AGENDA

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

January 3, 2018
9:00-11:00 am
Portland State Office Building, room 915

Conference line: (877) 873-8017
Access code: 767068#
Webinar link: https://attendee.gotowebinar.com/register/5150607625475124481

Meeting Objectives

- Approve November meeting minutes
- Discuss input gathered on process measures for effective contraceptive use
- Provide feedback on local public health process measure data presentation, benchmarks and improvement targets
- Hear about OHA's priorities for oral health and provide guidance to the Public Health Division on developing the oral health accountability metric and process measure

PHAB members: Muriel DeLaVergne-Brown, Eva Rippeteau, Eli Schwarz, Teri Thalhofer, Jennifer Vines

9:00-9:05 am	**Welcome and introductions** • Review and approve November minutes • Subcommittee updates	Sara Beaudrault, Oregon Health Authority
9:05-9:20 am	**Effective contraceptive use** • Discuss feedback received from the Coalition of Local Health Officials (CLHO) on proposed effective contraceptive use process measures • Discuss ECU process measures to recommend to PHAB for a vote	Sara Beaudrault, Oregon Health Authority Myde Boles, Program Design and Evaluation Services
9:20-10:10 am	**Local public health process measure benchmarks and targets** • Review format for presenting data in public health accountability metrics report • Discuss challenges for reporting on adopted accountability metrics and local public health process measures • Hear about the methodology OHA proposes to use to set benchmarks and targets	Myde Boles, Program Design and Evaluation Services

10:10-10:50 am	**OHA's priorities for oral health** • Hear about OHA's priorities for oral health and data that are available to monitor trends in dental visits for children • Review data that are available to monitor trends in dental visits for children • Provide guidance to the Public Health Division on next steps for developing the oral health accountability metric and process measure	Amanda Peden, Oregon Health Authority Amy Umphlett, Oregon Health Authority Kelly Hansen, Oregon Health Authority
10:50-10:55 am	**Subcommittee business** • Subcommittee work plan for 2018 included with meeting materials • Discuss meeting structure. Should a Chair be appointed? • Identify who will provide subcommittee update at January 18 PHAB meeting • Identify agenda items for January 24 meeting	All
10:55-11:00 am	**Public comment**	
11:00 am	**Adjourn**	

PUBLIC HEALTH ADVISORY BOARD
DRAFT Accountability Metrics subcommittee meeting minutes

November 22, 2017

PHAB Subcommittee members in attendance: Eva Rippeteau, Eli Schwarz, Eva Rippeteau, and Teri Thalhofer

Oregon Health Authority staff: Sara Beaudrault, Cara Biddlecom, Myde Boles, Julia Hakes, and Luci Longoria

Members of the public: Caitlin Hill, and Lindsay Channa

Welcome and introductions
The October 13, 2017 meeting minutes were approved.

Effective contraceptive use

Myde shared the PHAB summary of local public health process measure recommendations from their meeting on October 19, 2017. PHAB did not adopt an effective contraceptive use process measure and requested that this committee do additional work to identify a process measure for effective contraceptive use.

Myde shared four options for local health process measures for effective contraceptive use, based on feedback received from PHAB at the 10/19 meeting.

Eli reported that the Metrics and Scoring Committee expanded the age range for the effective contraceptive use metric and this was approved by the Health Plan Quality Metrics Committee. The minutes from these meetings may contain useful information for this group.

Regarding option #4, Eli asked if PRAMS and BRFSS can be stratified down to the local public health department level. Myde said yes they can.

Teri liked option #1 because it aligns well with the new program element with modernization and will be measured. Teri noted that BRFSS and PRAMS at the local level can be meaningless for smaller counties. Teri expressed concern that #3 can be affected by the political environment.

Eli asked why process measures from CLHO not put forward. Sara answered that the PHAB suggested OHA reexamine CLHO's process measures again and that the PHAB felt #3 would be the easiest to implement.

Eli suggested that OHA and PHAB could monitor measures without establishing them as an accountability metric if there is high level of interest. Eli recommended data could be shared out every 5 years.

Sara shared that OHA would like to bring #4 to CLHO. Elia would like an explanation of the data in #4.

Decision: OHA will take #1 and #4 to CLHO for their review.

Jen asked if the subcommittee is wedded to the effective contraceptive use metric. Cara answered that there was strong support for an effective contraceptive metric in the stakeholder feedback survey.

Benchmarks and improvement targets

Myde shared an update on LPHA process measures and timeline and the local public health process measures.

Eli asked how benchmarks will be set. Myde answered if there is not an established benchmark, the intent is to work with OHA programs and stakeholders to identify an appropriate.

Eli asked how top prescribers are defined. Sara answered they are top 20% of prescribers in Oregon who write the most prescriptions for prescription opioids. This includes all prescriber types, including dentists.

Eli requested that OHA add a fourth column listing the data source for the local public health process measures table. Myde said she will add a fourth column with the data source.

Subcommittee business

- Benchmarks and improvement targets will be discussed at the next subcommittee meeting.
- Amanda Peden and Amy Umphlett from OHA will be presenting on OHA's priorities for oral health.

Public comment

No public comment was provided.

Adjournment

The meeting was adjourned.

The next Accountability Metrics Subcommittee meeting is scheduled for:

January 3, 2017 from 9-11am

PHAB Accountability Metrics subcommittee

Effective contraceptive use process measure recommendations

January 3, 2018

Background: In October PHAB adopted a set of local public health process measures, but did not adopt the local public health process measure for effective contraceptive use that was recommended to them by the Accountability Metrics subcommittee. PHAB requested that this subcommittee do additional work to develop a process measure for effective contraceptive use.

Purpose: Review additional information provided by CLHO members at their Dec 21, 2017 meeting. Confirm that both process measures listed below will be presented to PHAB on Jan 18, 2018.

Option	Measure	Data Source	Considerations
#1. Make adjustments to process measure that was recommended to PHAB in October *"Number of local policy strategies for increasing access to effective contraceptives".*	Annual strategic plan that identifies gaps, barriers and opportunities for improving access to effective contraceptive use	LPHA reporting[1]	Consistent with activities proposed in new Reproductive Health Program Element. Developing a strategic plan will become a Program Element requirement. Annual strategic plans will already be submitted annually Aligns with core system functions for assuring access to clinical preventive services. Although this measure is yes/no, an LPHA would need to demonstrate it meets established criteria for a strategic plan (i.e. working with partners, focusing on reducing disparities, has a plan to monitor implementation, etc).
#2 Change the outcome measure to unintended pregnancies. Use Effective contraceptive use as the local public health process measure	Percent of pregnancies that are unintended (public health accountability metric) Effective contraceptive use among women at risk of pregnancy (local public health process measure)	Unintended pregnancies: Pregnancy Risk Assessment Monitoring System (PRAMS) and Vital Statistics data Effective contraceptive use: Behavioral Risk Factor Surveillance System (BRFSS)	Using effective contraceptive use as the local public health process measure does not clearly define what an LPHA must do to increase the rate of effective contraceptive use. BRFSS/PRAMs data can be meaningless for very small counties. Difficult to see impact of interventions. CLHO members discussed challenges related to CCO data reporting. CLHO members asked whether the All Payer/All Claims database is a potential source for population-level data on LARC use. OHA will follow up. CLHO members asked whether this measure aligns with recommendations that may come out of the OHA Unintended Pregnancy workgroup. OHA will follow up.

