (July 2014 – June 2015) for 14 measures, reported for Medicaid members with mental health diagnoses, compared to statewide. Additional measures will be included in the 2015 Final Report (published in June 2016).

**With mental health diagnoses** refers to people who have had two or more services in the past 36 months with any of the qualifying diagnoses for schizophrenia, bipolar, delusional, developmental, anxiety, personality or depressive disorders, as well as other mental health disorders (ICD9 295 – 302.9 and 306.51 – 347). This includes the subset of disorders for the severe and persistent mental illness (SPMI) breakout, on pages 103-104.

### Developmental screenings during the first 36 months of life for children with mental health diagnoses compared with statewide.




### Mental, physical, and dental health assessments for children in DHS custody with mental health diagnoses compared with statewide.



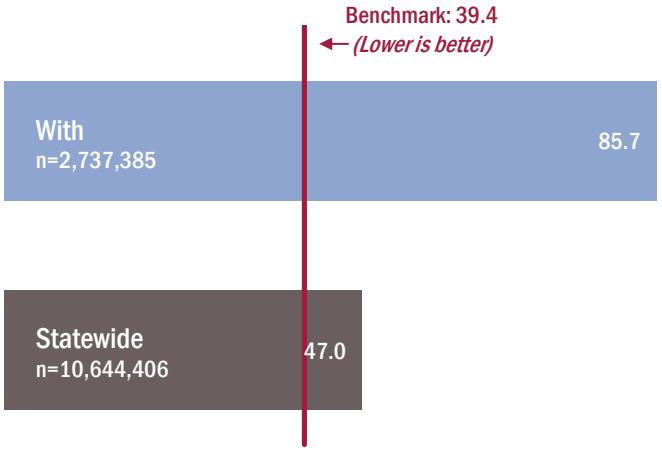

## Mid-2015 data

Children with mental health diagnoses have slightly higher rates of developmental screening during the first three years of life.

However, children with mental health diagnoses in DHS custody had lower rates of mental, physical, and dental health assessments upon entering foster care, which may reflect even greater challenges with care coordination, and a particular need for mental health services in this population.

# MEASURES BY MENTAL HEALTH DIAGNOSES

## Emergency department utilization among members with mental health diagnoses compared with statewide.



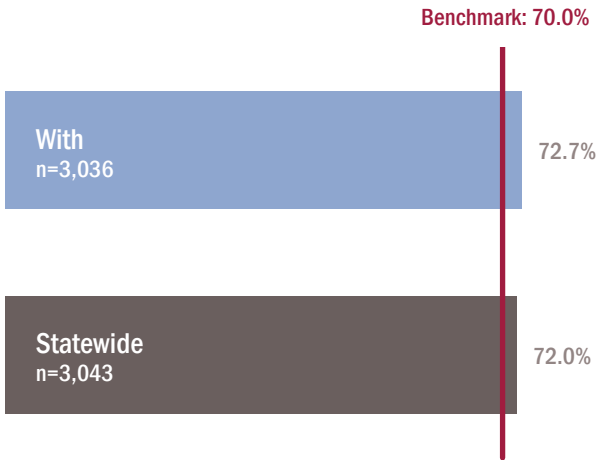

## Mid-2015 data

While emergency department utilization has been declining in Oregon (see page 17), Medicaid members with mental health diagnoses have much higher rates of emergency department utilization than statewide rates.

National data indicate that individuals with more severe mental health conditions were more likely to have multiple emergency department visits during a year. Oregon will continue to monitor this metric to determine if additional community services made possible by recent investments lead to a decreased utilization of emergency departments for individuals with mental health diagnoses.

# MEASURES BY MENTAL HEALTH DIAGNOSES

## Follow-up after hospitalization for mental illness among members (ages 6+) with mental health diagnoses compared with statewide.

