Oregon's Health System Transformation
2013 Performance Report
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EXECUTIVE SUMMARY

Incentives for better services

The report lays out how Oregon’s coordinated care organizations (CCO) performed on quality measures in 2013. This is the fourth such report since coordinated care organizations were launched in 2012 and the first to show a full year of data. This report also shows the quality measures broken out by race and ethnicity.

In addition, based on a full year’s performance measurement, the coordinated care model is entering a new phase - for the first time part of the reimbursement for the services CCOs performed for Oregon Health Plan members will be based on how well they performed on 17 of these key health care measurements.

Under the coordinated care model, the Oregon Health Authority held back 2 percent of the monthly payments to the CCOs which were put into a common "quality pool." To earn their full payment, CCOs had to meet improvement targets on at least 12 of the 17 measures and have at least 60 percent of their members enrolled in a patient-centered primary care home. All CCOs showed improvements in some number of the measures and 11 out of 15 CCOs met 100 percent of their improvement targets.

In addition, coordinated care organizations are continuing to hold down costs. Oregon is staying within the budget that meets its commitment to the Centers for Medicare and Medicaid Services to reduce the growth in spending by 2 percentage points per member, per year.

Overall, the coordinated care model showed large improvements in the following areas for the state's Oregon Health Plan members:

- Decreased emergency department visits. Emergency department visits by people served by CCOs have decreased 17% since 2011 baseline data. The corresponding cost of providing services in emergency departments decreased by 19% over the same time period.
√ Decreased hospitalization for chronic conditions. Hospital admissions for congestive heart failure have been reduced by 27%, chronic obstructive pulmonary disease by 32%, and adult asthma by 18%.

√ Developmental screening during the first 36 months of life. The percentage of children who were screened for the risk of developmental, behavioral, and social delays increased from a 2011 baseline of 21% to 33% in 2013, an increase of 58%.

√ Increased primary care. Outpatient primary care visits for CCO members' increased by 11% and spending for primary care and preventive services are up over 20%. Enrollment in patient-centered primary care homes has also increased by 52% since 2012, the baseline year for that program.

The report also shows areas where there has been progress but more gains need to be made, such as screening for risky drug or alcohol behavior and whether people have adequate access to health care providers. While there were gains in both areas, officials say that the state will put greater focus on them in the year to come. Access to care is particularly important with more than 340,000 new Oregon Health Plan members joining the system since January of 2014.

Oregon is at the beginning of its efforts to transform the health delivery system. By measuring our performance, sharing it publically and learning from our successes and challenges, we can see clearly where we started, where we are, and where we need to go next.
2013 Quality Pool

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

The first annual quality pool is $47 million. This represents two percent of the total amount all CCOs were paid in 2013. The quality pool is divided amongst all CCOs, based on their size (number of members) and their performance on the 17 incentive metrics.

Quality Pool: Phase One Distribution

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

* meeting the benchmark or improvement target on 12 of 16 measures; and
* meeting the benchmark or improvement target for the Electronic Health Record adoption measure (as one of the 12 measures above); and
* scoring at least 0.6 (60%) on the PCPCH enrollment measure.

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

Challenge Pool: Phase Two Distribution

The challenge pool includes funds remaining after quality pool funds are distributed in phase one. The first challenge pool is $2.4 million. Challenge pool funds were distributed to CCOs that met the benchmark or improvement target on four measures:

* Alcohol and drug misuse (SBIRT)
* Diabetes: HbA1c poor control
* Depression screening and follow up plan
* PCPCH enrollment

Through the challenge pool, some CCOs earned more than 100 percent of their maximum quality pool funds. The next pages show the percentage and dollar amounts earned by each CCO.
## 2013 CCO Performance and Quality Pool Distribution

