

Information for a Healthy Oregon



Statewide Report on Health Care Quality 2014

OREGON HEALTH CARE
QUALITY
CORPORATION

Welcome

Letter from the
Board Chair
and Executive
Director

One of our favorite sayings is “data flows at the speed of trust.” Over the past year, we’ve learned that trust in the power of collaboration and transparency to help improve health care is a value shared by Oregonians. As a testament to this value, many of our partners and data suppliers have signed on to support our groundbreaking efforts to measure and report on the costs of health care in Oregon. Multiple stakeholders have dedicated their time and expertise to guide the development of those reports. And through our work with national initiatives to improve care, we’re continuously reminded that our Oregon partnerships are truly unique and valuable.

Two years ago, the Oregon Health Care Quality Corporation’s board of directors and committee members made a bold decision to move beyond quality and utilization to add cost of care to our measurement initiative. Our shared goal is to help multiple stakeholders achieve the Triple Aim outcomes of a healthy population, exceptional patient care and affordable costs. Based on strong feedback and support, we’ve set out to develop actionable cost of care reports. Our initial focus is on the development of the Total Cost Index and Resource Use Index measures developed by HealthPartners® and endorsed by the National Quality Forum (NQF).

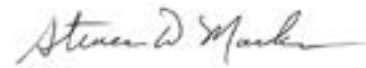
These measures were chosen because of their integrity and utility. In addition to being in existence for over 10 years and used in 29 states, these measures are the foundation of reports that can be used to improve the quality and affordability of care. (For more information on our cost of care program and the HealthPartners measures, see page 23.)

This fall we’ll be rolling out our cost of care reports to providers, with reports for additional audiences to come in 2015.

Though we recognize that this is an evolving process that requires the guidance of all stakeholders on the appropriate use of this information, over the years to come we believe the utility of these reports will continue to expand and be used in the following ways:

- Providers can use the reports to evaluate overall costs and practice efficiency through comparison with statewide and national benchmarks.
- Payers can use the reports to help design benefits packages and develop payment approaches.
- Policymakers can use the reports to inform development of innovations that assess quality and cost for plans and providers.
- Researchers can use the reports to evaluate quality measures and cost and resource drivers in the health care industry.
- Individuals and employers can use the public reports to guide decisions about providers and services based on both quality and cost.

As with all of our work, we also plan to use these reports for multi-stakeholder collaboration in Oregon. We hope you will join us in these collaborative efforts as we continue on this groundbreaking journey.



Steven D. Marks, MD, MHA
Board Chair



Mylia Christensen
Executive Director



In April 2014 the Patient-Centered Primary Care Institute hosted more than 60 quality improvement, technical assistance and primary care home experts from more than 30 organizations in Oregon to network, share tools and resources and brainstorm solutions to primary care transformation challenges.

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Producing unbiased information to improve health care in Oregon

As a trusted resource for unbiased and actionable health care information, the Oregon Health Care Quality Corporation (Q Corp) produces reports for multiple stakeholders to help improve the health of all Oregonians. The goal of this annual report is to analyze information across populations to identify opportunities for improving the quality, affordability and patient experience of health care in Oregon. This report also helps track the progress and impact of local and national health care reform efforts.

OVERVIEW

The data in this report is based on administrative (billing) claims from 10 of Oregon's largest health plans, two managed Medicaid organizations, the Oregon Health Authority Division of Medical Assistance Programs (Medicaid) and the Centers for Medicare & Medicaid Services (CMS) Medicare Fee-for-Service.* Q Corp now has seven years of historical claims data, representing care for more than three million Oregonians since 2006. Data for the current measurement year—July 2012 to June 2013—represents care for 2.6 million members. The data in this report represent 80 percent of the fully insured commercial population, 35 percent of the self-insured commercial population, 100 percent of the Medicaid population and 92 percent of the Medicare population in Oregon. The aggregated dataset allows Q Corp to track care when patients change health care coverage, providing a more complete view of health care quality and utilization than would be possible with data from a single source. For more information, a detailed Technical Appendix is available at Q-Corp.org.

KEY HIGHLIGHTS

- Q Corp is committed to expanding its data sources. In November 2012 Q Corp became one of the first three organizations in the U.S. to become a certified qualified entity to receive Medicare Fee-for-Service data from CMS. In August 2014 Q Corp was the first organization in the U.S. to use this data in its public reports of health care quality. This report now includes information for 92 percent of the Medicare population, compared to 41 percent last year.
- An analysis of chlamydia screening shows that rates have increased from 28.8 percent in 2009 to 45.5 percent for the measurement year in this report. However, significant opportunity exists to improve this area of care, particularly for adolescents. (See page 10 for further discussion of practices that primary care clinics are adopting to improve chlamydia screening rates for adolescents.)
- Analysis of potentially avoidable emergency department (ED) visits shows that rates for different payer types have had an overall slight downward trend since 2010. Though Medicaid has the highest overall rates across the measurement years as compared to other payer types, the Medicaid population has had the greatest overall downward trend for potentially avoidable ED visits for both children and adults.

*The following measures in this report include Medicare Fee-for-Service data:

Ambulatory Care: Emergency Department Visits
 Ambulatory Care: Outpatient Visits
 Breast Cancer Screening
 Cholesterol (LDL-C) Screening for People with Heart Disease
 Diabetes Blood Sugar (HbA1C) Screening
 Diabetes Cholesterol (LDL-C) Screening
 Diabetes Eye Exam
 Diabetes Kidney Disease Monitoring
 Potentially Avoidable Emergency Department Visits (Medi-Cal and NYU Methodologies)

WHAT'S BEING MEASURED

Each year with the guidance of Q Corp's multi-stakeholder Measurement and Reporting Committee, quality, cost and resource use measures are reviewed and selected for reporting to a variety of audiences to support health care transformation efforts. Regionally and nationally there is a growing volume of new measures being

introduced and interest in aligning measures across initiatives. As part of Q Corp's annual review process, committee members evaluate both existing and new measures to produce a relevant and actionable measure set. The table below shows the alignment of Q Corp's measures across these initiatives.

Alignment of Q Corp 2014 Measures	OHA CCO Performance Measures	PCPCH Quality Measures	Cover Oregon 2013 Measures	CMS 5-Star Performance
30-Day All-Cause Readmissions	✓			✓
Adolescent Well-Care Visits	✓*	✓		
Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment (SBIRT)	✓*	✓		
Ambulatory Care: Outpatient and ED Visits	✓*			
Antidepressant Medication Management			✓	
Appropriate Asthma Medications		✓		
Appropriate Low Back Pain Imaging				
Appropriate Use of Antibiotics for Children with Sore Throats	✓	✓		
Breast Cancer Screening		✓	✓	✓
Cervical Cancer Screening	✓	✓		
Chlamydia Screening	✓			
Cholesterol (LDL-C) Screening for People with Heart Disease		✓	✓	✓
Developmental Screenings in the First 36 Months of Life	✓*			
Diabetes Blood Sugar (HbA1c) Screening	✓	✓	✓	
Diabetes Cholesterol (LDL-C) Screening	✓	✓	✓	✓
Diabetes Eye Exam			✓	✓
Diabetes Kidney Disease Monitoring			✓	✓
Follow-up Care for Children Prescribed ADHD Medications	✓*	✓		
Potentially Avoidable Hospital Admissions	✓		✓	
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life		✓		
Well-Child Visits in the First 15 Months of Life	✓	✓	✓	

*CCO Incentive Measure

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STATE SNAPSHOT

Q Corp continually tracks the performance of primary care clinics in Oregon on a number of quality and resource use metrics. The combination of Q Corp's expansive claims dataset and unique Oregon provider directory allows patient care to be assigned to the appropriate provider and clinics for reporting. (For more information on Q Corp's provider directory, which includes 3,453 practicing primary care providers in Oregon, see page 13.) The table on the following page provides a snapshot of Oregon's overall clinic performance on these measures, which are analyzed in greater detail later in the report.

The table shows Oregon's mean clinic scores compared to local and national benchmarks. For the local benchmark, Q Corp calculates the Oregon Achievable Benchmark of Care, labeled "Oregon's Best Benchmark." This benchmark provides a method to identify performance levels already being achieved by "best-in-class" clinics within Oregon. Best-in-class Oregon clinic scores are calculated using the pared mean rate of the highest performing clinics providing care to at least 10 percent of the patient population.

The national benchmarks come from the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS®). For each measure, the national mean and 90th percentile were calculated by weighting the 2013 HEDIS benchmarks for each line of business based on the proportion of each population (commercial, Medicaid and Medicare).

Key findings

- Oregon's mean clinic score is significantly higher than the combined national HEDIS mean and 90th percentile for appropriate low back pain imaging and short-term and long-term antidepressant medication management.
- Oregon's mean clinic score is significantly lower than the combined national HEDIS mean on eight quality measures, including a newly added measure, adolescent well-care visits.
- For the first time, mean clinic scores for cholesterol screening for people with heart disease and diabetes kidney disease monitoring have fallen below the national averages. However this may be due to changes in Q Corp's data and methodologies. For a more detailed discussion of these findings, see page 8.