[1] For areas where no established data collection system exists, each LPHA would be responsible for creating and supporting an internal mechanism to collect the data.

Public Health Accountability Metrics:
Update on data collection and reporting

PHAB Accountability Metrics Subcommittee Meeting
January 3, 2018

Myde Boles, Program Design and Evaluation Services

PUBLIC HEALTH DIVISION
Office of the State Public Health Director

Purpose for today's discussion

- Review data collected to date for public health accountability metrics report (health outcome measures and local public health process measures)
  - Refer to Public Health Accountability Metrics Preliminary Report
- Review how data will be presented in public health accountability metrics report
  - Refer to Public Health Accountability Metrics Preliminary Report
- Discuss challenges related to data collection and reporting
- Introduce interrelationship between process measures and incentive payment system, including:
  - Benchmarks
  - Improvement targets

Benchmarks and improvement targets

For consideration:

Adapt CCO metrics approach

- CCO core performance metric ~= public health accountability metric
  - No financial incentives or penalties for performance on these metrics
- CCO incentive metrics ~= local public health process measures
  - LPHAs receive payment based on their performance on process measures

Process measure benchmarks and improvement targets

- Benchmarks recommended by PHAB Accountability Metrics subcommittee, approved by PHAB
- Benchmarks meant to be aspirational
- Improvement targets indicate progress toward benchmarks
- Incentive payment for either:
  - Achieving benchmark or
  - Achieving improvement target

Benchmarks and improvement targets - example

Step 1. Suppose LPHA's performance in 2017 (baseline) on measure 1 is 60%

Step 2. Benchmark for measure 1 is 100%

Step 3. The gap between baseline and benchmark is 40% (100% - 60%)

Step 4. Use the "Minnesota Method" to determine improvement target which requires at least a 10% reduction in the gap:

>10% of 40% = 4%

>LPHA must improve by at least 4 percentage points in 2018

>The improvement target is (baseline +4%) = (60% + 4%) = 64%

Step 5. If LPHA performance in 2018 is 65%, LPHA achieved their improvement target and will be eligible for incentive payment

Step 6. Technical note: "floor" or minimum level of improvement required (see p.17 of 2016 CCO Metrics Final Report)

Oregon Health Authority

OHA Oral Health Priorities and Metrics

PHAB Accountability Metrics Subcommittee meeting
January 3, 2018

Amanda Peden, Policy Analyst, Health Policy and Analytics

Oregon Health Authority

Purpose for today's discussion

- Review OHA Oral Health Priorities
- Review metrics priorities
- Review key findings from Oral Health in Oregon CCOs Metrics Report
  - Any dental services/any preventive services for children

Oral health at OHA

Vision: All Oregonians have equitable access across the lifespan to better oral health, and oral health access and outcomes. Improving oral health will impact overall health costs.

Strategic Focus Areas

- Improve oral health equity
- Improve population health
- Improve access to oral health care
- Increase integration and coordination of care

Oregon Health Authority

OHA oral health select metrics by focus area

Improve oral health equity

- Percentage of oral health care providers who complete cultural competency training (data not yet available)
- Metrics by race, ethnicity, gender, disability, etc.

Improve population health

- Children ages 6-9 with dental sealants on one or more permanent molars ◄
- Adults 65 to 74 years who have lost 6 or more teeth due to tooth decay or gum disease
- Percentage of people in Oregon residing in areas served by optimally fluoridated water

Improve access to oral health care

- Adults with any dental visit (Medicaid and population)
- Adults and children receiving preventive dental care – including children age 0-5, pregnant women (Medicaid) ◄

Increase integration and coordination of care

- Dental care for adults with diabetes (Medicaid and population) ◄
- Follow-up after ED visit for non-traumatic (caries-related) dental reason (Medicaid)
- Oral health assessments in primary care (Medicaid)
- Physical, mental and oral health assessments for children in DHS custody (Medicaid) ◄