<table>
<thead>
<tr>
<th>Coordinated Care Organization</th>
<th>Number of measures met*</th>
<th>Percent of total quality pool funds earned†</th>
<th>Total dollar amount earned</th>
<th>CCO Enrollment•</th>
<th>Which challenge pool measures were met</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Care Health Plan</td>
<td>11.6</td>
<td>84%</td>
<td>$2,239,160</td>
<td>27,878</td>
<td>Diabetes, Depression</td>
</tr>
<tr>
<td>Cascade Health Alliance^</td>
<td>13.7</td>
<td>100%</td>
<td>$748,517</td>
<td>10,153</td>
<td>Diabetes, Depression, PCPCH</td>
</tr>
<tr>
<td>Columbia Pacific</td>
<td>13.8</td>
<td>104%</td>
<td>$1,461,310</td>
<td>14,413</td>
<td>Diabetes, Depression, PCPCH</td>
</tr>
<tr>
<td>Eastern Oregon</td>
<td>11.6</td>
<td>83%</td>
<td>$1,961,432</td>
<td>29,234</td>
<td>Diabetes, PCPCH</td>
</tr>
<tr>
<td>FamilyCare</td>
<td>13.7</td>
<td>105%</td>
<td>$4,354,150</td>
<td>50,064</td>
<td>Diabetes, Depression, PCPCH</td>
</tr>
<tr>
<td>Health Share</td>
<td>12.8</td>
<td>104%</td>
<td>$13,720,133</td>
<td>148,201</td>
<td>Diabetes, Depression, PCPCH</td>
</tr>
<tr>
<td>Intercommunity Health Network</td>
<td>11.9</td>
<td>84%</td>
<td>$2,669,122</td>
<td>32,728</td>
<td>Diabetes, Depression, PCPCH</td>
</tr>
<tr>
<td>Jackson Care Connect</td>
<td>11.4</td>
<td>74%</td>
<td>$1,286,078</td>
<td>18,539</td>
<td>Diabetes, Depression</td>
</tr>
<tr>
<td>PacificSource</td>
<td>12.9</td>
<td>106%</td>
<td>$3,452,010</td>
<td>36,667</td>
<td>Diabetes, Depression, PCPCH, SBIRT</td>
</tr>
<tr>
<td>Primary Health of Josephine County</td>
<td>13.0</td>
<td>102%</td>
<td>$1,024,938</td>
<td>5,957</td>
<td>Diabetes, Depression, PCPCH</td>
</tr>
<tr>
<td>Trillium</td>
<td>12.9</td>
<td>104%</td>
<td>$4,949,647</td>
<td>49,677</td>
<td>Diabetes, Depression, PCPCH</td>
</tr>
<tr>
<td>Umpqua Health Alliance</td>
<td>13.7</td>
<td>105%</td>
<td>$1,716,647</td>
<td>16,102</td>
<td>Diabetes, Depression, PCPCH, SBIRT</td>
</tr>
<tr>
<td>Western Oregon Advanced Health</td>
<td>14.7</td>
<td>104%</td>
<td>$1,282,648</td>
<td>11,664</td>
<td>Diabetes, Depression, PCPCH</td>
</tr>
<tr>
<td>Willamette Valley Community Health</td>
<td>14.9</td>
<td>107%</td>
<td>$4,987,244</td>
<td>64,044</td>
<td>Diabetes, Depression, PCPCH, SBIRT</td>
</tr>
<tr>
<td>Yamhill CCO</td>
<td>14.8</td>
<td>105%</td>
<td>$1,137,005</td>
<td>13,368</td>
<td>Diabetes, Depression, PCPCH</td>
</tr>
</tbody>
</table>

*Out of 17 total CCO incentive measures.  
† Includes both phase one distribution and challenge pool.  
^ Reflects prorated quality pool for partial year as CCO.  
• CCO enrollment as of December 2013.

The 2013 quality pool distribution methodology is published online at: http://www.oregon.gov/oha/CCOData/ReferencelInstructions.pdf
Percent of 2013 Quality Pool: Phase One Distribution Earned

Does not include Challenge Pool funds

- All Care Health Plan: 80%
- Cascade Health Alliance: 100%
- Columbia Pacific: 100%
- Eastern Oregon: 80%
- FamilyCare: 100%
- Health Share: 100%
- Intercommunity Health Network: 80%
- Jackson Care Connect: 70%
- PacificSource: 100%
- Primary Health of Josephine County: 100%
- Trillium: 100%
- Umpqua Health Alliance: 100%
- Western Oregon Advanced Health: 100%
- Willamette Valley Community Health: 100%
- Yamhill CCO: 100%
Percent of 2013 Quality Pool Earned in Total
Includes both Phase One Distribution and Challenge Pool funds

- All Care Health Plan: 84%
- Cascade Health Alliance^: 100%
- Columbia Pacific: 104%
- Eastern Oregon: 83%
- FamilyCare: 105%
- Health Share: 104%
- Intercommunity Health Network: 84%
- Jackson Care Connect: 74%
- PacificSource: 106%
- PrimaryHealth of Josephine County: 102%
- Trillium: 104%
- Umpqua Health Alliance: 105%
- Western Oregon Advanced Health: 104%
- Willamette Valley Community Health: 107%
- Yamhill CCO: 105%

^ Reflects prorated quality pool for partial year as CCO.
The 17 CCO incentive measures were chosen in an open and public process by the Metrics & Scoring Committee and approved by the Centers for Medicare and Medicaid Services (CMS). Challenge pool measures are marked with an asterisk below.