	Oregon Mean Clinic Score	N / Clinics	Oregon Clinic Low – High Score	Standard Deviation	2013 Combined HEDIS National Mean*	2013 Combined HEDIS National 90th Percentile*	Oregon's Best Benchmark
Primary Care Quality Measure							
Antidepressant Medication Management (Long Term)	61.0%	10,212 / 137	34.9 – 87.0	12.6	47.1	56.2	86.4
Appropriate Low Back Pain Imaging	86.9%	10,638 / 163	65.6 – 99.6	6.7	74.7	81.7	99.1
Antidepressant Medication Management (Short Term)	73.6%	10,212 / 137	47.9 – 97.5	10.8	62.6	71.1	96.1
Appropriate Use of Antibiotics for Children with Sore Throats	77.5%	9,050 / 118	17.6 – 97.4	17.3	72.2	86.3	95.9
Diabetes Eye Exam	62.4%	95,382 / 522	32.4 – 91.5	10.1	59.3	73.0	80.6
Appropriate Asthma Medications	88.2%	16,820 / 241	63.6 – 100.0	6.1	87.7	91.9	96.8
Breast Cancer Screening	65.6%	245,271 / 641	20.0 – 93.5	11.9	65.3	73.6	84.8
Diabetes Blood Sugar (HbA1c) Screening	88.1%	95,382 / 522	39.0 – 100.0	7.1	88.8	93.9	96.2
Chlamydia Screening	45.5%	37,066 / 371	11.6 – 85.7	12.5	49.1	61.0	71.3
Cholesterol (LDL-C) Screening for People with Heart Disease	82.9%	17,188 / 219	53.5 – 100.0	9.0	87.4	93.5	95.7
Diabetes Cholesterol (LDL-C) Screening	79.7%	95,382 / 522	30.0 – 100.0	10.7	84.4	90.8	92.5
Cervical Cancer Screening	64.9%	253,794 / 637	17.5 – 95.9	11.7	71.3	78.4	87.8
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	58.0%	106,716 / 354	16.7 – 87.8	15.2	64.6	79.7	82.3
Well-Child Visits in the First 15 Months of Life, Six or More	64.0%	24,240 / 184	10.4 – 96.4	15.5	73.2	84.0	86.4
Diabetes Kidney Disease Monitoring	72.8%	95,382 / 522	29.4 – 98.5	14.1	84.9	90.8	95.1
Adolescent Well-Care Visits	29.9%	175,592 / 587	4.8 – 67.1	12.0	44.6	61.2	52.4
Generic Prescriptions Fills, Statins	89.8%	666,121 / 643	34.8 – 100.0	7.6	n/a	n/a	98.8
Generic Prescriptions Fills, SSRIs	88.4%	1,112,464 / 715	58.1 – 100.0	7.0	n/a	n/a	96.2

* Benchmarks were created using a weighted formula based on the proportion of Q Corp commercial, Medicaid and Medicare members within each measure.

The HEDIS® diabetes definition requires only a single face-to-face encounter in an acute inpatient or emergency room setting with a diagnosis of diabetes. Based on clinic chart review results, Q Corp modified the definition to require two or more face-to-face encounters beginning with fall 2012 reporting. The modified definition is expected to impact less than 2.5 percent of patients identified in the measure.

KEY

- Score is significantly higher than the national mean and 90th percentile
- Score is significantly higher than the national mean, and significantly lower than the 90th percentile
- Score is not significantly different than the national mean
- Score is significantly lower than the national mean
- No national benchmarks are available for comparison

Producing unbiased information to improve health care in Oregon

For the first time, Q Corp has found that the mean clinic scores for cholesterol screening for people with heart disease and diabetes kidney disease monitoring have fallen below the national averages. Some notable changes in Q Corp's data and methods have occurred over five editions of the statewide report, including the expansion of Q Corp's database to include 100 percent of the Medicaid population and 92 percent of the Medicare population in Oregon.

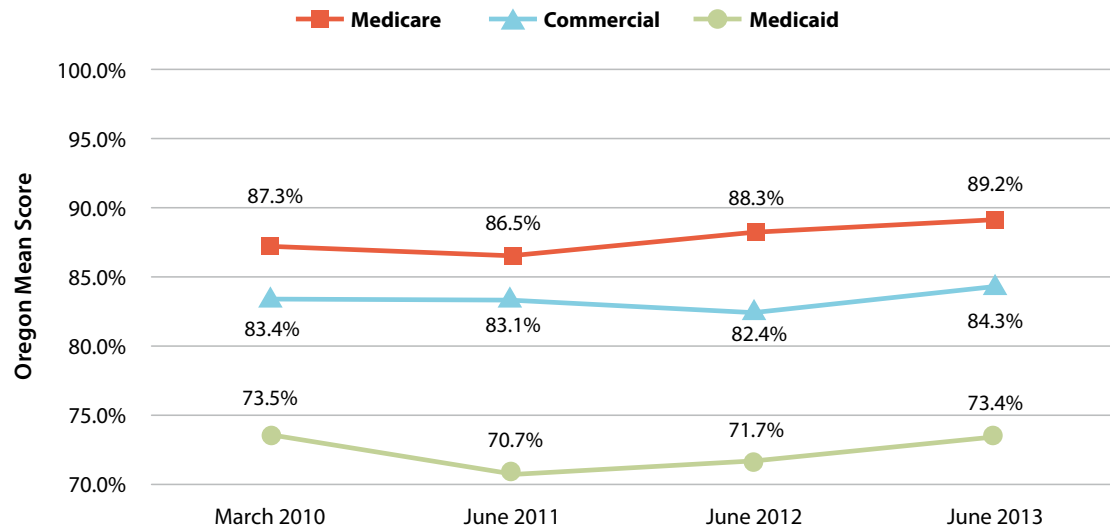
Noting these changes, the graphs on the following page illustrate the difference in scores across payer types since 2010. For Medicare members with diabetes, 89.2 percent are screened for kidney disease, up from 87.3 percent in 2010 and falling just below the HEDIS national average for Medicare (89.3 percent). For cholesterol screening for people with heart disease, the scores for the Medicare and commercial populations are above the national HEDIS averages for these payer types (88.7 and 83.7 percent, respectively) and show a slight increase since 2010. For both measures, the Medicaid population falls below the Medicaid HEDIS averages (77.8 percent for kidney disease monitoring and 82.0 percent for cholesterol screening). However the scores for Medicaid since 2010 on both measures have remained flat, indicating that Oregon providers have an opportunity to improve care in these areas.

Q Corp's Public Reports Include Medicare Data to Help Consumers Better Compare the Quality of Health Care in Oregon

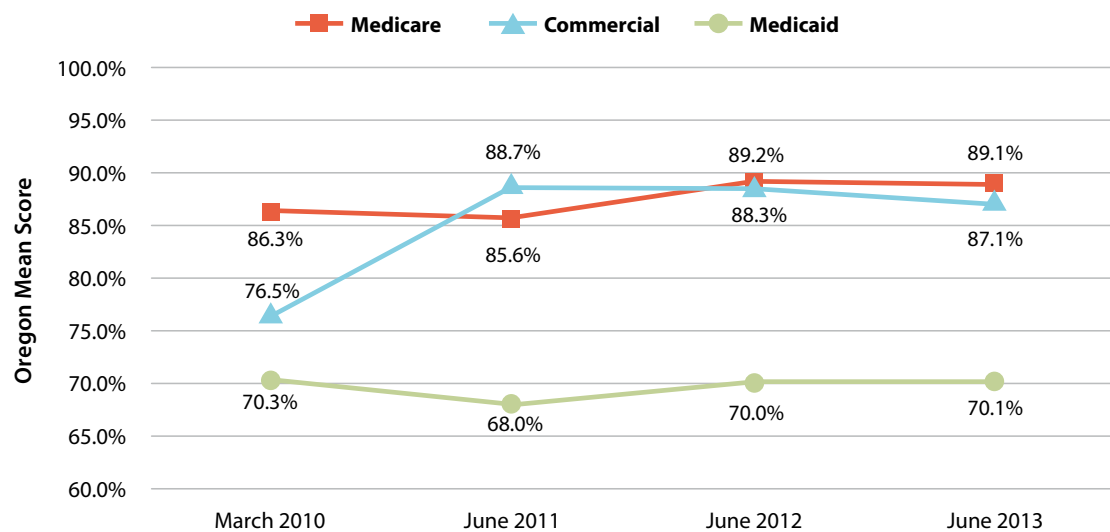
In August 2014 Q Corp released the nation's first public reports on the quality of local primary care that include data provided by CMS through the Qualified Entity Certification Program. The addition of this data significantly expands the information consumers can access about the quality of care in Oregon by increasing the number of clinics that meet the public reporting criteria of at least 30 patients in a measure. For example, consumers can now compare the quality of care for heart disease provided by more than twice as many clinics as in the previous report. For diabetes care, the number of clinics that are now included in the public report increased to 342, up from 250 in 2013.