◄ Selected/endorsed by the Metrics & Scoring Committee

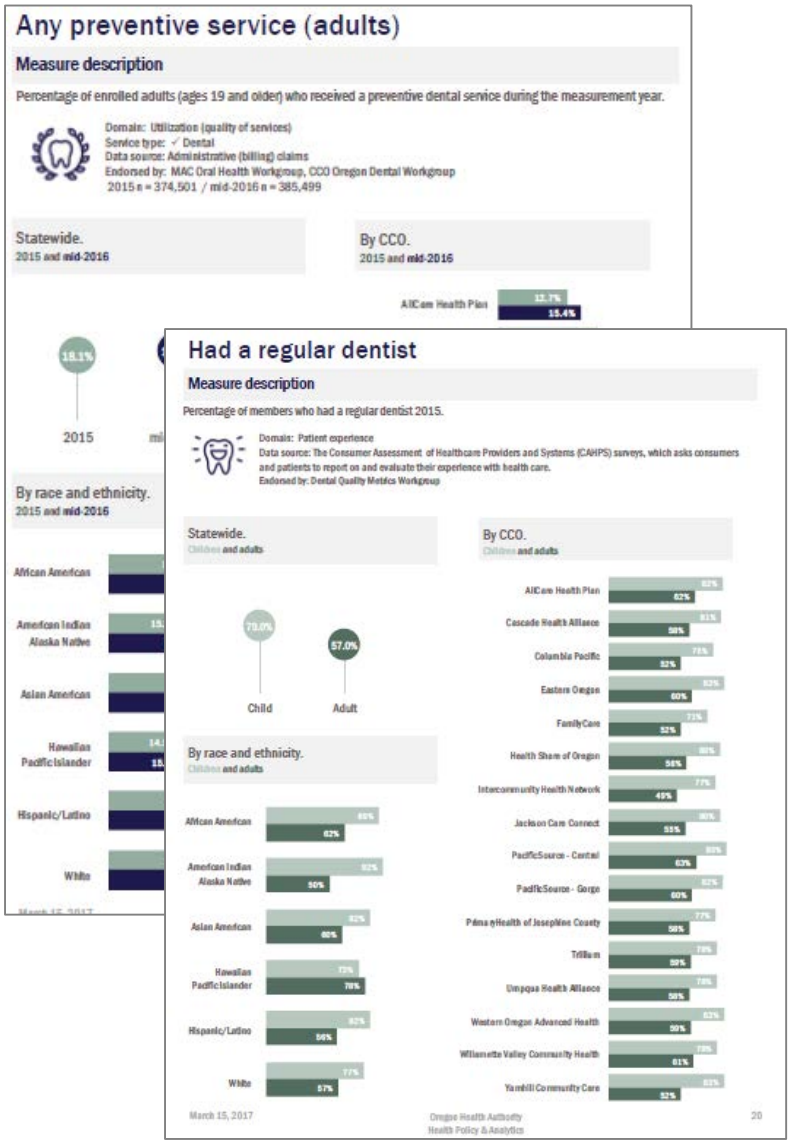
Oral Health in Oregon's CCOs



A metrics report

March 2017

Oregon Health Authority

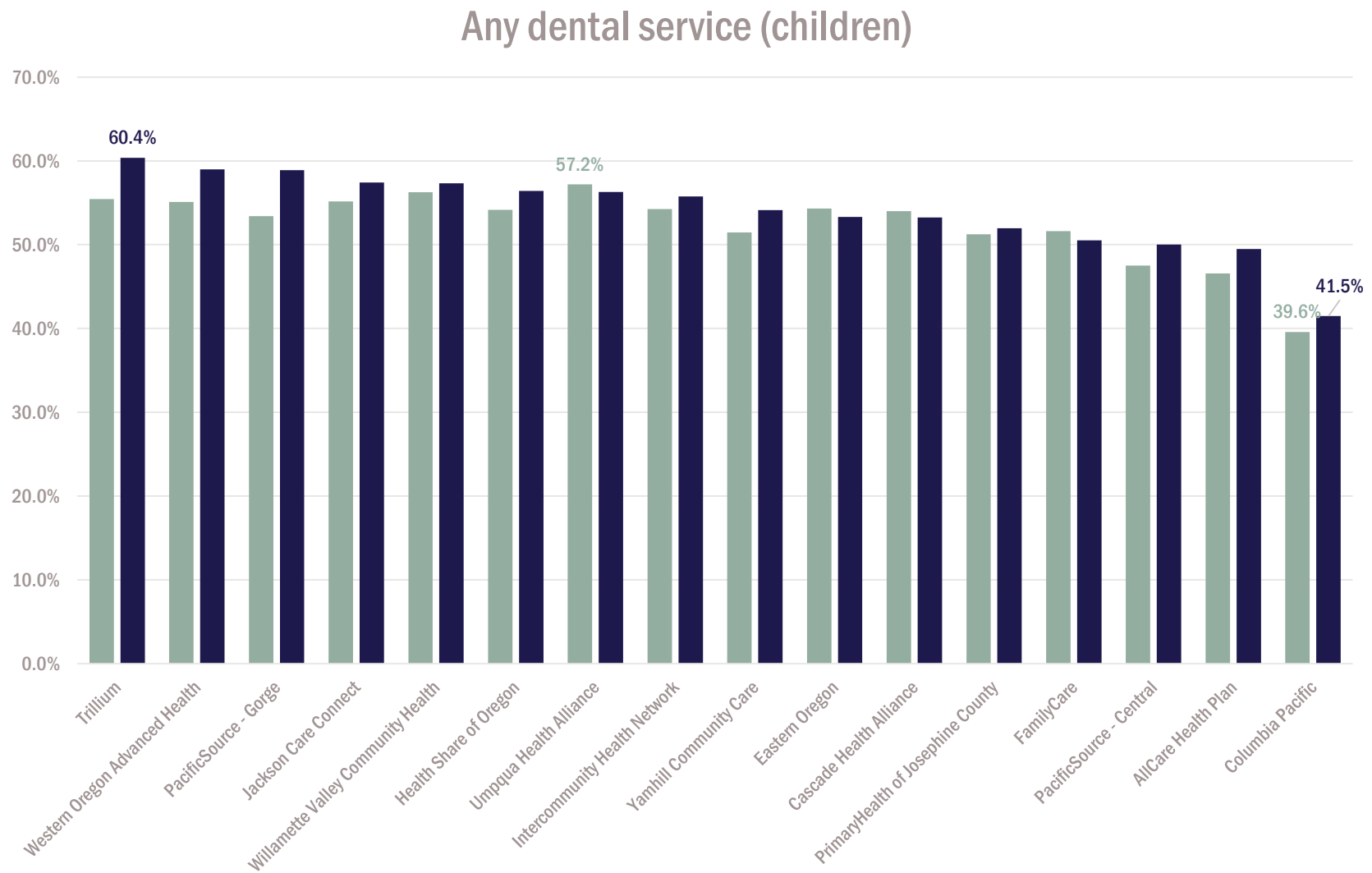


https://www.oregon.gov/oha/analytics/Documents/oral-health-ccos.pdf

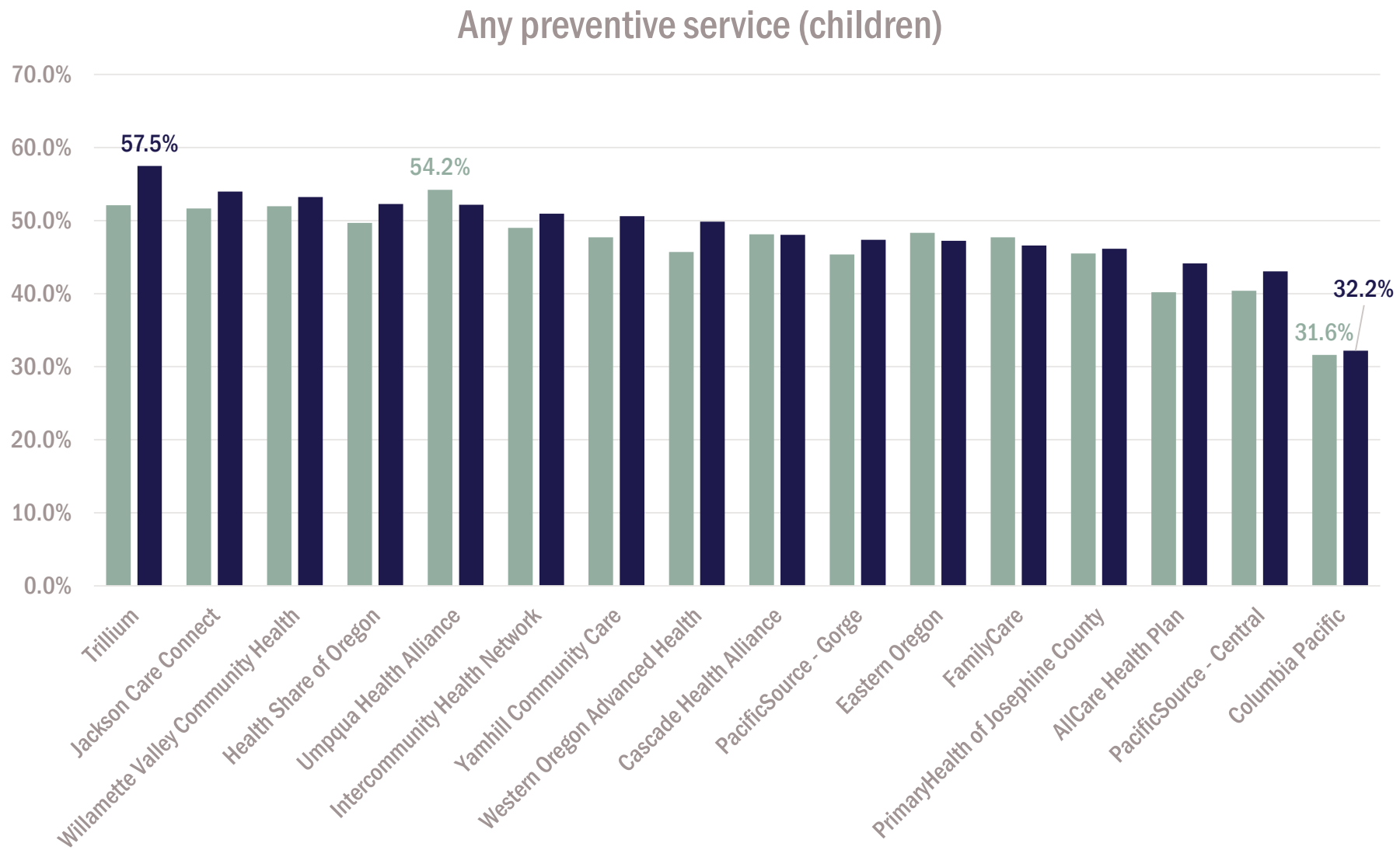
Stakeholders informed metrics

	Metrics & Scoring Committee & Dental Quality Metrics WG	CCO Oregon Dental WG	MAC Oral Health WG	Strategic Plan for Oral Health in Oregon
Purpose	Recommend incentive metrics for CCOs	Quality metrics core and a la carte set for use in CCO contracts	Oral health monitoring measures for understanding access in Oregon Health Plan	Statewide strategic plan to align stakeholders around common goals and metrics
Key measures	• Current measures selected by MSC: dental sealants and foster care • Addtl on-deck measures: dental care/adults with diabetes, preventive services • Addtl measures for monitoring/incentives recommended by DQMWG	CCO-DCO Quality Measure Sets Utilization, patient experience, care coordination (ED use), measures focused on specific populations (e.g. pregnant women, people with