Access to care (CAHPS)
Adolescent well child visits
Alcohol or other substance misuse (SBIRT)*
Ambulatory care: emergency department utilization
Colorectal cancer screening
Controlling hypertension (clinical measure)
Depression screening and follow up plan* (clinical measure)
Developmental screening
Diabetes: HbA1c poor control* (clinical measure)
Early elective delivery
Electronic health record (EHR) adoption
Follow up after hospitalization for mental illness
Follow up care for children prescribed ADHD medication
Mental and physical health assessments for children in DHS custody
Patient centered primary care home (PCPCH) enrollment*
Prenatal and postpartum care: timeliness of prenatal care
Satisfaction with care (CAHPS)

Additional information about the Metrics & Scoring Committee available online at http://www.oregon.gov/oha/Pages/metrix.aspx
HOW TO READ THESE GRAPHS

The subtitle indicates which measure set(s) the measure is part of

Measure title
Measure description:
Brief description of the measure.

Purpose:
Brief summary of the importance of the measure.

2013 data (n=XX,XXX)
Summary of 2013 data compared to 2011 baseline and the benchmark;
Overall comments on statewide and CCO performance.

Data source, benchmark source, and additional information.

Statewide benchmark bar in red.

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

2013 year in darker shade.

2011 baseline year in light shade.

2011
2013

Benchmark 50%

Percent of respondents with missing race/ethnicity data; additional information.

2013 data missing for xx% of respondents

Data source, benchmark source, and additional information.

Data missing for xx% of respondents

Race and ethnicity data between 2011 & 2013

Data missing for xx% of respondents

Categories are sorted by amount of change between 2011 - 2013. That is, the racial or ethnic groups with the most improvement in 2013 are listed first.

Arrows highlight negative change (away from the benchmark).
Access to care (CAHPS)

**Measure description:** Percentage of patients (adults and children) who thought they received appointments and care when they needed them.

**Purpose:** Improving access to timely care and information helps increase the quality of care and reduce costs. Measuring access to care is also an important part of identifying disparities in health care and barriers to quality care, including a shortage of providers, lack of transportation, or long waits to get an appointment.

**2013 data**

The percentage of individuals reporting they were able to access care quickly increased from 83% in 2011 to 84% in 2013.

However, only five CCOs met the benchmark or improvement target showing that improving access to care may be a challenge for CCOs moving forward. Adult access to care decreased from 2011 to 2013 while access for children improved.
Race and ethnicity data between 2011 & 2013

CAHPS data by race and ethnicity will be available in future reports
Percentage of patients who thought they received appointments and care when needed in **2011 & 2013**

**Bolded** names met benchmark or improvement target

*CCO baseline could not clearly be attributed to a past FCHP. Baseline provided is state average.

- **Western Oregon Advanced Health**
  - 2011: 82.0%
  - 2013: 88.3%

- **Primary Health of Josephine County**
  - 2011: 83.0%
  - 2013: 88.0%

- **Jackson Care Connect***
  - 2011: 83.0%
  - 2013: 87.5%

- **Columbia Pacific**
  - 2011: 83.0%
  - 2013: 87.0%

- **Intercommunity Health Network**
  - 2011: 82.0%
  - 2013: 85.8%

- **Willamette Valley Community Health**
  - 2011: 81.0%
  - 2013: 83.1%

- **All Care Health Plan**
  - 2011: 83.0%
  - 2013: 85.0%

- **Umpqua Health Alliance**
  - 2011: 81.0%
  - 2013: 82.4%

- **Family Care**
  - 2011: 81.0%
  - 2013: 81.2%

- **Eastern Oregon**
  - 2011: 84.0%
  - 2013: 84.2%

- **PacificSource**
  - 2011: 80.6%
  - 2013: 81.0%

- **Cascade Health Alliance**
  - 2011: 80.4%
  - 2013: 81.0%

- **Yamhill CCO***
  - 2011: 81.6%
  - 2013: 83.0%

- **Health Share**
  - 2011: 80.2%
  - 2013: 83.0%

- **Trillium**
  - 2011: 84.7%
  - 2013: 90.0%
Adolescent well-care visits

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

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

2013 data (n=97,125)

In 2013, 29.2% of adolescents ages 12-21 received a qualifying well-care visit compared to 27.1% in 2011. Some CCOs made progress with seven surpassing their improvement target.

While there has been progress in this measure, there are still improvements to be made to reach the benchmark of 53.2%.

Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile (administrative data only)

Race and ethnicity data between 2011 & 2013

Data missing for 6.9% of respondents
Each race category excludes Hispanic/Latino

Benchmark 53.2%
ADOLESCENT WELL-CARE VISITS
CCO Incentive and State Performance Measure

Percentage of adolescents and young adults (ages 12-21) who had at least one well-care during the last year in 2011 & 2013

Bolded names met benchmark or improvement target

- FamilyCare
  Benchmark: 43.4%

- Umpqua Health Alliance
  2011: 21.2%
  2013: 28.6%

- Yamhill CCO
  2011: 24.8%
  2013: 28.9%

- Western Oregon Advanced Health
  2011: 20.7%
  2013: 24.2%

- Cascade Health Alliance
  2011: 26.3%
  2013: 29.3%

- PacificSource
  2011: 23.8%
  2013: 26.8%

- Trillium
  2011: 31.2%
  2013: 33.5%

- Health Share
  2011: 23.4%
  2013: 25.5%

- PrimaryHealth of Josephine County
  2011: 21.3%
  2013: 22.3%

- Columbia Pacific
  2011: 24.8%
  2013: 25.9%

- Willamette Valley Community Health
  2011: 22.3%
  2013: 23.7%

- Eastern Oregon
  2011: 22.0%
  2013: 23.7%

- Intercommunity Health Network
  2011: 22.0%
  2013: 23.7%

- All Care Health Plan
  2011: 20.5%
  2013: 22.8%

- Jackson Care Connect
  2011: 22.6%
  2013: 24.9%

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Oregon Health Authority
Office of Health Analytics
Alcohol or other substance misuse (SBIRT)

Measure description: The SBIRT measure, or Screening, Brief Intervention, and Referral to Treatment, measures the percentage of adult patients (ages 18 and older) who had appropriate screening and intervention for alcohol or other substance abuse.

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

2013 data (n=200,135)

The percentage of adult patients (ages 18 and older) who had screening, brief intervention and referral for treatment (when appropriate) for alcohol or other substance abuse is a measurement where improvement is still needed across all CCOs. Providers are continuing to learn more about this measure and how to include screening in their daily practice and billing processes.

In 2011, the baseline was 0.0% for this new measure. In 2013, the statewide rate rose to 2.0%, a marked increase. Three CCOs met their improvement target, but much improvement is still possible.
### ALCOHOL OR OTHER SUBSTANCE MISUSE (SBIRT)

**CCO Incentive and State Performance Measure**

Percentage of adult patients who had appropriate screening and intervention for alcohol or substance abuse (SBIRT) in 2011 & 2013

*Bolded* names met benchmark or improvement target

<table>
<thead>
<tr>
<th>Health Shares</th>
<th>2011</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willamette Valley Community Health</td>
<td>0.0%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Umpqua Health Alliance</td>
<td>0.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>PacificSource</td>
<td>0.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Columbia Pacific</td>
<td>0.0%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Western Oregon Advanced Health</td>
<td>0.2%</td>
<td>2.3%</td>
</tr>
<tr>
<td>FamilyCare</td>
<td>0.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Yamhill CCO</td>
<td>0.0%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Cascade Health Alliance</td>
<td>0.0%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Primary Health of Josephine County</td>
<td>0.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Health Share</td>
<td>0.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>All Care Health Plan</td>
<td>0.0%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Eastern Oregon</td>
<td>0.2%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Trillium</td>
<td>0.0%, 0.2%</td>
<td></td>
</tr>
<tr>
<td>Jackson Care Connect</td>
<td>0.0%, 0.1%</td>
<td></td>
</tr>
<tr>
<td>Intercommunity Health Network</td>
<td>0.0%, 0.0%</td>
<td></td>
</tr>
</tbody>
</table>

Benchmark: 13.0%
All-cause readmission

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

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

**2013 data** (n=19,878)

The 2013 data shows lowered (better) readmission rates. The percentage of adults who had a hospital stay and were readmitted for any reason within 30 days of discharge dropped from a 2011 baseline of 12.3% to 11.7% in 2013, a reduction of 5%.

**Statewide**

(Lower scores are better)

<table>
<thead>
<tr>
<th>Year</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>12.3%</td>
</tr>
<tr>
<td>2013</td>
<td>11.7%</td>
</tr>
</tbody>
</table>

**Benchmark source:** Average of 2012 Commercial and Medicare 75th percentiles

**Race and ethnicity data between 2011 & 2013**

(Lower scores are better)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2011</th>
<th>2013</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American/Black</td>
<td>13.7%</td>
<td>16.0%</td>
<td>10.5%</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>14.7%</td>
<td>16.6%</td>
<td></td>
</tr>
<tr>
<td>Asian American</td>
<td>9.8%</td>
<td>10.5%</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>11.6%</td>
<td>12.2%</td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>10.1%</td>
<td>11.1%</td>
<td></td>
</tr>
<tr>
<td>Hawaiian/Pacific Islander</td>
<td>0.0%</td>
<td>1.9%</td>
<td></td>
</tr>
</tbody>
</table>
Percentage of adult patients who had a hospital stay and were readmitted for any reason with 30 days of discharge in 2011 & 2013

(Lower scores are better)

