CareOregon®

2022

Quality Metrics Toolkit: Medicaid-Only Measures

CareOregon Quality Metrics Toolkit

The CareOregon Quality Metrics Toolkit was created to support our network partners in caring for our members. Our goals are to share knowledge about Oregon Health Authority's Coordinated Care Organization Incentive Metrics and the CMS Medicare Stars Measures; help create a better understanding of the quality health metrics and why they are important; assist with the implementation of workflows and best practices; and assist with tracking and monitoring of quality performance.

This is the first edition of the quality metrics toolkit for 2022. This edition only includes the OHA incentive measures that are focused on the Medicaid measures. A second edition will be released later in 2022 with a complete guide of the Medicaid and Medicare measures. For any questions, please reach out to your Quality Improvement Analyst or Primary Care Innovation Specialist with any questions or comments.

The purpose of this document is to help you and your clinic understand and navigate the OHA incentive metrics for 2022. If you need any additional assistance or support, please reach out to your Primary Care Innovation Specialist or Quality Improvement Analyst.

CareOregon Quality Metrics Toolkit Measure Sheet Definitions

Performance Measure Set:

CCO Incentive Metric: The Coordinated Care Organization (CCO) Incentive Metrics are determined by the Oregon Metrics& Scoring Committee, which was established in 2012 by Senate Bill 1580 to create outcomes and quality measures for CCOs. The measures are negotiated with the Centers for Medicaid and Medicare Services (CMS) as part of Oregon's 1115 waiver agreement. The CCO has then individualized improvement targets that are designed to decrease the distance between current performance and the OHA-established benchmark each year.

Medicare Star Measure: The Medicare Stars Measures are determined by CMS. The Star Rating System measures the performance of Medicare Advantage and Part D plans by comparing them against the rest of the country. There are over 40 measures which constitute the Star Rating System, with plans scored on a 5 Star scale for each. The individual measures are scored and weighted to determine a plan's overall Stars score. 5 Star plans have a special enrollment period and earn increased reimbursement from CMS.

Quality Measurement Type:

Structural Measures: Gives consumers a sense of a health care provider's access capacity, systems, and processes to provide high-quality care, e.g., whether the health care organization uses electronic medical records or medication order entry systems.

Process Measures: Indicates what a provider does to maintain or improve health of patients. They are typically generally accepted recommendations for clinical practice. They are the parts/steps in the system which measures whether it was performed as planned, e.g., for diabetes: percent of patients whose hemoglobin A1c level was measured twice in the past year.

Outcome Measures: Reflect the impact of the health care service or intervention on the health status of patients. How does the system impact the clinical values of patients, e.g., for diabetes: average hemoglobin A1c level for the population of patients with diabetes?

Patient Experience: Captures a person's perception of their experience with healthcare service using surveys, e.g., access and ability to navigate services, or time spent waiting.

Data Source/Type:

These data types refer to how measurement information is collected for performance monitoring.

Claims: An invoice a provider sends to a health plan for services of care provided to a plan member. CPT and diagnosis codes contained in the invoice serve to capture care outlined in quality improvement CCO Incentive Metrics and Medicare Star Measures.

Chart Documentation: How clinical care providers and staff record a patient's health status and care services received during a visit. This information is critical when conducting a comprehensive medical record review. When looking for evidence of care (not reflected through claims or diagnosis), if care is given but it is not reflected in a patient chart, it didn't happen.

eCQMs: Clinical Quality Measures (CQM) are a mechanism for assessing observations, treatment, processes, experience, and/or outcomes of patient care. Electronic CQMs are reported using electronic specifications from an electronic health record (EHR) in the form of a report.

Survey: survey instruments capture self-reported information from patients about their health care experience and outcome. Surveys are typically administered to a sample of patients by mail, by telephone, or via the intranet.

Other: Data source not addressed via claim, chart documentation, eCQM, or survey.

Part One
CCO Incentive Metrics

- Assessments for Children in DHS Custody
- Child and Adolescent Well-Care Visits (WCV)
- Childhood Immunization Status (Combo 3)
- Cigarette Smoking Prevalence
- Diabetes HbA1c Poor Control (>9.0%)
- Drug & Alcohol Screening (SBIRT)
- IET Initiation and Engagement of SUD 202
- Immunizations for Adolescents (Combo 2)
- Meaningful Language Access to Health Care Services
- Oral Evaluation for Adults with Diabetes
- Prenatal & Postpartum Care
- Preventive Dental Services, Ages 1-5 and 6-14
- Screening for Depression and Follow-Up
- Social-Emotional Health

Assessments for Children in DHS Custody

Performance Measure Set: ☒CCO Incentive Metric ☐Medicare Star Measure

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other

State Benchmark: 90%; (Metrics & Scoring Committee Consensus).

Who: Children and adolescents aged 0–17 years newly placed in DHS custody between November 1, 2021, and October 31, 2022. Note the cut-off date of notification is on October 31st so the health assessment period can occur by the end of the year.

Why: OHA developed these specifications based on requirements for physical, mental, and dental health assessments for children who enter foster care. Children in foster care are among the most vulnerable that CCOs serve. This measure ensures that they receive necessary care during a challenging transition.

What: Completion of the following health assessments within 60 days after the CCO is notified that the child has entered DHS custody, or within the 30 days prior to notification.

	Required assessments for children entering DHS custody		
Age on CCO Notification Date	**Physical**	**Dental**	**Mental**
Less than 12 months old	YES	NO	NO
1 to 3 years old	YES	YES	NO
4 to 17 years old	YES	YES	YES

How: The CCO coordinates with dental, mental, and physical health providers to schedule necessary assessments, and providers agree to prioritize foster children for appointment scheduling.

Exclusions: Children will be excluded from the final measure denominator if:

- The CCO does not receive notification from OHA within 30 days of the child entering DHS custody.
- The child does not remain in DHS custody and enrolled with the CCO for 60 days after notification.

See OHA technical specifications for a complete list of other exclusions handled on a case-by-case basis.

Coding:

Physical Health Assessment	Mental Health Assessment	Dental Health Assessment
99201 – 99205 (can count for mental health assessment as well if mental health dx code is included on claim) 99212 – 99215, 99381 – 99384, 99391 – 99394, G0438, G0439	90791, 90792, 96130, 96131, 96136, 96137, 96138, 96139 H0031, H1011 H2000 – TG **(*need modifier*)** H0019, H2013, H0037	D0100 – D0199
	Mental Health dx codes on 99201-99205: F03, F20–F53, F59–F69, F80-F99	

Assessments for Children in DHS Custody FAQs

Q: How does the CCO coordinate this measure?

A: CCO staff maintain a list of children in foster care and points of contact with local DHS offices. They work with physical, mental, and dental health plan staff to outreach to foster parents and facilitate the scheduling of needed services.

Q: How often is the data refreshed?

A: The CCO receives a weekly file from the OHA with a list of children who are on the foster list. Each CCO works on this list to keep on top of the timeliness of the metric. The OHA will send a monthly report of the progress of this metric. However, the data (current % & list of members) is four months behind. Use this report to review the CCOs notes on each child.

Q: What event date starts the metric?

A: The start date is according to the weekly file sent from the OHA, “First Notification Date by the OHA”.

Child and Adolescent Well-Care Visits (WCV)

formally known as Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life(W34)

Performance Measure Set: ☒ CCO Incentive Metric ☐Medicare Star Measure

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience ☒Other Specify: HEDIS

Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other

State Benchmark: 64.1% for children age 3-6 (2020 CCO 75th percentile)

Who: Children who are 3–21 years-old as of December 31 of the measurement year.

Why: Regular check-ups during the preschool and early school-age children are important for detection of vision, speech and language problems. Early intervention can help a child improve communication skills and avoid or reduce language and learning problems. Annual well-care visits are recommended for those age 2-21 year-olds, "as they are a strong vehicle to deliver screening, anticipatory guidance, and health education to support healthy development now and in the future" (source: OHA Guidance Document).

What: The percentage of members 3–21 years of age who had one or more well-child visits during the measurement year. There are four age stratifications, race and ethnicity stratifications, and a total rate which must be reported; however ONLY the age group 3-6 is incentivized for this measure:

Age Stratifications

- *3-6 Years
- 7-11 Years
- 12-17 Years
- 18-21 Years
- Total

Race Stratifications

- Black or African American
- American Indian and Alaska Native
- Asian
- Native Hawaiian and Other Pacific Islander
- Some Other Race
- Two or More Races
- Asked but No Answer
- Unknown

How: At least one well-child visit, which can be completed via telemedicine (see codes below), by any provider type during the measurement year. Some ideas to improve Well Care visits include:

- Regularly pull member lists for outreach
  - Tip: you can find actionable member lists in the Metrics Dashboard in FIDO
- Create well-child visit reminders
- Build relationships with community organizations to reinforce the importance of the well-child visit
- For more support, reach out to Quality Improvement or your clinic's Innovation Specialist.