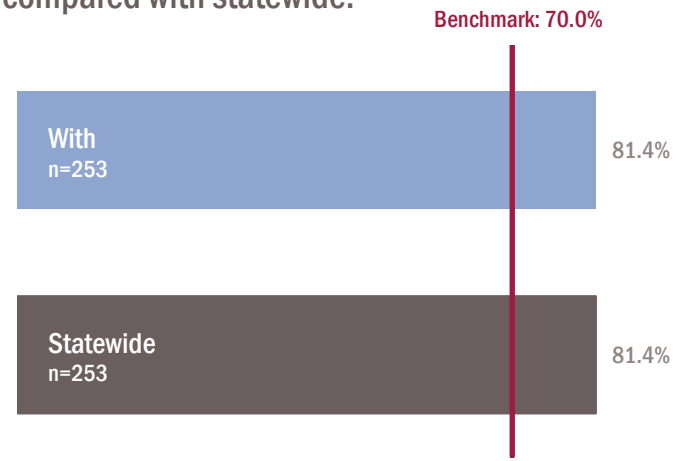



## Mid-2015 data

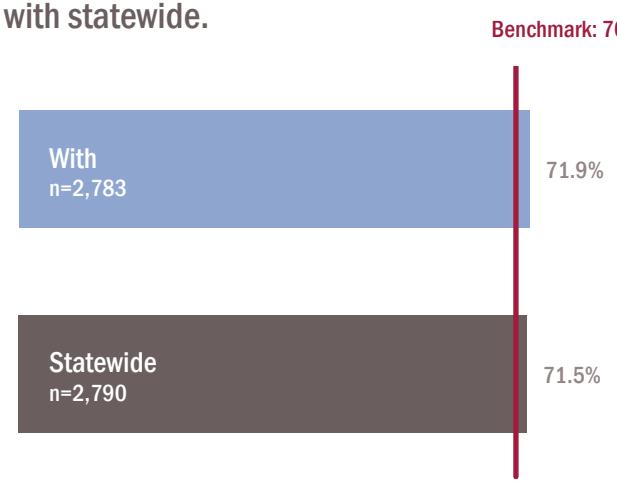
Follow-up visits after hospitalization for mental illness are very similar for members with mental health diagnoses, which makes sense, given that the measure looks for mental health related hospitalizations.

Follow-up is higher for children and adolescents (ages 6-17) with mental health diagnoses than for adults.

## Follow-up after hospitalization for mental illness among members (ages 6-17) with mental health diagnoses compared with statewide.

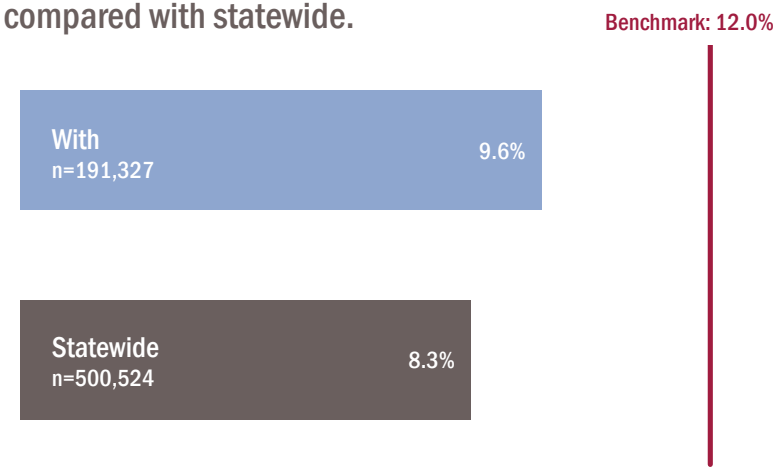



## Follow-up after hospitalization for mental illness among members (ages 18+) with mental health diagnoses compared with statewide.