- Primary Health of Josephine County
  - 2011: 8.5%
  - 2013: 14.6%
- All Care Health Plan
  - 2011: 6.6%
  - 2013: 11.2%
- Umpqua Health Alliance
  - 2011: 8.2%
  - 2013: 12.5%
- Columbia Pacific
  - 2011: 9.0%
  - 2013: 10.7%
- Eastern Oregon
  - 2011: 10.0%
  - 2013: 11.6%
- Trillium
  - 2011: 9.0%
  - 2013: 10.7%
- Jackson Care Connect
  - 2011: 13.4%
  - 2013: 14.2%
- Health Share
  - 2011: 10.7%
  - 2013: 13.6%
- Cascade Health Alliance
  - 2011: 10.1%
  - 2013: 12.0%
- FamilyCare
  - 2011: 10.5%
  - 2013: 13.6%
- Willamette Valley Community Health
  - 2011: 8.7%
  - 2013: 11.1%
- PacificSource
  - 2011: 10.1%
  - 2013: 11.0%
- Yamhill CCO
  - 2011: 10.5%
  - 2013: 13.4%
- Intercommunity Health Network
  - 2011: 9.4%
  - 2013: 12.4%
- Western Oregon Advanced Health
  - 2011: 10.5%
  - 2013: 13.4%
Ambulatory care: emergency department utilization

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

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

2013 data (n=6,476,701 member months)
This metric represents emergency department visits that occurred in 2013. Emergency department visits by people served by CCOs have decreased 17% since 2011 baseline data. Financial data (starting on page 81) is consistent in showing reduced emergency department visits.

All 15 CCOs met their improvement target on this measure showing a strong trend toward fewer emergency department visits and more coordinated care.

Statewide
(Lower scores are better)
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

<table>
<thead>
<tr>
<th>Year</th>
<th>White</th>
<th>American Indian/Alaskan Native</th>
<th>African American/Black</th>
<th>Hawaiian/Pacific Islander</th>
<th>Hispanic/Latino</th>
<th>Asian American</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1.0</td>
<td>61.0</td>
<td>50.5</td>
<td>44.4</td>
<td>25.1</td>
<td>22.3</td>
</tr>
<tr>
<td>2013</td>
<td>54.9</td>
<td>62.0</td>
<td>68.5</td>
<td>52.7</td>
<td>36.6</td>
<td>25.1</td>
</tr>
</tbody>
</table>

Benchmark 44.4

Data missing for 7.4% of respondents
Rate of patient visits to an emergency department in 2011 & 2013
(Lower scores are better)
Bolded names met benchmark or improvement target
Ambulatory care: outpatient utilization

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

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

2013 data (n=6,476,701 member months)

This metric represents outpatient visits that include office visits or routine visits to hospital outpatient departments, visits to primary care and specialists, as well as home and nursing home visits by people served by CCOs in 2013.

This metric shows a trend toward fewer outpatient visits; however, the financial data shown in this report point toward an increase in primary care visits.
Rate of patient visits to a doctor’s office or urgent care in 2011 & 2013
Rates are reported per 1,000 member months

- Cascade Health Alliance: 345.7, 409.6
- Umpqua Health Alliance: 342.6, 396.7
- Trillium: 339.6, 375.0
- Willamette Valley Community Health: 337.4, 357.6
- Health Share: 337.4, 363.0
- Jackson Care Connect: 328.7, 373.3
- Intercommunity Health Network: 328.6, 404.1
- Columbia Pacific: 327.3, 412.3
- Western Oregon Advanced Health: 325.2, 384.2
- PacificSource Columbia Gorge Region: 318.7, 363.0
- PrimaryHealth of Josephine County: 312.9, 337.9
- Yamhill County: 302.9, 356.2
- AllCare Health Plan: 302.4, 406.5
- Eastern Oregon: 298.2, 339.6
- FamilyCare: 267.4, 296.9

Benchmark: 439.0
Appropriate testing for children with pharyngitis

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

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

2013 data (n=6,602)

This metric tracks the percentage of children with a sore throat (pharyngitis) who had a strep test before being prescribed antibiotics. The 2013 data is comparable to the 2011 baseline.
Percentage of children with a sore throat who were given a strep test before getting an antibiotic in 2011 & 2013

- FamilyCare: 70.0% - 82.0%
- Cascade Health Alliance: 75.3% - 82.2%
- PacificSource: 65.3% - 70.2%
- Yamhill CCO: 78.8% - 82.4%
- Trillium: 72.1% - 78.8%
- Health Share: 76.6% - 80.6%
- Jackson Care Connect: 69.2% - 72.2%
- Intercommunity Health Network: 61.4% - 76.6%
- Eastern Oregon: 72.2% - 76.8%
- All Care Health Plan: 70.1% - 80.9%
- Umpqua Health Alliance: 36.7% - 41.9%
- Western Oregon Advanced Health: 64.6% - 71.3%
- Willamette Valley Community Health: 59.0% - 83.6%
- Columbia Pacific: 66.5% - 90.7%
- PrimaryHealth of Josephine County: 67.7% - 80.9%

Benchmark: 76.0%
Cervical cancer screening

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

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

2013 data (n=71,364)
This metric tracks the percentage of women (ages 21 to 64) who had one or more Pap tests for cervical cancer in the past three years.