Exclusions: Members in hospice or using hospice services anytime during the year are excluded from this measure.

Coding: Diagnosis codes do not have to be primary.
CPT: 99381-99385, 99391-99395, 99461, G0438, G0439, S0302
ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z02.5, Z76.1, 276.2

Child and Adolescent Well-Care Visits (WCV)

Q: Can Behavioral Health Clinics (BHC's) help?

A: Behavioral Health Clinician (BHC) meets with families before PCP comes into appointment to assess for psycho-social issues needing to be addressed during well child check. BHC can help create a robust appointment that assures that all aspects of care are addressed, while allowing PCP to focus on physical health issues. Any concerns can lead to follow up appointments.

Q: What are the required elements of a well child visit?

A:

- **A health history.** Health history is an assessment of the member's history of disease or illness. Health history can include, but is not limited to, past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization) and family health history.
- **A physical developmental history**. Physical developmental histories assess specific age-appropriate physical developmental milestones, which are physical skills seen in children as they grow and develop.
- **A mental developmental history**. Mental developmental histories assess specific age-appropriate mental developmental milestones, which are behaviors seen in children as they grow and develop.
- **A physical exam.** Include height and weight measurements as well as condition of gums and teeth among others.
- **Health education/anticipatory guidance**. Health education/anticipatory guidance is given by the health care provider to parents or guardians in anticipation of emerging issues that a child and family may face.

Q: Do school-based clinic visits count for this measure?

A: Yes, as long as the visit meets the requirements of a well child visit, and the documentation is available in the medical record or administrative system in the time frame specified by the measure.

Q: Does the patient need to be seen by their PCP for it to count for the metric?

A: No, the provider does not have to be the assigned PCP. However, the provider must be a PCP per Oregon's Primary Care Provider Types or an OB/GYN practitioner. The PCP can be defined as the Billing or Performing Provider. Contact Quality Improvement for more support.

Q: What telehealth codes count for this measure?

A: G0438-G0439 per the ANCILLARY GUIDELINE A5, TELEHEALTH, TELECONSULTATIONS AND ONLINE/TELEPHONIC SERVICES published by OHA as of October 1, 2021.

Please note that while this measure is telehealth eligible as the qualifying numerator services do not require in-person place of service codes in claims data, we recommend scheduling an in-person physical health exam as medically appropriate and safe to do so considering COVID-19 precautions.

Childhood Immunization Status (Combo 3)

Performance Measure Set: ☒CCO Incentive Metric ☐Medicare Star Measure

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☐Claims ☐Chart Documentation ☐eCQM ☐Survey ☒Other: ALERT IIS Registry

State Benchmark: 71.1% (2020 National Medicaid 50th Percentile)

Who: Children who turn two years of age in 2022.

Why: Childhood vaccines protect children from a number of serious and potentially life-threatening diseases such as diphtheria, measles, meningitis, polio, tetanus and whooping cough, at a time in their lives when they are most vulnerable to disease. Approximately 300 children in the Unites States die each year from vaccine preventable diseases. Immunizations are essential for disease prevention and are a critical aspect of preventable care for children. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.

What: This measure reports the percentage of children who turn two-years-old in 2022 and receive all the following immunizations **before their second birth date**:

- 4 DTaP (Diphtheria, Tetanus, and Pertussis)
- 3 IPV (Inactivated Polio Vaccine)
- 1 MMR* (Measles, Mumps, Rubella)
- ***4 PCV (Pneumococcal conjugate) – New***
- 3 HiB (Haemophilus Influenzae Type B)
- 3 Hepatitis B
- 1 VZV* (Varicella Zoster Vaccine)

Please note that multiple vaccines within the same type must have different dates of service to count toward requirement (i.e., to meet the four required DTaP vaccines there must be at least four dates of service on which a DTaP was provided).

*1 MMR and 1 VZV must have a date of service on or between the child's first and second birthdays.

How: Some ideas to improve Childhood Immunization Status rate:

- Utilizing member gap lists to identify members who are most in need.
- Ensure that immunization records in ALERT IIS are up to date and that all patient information is correct (e.g., name spelled correctly, correct date of birth, etc.).
- Schedule immunizations visits months before their second birthday. This is especially vital for members who have their second birth within January or February.
- Ensure that patient decision-aid tools and catch-up schedules are available for all parents when deciding to vaccinate their children (see resources for more information).
- Schedule subsequent vaccine visits before parents leave the office.
- Implement patient recall workflows.
- Behavioral Health Support: BHCs can support families who may be contemplative or undecided about vaccines. Utilizing motivational interviewing techniques and exploring concerns in a supportive environment can help families in the decision-making process. BHCs can scrub their daily schedule to see if any of their patients need vaccines and support them in getting scheduled.
- Reach out to your clinic's assigned Quality Improvement Analyst or Innovation Specialist for more support.

Exclusions: Members who have had severe immunodeficiency, HIV, various blood cancers, bowel obstruction, or who are in hospice care. *(Specifications no longer exclude members who are deceased.)*

Childhood Immunization Status (Combo 2) FAQ

Q: What immunization combination does this metric follow?

A: HEDIS® MY2022 Combination 3.

Q: How do I know which members are due for vaccinations?

A: A child's immunization history in ALERT should be checked before each visit. Additionally, CareOregon prepares and distributes member gap lists using ALERT data provided by OHA on a quarterly basis. If parents decline the vaccine, the child remains in the measure denominator. Please reach out to your Primary Care Innovation Specialist for additional resources.

Q: Who is included in the denominator for this measure?

A: Members whose second birthday is within 2022 and have had physical health coverage with the CCO continuously for the 12 months prior to their second birthday are included in the denominator.

Q: If parents decided to not have their child vaccinated, are they excluded from the metric?

A: No. If the child does not receive immunizations, they will remain in the denominator but not the numerator.

Resources

CDC recommended schedule for immunizations for children:
https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

NCQA Childhood Immunization Status
https://www.ncqa.org/hedis/measures/childhood-immunization-status/

Cigarette Smoking Prevalence 2022

Performance Measure Set: ☒CCO Incentive Metric ☐Medicare Star Measure
Quality Measurement Type: ☐Structure ☐Process ☒Outcome ☐Patient Experience
Data Type: ☐Claims ☐Chart Documentation ☒eCQM ☐Survey ☐Other
Benchmark: 25% (Committee Consensus for 2022)

Who: All Medicaid members 13 years or older by the beginning of the measurement year (Birth Year 2008 or earlier for 2022), who had a qualifying visit with a provider during the measurement period.

Why: Tobacco dependence is a chronic condition known to have a negative impact on overall health. Effective treatments exist, and research shows that 70% of tobacco users report wanting to quit. Many users have had at least one failed attempt and believe advice from a health care provider is important.

What: Three rates are reported for this measure using EHR-based data: rate of screening for smoking and/or tobacco use (Rate 1), prevalence of cigarette smoking (Rate 2), and prevalence of tobacco use (Rate 3). However, only cigarette smoking prevalence (rate 2) is incentivized.

> ***Rate 1***: Of all patients with a qualifying visit during the measurement year, how many have their cigarette smoking or tobacco use status recorded as structured data? (This value will be your numerator for Rate 1 and the denominator for Rate 2 and Rate 3.)
>
> ***Rate 2***: Of all patients with their cigarette smoking or tobacco use status recorded, how many are current cigarette smokers?
>
> ***Rate 3***: Of all patients with their cigarette smoking or tobacco use status recorded, how many are current smokers and/or tobacco users?

Exclusions: E-cigarettes, marijuana, and nicotine replacement therapy products do not qualify as cigarette or tobacco use. However, if a patient is using nicotine replacement therapy products and using cigarettes and/or other tobacco products, they will be counted in the numerator.

Data reporting: This measure is similar to but **does not directly align with NQF 0028e/CMS 138v10** (which looks for patients aged 18 or older). If your reporting is based on NQF 0028e/CMS 138v10, you will need to incorporate adolescents aged 13-17 through custom query. Please note that clinics must report the three prevalence rates regardless whether they are using custom query reporting or NQF 0028e/CMS 138v9.