Published on Q Corp's *Partner for Quality Care* website, the public reports enable Oregonians to compare how clinics perform in areas such as preventive care, chronic disease care and appropriate use of health care services. To be included in the reports, a clinic must have at least three primary care providers and at least 30 patients who meet the strict criteria to be included in the measures of care. For more information, visit PartnerforQualityCare.org.

Diabetes Kidney Disease Monitoring Mean Scores for Oregon Primary Care Clinics by Payer Type



Cholesterol Screening for People with Heart Disease Mean Scores for Oregon Primary Care Clinics by Payer Type



Oregon opportunities for improvement

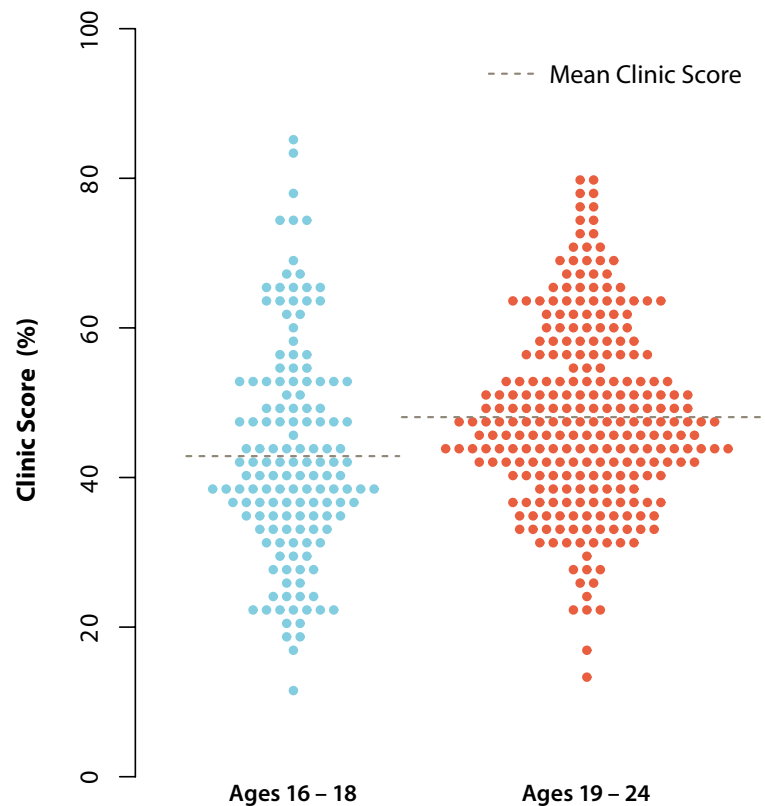
IMPROVING PREVENTIVE CARE

CHLAMYDIA SCREENINGS

In 2009, Q Corp published its first statewide report, which showed that Oregon's chlamydia screening rate of 28.8 percent was lower than the national average of 32.9 percent. This year Oregon's chlamydia screening rate is still lower than the national average, though it has increased to 45.5 percent of eligible women receiving this service. Chlamydia continues to be the most common reportable illness in Oregon, with nearly 14,000 cases reported in 2011.¹ Chlamydia disproportionately affects younger people, with 69 percent of cases occurring in men and women 15 to 24 years of age in the US in 2012.² For young women, early diagnosis and treatment of chlamydia can help them avoid further complications, including infertility.

The introduction of Q Corp's chlamydia screening measure has prompted conversations by health care stakeholders about ways to improve this area of care. To determine if there are age-related barriers to providing recommended chlamydia screenings, this year Q Corp conducted an analysis of screening rates for women ages 16 to 18 compared to women ages 19 to 24. The analysis, shown in the graph on this page, found a significantly lower rate for the younger age band (42.5 percent for women ages 16 to 18 versus 48.9 percent for women ages 19 to 24). However the analysis also shows that some clinics have rates over 80 percent for providing recommended chlamydia screenings to women ages 16 to 18.

**Chlamydia Screenings:
Oregon Primary Care Clinic Variation
by Age Group**



Informal interviews with the top performing clinics in the younger age band found that confidentiality and access issues are major barriers to providing chlamydia screenings to women 16 to 18 years of age. This includes fear among young people of parental notification of a chlamydia screening through an Explanation of Benefits (EOB) that accompanies a bill for health care services. The clinics that were interviewed either receive Title X funding or have a high percentage of patients covered by Medicaid, which means confidentiality concerns are mitigated by the fact that the billing system does not generate an EOB. However, issues of access and confidentiality for commercially insured young patients remain. The clinics that were interviewed provided the following examples of workflow processes that have been implemented to address these barriers:

1. All patients, regardless of the reason for the medical appointment, are assessed for sexual activity by a medical assistant prior to meeting with the provider. If the assessment confirms that the patient is sexually active, he or she is screened for chlamydia.
2. All patients are screened for chlamydia at their annual visits as a clinic policy. When a patient is taken into a procedure room, a urine sample is collected to be screened as part of routine care. If an EOB is sent home, parents are informed of the policy. If parents ask for the results of the screening, they are informed that the patient must release the results.

The clinics that were interviewed noted that the issue of confidentiality for STD screening in younger people is a problem across the nation. Q Corp will continue to track chlamydia screening rates and share further information with providers and other stakeholders across Oregon.

Regional Equity Atlas: Geography of Opportunity for the Portland Metro Region and Beyond

The Regional Equity Atlas developed by the Coalition for a Livable Future (CLF) uses maps, policy analysis, community based research and other tools to assess how well different populations across the Portland-Vancouver metro region can access key resources necessary for meeting their basic needs and advancing their health and well-being. With support from *Aligning Forces for Quality*, a program of the Robert Wood Johnson Foundation, in 2012 Q Corp partnered with CLF to provide information on chronic disease incidence, pediatric preventive care and potentially avoidable ED visits to the Regional Equity Atlas 2.0. By combining these health measures with information on demographics and access to social services, the

Regional Equity Atlas 2.0 helps demonstrate how social determinants play a critical role in the health of the population.

Today Q Corp and CLF are working to develop a toolkit to help other communities across the country replicate the Regional Equity Atlas model. Supported by RWJF, the toolkit aims to share the Regional Equity Atlas model to inspire and support other communities to better understand their region's geography of opportunity and help promote greater regional equity. For more information about the Equity Atlas 2.0, visit www.equityatlas.org.

Oregon opportunities for improvement

BREAST CANCER SCREENINGS

Last year Q Corp conducted an analysis of breast cancer screening rates by age band to track the use of this service compared to updated recommendations from the United States Preventive Services Task Force (USPSTF). The updated recommendations include biennial screening for women 50 to 74 years of age, and states that the decision to start regular, biennial screening before 50 years of age should be based on a patient's individual circumstances. The USPSTF also concluded that there is insufficient evidence on the additional benefits and harms of screening mammography in women 75 years and older.

Comparing results for breast cancer screening by age band from this year to the 2013 statewide report reveals some similarities. For women 50 to 74 years of age, both the 2013 and 2014 analyses reveal significant room for improvement in meeting the USPSTF recommendation of biennial screening for this age group. The analyses also showed significant variation in screening women younger than 50 years and older than 75.

Comparing results from the 2013 report also shows significant decreases for all age bands in the rate of breast cancer screenings. Q Corp conducted additional analyses to determine if this finding is due to the inclusion of Medicare Fee-for-Service data for the first time in this year's report. As indicated in the chart below, excluding Medicare Fee-for-Service data shows that a significant decrease in rates still occurs for women 40 to 49 and 50 to 74 years of age as compared to the findings in the 2013 report. However, for women older than 75 years of age no significant change in breast cancer screening rates occurs when Medicare Fee-for-Service data is excluded from the analyses. The decrease in rates for women 40 to 49 years of age may be an indication that the changes to the USPSTF recommendations are being adopted for this age band. However, the decrease in rates for women 50 to 74 years of age shows an opportunity for improving screening practices for this age band. The rates for women 75 years of age and older also demonstrates an opportunity to educate providers and consumers about the potential overuse of screening for these age groups.