The 2013 data shows there is room for further development and attention for cervical cancer screening. The 2013 percentage is lower than the percentage of women screened in 2011. The lowered screening rates may be due to a number of factors including national guideline changes reported in 2012 for cervical cancer screening.
CERVICAL CANCER SCREENING
State Performance Measure

Percentage of women patients (age 21 to 64) who got one or more Pap tests for cervical cancer in the past three years in 2011 & 2013

- Yamhill CCO: 58.9% (2013) / 59.8% (2011)
- All Care Health Plan: 51.4% (2013) / 52.7% (2011)
- Health Share: 55.3% (2013) / 56.9% (2011)
- Umpqua Health Alliance: 55.6% (2013) / 57.2% (2011)
- Willamette Valley Community Health: 55.8% (2013) / 57.7% (2011)
- Cascade Health Alliance: 54.0% (2013) / 56.2% (2011)
- Columbia Pacific: 50.3% (2013) / 52.5% (2011)
- FamilyCare: 54.4% (2013) / 56.7% (2011)
- Jackson Care Connect: 55.9% (2013) / 58.4% (2011)
- PacificSource: 53.8% (2013) / 56.6% (2011)
- Intercommunity Health Network: 51.4% (2013) / 54.3% (2011)
- Eastern Oregon: 51.6% (2013) / 56.0% (2011)
- Western Oregon Advanced Health: 48.3% (2013) / 52.9% (2011)
- Trillium: 48.5% (2013) / 54.2% (2011)
- PrimaryHealth of Josephine County: 40.5% (2013) / 47.5% (2011)

Benchmark: 74.0%
CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (ALL AGES)

State Performance Measure

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

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

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

2013 data (n=283,928)

This measure tracks child and adolescent access to primary care providers by measuring the percentage of children who had a visit with a primary care provider during the last year. The measure is split into five categories: all ages, 12-24 months, 26 months - 6 years, 7-11 years, and 12-19 years.

This set of measures shows an area with an opportunity for improvement. In 2013 statewide, there was not improvement on these measures when compared to 2011.

This measure cannot be reported at the CCO level for 2013.

Statewide

Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 75th percentile (average of the four age breakouts for this measure)

Benchmark 93.6%

2011 88.5%
2013 87.0%

Race and ethnicity data between 2011 & 2013

Data missing for 8.3% of respondents

White

2011 81.7%
2013 86.6%

Asian American

2011 85.2%
2013 86.2%

African American/Black

2011 85.4%
2013 85.6%

Hispanic/Latino

2011 88.1%
2013 89.5%

American Indian/Alaskan Native

2011 77.9%
2013 88.6%

Hawaiian/Pacific Islander

2011 89.2%
2013 93.6%
**Childhood and adolescent access to primary care providers (12 - 24 months)**

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

**Purpose:** Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

**2013 data (n=21,184)**

**Statewide**

- **Data source:** Administrative (billing) claims
- **Benchmark source:** 2011 National Medicaid 75th percentile

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>97.4%</td>
<td></td>
<td>Benchmark 98.2%</td>
</tr>
<tr>
<td>96.4%</td>
<td></td>
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</tbody>
</table>

**Race and ethnicity data between 2011 & 2013**

- **Data missing for 9.9% of respondents**
- **Benchmark 98.2%**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2011</th>
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<tr>
<td>American Indian/Alaskan Native</td>
<td>96.2%</td>
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<tr>
<td>African American/Black</td>
<td>95.7%</td>
<td>96.3%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>95.8%</td>
<td>96.8%</td>
</tr>
<tr>
<td>White</td>
<td>95.4%</td>
<td>97.4%</td>
</tr>
<tr>
<td>Asian American</td>
<td>94.3%</td>
<td>98.5%</td>
</tr>
<tr>
<td>Hawaiian/Pacific Islander</td>
<td>(75%)</td>
<td>(100%)</td>
</tr>
</tbody>
</table>
Childhood and adolescent access to primary care providers (25 months - 6 years)

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

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

2013 data (n=96,722)
CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (7-11 YEARS)

State Performance Measure

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

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

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

2013 data (n=75,393)

Statewide

Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 75th percentile

Race and ethnicity data between 2011 & 2013

Data missing for 8.0% of respondents

- Asian American: 84.3% (2011) vs. 85.5% (2013)
- Hispanic/Latino: 88.4% (2011) vs. 88.7% (2013)
- African American/Black: 84.1% (2011) vs. 85.2% (2013)
- American Indian/Alaskan Native: 87.7% (2011) vs. 89.3% (2013)
- White: 86.7% (2011) vs. 88.6% (2013)
- Hawaiian/ Pacific Islander: 76.7% (2011) vs. 79.4% (2013)
**Childhood and adolescent access to primary care providers (12 - 19 years)**

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

**Purpose:** Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

**2013 data** (n=90,629)

---

**Statewide**

Data source: Administrative (billing) claims  
Benchmark source: 2011 National Medicaid 75th percentile

![Bar chart showing comparison of 2011 and 2013 data for childhood and adolescent access to primary care providers.]