diabetes)	15 total measures under 6 priorities of access: provider distribution, utilization (quality of services), patient experience, care coordination, integration, patient-centered care	Community water fluoridation, pregnant women dental visit, children 0-5 with a dental visit, children ages 6-9 with sealants, older children and adults with any dental visit, ED utilizations for non-traumatic dental

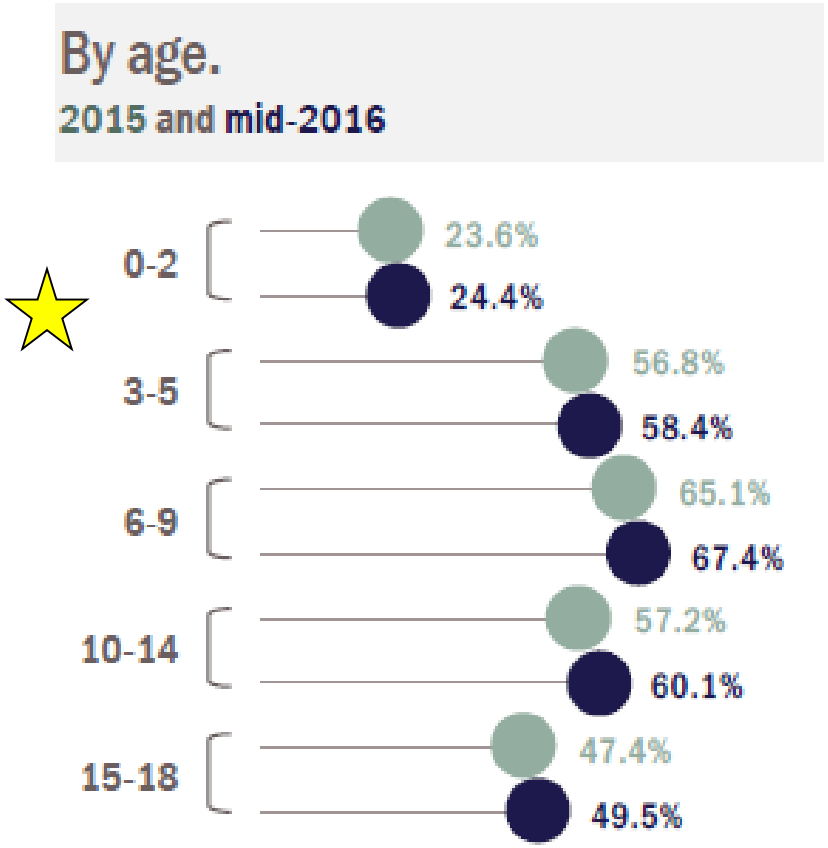
Statewide:
2015–53.1%
Mid-2016–54.8%



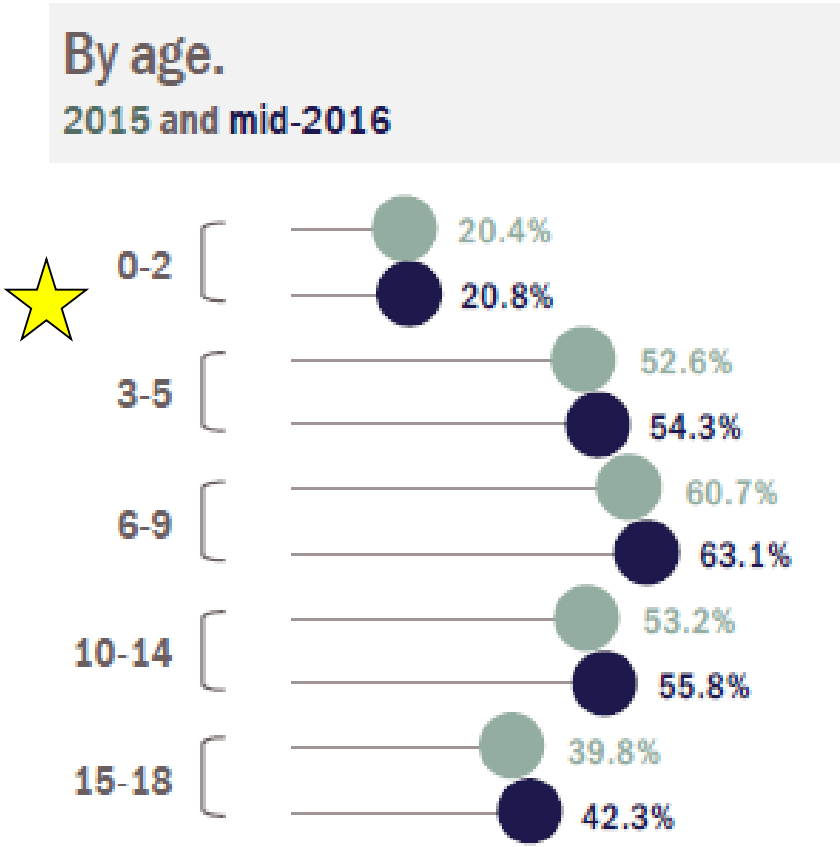
Statewide:
2015–48.3%
Mid-2016–50.1%



Any Dental Service



Any Preventive Service



Oregon Health Authority

Questions?

Oregon Health Authority

Please note:

- This logic model is a living document and will be revised as work evolves.
- It is not meant to be a stand alone document; rather it is inclusive of all the oral health work being conducted at OHA, including current work.
- Finally, the timeframe for all outcomes is not discrete. While the focus for the 2017 biennium will be on short term outcomes, this will also ignite some of the preliminary work for intermediate and long term outcomes leading to the ultimate goals.