CareOregon must receive data from each clinic's EHR for this measure. The data is then aggregated across all clinics in the CCO region and submitted to OHA. Please note the following reporting requirements:

- Member-level detail, for CareOregon members only, is preferred.
- Reporting must be for the full calendar year of 2022; bi-monthly reports in a rolling 12-month timeframe are preferred
- Data must be formatted in Excel

Please email your Quality Improvement Analyst or Primary Care Innovation Specialist with any questions about data reporting.

Note on telehealth: This measure is telehealth eligible. The qualifying visits for the rate 1 (screening) denominator may be derived from the tobacco screening and cessation intervention measure (CMS138), which according to CMS 2022 telehealth guidance is telehealth eligible.

Note on Time Frame for Recording Status: Cigarette smoking and/or tobacco use status must be recorded during the measurement year or the year before. It does not need to be recorded on the date of the qualifying visit, but the recorded status cannot be older than 24 months. For the 2022 measurement year, this means any status recorded prior to January 1, 2021 should not be included.

Note on Multiple Recordings of Status: If smoking or tobacco use status has been recorded multiple times from several providers within the same practice, use the most recent status on record from that practice, even if the individual saw multiple providers. If reporting at the practice level, then the individual will be in the denominator and the numerator once.

How: To help reduce the prevalence rate, clinics should:

- Ask their CareOregon Primary Care Innovation Specialist about CareOregon smoking cessation benefits.
- Encourage members to call the State Quit Line, 800-QUIT-NOW or 1-800-784-8669 English, or 855- DEJELO-YA (1-855-335356-92) for Spanish and identify that they have CareOregon coverage for expanded services.
- Refer members using Oregon Tobacco Quit Line Fax Referral Form via fax 1-800- 483-3114.
- Follow the 5A's model for treating tobacco use and dependence.
- Ask about cigarette smoking and/or tobacco use status at every visit and provide counseling and/or recommend nicotine replacement therapy.
- BHCs can support patients who identify as tobacco users to help engage in quit plans via motivational interviewing techniques. BHCs can aid in connecting to resources like quit lines. Supportive workflows would include connecting BHCs to anyone interested in nicotine replacement therapy.

Cigarette Smoking Prevalence FAQs

Q: What supports does the CCO provide to members who want to quit smoking?

A: CareOregon covers tobacco cessation counseling, nicotine replacement therapy products such as gum and lozenges with no prior authorization, and other pharmacotherapy options with a prior authorization. CareOregon also covers cessation counseling through Quit For Life.

Q: Can an integrated behavioral health clinician support smoking cessation?

A: Yes, BHC visits can support the smoking cessation metric. If a BHC asks and documents a patient's tobacco use status during their appointment, that can count towards the metric. BHCs can also support the cigarette smoking prevalence metric, by utilizing motivational interviewing and other therapeutic skills to engage patients in conversations around quitting, explore readiness for change and approach the topic of quitting from a trauma informed lens.

Support your BHC in understanding where to properly document tobacco use so as to properly track and support the metric.

Q: What is the difference between the Oregon Tobacco Quit Line and Quit For Life?

A: CareOregon contracts for cessation counseling services with the same vendor that staffs the Oregon Tobacco Quit Line. The state's Tobacco Quit Line provides free counseling to anyone who calls. However, after identification of CareOregon coverage, the individual is transferred to a Quit For Life representative for additional, expanded counseling services. Please note that while the state's Tobacco Quit Line accepts individuals aged 13 and older, the age requirement for CareOregon's Quit For Life contract is 18 and older.

Q: Is it required to ask about cigarette smoking status at every visit?

A: No. Although, while cigarette smoking and/or tobacco use status is not required at every visit, it is important to ensuring that an accurate status is captured for each patient. If a patient's status is recorded during multiple visits in the measurement year or year prior, only the most recent screening will be used.

Q: What if a patient quits smoking after a visit to PCP?

A: They will need to come back in so that their new status is recorded. That is why it's important to ask about cigarette smoking and/or tobacco use status at every visit.

Q: Does the smoking status need to be recorded during the calendar year to count for the measure?

A: No. Cigarette smoking and/or tobacco use recorded status must be recorded within the previous 24 months.

Diabetes Care: HbA1c Poor Control

Performance Measure Set: ☒CCO Incentive ☒Medicare Star Rating
Quality Measurement Type: ☐Structure ☐Process ☒Outcome ☐Patient Experience
Medicaid Data Type: ☐Claims ☐Chart Documentation ☒ eCQM ☐Survey ☐Other
Medicare Data Type: ☐Claims ☒Chart Documentation ☐eCQM ☐Survey ☐Other
Medicaid State Benchmark: 27.5% or lower (2020 National Commercial median)
HEDIS Benchmarks National Percentile: 86.25% (75th), 88.81% (90th)

Who: All patients aged 18-75 years old with a diagnosis of type 1 or type 2 diabetes during, or any time prior to, the calendar year. Medicaid members must receive a qualifying outpatient service during the measurement period; this is not a requirement for Medicare.

Note: Only patients with a Type 1 or Type 2 diabetes diagnosis are included. Members with a diagnosis of gestational diabetes, steroid-induced diabetes or pre-diabetes are excluded.

Why: People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney failure, amputation of toes, feet or legs, and premature death. HbA1c testing helps clinicians identify potential need for further intervention to ensure that all patients with a diagnosis of diabetes receive appropriate and comprehensive care.

What: Percentage of patients with a diabetes diagnosis, whose most recent HbA1c level is above 9.0%, or whose value is missing or was not performed during the measurement period.

How: Best practices to improve Diabetes Poor Control include

- Educating patients about healthy lifestyle choices through motivational interviewing
- Employing diabetes educators, clinical pharmacists, behavioral health clinicals or registered dietitians in the care management team
- Using an evidence-based diabetes care pathway for medication management and other care options
- Establish workflows where the BHC sees patients who are newly diagnosed with diabetes and patients with an A1C over 9. BHCs work with patients on behavior and lifestyle changes that support diabetes control. BHCs can assess and support risk factors (e.g. binge eating, substance use, mood disorders) that can contribute to poor control.
- Clinics asks patient and/or scrubs their schedule to assure those who need labs are connected for scheduling or same-day appointment. Those who have been working on improving DM management and/or are close to 9% can be identified as good candidates for being retested.
- Retesting patients that resulted in A1c out of control. Many clinics that re-test their patients have seen an improvement in test results after engaging in care.

Exclusions:

- Patients in hospice, using hospice services, or receiving palliative care during the calendar year.
- Patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period.
- Patients 66 and older with advanced illness and frailty.

Note on telehealth: CMS 2022 telehealth guidance states that this electronic clinical quality measure is telehealth eligible. Eligible Professionals and Eligible Clinicians performance could be impacted if the quality action being evaluated cannot be completed during the telehealth encounter.

Medicaid Data Reporting: This measure aligns with **CMS122v9.** CareOregon must collect data from each clinic's EHR for this measure. Data is then aggregated across all clinics in the CCO region and submitted to OHA. Please note the following reporting requirements:

- Patient-level detail for CareOregon members only is preferred
- Reporting must be for the full calendar year of 2021; mid-year reports preferred in a rolling 12- month time frame
- Data must be formatted in Excel

Please email your Quality Improvement Analyst or Primary Care Innovation Specialist if you need additional support in reporting this metric.

Medicare reporting: Comprehensive diabetes care (CDC) measures use the HEDIS HbA1c poor control specifications, however, the reverse of poor A1c control is reported as blood sugar control.

Diabetes Care: HbA1c Poor Control FAQs

Q: Why are the targets for Medicaid and Medicare so different?

A: The Medicare Star measure is reporting patients with diabetes who have an A1c test during the measurement year and that their blood sugar is in control, therefore a higher number indicates more patients are in control. CareOregon dashboards, performance reporting, and targets for Medicare members reflect this rate of A1c control, the reverse score/target of poor control as reported for Medicaid The HEDIS national percentile also reflects the benchmark for poor control.

Q: What if the member didn't have an A1c test completed in the measurement year?

A: A member is considered in *poor control* if they have a diagnosis of diabetes and do not have an A1c test in the measurement year***. It is highly beneficial to complete HbA1c testing in the first and second quarter of the measurement year*** to allow time for intervention, regaining control of blood glucose levels, and retesting A1c before the end of the year if necessary because the last A1c in the measurement year is the value reported for both line of business. It is also **important to ensure the A1c results from specialists are recorded as structured data** (and therefore captured in the EHR reporting) and not simply attached to the patient's chart as a pdf.