- **2011:** 88.9%  
- **2013:** 87.6%

**Race and ethnicity data between 2011 & 2013**

Data missing for 7.2% of respondents

- **Hawaiian/Pacific Islander:** 81.0% - 91.7%  
- **Asian American:** 83.2% - 84.4%  
- **African American/Black:** 87.0% - 87.0%  
- **Hispanic/Latino:** 87.5% - 88.0%  
- **American Indian/Alaskan Native:** 88.6% - 90.3%  
- **White:** 87.9% - 89.8%
**Childhood immunization status**

**Measure description:** Percentage of children who received recommended vaccines before their 2nd birthday.

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

**2013 data (n=7,581)**

This metric tracks the percentage of children who received their recommended vaccines before their 2nd birthday. The 2013 data shows mixed results. While some CCOs improved the percentage of children up to date on immunizations, the statewide rate is slightly lower than 2011.
Percentage of children who received recommended vaccines before their 2nd birthday in 2011 & 2013

- Columbia Pacific: 58.5% (2011), 65.3% (2013) vs. Benchmark 82.0%
- PrimaryHealth of Josephine County: 69.7% (2011), 74.5% (2013)
- Eastern Oregon: 65.6% (2011), 68.3% (2013)
- Willamette Valley Community Health: 66.5% (2011), 68.8% (2013)
- Health Share: 68.0% (2011), 69.4% (2013)
- FamilyCare: 67.5% (2011), 68.5% (2013)
- Cascade Health Alliance: 73.1% (2011), 74.0% (2013)
- Trillium: 63.9% (2011), 64.2% (2013)
- Intercommunity Health Network: 55.1% (2011), 58.0% (2013)
- Yamhill CCO: 55.9% (2011), 59.0% (2013)
- Umpqua Health Alliance: 63.6% (2011), 67.7% (2013)
- All Care Health Plan: 58.8% (2011), 64.1% (2013)
- PacificSource: 58.3% (2011), 64.6% (2013)
- Jackson Care Connect: 58.1% (2011), 69.6% (2013)
- Western Oregon Advanced Health: 49.0% (2011), 67.0% (2013)
**CHLAMYDIA SCREENING IN WOMEN AGES 16-24**

State Performance Measure

**Chlamydia screening in women ages 16-24**

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

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

**2013 data (n=18,636)**

This metric tracks the percentage of sexually active women ages 16-24 who were tested for chlamydia infection. The 2013 data show a decrease in chlamydia screening across the state when compared to 2011.

**Statewide**

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile

<table>
<thead>
<tr>
<th>2011</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>59.9%</td>
<td>54.4%</td>
</tr>
</tbody>
</table>

**Race and ethnicity data between 2011 & 2013**

Data missing for 7.8% of respondents

- **Hawaiian/Pacific Islander**
  - 2011: 53.1%
  - 2013: 64.9%

- **American Indian/Alaskan Native**
  - 2011: 51.0%
  - 2013: 51.3%

- **Hispanic/Latino**
  - 2011: 54.9%
  - 2013: 56.2%

- **White**
  - 2011: 52.9%
  - 2013: 57.8%

- **African American/Black**
  - 2011: 70.4%
  - 2013: 77.4%

- **Asian American**
  - 2011: 46.5%
  - 2013: 60.3%

Benchmark 63.0%
Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection in 2011 & 2013

- PacificSource: 52.7% in 2011, 56.2% in 2013
- Willamette Valley Community Health: 58.0% in 2011, 59.7% in 2013
- Yamhill CCO: 52.1% in 2011, 54.9% in 2013
- Cascade Health Alliance: 52.5% in 2011, 56.0% in 2013
- Health Share: 62.3% in 2011, 65.8% in 2013
- Eastern Oregon: 50.2% in 2011, 54.8% in 2013
- Trillium: 48.9% in 2011, 54.4% in 2013
- FamilyCare: 58.7% in 2011, 54.4% in 2013
- Jackson Care Connect: 51.2% in 2011, 58.0% in 2013
- PrimaryHealth of Josephine County: 43.5% in 2011, 50.7% in 2013
- Umpqua Health Alliance: 41.5% in 2011, 49.6% in 2013
- Western Oregon Advanced Health: 51.5% in 2011, 59.8% in 2013
- Intercommunity Health Network: 47.4% in 2011, 57.1% in 2013
- All Care Health Plan: 43.6% in 2011, 57.9% in 2013
- Columbia Pacific: 48.8% in 2011, 60.6% in 2013

Benchmark: 63.0%
Colorectal cancer screening

**Measure description:** Rate of adult patients (ages 50-75) who had appropriate screenings for colorectal cancer during the measurement year. Rates are reported per 1,000 member months.