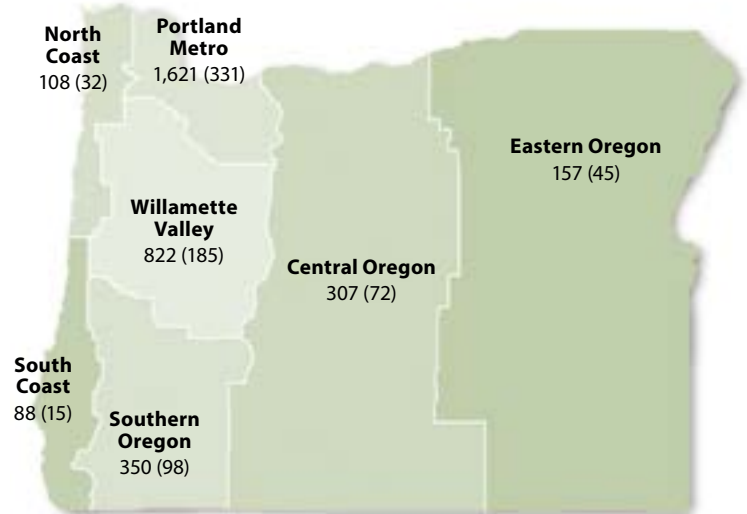
Age Group	OREGON RATES (N)		
	2013 Statewide Report (July 2011–June 2012 Measurement Year)	2014 Statewide Report (July 2012–June 2013 Measurement Year)	2014 Statewide Report (Excluding Medicare Fee-for-Service)
40 – 49	64.5% (97,793)	60.4% (108,979)	61.8% (100,197)
50 – 74 (USPSTF recommended)	74.3% (220,839)	67.9% (333,970)	73.7% (213,170)
75 – 84	57.3% (41,529)	55.1% (92,153)	60.7% (37,509)
85 and older	26.3% (23,421)	25.3% (50,993)	26.7% (20,550)

TRANSFORMING PRIMARY CARE

PROVIDER DIRECTORY INCLUDES 3,453 PROVIDERS

Q Corp maintains the most comprehensive provider directory in Oregon. This directory links practicing primary care providers with the clinics and medical groups where they work, allowing Q Corp to attribute patients to the appropriate provider, clinic and medical group for reporting. The provider directory now includes information for 3,453 practicing primary care providers in 778 clinics across Oregon, up from 3,394 providers in 741 clinics a year ago. Providers in Q Corp's database include adult and family primary care physicians, pediatricians, nurse practitioners and physician assistants. The map to the right illustrates the regional distribution of clinics and providers in the provider directory. More information can be found in the Technical Appendix available online at Q-Corp.org.

Geographic Distribution of Primary Care Providers and Clinics Included in Q Corp's Provider Directory March 2014

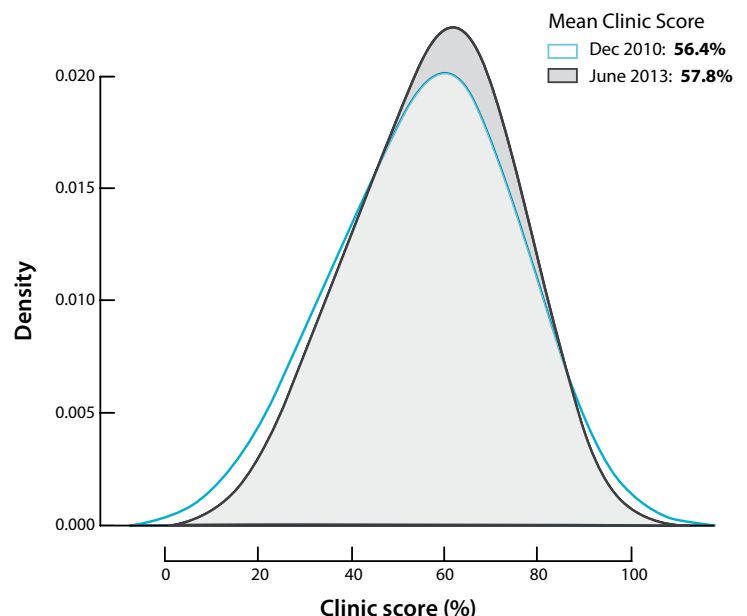


Primary Care Providers Included in Provider Directory
(Clinics Included in Provider Directory)

IMPROVEMENTS IN CARE VARIATION: WELL CHILD VISITS

Well-child visits represent an important opportunity for children and families to develop a relationship with their primary care provider as well as to receive immunizations and other necessary screenings. Yet well-child visits have been an area with significant opportunity for improvement since the measures were first introduced in Q Corp's 2012 statewide report. The 2012 statewide report revealed a wide range of variation in clinic performance for well-child visits. The good news is that an analysis of clinic performance for well-child visits for children 3–6 years of age shows that a large proportion of clinics have increased their scores and there is less variability in the distribution of scores.

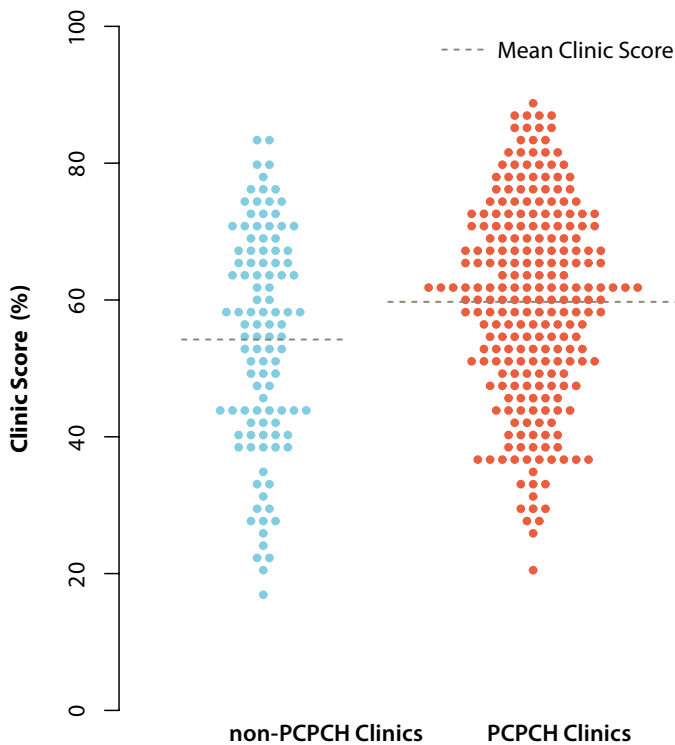
Well-Child Visits (3–6 years)



Oregon opportunities for improvement

Further examination of well-child visits for children 3–6 years also shows that clinics that are recognized as Patient-Centered Primary Care Homes (PCPCH) by the Oregon Health Authority (OHA) have a significantly higher mean clinic score than those not recognized (60.0 percent versus 54.2 percent). As indicated in the graph shown on this page, PCPCH recognized clinics also had the highest scores for this measure. The goal of PCPCH clinics is to improve the quality of health services delivery by improving access, coordinating comprehensive care and focusing on strong relationships with patients and families.

**Well-Child Visits 3–6 Years:
Oregon Primary Care Clinic Variation
PCPCH-Recognized vs. Non-Recognized Clinics**



Patient-Centered Primary Care Institute Launches Online Learning Modules to Help Clinics Become PCPCH Recognized

The Patient-Centered Primary Care Institute has launched online learning modules to help clinics meet the 2014 recognition standards of the OHA Patient-Centered Primary Care Home (PCPCH) program. The interactive modules are an educational resource for clinic team members, administrators and other primary care stakeholders working toward primary care home transformation.

Founded in 2012, the Institute brings together health care providers, clinic staff, technical experts, patient advisors, quality improvement professionals, policymakers and academic centers to gather and share valuable practice transformation knowledge and resources. The Institute accelerates primary care transformation in Oregon by connecting practices in all stages of primary care home transformation — from those looking to begin the process to those already recognized — to a broad array of technical assistance.

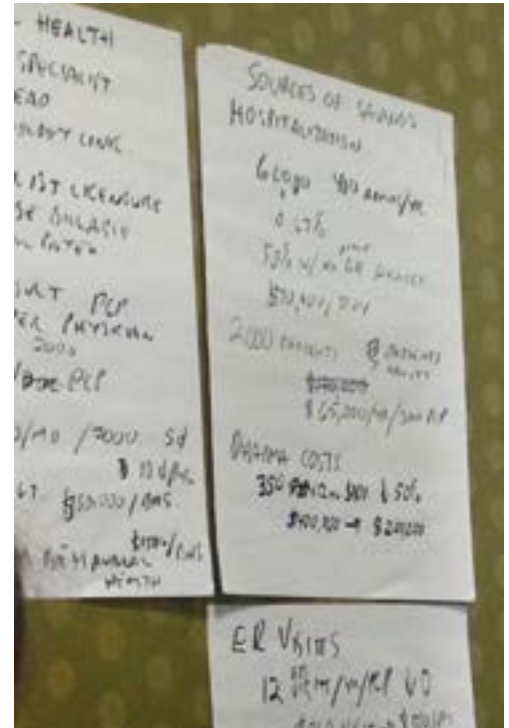
The Institute partners with technical assistance experts and practices from across Oregon on Learning Collaboratives that include in-person learning sessions and individualized practice coaching. Additionally, the Institute hosts webinars on a variety of topics related to primary care transformation. Upcoming webinars and recordings of past webinars, as well as a wealth of other resources, are available at PCPCI.org.