Q: Is prior authorization required for GLP1 diabetes pharmaceuticals?

A: CareOregon covers exenatide (BYETTA/BYDUREON) and liraglutide (VICTOZA), however, a prior authorization is required for Medicaid patients.

Alcohol and Drug Misuse: Screening, Brief Intervention and Referral to Treatment (SBIRT)

Performance Measure Set: ☒CCO Incentive ☐Medicare Star Rating

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☐Claims ☐Chart Documentation ☒eCQM ☐Survey ☐Other

State Benchmark: 68.2% for Rate 1, screening and 53.5% Rate 2, brief intervention (2019 CCO 75th percentile). Note that in 2019-2021, SBIRT was a reporting only measure.

Who: All patients aged 12 and older with at least one eligible encounter during the year.

Why: Screening for alcohol and drug misuse is important for early detection and prevention of substance use disorder.

What: Percent of all patients aged 12 years and older who are screened for alcohol and drug misuse using an age-appropriate screening tool, and received appropriate follow-up as clinically indicated.

How: Two rates are reported for this measure using EHR-based data:

1. Screening Rate: of the patients aged 12 years and older who had a visit during the year (including telehealth visits), what percentage received age-appropriate screening for alcohol and drug misuse and had either a brief screen with a negative result or a full screen.
   a. The denominator for rate 1 uses the same denominator criteria as the depression screening and follow-up measure (NQF0418e/CMS2v10).
2. Follow-up Rate: of those patients who had a positive full screen during the year, what percentage of patients received a brief intervention, referral to treatment, or both that is documented within 48 hours of the date of the full screen.
   a. The denominator for rate 2 includes those patients in the rate 1 numerator who had a positive full screen (i.e. subset of rate 1 numerator).

Example:

Scenario	Rate 1		Rate 2	
	Denom	Num	Denom	Num
Patient refuses screening any point before required screening is completed.	No	No	No	No
Patient completes brief screen that is positive but refuses to complete full screen.	**Yes**	No	No	No
Patient completes brief screen that is negative.	**Yes**	**Yes**	No	No
Patient completes brief screen that is positive and completes full screen that is also positive. Results are discussed, and brief intervention or referral is completed.	**Yes**	**Yes**	**Yes**	**Yes**
Patient completes full screen that is positive but refuses brief intervention or referral to treatment.	**Yes**	**Yes**	**Yes**	No

How (Continued): Some ideas to improve Depression Screening and Follow-Up performance:

- Standardized, age appropriate, annual screening tools should be used for screening patients at least once per measurement period; ideally integrated in EHR workflows.
- Workflows that include front desk staff, MAs, and providers are necessary to ensure each patient receives the appropriate screening, correct scoring, review, and documentation during at least one encounter per year.
- Assure that staff understand the workflows for documentation. Most staff are screening and having the important follow up conversations with their patients, however, documenting and placing information in the correct place for it to be counted continues to be an area for improvement.
- Create missed opportunity reports. Follow up with those who were not screened or did not receive a follow up conversation. BHCs or other support staff (e.g., THWs) can follow up with patients within the 14-day timeframe to provide follow up.
- Create collaborative appointments, such as the BHC sees patients who score positive on the depression screening (e.g. PHQ-9 of 10+). BHC can see the patient before PCP to assess for safety and develop follow up plan. BHC can inform PCP of the plan during warm hand off, which allows PCP to address additional issues during visit.

Exclusions:

Rate1 Numerator:

- SBIRT services received in an emergency department or hospital setting;

Any of the following criteria remove people from the denominator:

- Patients with an active diagnosis of alcohol or drug dependency, engagement in treatment, dementia or mental degeneration;
- Patients with limited life expectancy, in palliative care (including comfort care) or hospice;
- Situations where the patient's functional capacity or motivation to improve impact the accuracy of results of standardized assessment tools;
- Patient refuses to participate;
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

Reporting: This is an EHR-based measure and does not require billing codes or claims data. CareOregon must receive data pulled from each clinic's EHR for this measure; the data is then aggregated across all clinics in the CCO region and submitted to OHA. Please note the following reporting requirements:

- Patient-level detail for CareOregon members only is preferred.
- Final reporting must be for the full 2022 calendar year; mid-year reports preferred in a rolling 12-month timeframe.
- Data must be formatted in Excel.

Please email your Quality Improvement Analyst or Primary Care Innovation Specialist with any questions about data reporting.

Alcohol and Drug Misuse (SBIRT) FAQ

Q: Does a brief screen count toward the measure?

A: Although a negative brief screen is numerator compliant, a positive brief screen, by itself, is not numerator compliant. This measure leaves flexibility for clinical preferences on whether to do a brief screen before a full screen. If a patient has a positive brief screen, then a full screen must be completed for numerator compliance on Rate 1. A full screen is numerator compliant for Rate 1, regardless of the result.

Q: What score counts as a "positive" screening result?

A: The clinician should interpret the age-appropriate screening tool to determine if the result is positive or negative. Where the screening tool includes guidance on interpreting scores, the clinician should consult that guidance. This is the same approach used to identify positive or negative results for depression screening in NQF0418e/ CMS2v9. There may be instances in which it is appropriate for clinicians to use their discretion in interpreting whether a result is positive or negative, such as for patients reporting use of topical medicinal marijuana.

Q: What counts as a brief intervention? Is there a time requirement?

A: Brief interventions are interactions with patients that are intended to induce a change in a health-related behavior. They are short, one-on-one counseling sessions ideally suited for people who use substances or drink in ways that are harmful or abusive. Examples of brief interventions include assessment of the patient's commitment to quit and offer of pharmacological or behavioral support, provision of self-help material, or referral to other supportive resources. There is no required time limit for a brief intervention – a brief intervention of less than 15 minutes can count towards this measure.

Q: How can an integrated behavioral health clinician support SBIRT?

A: Yes. BHC visits are qualifying visits for the SBIRT metric. BHC's can provide the SBIRT screening and brief intervention in their daily appointments. By making it part of their workflow, they can provide high quality patient care and contribute to the metric. Support your BHCs in understanding where/how to document SBIRT so as to assure it is properly captured in your data.

Q: Does the referral to treatment need to be completed?

A: No, a referral to treatment is counted when the referral is made and documented in the EHR. Given the challenges of documenting whether a referral was completed (that is, whether the patient actually saw the provider to whom the patient was referred), numerator compliance is not dependent on referral completion.

Q: What screening tools are recommended?

A: Approved Evidence-Based Screening Resources/Tool are located here: https://www.oregon.gov/oha/HSD/AMH/Pages/EB-Tools.aspx

We recommend that you check this list to ensure your screening tool is OHA-approved.

Q: Do I need to screen patients at every visit?

A: Screening in an ambulatory setting is required once per measurement year. This measure does not require screening to occur at all encounters.

Initiation and Engagement of Alcohol and Other Drug Use Treatment (IET)

Performance Measure Set: ☒CCO Incentive ☐Medicare Star Rating

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other

State Benchmark: Initiation for Age 18+ – 43.0% (2020 National Medicaid Median)
Engagement for Age 18+ – 13.9% (2020 National Medicaid Median) *Must meet both components to achieve measure.*

Who: Members aged 18 years and older with a new diagnosis of alcohol or other drug use between November 15, 2021–November 14, 2022. A diagnosis is considered "new" if the member has not had a diagnosis of (or received medication for) alcohol or other drug use in the previous 194 days.

Why: Access to treatment for substance use disorder is a critical aspect of a person's health and their journey through recovery. The IET metric is a tool to encourage coordination across the network of care providers for substance use treatment and helps ensure people have timely access to appropriate care.

What: Two rates are reported for this measure: Initiation and Engagement. Both measures use the same denominator.

1. Initiation – For members with a new episode of alcohol or other drug use (diagnosis on a claim with no other diagnosis in the previous 194 days), this metric measures the percentage of those who initiated treatment within 14 days through either medication dispensing or a SUD visit with a provider.
    a. Initiation of treatment can be on the same day as the new alcohol or other drug use diagnosis if the services are with different providers.
2. Engagement - For members with a new episode of alcohol or other drug use (diagnosis on a claim with no other diagnosis in the previous 194 days), this metric measures the percentage of those who had two treatment events, either medication dispensing or a SUD visit with a provider, within 34 days from their initial treatment event.
    a. If treatment was initiated through a medication dispensing event, only one of the two required engagement events can be through medication and the other must be through a SUD visit with a provider.
    b. Both engagement events can be on the same day if the services are with different providers; the exception being if one event is for medication-assisted treatment there is no requirement that they be different providers.