OHA Oral Health Roadmap Logic Model

INPUTS
Fundamental resources needed to meet project goals

ACTIVITIES
Draws on resources to support project goals

OUTCOMES
Changes resulting from activities and outputs

Inputs

- Statewide Dental Director, Executive Oral Health team, OHA Oral Health Team, which includes:
  - External Relations Division
  - Health Policy & Analytics Division
  - Health Systems Division
  - Office of Equity & Inclusion
  - Public Health Division
- Funding
  - Federal Funds (e.g. Medicaid, Title V, HRSA)
  - General Funds
  - Grants
- Stakeholders and Partners
- Contractors and Consultants
- Oregon Health Plan oral health delivery system
  - Managed care
  - FFS/Open Card
- Federal/State Statute and Scope of Practice

Activities

- Collaboration across OHA
- Policy
- Education
- Communication
- Direct Services
- Data and Analytics
- Community Partnerships

Outcomes

Short Term
2017-2019 Biennium

- Expand and improve Oregon's surveillance system, including monitoring:
  - Hospital and ED visits for oral health
  - Improve data monitoring & surveillance to include race, ethnicity, language & disability
- Increasing awareness and understanding of oral health among:
  - Internal OHA staff ; and
  - Oregonians (members of the public, providers, plans)
- Increase incentives for private and public health plans and healthcare providers to improve oral health
- Expanding access for elementary and middle school dental sealant program

Intermediate
2017 – 2022 (5 years)

- Increase early preventative care for children, pregnant women, and others across the lifespan
- Increase oral health services through community clinics, including school based health clinics
- Integrate oral health in chronic disease prevention and management models
- Increase access to dental services for optimal oral health maintenance
- Advance CCO integration of oral health
- Increase access for all Oregonians to oral health providers of all types
- Increase cultural competency in the oral health workforce
- Active cross-agency participation in oral health

Long Term
2027 (10 years)

- Reduce the number of dental-related visits to emergency rooms
- Increase the number of fluoridated public water districts
- Recognized cross-agency oral health team

Ultimate Goals

- Improve oral health equity
- Improve access to oral health
- Increase integration and coordination of care
- Improve population oral health

Assumptions/External Factors/Influences: Federal and State statute, Funding, CCO/Dental Delivery System, Medicaid Dental Benefits

Updated 11-06-2017

Accountability Metric: Dental Visits for Children 0-5:
Review of public health data

PHAB Accountability Metrics subcommittee meeting
January 3, 2018

Amy Umphlett and Kelly Hansen, Oregon Health Authority

Oregon Health Authority

Purpose for today's discussion

- Review available Medicaid and PRAMS2 data for dental visits for 0-5 year olds
- Make recommendation for whether to use either data source to report on dental visit for 0-5 year olds