TRANSFORMING CARE ACROSS OREGON

POTENTIALLY AVOIDABLE EMERGENCY DEPARTMENT VISITS

Since 2012, Q Corp has tracked the rates of potentially avoidable ED visits. This measure provides health care stakeholders with information to help identify areas where care could have been provided in a more appropriate and affordable setting. The analyses in this section are based on a measure developed by the Medi-Cal Managed Care Division of the California Department of Services. This measure identifies potentially avoidable ED visits by using a conservative list of diagnosis codes for conditions that are typically treated by a primary care provider in an outpatient setting (e.g., colds). The list of diagnosis codes does not include mental health, dental care or exacerbation of certain chronic conditions. Lower scores for avoidable ED visits indicate that a higher proportion of cases in the ED were indicated based on the diagnosis.

The table below shows the scores for potentially avoidable ED visits for both children and adults. Compared to last year Oregon's scores for potentially avoidable ED visits have increased slightly. However, looking back to 2010, further analysis of potentially avoidable ED visits shows that rates for different payer types have had an overall slight downward trend. Though Medicaid has the highest overall rates across the measurement years as compared to other payer types, the charts on page 16 show that the Medicaid population has had the greatest overall downward trend for potentially avoidable ED visits for both children and adults. For the Medicaid population, avoidable ED rates have decreased from 19.4 percent to 16.7 percent in children and from 12.7 percent to 11.9 percent in adults. Decreases seen in potentially avoidable ED visits may be partially explained by the introduction of CCOs. In a recent CCO progress report, the OHA reports a 13 percent decrease in overall ED utilization when comparing preliminary 2013 data to the 2011 baseline.

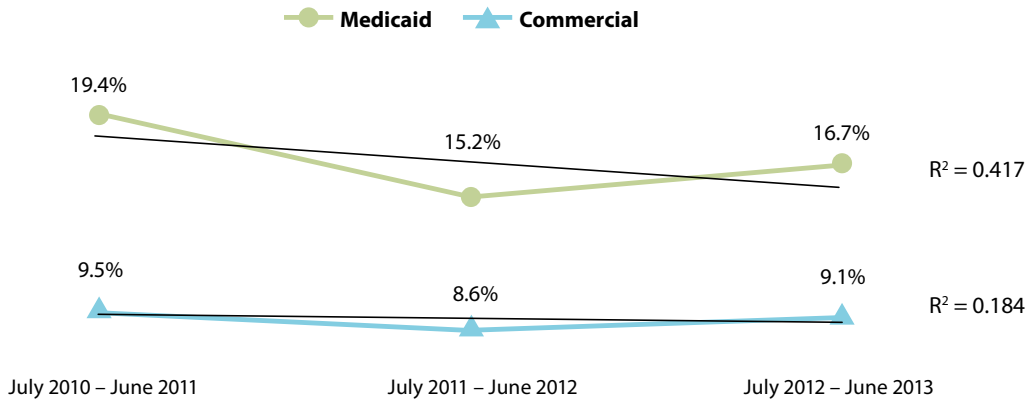


Measure	Oregon Score Potentially Avoidable ED Visits/Total ED Visits	95% Confidence Interval	Total ED Visits	Oregon Rate Potentially Avoidable ED Visits/100,000 Members
Potentially Avoidable ED Visits (Child age 1–17)	15.6%	15.4% – 15.8%	147,762	4,074
Potentially Avoidable ED Visits (Adult age 18+)	10.4%	10.3% – 10.5%	450,513	2,433

Oregon opportunities for improvement

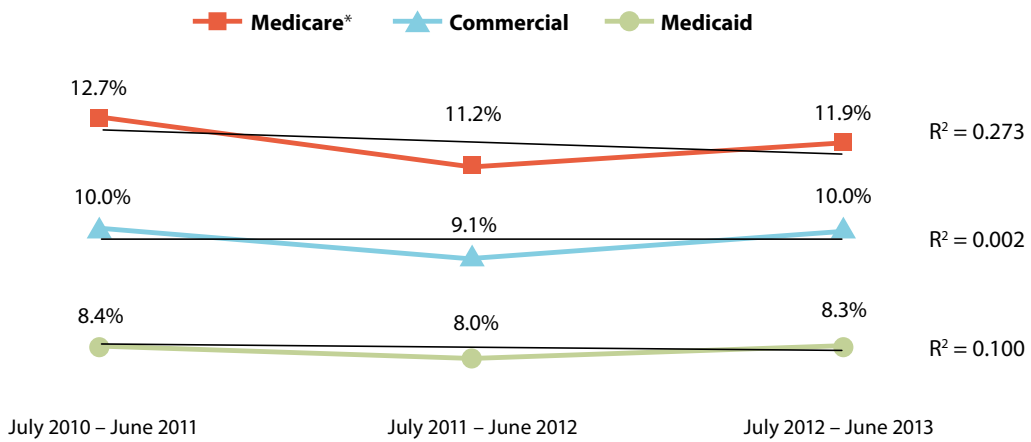
Potentially Avoidable ED Visits — Child

Avoidable ED Visits / Total ED Visits (%)
(Low scores indicate higher quality)



Potentially Avoidable ED Visits — Adult

Avoidable ED Visits / Total ED Visits (%)
(Low scores indicate higher quality)

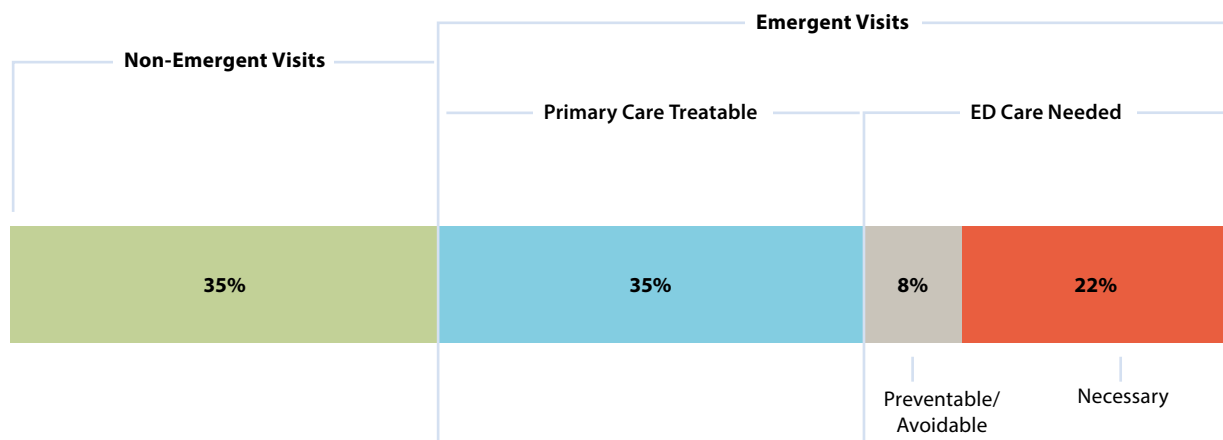


*Excludes Medicare Fee-For-Service

Another way to measure emergency department utilization is by classifying ED visits based on diagnoses into the following groups: necessary, preventable/avoidable, primary care treatable and non-emergent. The algorithm for this classification system was developed by the New York University Center for Health and Public Service Research, which excludes ED visits related to injuries, mental health, substance abuse and certain other diagnoses.

Using the NYU algorithm, this analysis shows that 70.0 percent of ED visits in Oregon were for non-emergent or primary care treatable conditions. This finding is consistent with other reports, including a study that found 74.8 percent of all ED visits in New York were for conditions that were either non-emergent or emergent but treatable in a primary care setting.³ For the proportion of cases in Oregon where ED care was indicated it is assumed based on the measure that 8 percent could have been avoided if timely and effective care in another setting was received during the episode of illness, increased from 6 percent last year. These preventable/avoidable visits, which include visits for asthma exacerbations and complications from heart disease or diabetes, may represent one of the greatest potential areas for improving care and affordability. Non-emergent visits remained the same and primary care treatable ED visits dropped 1 percent from last year. As noted above, these data exclude ED visits related to injuries (27 percent), mental health (5 percent), substance abuse issues (1 percent) and certain other diagnoses that have not been classified in the NYU system.

Emergency Department Utilization NYU Algorithm



Oregon opportunities for improvement

COORDINATED CARE ORGANIZATION MEASURES

Across Oregon efforts are underway to transform the health care delivery system to improve the quality of care while lowering costs. The OHA's coordinated care organizations (CCOs) are one such effort, working to transform care for Medicaid members. To track progress on this effort, OHA has selected and implemented a set of measures that include targets for CCO performance. OHA has contracted with Q Corp to provide validation of these measures. With the increased attention to quality improvement on these specific measures, Q Corp chose to add five of these measures to its provider-level reports. The measures were reported by Q Corp to providers this year for the first time as combined rates that include the commercial, Medicaid and Medicare populations.

In June 2014, the OHA released the Health System Transformation 2013 Performance Report. This report highlighted the CCO metrics, and the progress that has been made toward improving the quality of care delivered to CCO enrollees. It should be noted that Q Corp's results for the CCO measures are not directly comparable to the metrics included in the OHA report. The Q Corp measurement period spans July 2012 through June 2013, which is different than the measurement period for the OHA report. The overall Q Corp results include commercial, Medicaid and Medicare enrollees. Also, Q Corp has included the entire Medicaid population, which includes Medicaid members who are not eligible for enrollment in CCOs.