How: There are over 230 codes that count toward numerator criteria through a visit with a provider; **please see IET Guide for Primary Care in the "Resources" section for additional information.** In general, initiation and engagement events can be through medication dispensing events, inpatient, outpatient, observation, or telemedicine visits.

NOTE: Methadone is not included in the medication lists for this measure because Methadone for opioid use disorder does not show up in pharmacy claims data. However, Methadone for opioid use disorder treatment **does count as treatment for this metric** and would be captured on medical claims.

Exclusions: Hospice during any point in the year.

Initiation and Engagement of Alcohol and Other Drug Use Treatment (IET) FAQs

Q: Is tobacco use included in this metric?

A: No. While we do consider tobacco use disorder to be included in the continuum of substance use disorders from a clinical perspective, it is not considered as one of the diagnosis codes that would qualify someone for the IET metric.

Q: Is cannabis use included in this metric?

A: Yes. The IET measure is looking for substance use disorder and cannabis is included. Please see the question below.

Q: What is considered as "other drugs" in this metric?

A: The IET measure is looking for substance use disorder diagnosis including alcohol, opioid and other drugs such as cocaine, cannabis, methamphetamine, hypnotics, sedatives, inhalants, etc. See OHA specifications for full list.

Q: How are initial alcohol or other drug use diagnoses identified?

A: Alcohol or other drug use disorder diagnosis codes are identified using claims for services that occurred in the following visit types:

- Outpatient visits
- Telehealth
- E-visit of virtual check-in
- Intensive outpatient visits
- Partial hospitalization
- Detoxification visits
- ED visits or Observation
- Acute or non-acute inpatient admits
- Online assessment
- Opioid treatment services

Immunizations for Adolescents (Combo 2)

Performance Measure Set: ☒CCO Incentive Metric ☐Medicare Star Measure
Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience
Data Type: ☐Claims ☐Chart Documentation ☐eCQM ☐Survey ☒Other: ALERT IIS Registry
State Benchmark: 36.9% (2020 National Medicaid 50th Percentile)

Who: Children who turn 13 years of age in 2022.

Why: Despite the effectiveness of vaccines to prevent disease and reduce unnecessary costs to the health care system, immunization rates for children in Oregon remain well below national Healthy People 2021 goals. Much attention is given to those who decide not to vaccinate their children; however, these families and communities represent the minority in Oregon. Most parents do intend to vaccinate their children according to the American Academy of Pediatrics schedule and as recommended by their health care provider. Thus, providers play a key role in immunization rates among their patients (Source: *CCO Resource Guide–Strategies to Improve Immunization Rates*, OHA July 2017).

What: This measure reports the percentage of adolescents who turn 13-years-old in 2022 who receive all the following immunizations **before their 13th birth date**.

- **Meningococcal** – any of the following meets criteria:
  - At least one meningococcal serogroups A, C, W, Y vaccine on or between the member's 11th and 13th birthdays
  - Anaphylaxis due to the meningococcal vaccine any time on or before the member's 13th birthday.
- **Tdap** – any of the following meets criteria:
  - At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine on or between the member's 10th and 13th birthdays.
  - Anaphylaxis due to tetanus, diphtheria, or pertussis vaccine any time on or before the member's 13th birthday.
  - Encephalitis due to the tetanus, diphtheria, or pertussis vaccine any time on or before the member's 13th birthday.
- **HPV** – any of the following meets criteria:
  - At least two HPV vaccines with different dates that are 146 days apart, occurring on or between the member's 9th and 13th birthdays.
  - At least three HPV vaccines with different dates of service on or between the member's 9th and 13th birthdays.
  - Anaphylaxis due to the HPV vaccine on or before the member's 13th birthday.

How: Some ideas to improve Immunizations for Adolescents performance:

- Utilizing member gap lists to identify members who are most in need.
- Ensure that immunization records in ALERT are up to date and that all patient information is correct (e.g. name spelled correctly, correct date of birth, etc.).
- Monitor and schedule immunizations visits months before their 13th birthday including ensuring the first HPV dose is administered at least 5 months prior to the patient's birthday.
- Ensure that patient decision-aid tools and catch-up schedules are available for all parents when deciding to vaccinate their children (see resources for more information).
- Discuss HPV vaccinations in the context of cancer prevention rather that sexual education. Ensure evidence-based resources on HPV vaccinations and cancer prevention are available for both adolescents and parents.
- Schedule subsequent vaccine visits before parents leave the office.
- Implement patient recall workflows.
- Behavioral Health Support: BHCs can support families who may be contemplative or undecided about vaccines. Utilizing motivational interviewing techniques and exploring concerns in a supportive environment can help families in the decision-making process. BHCs can also scrub their daily schedule to see if any of their patients need vaccines and support them in getting scheduled.
- Reach out to your clinic's assigned Quality Improvement Analyst or Innovation Specialist for more support.

Exclusions: Members who are deceased at the time of metric reporting or in hospice or using hospice services anytime during the measurement year.

Coding: OHA relies on ALERT IIS data and does not directly rely on claim/encounter codes.

Immunizations for Adolescents (Combo 2) FAQ

Q: What immunization combination does this metric follow?

A: HEDIS® MY2022 Combination 3.

Q: How do I know which members are due for vaccinations?

A: An adolescent's immunization history in ALERT should be checked before each visit. Additionally, CareOregon prepares and distributes member gap lists using ALERT data provided by OHA on a quarterly basis. If parents decline the vaccine, the adolescent remains in the measure denominator. Please reach out to your Primary Care Innovation Specialist for additional resources.

Q: Who is included in the denominator for this measure?

A: Members whose thirteenth birthday is within 2022 and have had physical health coverage with the CCO continuously for the 12 months prior to their thirteenth birthday are included in the denominator.

Q: If parents a parent decides to not have their adolescent vaccinated, are they excluded from the metric?

A: No. If the adolescent does not receive immunizations, they will remain in the denominator but not the numerator.

Resources

CDC recommended schedule of immunizations for adolescents:
https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

Health Equity Measure: Meaningful Access to Health Care Services for persons with limited English proficiency

Performance Measure Set: ☒CCO Incentive ☐Medicare Star Rating

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☐Claims ☐Chart Documentation ☐eCQM ☒Survey ☒Other: OHA-developed

2022 State Benchmark:

Component 1 – CCO-level language access self-assessment: minimum points required = 56

Component 2 – Must report with 80% interpreter service data collection rate; 2022 is hybrid quantitative report on sample of eligible population.

Who: Members who self-identify with the OHA as having interpretation needs, spoken or signed language, and had a health care visit in the measurement year.

Why: Communication problems present a significant barrier for individuals with Limited English Proficiency (LEP) to achieve their best health potential. Lack of access to quality oral and sign language interpretation results in decreased quality of care, increased medical errors, and widens existing gaps in disparities. Professional interpretation services are associated with improved clinical care in terms of comprehension, utilization, clinical outcomes, and satisfaction for both patients and clinicians.

Increasing access to spoken and sign language services are critical tools for advancing equity and meaningful access to health care services (Source: *Health Equity Measure Proposal, submitted to Health Plan Quality Metrics Committee,* OHA, May 2019.)

What: There are two components to this measure. A CCO language access self-assessment survey and a quantitative language access report.

Component 1: CCO language access self-assessment survey – The CCO must (1) answer all survey questions, (2) pass the questions required for that measurement period, and (3) meet the minimum total points required for each measurement year. This self-assessment is to be completed at the CCO-level.

Component 2: Quantitative language access report – This component reports the percentage of member visits with interpretation need in which interpreter services were provided.

- Denominator: Number of physical, mental, or dental health visits for members in the eligible population.
- Numerator: Number of those visits in which interpretation service was provided **by an OHA-certified/qualified interpreter**.