Public Health Advisory Board

Accountability Metrics subcommittee meeting

January 3, 2018

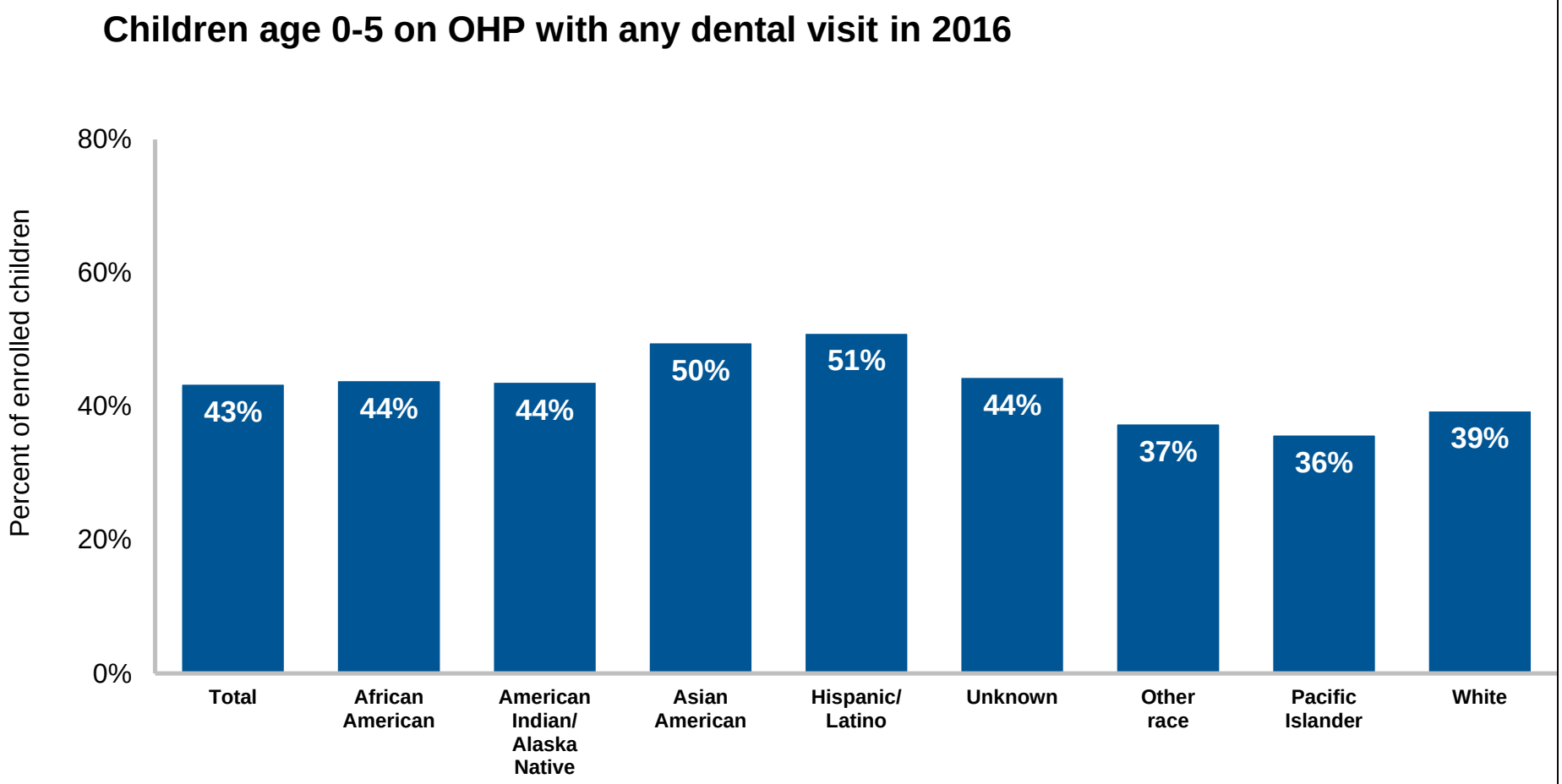
Oral Health Metrics

Measure	Children aged 0-5 with a dental visit in the previous year; percentage of OHP enrolled children who received any dental service during the measurement	Percentage of **enrolled** children (ages 0-18) who received a **preventive** dental service during the measurement year	Percentage of **enrolled** children (ages 0-18) who received any dental service during the measurement year	Children (ages 6-9) with the presence of untreated decay	Has your 2-year old ever been to a dentist or dental clinic?	Percent of children with a preventive dental visit in the past year
Data Source	Medicaid claims data	Medicaid claims data	Medicaid claims data	Smile Survey	PRAMS-2	National Survey of Children's Health
Data collection method	Medicaid claims	Medicaid claims	Medicaid claims	School-based survey	Statewide survey	National survey with state estimates
Sample	OHP enrolled and use services	OHP enrolled	OHP enrolled	1st, 2nd, 3rd grade sample	Sample of Oregon women	Children age 1-5 subgroup available
Description	Measure 2.3 in State Health Improvement Plan: Children aged 0 to 5 with a dental visit in the previous year. Target: 10% increase from baseline.	Reported in Oral Health in Oregon's CCOs: A metrics report March 2017	Reported in Oral Health in Oregon's CCOs: A metrics report March 2017	Last reported 2012	Resurvey of Oregon PRAMS respondents (all had a live birth) when their child was 2 years old. Results available for 2006-2013. 2016 data is forthcoming.	Indicator 4.2: During the past 12 months/since [his/her] birth, how many times did [child name] see a dentist for preventive dental care such as check-ups and dental cleanings?
Results	2016: 43.44% Statewide	Mid 2016: 50.1% statewide	Mid 2016: 54.8% statewide	20% untreated decay (6-9 year olds)	2013: 38.8% statewide	2016: 64.1% of 1-5 year olds statewide
Weaknesses	Medicaid population only; baseline not defined; SHIP measure is considered developmental; measure does not specify count or %; measure does not specify type of visit (assume all visits)	Medicaid population only	Medicaid population only	Not conducted annually; not population of interest	Covers only 2-year olds; no data for 2014, 2015.	Data from survey year 2016 and onward cannot be compared to prior years' surveys (2011/12, 2007); no county or regional estimates
Frequency	Annual	Annual	Annual	Every five years	Annual	Every two years
Statewide	Yes	Yes	Yes	Yes	Yes	Yes
By County/Region	Reported by CCO, county TBD	Reported by CCO	Reported by CCO	Reported by region	Reportable by region as a weighted percentage	No
By Race/ethnicity	Reported by race/ethnicity for statewide	Reported by race/ethnicity for statewide	Reported by race/ethnicity for statewide	Yes	Yes, of child's mother (from child's birth certificate)	Sample size for Oregon too small for analysis by race and ethnicity

Medicaid Data

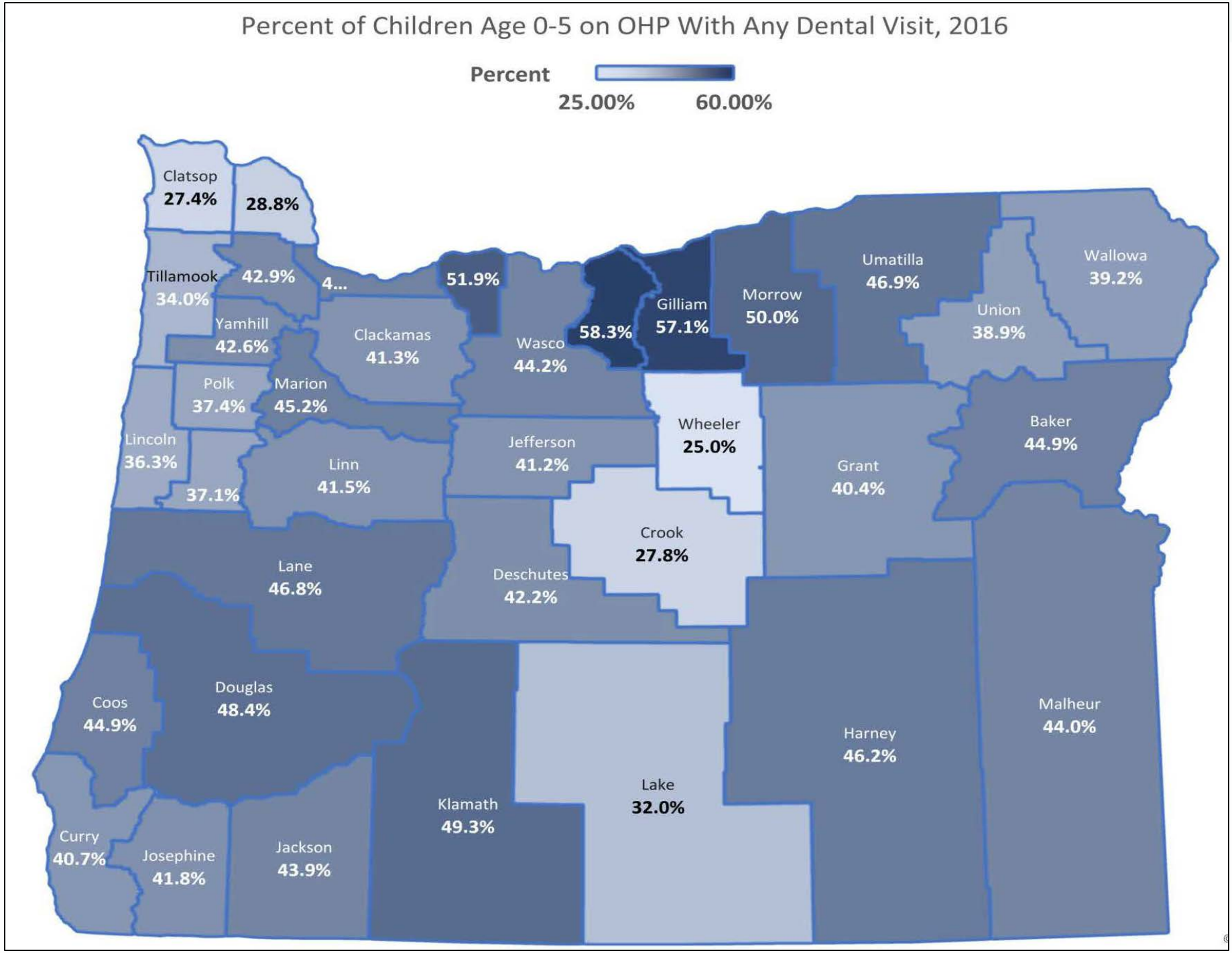
- Medicaid claims data is for the 2016 calendar year.
- Numerator – Number of clients who received any dental service under the supervision of a dentist or dental hygienist in the measurement year (2016).
- Denominator – Number of clients who have continuous enrollment for 12 months in a CCO.

Medicaid Claims Data – 2016



Notes: *All other groups exclude Hispanic ethnicity.*

Source: *DHS/OHA DSSURS Data Warehouse*


Percent of Children Age 0-5 on OHP With Any Dental Visit, 2016
Percent
25.00%
60.00%
Clatsop
27.4%
28.8%
Tillamook
34.0%
42.9%
4...
51.9%
Yamhill
42.6%
Clackamas
41.3%
Wasco
44.2%
58.3%
Gilliam
57.1%
Morrow
50.0%
Umatilla
46.9%
Union
38.9%
Wallowa
39.2%
Polk
37.4%
Marion
45.2%
Lincoln
36.3%
37.1%
Linn
41.5%
Jefferson
41.2%
Wheeler
25.0%
Grant
40.4%
Baker
44.9%
Crook
27.8%
Deschutes
42.2%
Lane
46.8%
Coos
44.9%
Douglas
48.4%
Klamath
49.3%
Lake
32.0%
Harney
46.2%
Malheur
44.0%
Curry
40.7%
Josephine
41.8%
Jackson
43.9%

Medicaid Data Limitations

- Not population-based
- Includes Medicaid enrollees only
- Does not include dental services provided in a medical setting

PRAMS Data

- PRAMS is a population based survey of new mothers in Oregon.
- PRAMS2 is a resurvey of Oregon PRAMS respondents (all of whom had a live birth) when their child was 2 years old.
  - Mothers are asked if their child has ever been to a dentist or dental clinic.
  - If they have not, a follow-up question asks for reasons their 2-year-old has not been to a dentist or dental clinic. They may answer as many reasons as apply.
- Most recent available PRAMS2 data is from **2013**.