The coordinated care model is focused on increasing primary care and preventing and managing chronic conditions, which

should help decrease ED visits. Measuring outpatient and ED visit rates is one way to track this shift in care. The OHA reports these visits per 1,000 member months because the enrollment periods for Medicaid members are often shorter than other populations. Since the rates in this report combine commercial and Medicare with Medicaid members, Q Corp's Measurement and Reporting Committee suggested the rates be presented as utilization per 1,000 members, a common metric used in the private health care insurance industry.

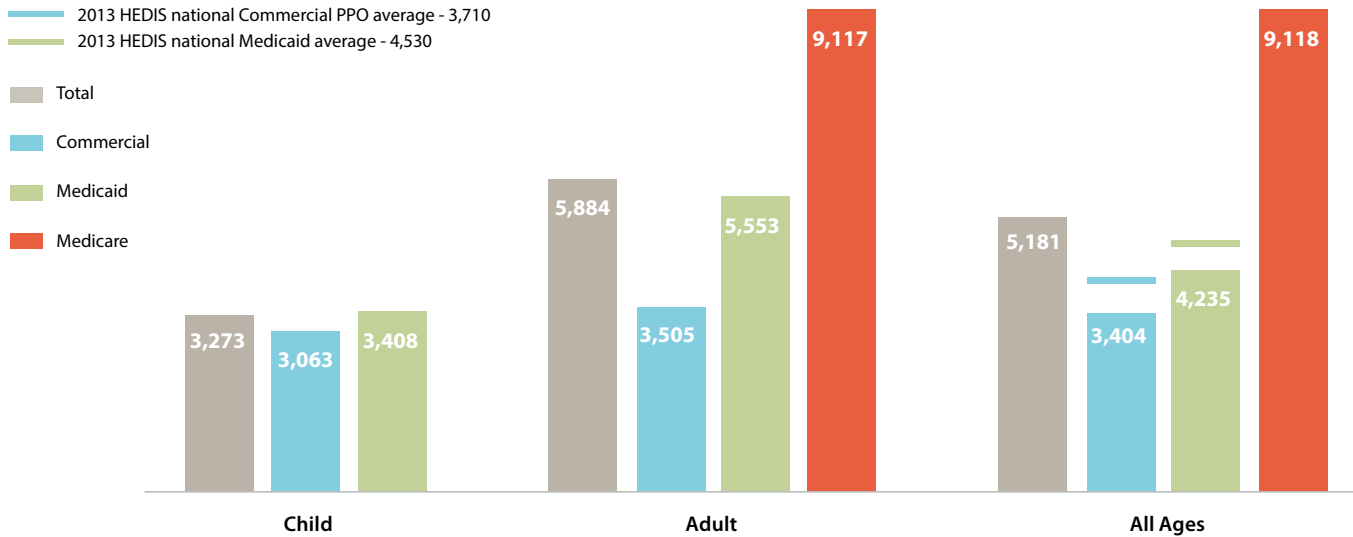
Outpatient and ED visits per 1,000 members for children and adults across payer types for the measurement period spanning July 2012 to June 2013 are shown in the charts on page 19. These results indicate the significant variation that exists between the different populations.

The measures for outpatient and ED visits are focused on overall utilization rates and do not differentiate between appropriate care and inappropriate care. For example, the average rates of ED visits for some payer types are below available national averages. Yet Q Corp's analysis of potentially avoidable ED visits in the previous section of this report shows that significant portions of ED visits are unnecessary or could have been provided in a less expensive setting. Q Corp and other stakeholders will continue to track these measures over time to evaluate whether there will be significant changes in both the volume and appropriateness of care and where patients are receiving their care.

Key findings

- For the commercial and Medicaid populations, the rates of outpatient and ED visits for all ages are lower than the 2013 HEDIS national averages. This finding may indicate a lower utilization of both outpatient and ED services in Oregon as compared to the nation.
- The Medicare population had the highest rate of outpatient visits for adults and all ages combined. This finding is consistent with the high prevalence of chronic conditions in the Medicare population, which are often appropriately managed in outpatient settings. In 2010, more than two-thirds of Medicare members in the U.S. had two or more chronic conditions.⁴
- The Medicaid population had the highest rate of ED visits. For adults, Medicaid rates of ED visits are 8.5 times higher than commercial rates. It is important to note that in the U.S. there are well-established differences in the health statuses of the Medicaid and commercially insured populations. Nonelderly adults with Medicaid have a higher illness burden, greater illness severity and higher rates of severe disability compared to privately insured adults. Medicaid members ages 21 to 64 with ED visits also more often have a diagnosis of a mental disorder than privately insured adults. Contrary to commonly held perceptions, the majority of ED visits by nonelderly Medicaid members are for symptoms suggesting urgent or more serious medical problems.⁵ For this reason, encouraging the development and use of urgent care as well as ambulatory care settings are also likely to be part of the solution to reducing ED use.

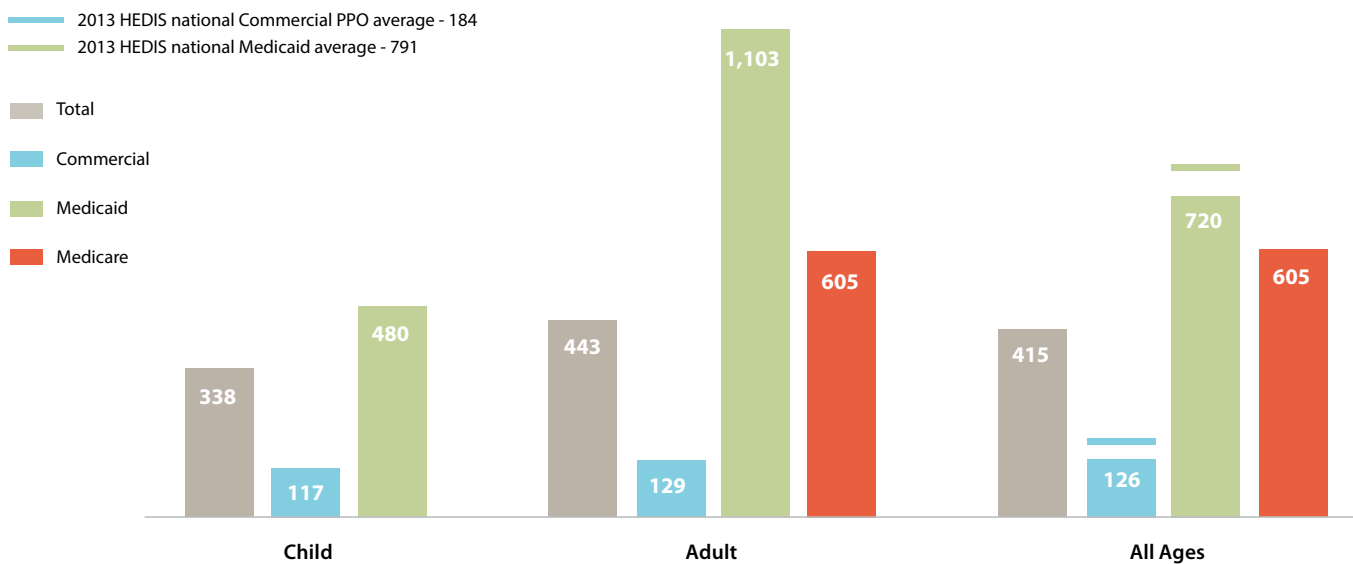
Outpatient Visits — Child and Adult Visits per 1,000 members



Q Corp measurement period: July 2012–June 2013 Note: CCOs first established in August 2012

2013 Medicaid CCO Benchmark: 439 visits per 1,000 member months
(converted to 5,268 visits per 1,000 members for children and adults combined for comparison to the chart above)

ED Visits — Child and Adult Visits per 1,000 members



Q Corp measurement period: July 2012–June 2013 Note: CCOs first established in August 2012

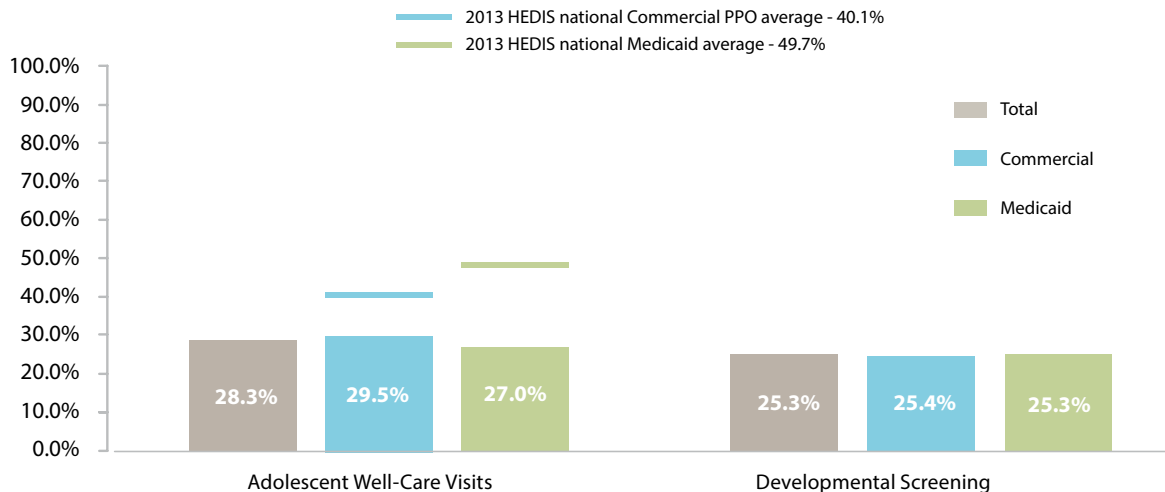
2013 Medicaid CCO Benchmark: 44.4 visits per 1,000 member months
(converted to 533 visits per 1,000 members for children and adults combined for comparison to the chart above)