How: To help members have meaningful language access:

- Ask member's their preferred spoken language and record this in their permanent record.
- Have a clear process and train staff to offer interpretation services to members. When a language need is identified, best practice is to have an interpreter discuss the process, availability, and benefits of having interpretation services with the member.
- Interpretation is an essential service that requires advance planning. Have a process for scheduling interpreters as soon as members make their appointment.
- Have a process for documenting the provision of interpreter services in the EHR as structured data (not as a note). Documentation should include what language, the modality (In-person, telephone, video), who provided the interpretation, whether they are certified or qualified, or if the member declines interpretation services.
- Interpretation should be provided by certified or qualified interpreters. Interpreters can be clinic staff who are certified, or through a contracted interpretation vendor. The measure will be incentivized based on an increasing proportion of interpretation services provided by OHA-certified/qualified providers.
- CareOregon contracts with three language service agencies. To arrange for an interpreter to be present during an appointment, complete the CareOregon Interpreter Request form on the CareOregon website at http://careoregon.org/providers/support/interpreters.

Exclusions: Only members who refuse interpreter services for the reasons of 1) in-language visit is provided (for example by provider) or 2) member confirms interpreter needs flag in MMIS is inaccurate. This data must be documented.

Data Reporting:

- Component 1: The CCO is responsible for completing the language access self-assessment survey.
- Component 2:
  - Eligible population is identified by having an interpretation need documented in MMIS. A member will not enter the measure if they have not informed the OHA that they have an interpretation need.
  - Denominator: Visits are identified by claims submitted to the CCO.
  - Numerator: Any information the CCO has available on interpretation service provision can be used for reporting: invoice from interpretation vendor, chart documentation, EHR data report, claims, etc.

Frequently Asked Questions

Q: What are clinics responsible for?

A: Clinics are responsible for documenting languages needs, refusal and services in a member's EHR. CareOregon will work with clinics on collecting sources of interpretation data for reporting.

Q: Do clinics need to proactively work on this measure?

A: Yes, clinics should work to identify members with language needs and schedule interpretation services for their appointments.

Q: What if a member declines interpretation service or insists on using a family member?

A: Explain the process and benefits of using qualified/certified interpretation services. If a member still declines, then document that services were offered, declined, and the reason for refusal in the EHR. Only members who refuse interpreter services for the reasons of 1) in-language visit is provided (for example by provider) or 2) member confirms interpreter needs flag in MMIS is inaccurate are acceptable for exclusion from the denominator of the metric.

Q: What if a provider or staff member (non-qualified/certified) is bilingual?

A: Explain the process and benefits of using qualified/certified interpretation services. Bilingual staff services do not automatically qualify for the numerator unless the staff is OHA qualified or certified for interpreter services. If a member still declines, then document that services were offered, declined, and the reason for refusal.

Q: If a member does not have an interpretation need listed in MMIS, will they be in the measure?

A: No. However, the goal is to provide meaningful access to language services to everyone regardless of whether they are in the measure. Please follow the same process for connecting members with interpretation even if their interpretation need is not in MMIS.

Resources:

CareOregon Provider Interpreter Service Handout

https://www.careoregon.org/providers/support/interpreters

Guidelines for medical providers for working with interpreters

http://delamorainstitute.com/wp-content/uploads/ALL-COURSE-CONTENTS-WITH-PAGE-NUMBERS.pdf

Best practice for using over-the-phone interpretation

https://blog.cyracom.com/best-practices-for-using-phone-interpretation-in-a-healthcare-setting

Helping patient express their preferred language

https://www.oregon.gov/oha/OEI/Documents/Preferred%20Language%20Cards%20Instructions%20for%20External%20Partners%2010_2017.pdf

Oral Evaluation for Adults with Diabetes

Performance Measure Set: ☒CCO Incentive ☐Medicare Star Rating
Quality Measurement Type: ☐Structure ☐Process ☒Outcome ☐ Patient Experience
Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other
Medicaid State Benchmark: 20.4% (2020 CCO 75th Percentile)

Who: All patients aged 18 years or older with type 1 or type 2 diabetes during the measurement year or the year prior to the measurement year (i.e. a diabetes dx since January 1, 2021) identified through medial or pharmacy claims.

Why: Efforts to promote whole-person care include bringing together physical and oral health. This is especially true for adults with diabetes. Diabetes increases the risk of gum disease, and untreated gum disease can worsen blood sugar control. Lack of oral health care has also been linked to costly emergency department visits, where prescription pain medication may be the only treatment available.[1]

What: Percent of members who received a comprehensive, periodic, or periodontal oral evaluation in the measurement year.

How:

- Ask patients – and document it in the chart – who is their dental provider and explore their level of engagement with dental services. It is recommended that patients with diabetes should attend dental services more than twice a year. CareOregon benefits cover 4 dental visits a year – explore what barriers members are facing for attendance.
- Request dental outreach for patients through CareOregon's provider portal or another internal referral processes. For additional dental support, refer to your region's dental webpage in the resources, below.
- Discuss the need for routine oral health care with all patients with diabetes.
- BHC can evaluate barriers to attending referral to dental, such as anxiety. BHCs can follow up with patients after their dental appointment to see if appointment was completed and, if it wasn't, explore barriers to engagement. After completing dental appointment, BHC can help with implementation of healthy behaviors.
- Refer to CCO-specific dental brochures that are printed for each region. These brochures explain the importance of oral health, the dental benefit package and how to connect to your dental plan. Due to COVID, these are also available on the dental resources webpage. For additional dental support, refer to your region's dental webpage in the resources, below.
- For further support, please reach out to your clinic's Quality Improvement Analyst, Innovation Specialist, or Dental Innovation Specialist.

[1]NASHP (National Academy for State Health Policy): https://nashp.org/wp-content/uploads/2017/09/DentaQuest-Brief.pdf

Exclusions: Patients identified with gestational diabetes or steroid-induced diabetes but who do not have a diagnosis of Type 1 or Type 2 diabetes in any care settings. Patients in hospice or palliative care. Patients 66 and older as of December 31 of the measurement year enrolled in an institutional SNP (I-SNP), or living long-term in an institution, or who meet the criteria for frailty and advanced illness.

Coding:

CDT codes: D0120, D0150, or D0180.

Note on teledentistry: This measure may be eligible for teledentistry. While the intent of the measure is to ensure that members with diabetes had a touchpoint with the dental delivery system and had diagnoses and treatment planning, these activities as documented in the claims data by the dentist/ dental health provider is based on their clinical judgment. If the rendering provider documents a qualifying CDT code (D0120, D0150 or D0180) in the claims form, the visit will be counted in the measure, irrespective if the visit was virtual (Teledentistry) or in person.

Resources

CareOregon Dental: https://careoregon.org/members/health-plan-resources/dental-health

Jackson Care Connect Dental: https://jacksoncareconnect.org/for-members/dental-health-resources

Columbia Pacific CCO Dental: https://www.colpachealth.org/for-members/dental-health-resources

[1]NASHP (National Academy for State Health Policy): https://nashp.org/wp-content/uploads/2017/09/DentaQuest-Brief.pdf

Timeliness of Prenatal and Postpartum Care

Performance Measure Set: ☒CCO Incentive Metric ☐Medicare Star Measure

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☒Claims ☒Chart Documentation ☐eCQM ☐Survey ☐Other

State Benchmark: Postpartum Care –80.9% (TBD) (2018 CCO statewide average)

A Note on Meeting This Metric

Although CCOs must submit data for timeliness of both prenatal and postpartum care, the 2022 CCO incentive measure and quality pool payments are tied to the Postpartum Care rate. Starting in 2021, services provided via telephone, e-visit or virtual check-in are eligible for use in reporting both rates.

Prenatal Care

Who: Members who had a live delivery with estimated delivery date (EDD) between October 8 of the year prior to the measurement year and October 7 of the measurement year who meet continuous enrollment criteria (i.e. October 8, 2021 – October 7, 2022).

Why: Appropriate perinatal service and education are crucial components of a healthy birth. Preventing complications that can affect the health of both parent and baby before, during and after pregnancy is equally important. The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend at least one exam during the first trimester for prenatal care in an uncomplicated pregnancy and one exam approximately 4–6 weeks after delivery for postpartum care.[1]

What: A prenatal visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment, to an OB/GYN or other prenatal care practitioner, or PCP.

How: A prenatal visit with an OB/GYN practitioner or midwife, family practitioner or PCP can satisfy this measure. Visits with a PCP require a diagnosis of pregnancy. Documentation of prenatal care in the medical record must include a note indicating the date of the prenatal care visit and *at least one* of the following:

1. Documentation indicating the patient is pregnant or references to the pregnancy.
2. A basic physical obstetrical examination that includes auscultation for the fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height.
3. Evidence that a prenatal care procedure was performed such as:
    - Screening test in the form of an obstetric panel
    - TORCH antibody panel alone, or
    - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or
    - Ultrasound of a pregnant uterus.