PRAMS2 Data – 2013

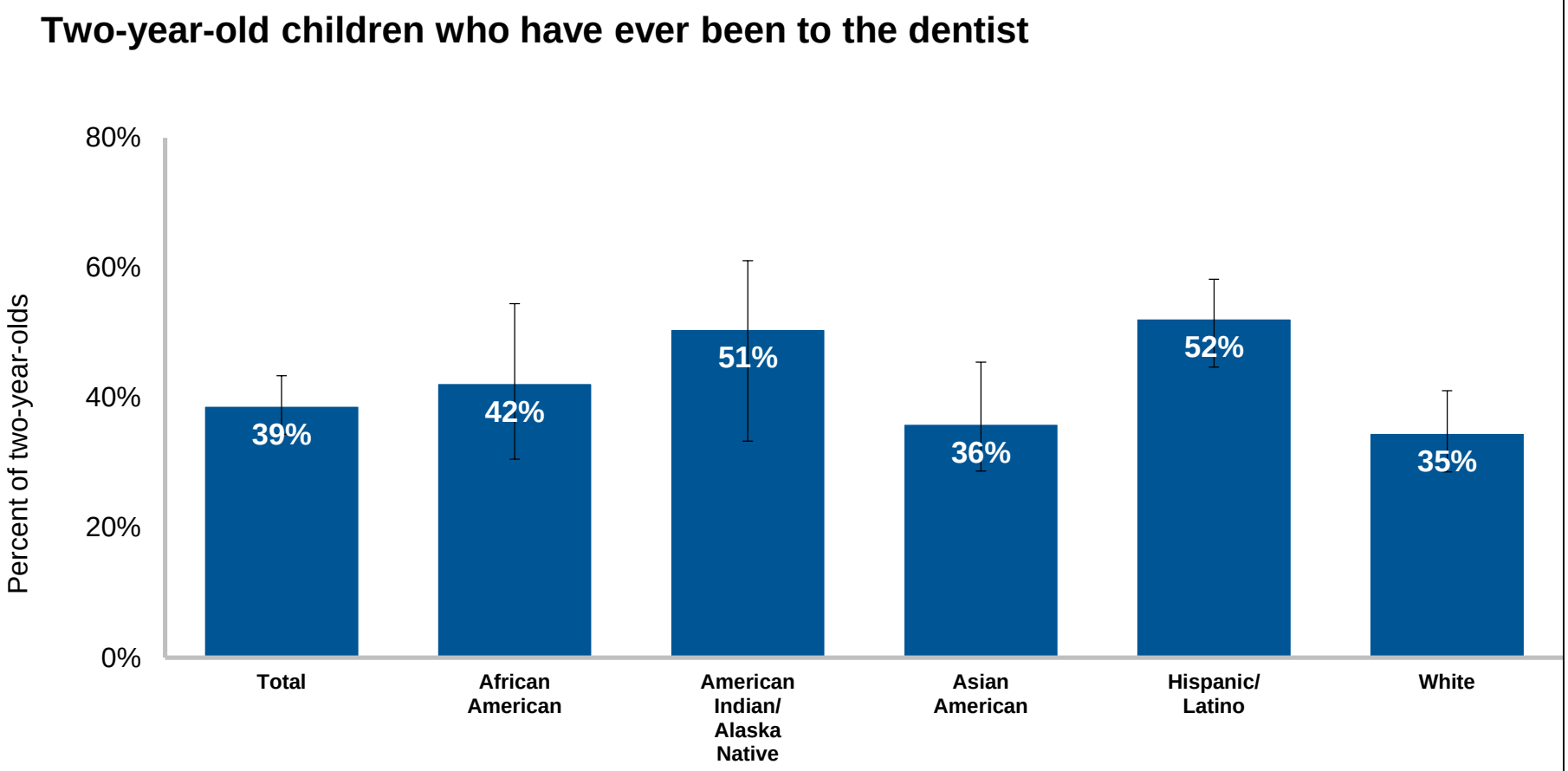
- **38.8%** of two-year-old children had visited a dentist or dental clinic.
- Of those that had not visited a dentist or dental clinic, the most common reasons given:
  - "I didn't know my child needed to go to a dentist" (31.2% of "no" respondents)
  - "A healthcare or dental care provider told me my child was too young to see the dentist" (23.8% of "no" respondents)
  - "I didn't have enough money or dental insurance to pay for the visit" (9.7% of "no" respondents)

PRAMS2 Data – 2013

- Percentage of two-year-old children with dental clinic experience varies based on race/ethnicity and state region.

- Due to low sample sizes in some counties, numbers may only be presented by region.