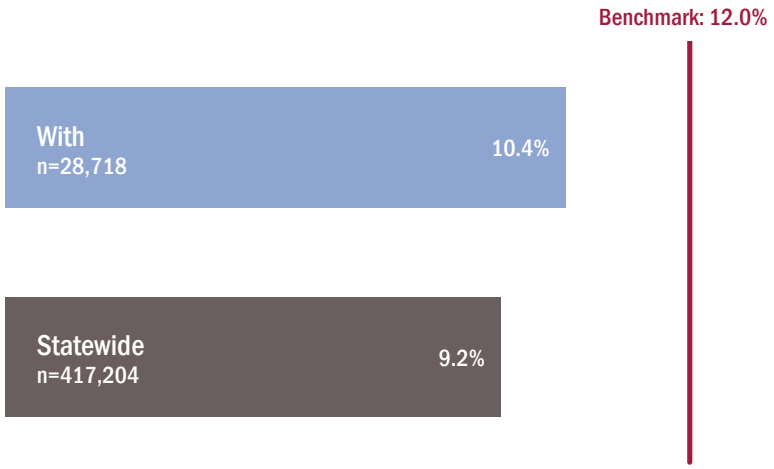


# MEASURES BY MENTAL HEALTH DIAGNOSES

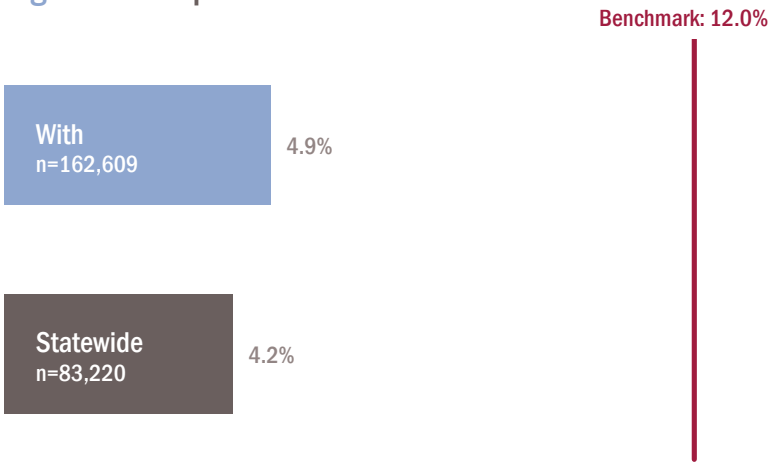
## Screening, brief intervention, and referral to treatment (SBIRT) for all ages (12+) with mental health diagnoses compared with statewide.




## SBIRT for adults (ages 18+) with mental health diagnoses compared with statewide.




## SBIRT for adolescents (ages 12-17) with mental health diagnoses compared with statewide.

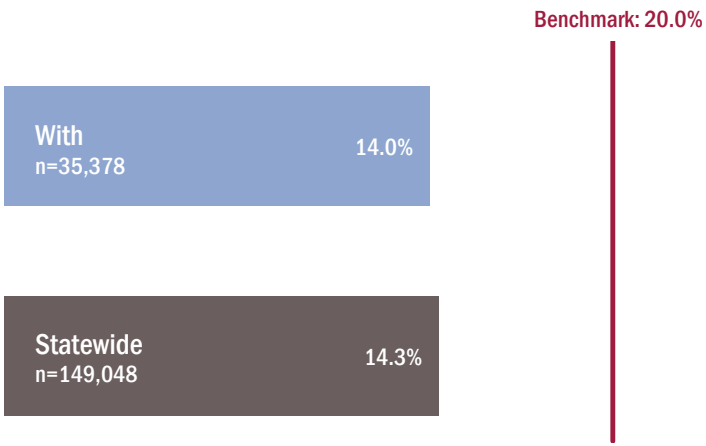



## Mid-2015 data

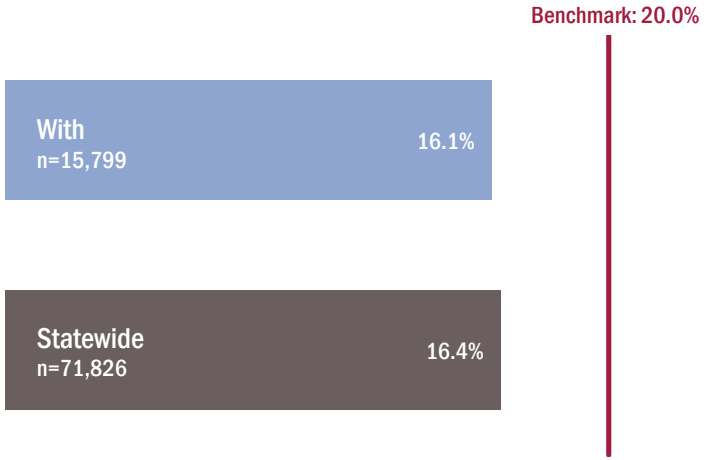
Screening, brief intervention, and referral to treatment (SBIRT) for alcohol or substance abuse is higher for Medicaid members with mental health diagnoses across all age breakouts, compared to statewide. Since people with mental health conditions may be at increased risk for alcohol or substance abuse disorders, this first look at SBIRT screenings is promising.