Postpartum Care

Who: Members who had a live delivery between October 8, 2021–October 7, 2022.

What: A postpartum visit for a pelvic exam or postpartum care on or between 7–84 days (1–12 weeks) after delivery.

How: A postpartum visit with an OB/GYN practitioner or midwife, family practitioner or other PCP (in-person, telephone, e-visit or virtual check-in) can satisfy this measure. Postpartum care provided in acute inpatient settings does not count towards this measure. Documentation of postpartum care in the medical record must include the date of the postpartum care visit and *at least one* of the following:

1. Pelvic exam.
2. Evaluation of weight, blood pressure, breasts and abdomen.
    - Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component.
3. Notation of postpartum care, including, but not limited to:
    - Notation of "postpartum care," "PP care," "PP check," or "6-week check;"
    - A preprinted "Postpartum Care" form in which information was documented during the visit.
4. Perineal or cesarean incision/wound check.
5. Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders.
6. Glucose screening for women with gestational diabetes.
7. Documentation of any of the following topics:
    - Infant care or breastfeeding;
    - Resumption of intercourse, birth spacing or family planning;
    - Sleep/fatigue;
    - Resumption of physical activity and attainment of healthy weight.

Exclusions: Non-live birth and patients in hospice.

[1] (NCQA HEDIS Measures and Technical Resources: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/

Timeliness of Postpartum Care FAQ

Q: My clinic does not provide prenatal care, does this measure affect us?

A: Yes, you should still encourage patients to seek timely prenatal care from a prenatal provider. In addition, some of the services that qualify as "prenatal care" are appropriate for primary care and may even improve the quality of the referral to OB/GYN.

Q: Can a BHC support these visits?

A: A BHC visit on its own does not count for the measure. However, the provider and BHC could structure a joint appointment where the BHC provides some of the services so as to support the provider (e.g., evaluation and intervention related to components of a postpartum visit—sleep/fatigue, screening for depression, tobacco use, anxiety, substance use, or other pre-existing mental health concerns). By the BHC providing those services, the provider is able to focus on the physical exam aspects and the patient is able to have a complete and robust appointment. The BHC can document in a separate or combined note with the PCP depending on clinic preferences.

Q: We only offer RN visits during the first trimester; will that count for the measure?

A: An RN visit on its own does not count for the measure. However, if a provider signs off on the RN visit note and/or the claim is billed under the provider we would consider this compliant, as the provider is evaluating the visit information and is ultimately responsible for the assessment.

Q: Will a Pap test alone count for the postpartum care visit?

A: Yes. Although a Pap test alone does not count as a prenatal care visit for the Timeliness of Prenatal Care rate, it will count for the Postpartum Care measure.

Q: How is this measure ultimately scored?

A: This measure is ultimately scored through a random sample from the OHA of the denominator (those who have had a live birth in the measurement year). The percentage from this sample list (appropriate visits within the 7- 84 days) must meet the target.

Preventive Dental Services for Children aged 1-5 and 6-14

Performance Measure Set: ☒ CCO Incentive Metric ☐Medicare Star Rating

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other

State Benchmark:
Preventive Dental Services, Ages 1-5: 43.1% (2020 CCO 75th percentile)
Preventive Dental Services, Ages 6-14: 52.0% (2020 CCO 75th percentile)

CCOs must meet benchmark or improvement target for one of the age groups to achieve measure.

Who: All patients who will turn age 1–14 years old during the calendar year.

Why: Poor oral health has been linked to chronic pain, lost school days, and avoidable visits to the emergency department. Oral health can also affect speech, nutrition, growth and function, social development. Ensuring all children have access to dental health care during these formative years is important to their overall health and quality of life.

What: All patients who will be age 1–14 years by the end of the 2022 calendar year who are continuously enrolled with the CCO for at least 6 months and have at least one preventive dental service with either a dental or non-dental provider.

This measure is reported using two separate age stratification: patients aged 1–5 years and 6–14 years, who received a preventive dental service during the measurement year. Both age stratification groups must meet either the state benchmark or CCO improvement target to comply with this incentive measure.

How:

- Discuss the importance of dental health during all physical health wellness visits
- Include dental visits in your existing referral coordination workflow
- Use CareOregon's dental referral process in the OneHealth Portal to easily connect CareOregon members to a dental care coordinator who can help them schedule with a dental provider
- Utilize your BHC to support children and families for successful dental visits:
    - BHC asks families and/or scrubs their schedule to identify children in need of dental appointment when they're in clinic for their BHC appointment. Those who need appointment are connected for scheduling.
    - BHC provides supports for family implementing healthy behaviors (e.g. brushing routine).
- Reach out to your clinic's assigned Quality Improvement Analyst, Innovation Specialist, or Dental Innovation Specialist for further technical assistance and support.

Exclusions: N/A

Coding:
Preventive Dental Services:
CDT codes D1000 – D1999 billed by dental providers, Federally Qualified Health Centers, or Rural Health Centers.

Preventive Oral Health Services: CDT codes D1000 – D1999 or CPT code 99188 billed by non-dental providers.

Members Receiving Dental Services FAQ

Q: Can a member qualify for the denominator for two separates CCOs?

A: Yes, if the member switched from one CCO to another and had continuous enrollment for at least 180 days (i.e. 6 months) in the same year with both CCOs. The numerator services are attributed independently to the CCOs that paid and submitted the claim; thus, the member would not automatically count in the numerator for both CCOs, but only that CCO which paid the claims for the preventive service.

Q: Will services provided by dental hygienists count if they are not under supervision of a dentist?

A: Yes. Although the technical specifications state that "services provided by dental hygienists should only be counted when they are under supervision of a dentist," the OHA does not adopt this requirement because administrative claims data generally do not indicate supervision between health care providers.

Q: Does a First Tooth visit count as a preventive dental service for this measure?

A: CPT code 99188 (topical fluoride varnish) billed with a First Tooth visit on a medical claim does count towards the metric numerator. For additional support, please reach out to your dental innovation specialist.

Q: Do Telehealth visits count toward the metric?

A: This measure is eligible for telehealth/teledentistry. Some qualifying services such as D1310 'nutritional counseling' and D1330 'oral hygiene instructions' may be delivered in a teledentistry visit but are subject to providers' determination whether required components can be provided equivalent to an in-person visit.

Screening for Depression and Follow-Up Plan

Performance Measure Set: ☒CCO Incentive Metric ☐Medicare Star Rating

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☐Claims ☐Chart Documentation ☒eCQM ☐ Survey ☐Other

State Benchmark: 64.6%

Who: All patients aged 12 and older with at least one eligible encounter during the year.

Why: Major depression is a serious mental illness affecting millions of adults and children each year with impacts on health outcomes, quality of life, and cost of care. Comprehensive screening in primary care may help clinicians identify undiagnosed depression, earlier in the course of depression, and initiate appropriate treatment (Source: OHA Guidance Document, 2014).

What: This measure includes all members aged 12 and older who have at least one visit during the year (including telehealth visits). It reports those who were screened for clinical depression using an age-appropriate standardized tool, and, if positive, have a follow-up plan documented on the same day as the positive screening result. Therefore, there are two ways to meet numerator:

1. members received an initial depression screening and it was negative
2. members received an initial depression screening and it was positive, AND they received appropriate follow up documented on the same date

NOTE: PHQ-9 no longer counts as follow-up to a positive PHQ-2 screening and additional follow-up options need to be completed and documented. Please see FAQ page below for detail on the changes.

How: Some ideas to improve Depression Screening and Follow-Up performance:

- Standardized, age appropriate, annual screening tools should be used for screening patients at least once per measurement period; ideally integrated in EHR workflows.
- Workflows that include front desk staff, MAs, and providers are necessary to ensure each patient receives the appropriate screening, correct scoring, review, and documentation during at least one encounter peryear.
- Create missed opportunity reports. Follow up with those who were not screened or did not receive a follow up conversation. BHCs or other support staff (e.g., THWs) can follow up with patients within the 14-day timeframe to provide follow up.
- Create collaborative appointments such as the BHC sees the patients who score positive on the depression screening (e.g. PHQ-9 of 10+). BHC can see patient before PCP to assess for safety and develop follow up plan. BHC can inform PCP of the plan during warm hand off, which allows PCP to address additional issues during visit.