Oregon opportunities for improvement

In addition to tracking outpatient and ED visits, CCO metrics also examine important preventive care measures. The chart below shows two pediatric CCO measures, adolescent well-care visits and developmental screening in the first 36 months of life. As indicated in the charts below, the rates for these measures are notably low for both payer types and show significant opportunities for improving pediatric care. Although there is only a 2.5 percent difference by payer type, the adolescent well-care visit rate in Oregon is statistically higher in the commercial population compared to the Medicaid population (29.5 percent (N=150,812) versus 27.0 percent (N=131,148), respectively). There is no significant difference between the commercial and Medicaid populations in Oregon in developmental screening rates.

For adolescent well-care visits, 2013 HEDIS benchmarks are available, demonstrating that the Oregon rates for this measure for both payer types fall below national averages. The HEDIS commercial PPO national average is 40.1 percent compared to Oregon's commercial rate of 29.5 percent. Similarly, the HEDIS Medicaid national average is 49.7 percent for adolescent well-care visits, compared to Oregon's Medicaid rate of 27.0 percent. In contrast, on page 7 Q Corp reports on Oregon's mean clinic scores for well-child visit measures for children in the first 15 months of life (64.0 percent) and 3–6 years of age (58.0 percent). Though the scores for both well-child visit measures are below the national benchmarks, they are notably higher than the total mean clinic scores for the pediatric measures shown in the charts below. These analyses show significant room for improvement in pediatric care across all age groups and payers.

Pediatric CCO Incentive Measures



Q Corp measurement period: July 2012–June 2013 Note: CCOs first established in August 2012

2013 Medicaid CCO Benchmark for Adolescent Well-Care Visits: 53.2% (2011 National Medicaid 75th percentile)

2013 Medicaid CCO Benchmark for Developmental Screening:

50.0% (Selected by OHA Metrics & Scoring Committee; based on 2007 National Survey of Children's Health)

What's next for Q Corp

MEASURING AND IMPROVING MATERNITY CARE

MATERNITY CARE

As part of the final phase of the *Aligning Forces for Quality* (AF4Q) program, Q Corp is working with stakeholders across Oregon on efforts to measure and improve maternity care. This effort includes working with a statewide collaborative to create an Oregon maternal data center (see page 22) as well as developing claims-based measures of healthy term newborns and cesarean section rates for low risk, first time mothers (nulliparous term singleton vertex or NTSV).

For the claims-based measures, Q Corp's multi-stakeholder Measurement and Reporting Committee chose NTSV cesarean section rates and healthy term newborns as a starting point to help providers and health systems identify opportunities to improve care. Additionally, Q Corp plans to publicly report these measures in 2015.

The NTSV cesarean section rate provides critical information to providers and health systems to develop quality improvement activities that can help address differences in rates among hospitals. Though many organizations track the percentage of total births by cesarean delivery, the NTSV cesarean section rate provides actionable information by showing the number of these procedures that are performed without a documented medical reason. Reducing the number of cesarean deliveries that are not medically necessary will lead to better health outcomes for the mother and the baby while also decreasing costs. Healthy mothers and babies are the ultimate goal of good maternity care. For that reason, Q Corp is also developing the healthy term newborn measure. To stay updated on this effort, visit Q-Corp.org.

OREGON PERINATAL COLLABORATIVE

Many local and national efforts are underway to help improve maternal and child health care. In 2011, the Greater Oregon Chapter of the March of Dimes coordinated a campaign to establish hard stop policies against early elective deliveries before 39 completed weeks of gestation. The effort garnered national attention when 17 hospitals, including every birthing hospital in the Portland metro area, agreed to the policy within months of the campaign. Today all birthing hospitals in Oregon have agreed to institute the hard stop policy.

Building on the success of the 39 week campaign, the Greater Oregon Chapter of the March of Dimes formed the Oregon Perinatal Collaborative (OPC) to help improve perinatal outcomes through collaboration and evidence based practices. As part of this effort, the OPC identified the need to aggregate claims and clinical data to produce meaningful information on the status of maternal and child health care in Oregon.

What's next for Q Corp

OPC SUBCOMMITTEE ON DATA FOR MEASUREMENT AND IMPROVEMENT

With support from the AF4Q program and in partnership with the OPC, Q Corp convened the new OPC Subcommittee on Data for Measurement and Improvement in October 2013. This multi-stakeholder committee is developing a plan for shared data collection and reporting to multiple audiences, including clinicians, hospitals, health systems, purchasers and consumers. Over the past year, the committee has identified priorities for metrics that will support best practices for providing maternal and child care

from preconception to postpartum and early childhood. The goal is to create an Oregon maternal data center that will provide metrics to providers and administrators working on the ground to improve care, as well as information that consumers can use to make decisions about their care. Q Corp and a team of sponsors are working to release a pilot version of the maternal data center in early 2015.

Maternity Connect

Low income women who are pregnant are more likely than higher income women to have late and inadequate prenatal care; low birth weight infants; higher perinatal morbidity and mortality; mental health concerns such as depression and anxiety; and substance use disorders. The highest rates for these conditions are in the African American and Native American populations. To help address these disparities, Q Corp and a group of Oregon partners have proposed a project to build a community collaborative to transform maternity care for low-income women and apply tested payment reform strategies to maternity settings. The work of the community collaborative—composed of three prenatal care clinics, five culturally-specific outreach organizations, all Medicaid payers in the Portland metro area and CCOs—was chosen as a finalist for an award from RWJF. For more information about this work, contact Q Corp at info@q-corp.org.



OPC Subcommittee on Data for Measurement and Improvement meets monthly to identify priorities for metrics. Photo courtesy of the Robert Wood Johnson Foundation.

MEASURING AND IMPROVING AFFORDABILITY OF CARE

COST OF CARE

In recent years there has been national momentum to gather data and develop measures to assess the cost of health care services. Through generous funding from RWJF and the pioneering support of Oregon data suppliers and stakeholders, Q Corp has been able to be a part of this national conversation through several partnerships and projects.

As a part of the RWJF grant and a national pilot project led by the Network for Regional Healthcare Improvement, Q Corp and four other regional multi-stakeholder health improvement collaboratives are piloting production of cost of care measures which can be reported to primary care clinics and the public and can be compared across regions. These measures are based on a framework developed by HealthPartners,

a large nonprofit integrated health care organization based in Minnesota, and have been in use for over 10 years. The two measures, which are endorsed by NQF, are the Total Cost Index (TCI) measure which looks at the overall cost effectiveness of managing patient health, and the Resource Use Index (RUI) measure which looks at the frequency and intensity of services used to manage patient health. The chart on this page shows an example of a report using these measures.

Providers will begin to see the initial cost of care private reports in 2014 to allow them to review the data. Throughout the year Q Corp will be soliciting input from multiple stakeholders regarding the usefulness and meaningfulness of the reports. Q Corp plans to publicly report cost of care in fall of 2015.

Example Cost of Care Report:

PMPM by Service Category

	Clinic		Benchmark		
	Raw PMPM	Adj PMPM	PMPM	TCI	RUI
Inpatient Facility	\$83	\$75	\$82	0.92	1.04
Outpatient Facility	\$101	\$84	\$100	0.84	0.99
Professional	\$168	\$147	\$151	0.97	1.03
Pharmacy	\$38	\$41	\$44	0.94	0.94
Overall	\$391	\$347	\$377	0.92	1.01

What's next for Q Corp

PAYMENT REFORM

Another segment of Q Corp's RWJF cost of care work is the facilitation of two pilot payment reform projects. The goal of these condition-specific projects is the multi-stakeholder development of alternative payment models to support improved delivery of care while reducing costs. The projects are located in Central Oregon, focusing on osteoarthritis of the knee, and Lane County, focusing on physical health and behavioral health integration. These two projects will work to turn data into action to improve the quality of care and payment methodology for these services. Q Corp has worked to bring together multiple partners in each of the two communities to assess the current system and create solutions for all stakeholders.