# MEASURES BY MENTAL HEALTH DIAGNOSES

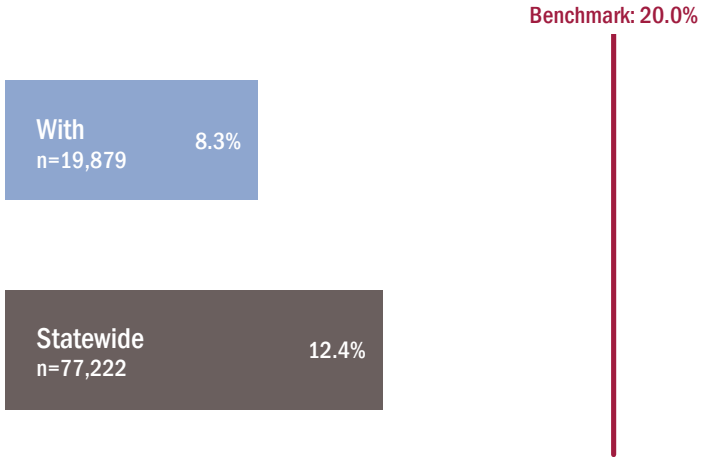
Dental sealants on permanent molars for children all ages (6-14) with mental health diagnoses compared with statewide.




Dental sealants on permanent molars for children ages 6-9 with mental health diagnoses compared with statewide.




Dental sealants on permanent molars for children ages 10-14 with mental health diagnoses compared with statewide.

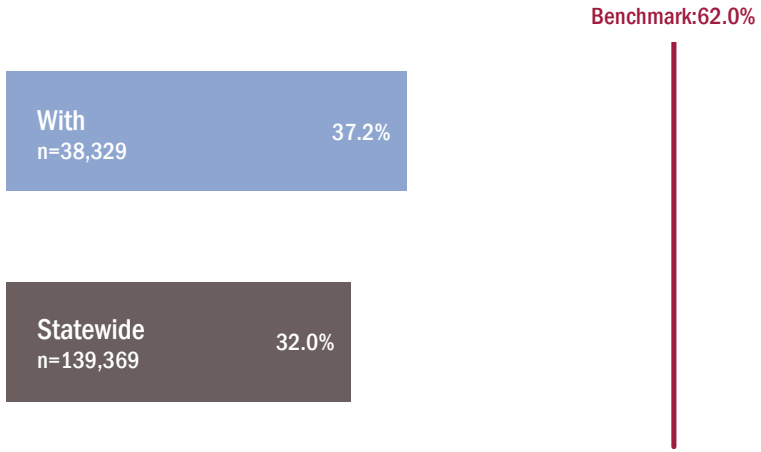



## Mid-2015 data

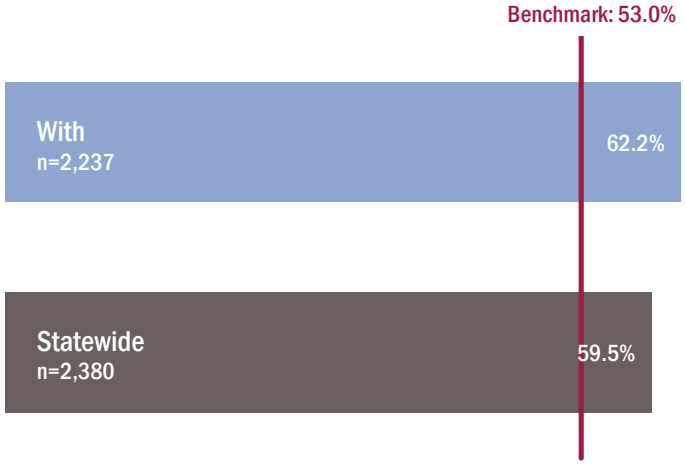
Dental sealants on permanent molars for children with mental health diagnoses are similar to statewide rates for the full age range (ages 6-14), and for younger children (ages 6-9); however, they are lower for children with mental health diagnoses ages 10-14, who may have unmet oral health needs.

# MEASURES BY MENTAL HEALTH DIAGNOSES

Adolescent well-care visits among members with mental health diagnoses compared with statewide.




Follow-up after ADHD prescription with mental health diagnoses compared with statewide.




## Mid-2015 data

Adolescent well-care visits and initiation of follow-up care for children newly prescribed ADHD medications were higher for individuals with mental health diagnoses than statewide performance. Because of rapid development occurring during adolescence, many mental health conditions first emerge during this time and the adolescent well-care visit may be when they are first identified. The adolescent well-care visit results are promising, however, only a third of adolescents on Medicaid receive an annual well-care visit, well below the benchmark of 62 percent.