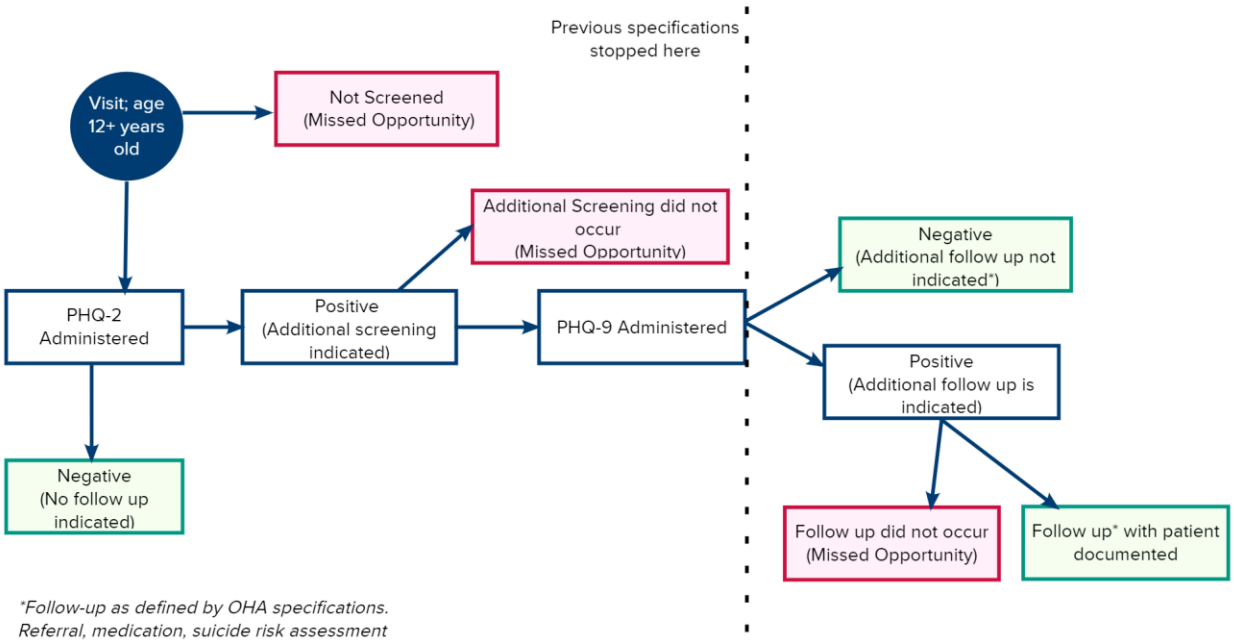
Exclusions: Patients with a current or historical diagnosis for depression or bipolar disorder, patients who refuse to participate in screening, if there is a medically urgent reason to delay screening, or if the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results.

Reporting: This measure aligns with **CMS 2v10**. CareOregon must collect data from each clinic's EHR for this measure. The data is then aggregated across all clinics in the CCO region and submitted to OHA. Please note the following reporting requirements:

- Patient-level detail for CareOregon members only is preferred.
- Reporting must be for the full calendar year of 2022; mid-year reports preferred in a rolling 12- month timeframe.

Please email your Quality Improvement Analyst or Primary Care Innovation Specialist for additional support for meeting this metric.

Recommend Workflow and Reporting Logic:



Screening for Depression and Follow-up Plan FAQ:

Q: Does the depression screening need to happen on the same date as the visit encounter?

A: No. Depression screenings performed 14 days prior to the encounter are accepted to allow alternative methods of screenings, such as pre-screenings within EHRs. However, follow-up plans for a positive initial screening must be documented on the date of the encounter.

Q: Can an Integrated Behavioral Health Clinician support Depression Screening and Follow up?

A: Yes, BHC visits count as a qualifying visit for the Depression Screening and Follow up metric.

BHCs can support via collaborative appointments such as the BHC sees patients who score positive on the depression screening (e.g. PHQ-9 of 10+). BHC can see the patient before PCP to assess for safety and develop follow up plan. BHC can inform PCP of the plan during warm hand off, which allows PCP to address additional issues during visit.

BHCs can provide the depression screening and follow up in their daily appointments. By making it part of their workflow, they can provide high quality patient care and contribute to the metric. Support your BHCs in understanding where/how to document depression screening and follow up so as to assure it is properly captured in your data.

Q: What counts as a "positive" score?

A: Determination of a "positive" score is up to the clinical discretion of each provider and will be dependent on the screening tool used. CareOregon does not provide clinical guidance and defers to the best clinical judgement of providers to interpret the screening results and identify appropriate follow-up plans.

Q: What types of "follow-up" are sufficient for this measure?

A: Documented of at least one of the following:

- **Referral to a practitioner or program** for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression. This can be an internal or external referral, and either type should be documented in a way that is captured in reporting.
- **Physical therapy evaluation**
- **Other interventions designed to treat depression** such as psychotherapy, pharmacological interventions, or additional treatment options.
    - Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

Screening for Depression and Follow-up Plan FAQ (Continued):

Q: What screening tools are recommended?

A: OHA does not require use of specific screening tools, only that screening tools are normalized, validated, and age appropriate. Implementation of tools is at the provider or clinic's discretion. Examples of depression screening tools include but are not limited to:

Adolescent Screening Tools (12-17 years)

- Patient Health Questionnaire for Adolescents (PHQ-A)
- Beck Depression Inventory-Primary Care Version (BDI-PC)
- Mood Feeling Questionnaire (MFQ)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Patient Health Questionnaire (PHQ-9)
- Pediatric Symptom Checklist (PSC-17)
- PRIME MD-PHQ2

Adult Screening Tools (18 years and older)

- Patient Health Questionnaire (PHQ9)
- Beck Depression Inventory (BDI or BDI-II)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Depression Scale (DEPS)
- Duke Anxiety-Depression Scale (DADS)
- Geriatric Depression Scale (GDS)
- Cornell Scale for Depression in Dementia (CSDD)
- PRIME MD-PHQ2
- Hamilton Rating Scale for Depression (HAM-D)
- Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)
- Computerized Adaptive Testing Depression Inventory (CAT-DI)
- Computerized Adaptive Diagnostic Screener (CAD-MDD) Perinatal Screening Tools
- Edinburgh Postnatal Depression Scale
- Postpartum Depression Screening Scale
- Patient Health Questionnaire 9 (PHQ-9)
- Beck Depression Inventory
- Beck Depression Inventory-II
- Center for Epidemiologic Studies Depression Scale
- Zung Self-Rating Depression Scale

Health Aspects of Kindergarten Readiness Measure: System-Level Social-Emotional Health Metric

Performance Measure Set: ☒ CCO Incentive Metric ☐Medicare Star Measure

Quality Measurement Type: ☐Structure ☐Process ☐Outcome ☐Patient Experience

Data Type: ☐Claims ☐Chart Documentation ☐eCQM ☐Survey ☒Other

Medicaid State Benchmark: 10/10 points based on Attestation Survey Form Completed by CCOs

Who: Children from birth to 5 years of age. This measure is aimed at supporting the social emotional health development in for kindergarten readiness.

Why: This measure is part of a broader effort to prepare children ages 0 to 5 for kindergarten. The vision of the measure is to utilize CCOs to address complex system-level factors that impact the services families receive and how they receive them. This is accomplished by building capacity within CCOs for enhanced services, integration of services, cross-sector collaboration, and future measurement opportunities.

What: Attestation Survey Form to be completed by Coordinated Care Organizations (CCOs), inclusive of four different components. Within Attestation Component 1 there is required review of child-level reach metric data (data provided by the Oregon Health Authority).

Note for clinics: This measure is conducted specifically at the CCO level. CCO's will reach out to clinics to coordinate the work within the network.

How: CCO's are required to attest to all required components for MY 1 (2022) for the following components, including submission of the following by timeline set by OHA (a) attestation survey; (b) asset map; (c) action plan

1) Social-Emotional Health Reach Metric Data Review and Assessment
2) Asset Map of Existing Social-Emotional Health Services and Resources
3) CCO-Led Cross-Sector Community Engagement
4) Action Plan to Improve Social-Emotional Health Service Capacity and Access

Measurement Period: Calendar year, measurement years are defined as follow:

- **MY1:** January 1st, 2022 – December 31st, 2022
- **MY2:** January 1st, 2023 – December 31st, 2023
- **MY3:** January 1st, 2024 – December 31st, 2024

Additional information can be found on the official OHA technical specifications can be found at https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2022-specifications-(SE%20health)-12.13.2021.pdf