Enhancing Health Insurance Rate Review and Increasing Health Care Price Transparency

Building on efforts to measure health care costs and improve price transparency, Q Corp has also been working with the Oregon Department of Consumer and Business Services (DCBS) to assist with their annual health insurance rate review process by developing cost of care products for insurance carriers using data from the All Payer All Claims database. Q Corp has been providing technical assistance and expertise to DCBS to support enhanced insurance rate review and to ensure the rate setting process is fair and transparent to consumers. The effort is supported by the third cycle of Rate Review Grant funding from the Centers for Medicare & Medicaid Services.



The Alternative Payment Models for Musculoskeletal Care Workshop was held in October 2013 as part of Q Corp's Central Oregon payment reform project.

Using claims data

The information in this report comes from administrative (billing) claims. Claims data reflects information submitted by providers to payers as part of the billing process. While claims data has limitations, it provides useful information about services provided by a very large segment of the Oregon health care delivery network.

Use of claims data relies on clinics and practices to process billing information accurately and comprehensively for services rendered. Limitations of claims data include timeliness and completeness of the information. Data in this report does not include uninsured patients, patients who pay for their own health care services, or patients served by a health plan that is not providing data to Q Corp. More information about claims data is available in the Technical Appendix, available online at Q-Corp.org.

2013–2014 FUNDING PARTNERS*

ATRIO Health Plans

Bridgespan Health Company

CareOregon

FamilyCare, Inc.

Health Net of Oregon

Health Republic Insurance

Kaiser Permanente

LifeWise Health Plan of Oregon

Moda Health

Northwest Health Foundation

Oregon Health Authority Division of Medical Assistance Programs

Oregon's Health CO-OP

PacificSource Health Plans

Providence Health Plans

Regence BlueCross BlueShield of Oregon

Robert Wood Johnson Foundation

Trillium Community Health Plan

Tuality Health Alliance

*Data suppliers for this report appear **in bold**. The Centers for Medicare and Medicaid Services (Medicare Fee-for-Service) is also a data supplier for this report. Q Corp's partnership with these organizations allows for more reliable and useful information than any single data supplier can provide on its own.

Measure definitions

This report is based on a measurement year of July 2012 through June 2013 and includes the following measures. More detailed information is available in the Technical Appendix online at Q-Corp.org.

Diabetes Care

Diabetes blood sugar (HbA1c) screening: Measures the percentage of patients with diabetes ages 18 to 75 who received a blood sugar (HbA1c) screening during the measurement year.

Diabetes cholesterol (LDL-C) screening: Measures the percentage of patients with diabetes ages 18 to 75 who received a cholesterol (LDL-C) screening during the measurement year.

Diabetes eye exam: Measures the percentage of patients with diabetes ages 18 to 75 who received a dilated eye exam by an eye care professional during the measurement year.

Diabetes kidney disease monitoring: Measures the percentage of patients with diabetes ages 18 to 75 who received a kidney screening or were treated for kidney disease, or who had already been diagnosed with kidney disease during the measurement year.

Other Chronic Disease Care

Appropriate asthma medications: Measures the percentage of patients ages 5 to 64 with persistent asthma who were appropriately prescribed and who filled long-term controller medications during the measurement year.

Antidepressant medication management: Measures the percentage of patients ages 18 and older diagnosed with a new episode of major depression during the measurement year who were prescribed and filled an antidepressant medication, and who remained on the medication for the following time intervals:

- 1) SHORT TERM: At least 12 weeks after the diagnosis
- 2) LONG TERM: At least 180 days (6 months) after the diagnosis

Cholesterol (LDL-C) screening for people with heart disease: Measures the percentage of patients ages 18 to 75 with a heart condition who had at least one cholesterol test (LDL-C) during the measurement year.

Pediatric Care

Adolescent well-care visits: Measures the percentage of adolescents (ages 12–21) who had at least one well-care visit during the measurement year.

Appropriate use of antibiotics for children with sore throats: Measures the percentage of children ages 2 to 18 that had a group A streptococcus test within three days of prescribing antibiotics to treat pharyngitis (sore throat).

Developmental screening: Measures the percentage of children (ages 1–3) who were screened for risk in delays in development, behavior and social delays during the measurement year.

Well-child visits in the first 15 months of life: Measures the percentage of children who had six or more well-child visits with a primary care provider during their first 15 months of life.

Well-child visits in the third, fourth, fifth and sixth years of life: Measures the percentage of children ages 3, 4, 5 or 6 years who had at least one well-child visit with a primary care provider.

Women's Preventive Care

Breast cancer screening: Measures the percentage of women ages 40 to 69 who had a mammogram during the measurement year or the year prior.

Cervical cancer screening: Measures the percentage of women ages 21 to 64 who received one or more Pap tests during the measurement year or two years prior.

Chlamydia screening: Measures the percentage of sexually active women ages 16 to 24 who had a test for chlamydia infection during the measurement year.

Hospital Resource Use

Ambulatory Care - ED visits: Measures the rate of emergency department (ED) visits during the measurement year.

Potentially avoidable ED visits: Measures the percentage of ED visits during the measurement year for clinical problems that could have been managed in a more appropriate care setting.

Ambulatory Resource Use

Ambulatory Care - Outpatient visits: Measures the rate of outpatient services such as doctor's office visits, home visits and urgent care during the measurement year.

Appropriate low back pain imaging: Measures the percentage of patients ages 18 to 50 who did not have an imaging study conducted within the 28 days following a new episode of low back pain.

Generic prescription fills: Measures the percentage of prescription fills for patients ages 18 and older that were filled with a generic drug, among the following classes of medications:

- 1) Selective serotonin reuptake inhibitors (SSRIs)
and other second generation antidepressants
- 2) Statins

The source for data contained in this publication is Quality Compass® 2013 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2013 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

About the Oregon Health Care Quality Corporation

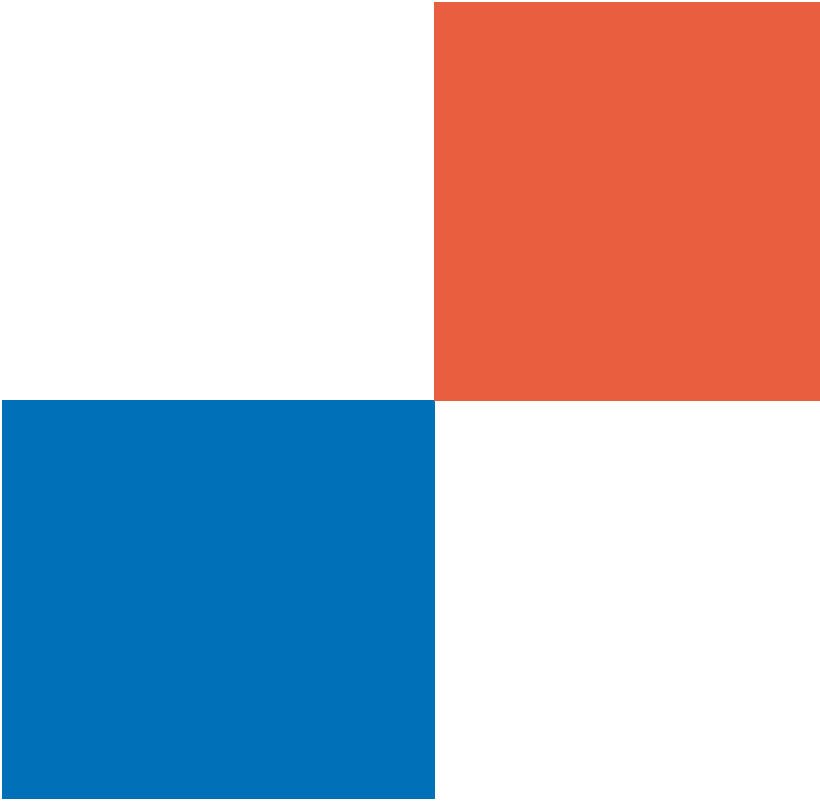


The Oregon Health Care Quality Corporation (Q Corp) is an independent, nonprofit organization dedicated to improving the quality and affordability of health care in Oregon by leading community collaborations and producing unbiased information. We work with the members of our community—including consumers, providers, employers, policymakers and health insurers—to improve the health of all Oregonians.

Q Corp's work is nationally recognized. In 2007, Q Corp became one of 16 organizations nationwide selected to participate in *Aligning Forces for Quality*, the Robert Wood Johnson Foundation's signature effort to improve the overall quality of health care in targeted communities. In 2008, Q Corp received the Chartered Value Exchange designation from the US Department of Health and Human Services in recognition of its leadership to improve care in Oregon. Q Corp is also a member of the Network for Regional Healthcare Improvement, a national coalition of regional health improvement collaboratives working to improve the quality and value of health care delivery. Additionally, in 2012 Q Corp was one of the first three organizations in the US to become selected as a Qualified Entity by the Centers for Medicare & Medicaid Services. Q Corp now receives Medicare claims data as part of the data sharing program.

For more information visit **Q-Corp.org**.

- 1 Oregon STD Statistics, 2011. Available from: <https://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/STD/Pages/index.aspx> [July 2014]
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