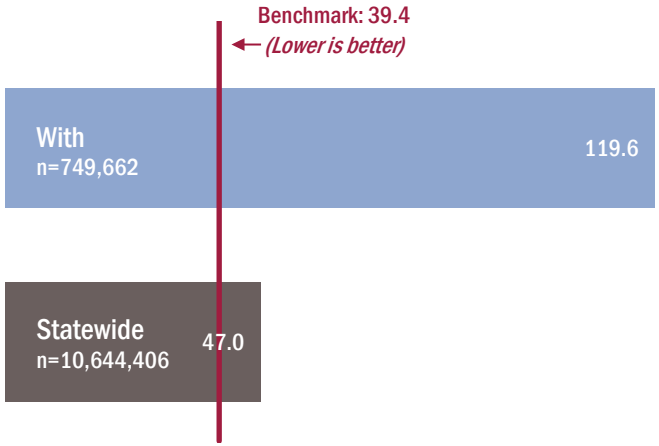
# MEASURES BY SEVERE AND PERSISTENT MENTAL ILLNESS

## Introduction

This section shows 2015 mid-year data (July 2014 – June 2015) for three measures, reported for Medicaid members with severe and persistent mental illness, compared to statewide. Additional measures will be included in the 2015 Final Report (published in June 2016).

**Severe and persistent mental illness** refers to people 18 years and older who have had two or more services with any of the qualifying diagnosis codes in the past 36 months: 295xx, 297.3, 298.8, 298.9, 300.3, 309.81, 301.22, 301.83, 296xx. This definition is also used for U.S. Department of Justice reporting.*

### Emergency department utilization among members with severe and persistent mental illness compared with statewide.




### Mid-2015 data

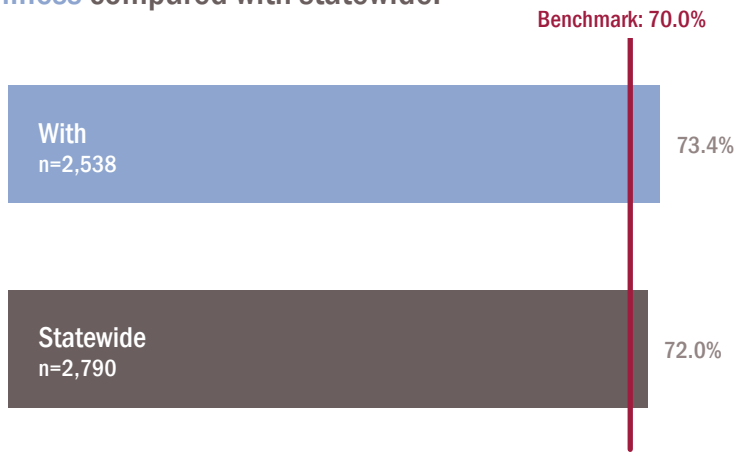
While emergency department utilization has been declining in Oregon, Medicaid members with severe and persistent mental illness have much higher rates of emergency department utilization than statewide.

National data indicate that individuals with more severe mental health conditions were more likely to have multiple emergency department visits during a year. Oregon will continue to monitor this metric to determine if additional community services made possible by recent investments lead to a decreased utilization of emergency departments for individuals with severe and persistent mental illness.

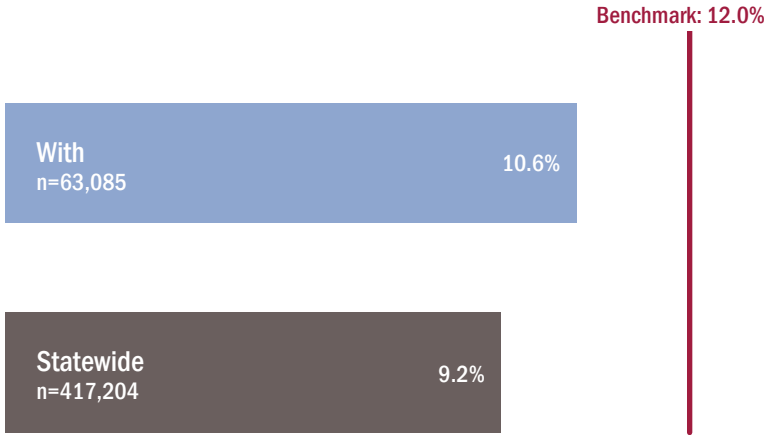
**For more information, visit www.oregon/gov/oha/amh/pages/doj.aspx*

# MEASURES BY SEVERE AND PERSISTENT MENTAL ILLNESS

Follow-up after hospitalization for mental illness for adult members with severe and persistent mental illness compared with statewide.




Screening, brief intervention, and referral to treatment (SBIRT) for adults with severe and persistent mental illness compared with statewide.