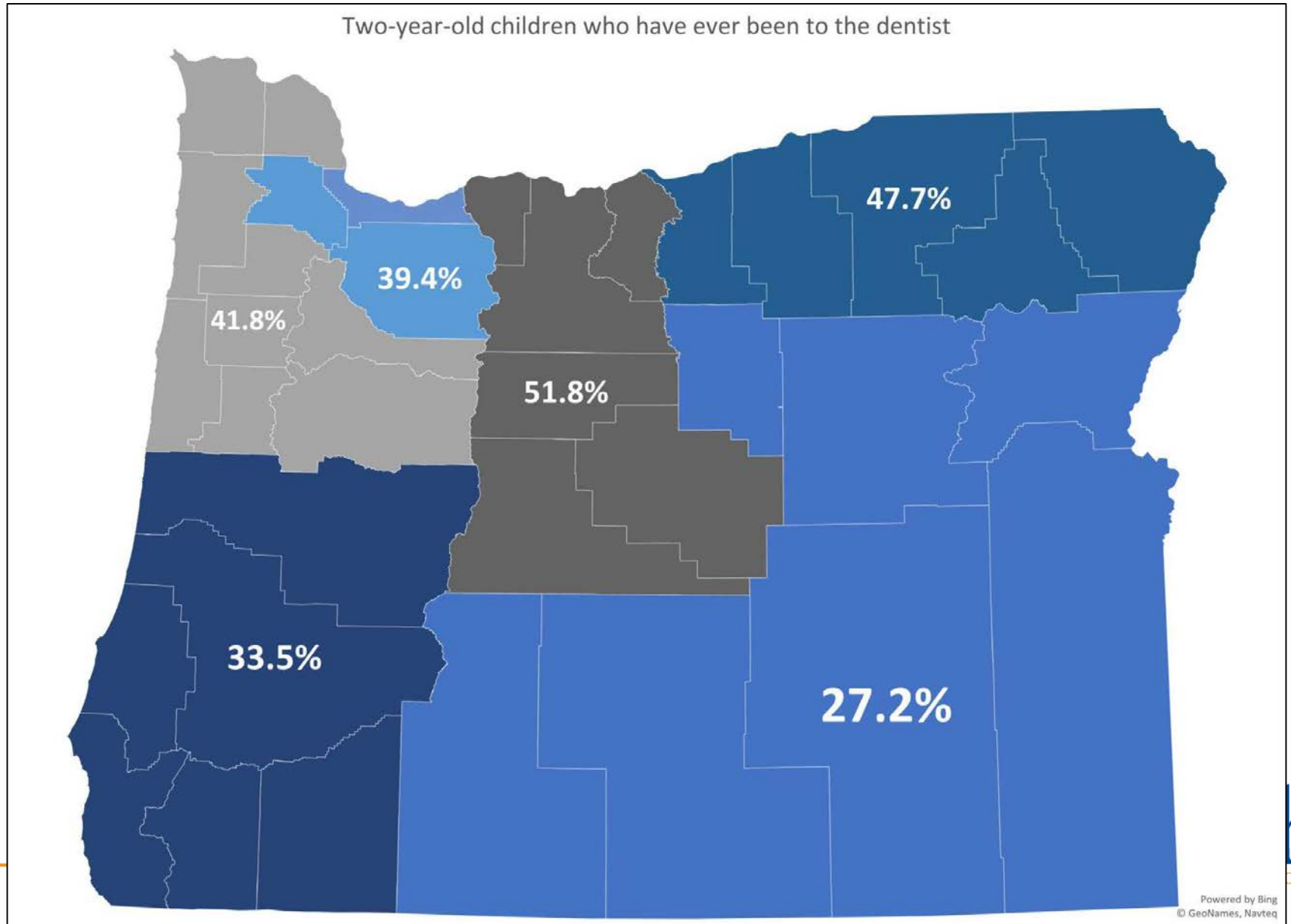
PRAMS2 Data – 2013



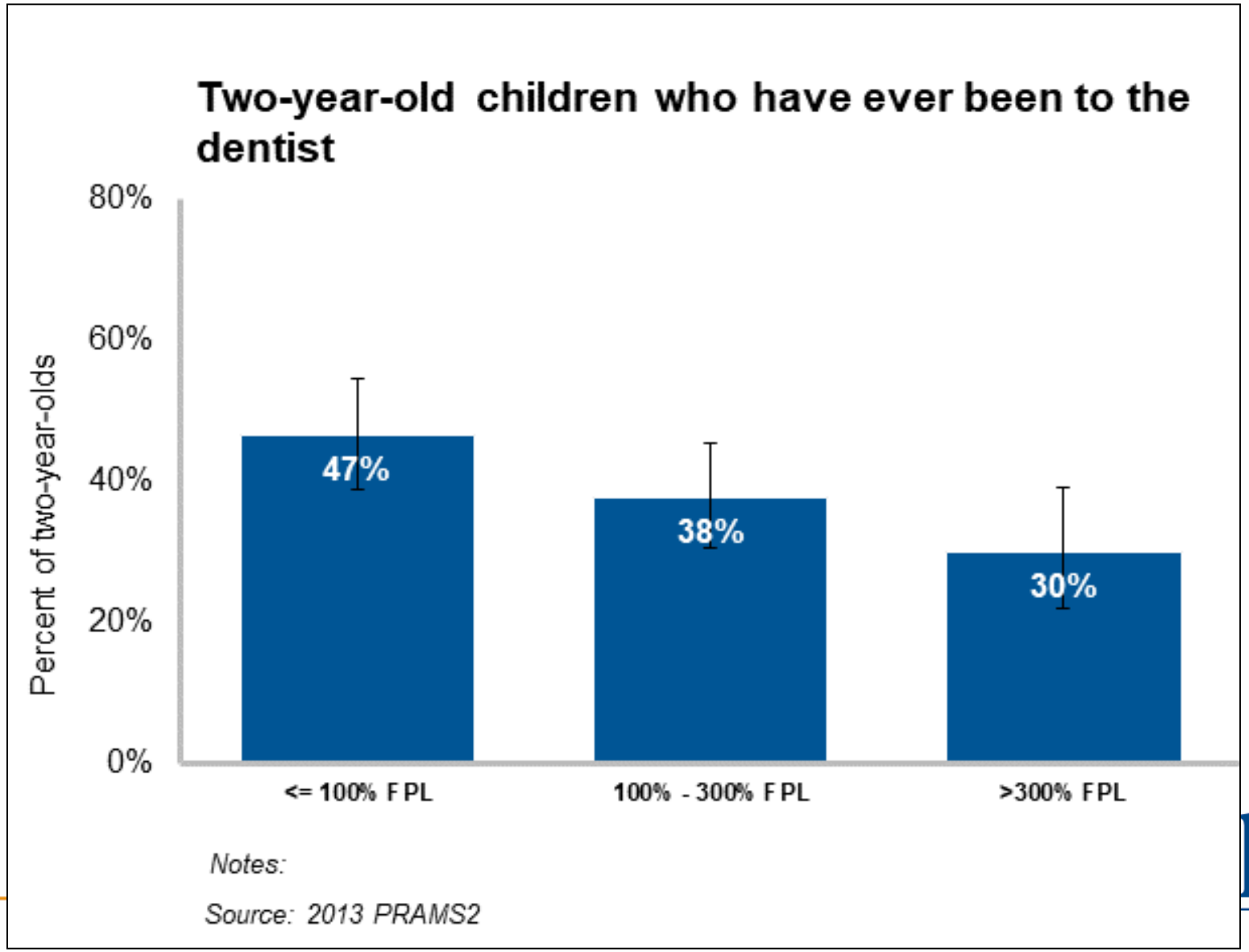
Notes: *All other groups exclude Hispanic ethnicity.*

Source: *PRAMS2*

PRAMS2 Data – 2013



PRAMS2 Data – 2013



PRAMS2 Data Limitations

- Covers only 2-year olds
- Small sample size
- No data for 2014 and 2015
- Reportable only by region

Recommendation

- Use Medicaid claims data as the data source for the metric.
  - Large sample size
  - Data can be updated frequently (guaranteed at least annually)
  - Dataset is easily restricted to age range of interest (children 0-5)
  - Allows for local comparisons and analysis

PHAB Accountability Metrics subcommittee
2018 work plan
January 3, 2018

Current membership: Muriel DeLaVergne-Brown, Eva Rippeteau, Eli Schwarz, Teri Thalhofer, Jennifer Vines

Key tasks for January-June 2018

1. Provide recommendations for setting metrics benchmarks and targets
2. Review and provide recommendations for public health accountability metrics report
3. Continue to develop oral health metric
4. Maintain communication with Metrics and Scoring; seek opportunities to expand cross sector partnerships for shared metrics

Key task for July-December 2018

1. Consider whether changes are needed to accountability metrics for 2019-21

	Agenda items	Outcomes and deliverables
January 3	• Recommend an ECU process measure to take to PHAB • Hear about OHA's oral health priorities and data • Review data for public health accountability metrics and process measures; review process used to set benchmarks	• ECU process measure recommendation • Guidance on oral health outcome metric • Approved methodology for setting benchmarks and targets
January 24	• Continue oral health metrics discussion • Continue review of accountability metrics data	• Guidance on oral health process measure • Oral health outcome metric and process measure recommendation to take to PHAB
February 28	• Review public health accountability metrics report	• *Tentative: accountability metrics report approved to take to PHAB*
March (to be scheduled)	• Joint meeting with PHAB Incentives and Funding subcommittee	• Strategy for incorporating incentives into funding formula
April 25, May 23, June 27	• Agenda to be determined	
July-December	• Discuss whether any changes will be made to the accountability metrics measure set for 2019-21	• Final set of public health accountability metrics for 2019-21