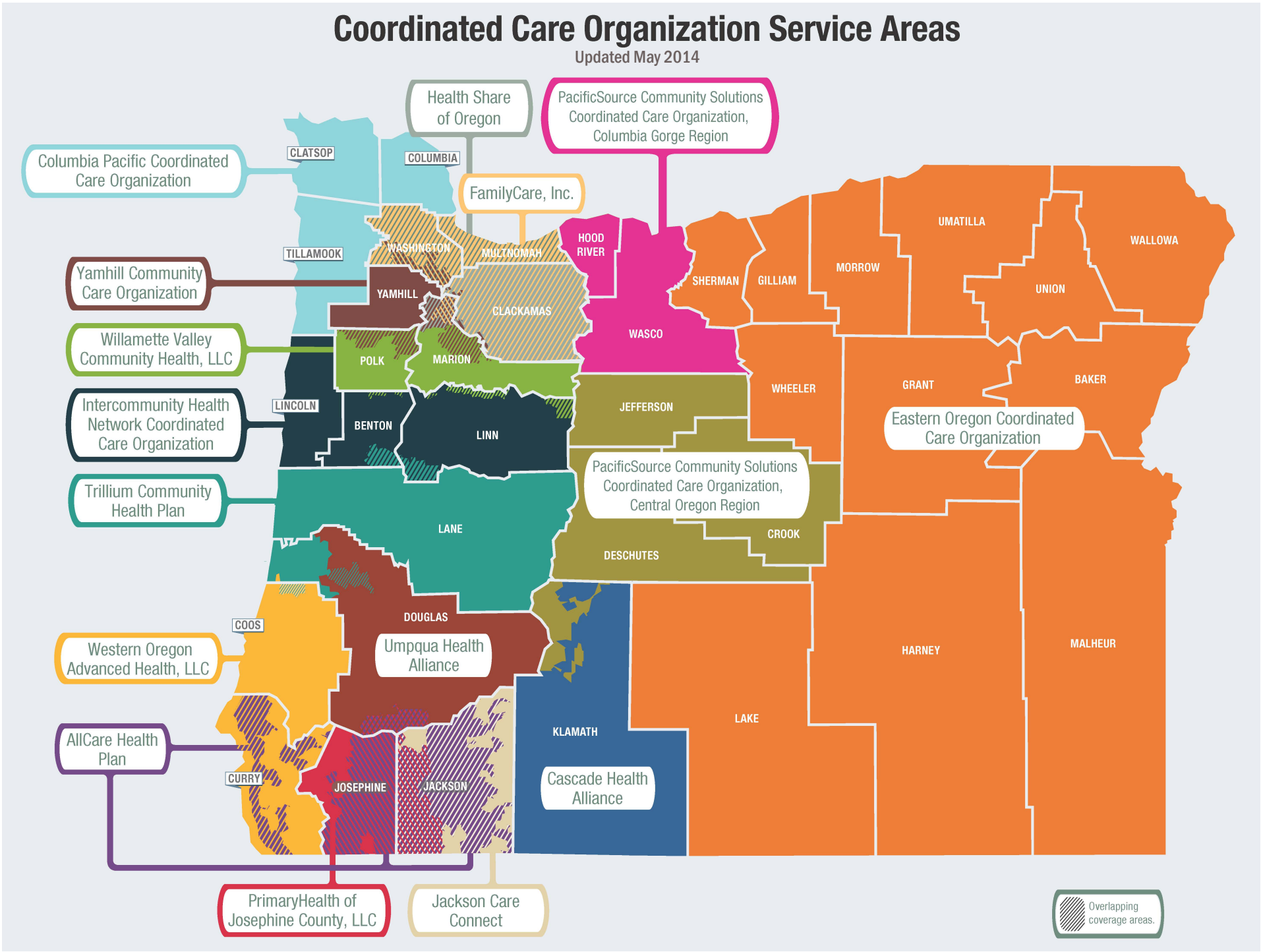

## Mid-2015 data

Screenings and brief intervention for alcohol or other substance abuse (SBIRT) are slightly higher for people with severe and persistent mental illness (SPMI) than statewide. Since people with SPMI are at increased risk for alcohol or substance abuse disorders, this first look at SBIRT screenings are promising.

Follow-up visits after hospitalization for mental illness are very similar for members with severe and persistent mental illness, which makes sense given that the measure looks for mental health related hospitalizations.

# Coordinated Care Organization Service Areas

Updated May 2014



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**For more information about technical specifications for measures, visit:** www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

**For more information about coordinated care organizations, visit:** www.health.oregon.gov

**To view this report and previous metrics reports online, visit:** www.oregon/gov/oha/metrics


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Office of Health Analytics