**Purpose:** Colorectal cancer is Oregon’s second leading cause of cancer deaths. With appropriate screening, abnormal growths in the colon can be found and removed before they turn into cancer. Colorectal cancer screening saves lives, while also keeping overall health care costs down.

**2013 data** (n=648,070 member months)

The colorectal cancer screening metric represents screenings that have occurred in 2013 for eligible members (those between 50 and 75 years of age). In 2013, the colorectal cancer screening rate was 11.4 screenings per 1,000 member months, an increase from 10.7 in 2011. Overall, six CCOs exceeded their improvement target.

**Statewide**

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

**Race and ethnicity data between 2011 & 2013**

Data missing for 2.1% of respondents

- **American Indian/Alaskan Native**
  - 2011: 6.5
  - 2013: 9.9

- **Asian American**
  - 2011: 14.4
  - 2013: 16.4

- **Hispanic/Latino**
  - 2011: 10.9
  - 2013: 12.6

- **Hawaiian/Pacific Islander**
  - 2011: 9.4
  - 2013: 11.0

- **White**
  - 2011: 9.6
  - 2013: 10.8

- **African American/Black**
  - 2011: 12.7
  - 2013: 13.6
COLORECTAL CANCER SCREENING
CCO Incentive and State Performance Measure

Rate of adult patients who had appropriate screenings for colorectal cancer during the measurement year in **2011 & 2013**

**Bolded** names met individual benchmark (3% above baseline)

Rates are per 1,000 member months

- **Yamhill CCO**
  - 2011: 6.1
  - 2013: 15.7

- **Eastern Oregon**
  - 2011: 4.5
  - 2013: 9.0

- **Willamette Valley Community Health**
  - 2011: 10.7
  - 2013: 14.0

- **FamilyCare**
  - 2011: 10.5
  - 2013: 13.5

- **Columbia Pacific**
  - 2011: 7.1
  - 2013: 9.2

- **Health Share**
  - 2011: 12.5
  - 2013: 14.0

- **PacificSource**
  - 2011: 8.6
  - 2013: 10.3

- **Trillium**
  - 2011: 8.8
  - 2013: 9.5

- **Intercommunity Health Network**
  - 2011: 8.4
  - 2013: 9.7

- **Jackson Care Connect**
  - 2011: 7.3
  - 2013: 8.4

- **Cascade Health Alliance**
  - 2011: 7.5
  - 2013: 8.7

- **PrimaryHealth of Josephine County**
  - 2011: 7.2
  - 2013: 10.7

- **Umpqua Health Alliance**
  - 2011: 7.4
  - 2013: 11.0

- **Western Oregon Advanced Health**

- **All Care Health Plan**
**Comprehensive diabetes care: HbA1c testing**

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

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

**2013 data (n=20,105)**

This metric tracks the percentage of adult patients with diabetes who received at least one A1c blood sugar test during 2013. The 2013 data is comparable to baseline.

---

**Statewide**

Data source: Administrative (billing) claims  
Benchmark source: 2012 National Medicaid 75th percentile

2011: 78.5%  
2013: 79.3%  

**Race and ethnicity data between 2011 & 2013**

Data missing for 3.1% of respondents

- **Asian American:** 77.8% (2011), 82.8% (2013)  
- **Hawaiian/Pacific Islander:** 79.5% (2011), 84.3% (2013)  
- **African American/Black:** 79.2% (2011), 82.1% (2013)  
- **American Indian/Alaskan Native:** 70.8% (2011), 73.0% (2013)  
- **Hispanic/Latino:** 80.3% (2011), 81.5% (2013)  
- **White:** 78.8% (2011), 78.8% (2013)  

Benchmark: 86.0%
Percentage of adult patients with diabetes who received at least one A1c blood sugar test in 2011 & 2013

- Trillium: 63.6% (2011) 80.0% (2013)
- Yamhill CCO: 74.0% (2011) 83.0% (2013)
- Cascade Health Alliance: 76.3% (2011) 82.5% (2013)
- FamilyCare: 78.6% (2011) 80.8% (2013)
- Willamette Valley Community Health: 77.0% (2011) 78.6% (2013)
- Health Share: 80.3% (2011) 80.7% (2013)
- Columbia Pacific: 76.8% (2011) 77.3% (2013)
- Intercommunity Health Network: 81.7% (2011) 83.5% (2013)
- PacificSource: 77.7% (2011) 80.6% (2013)
- Western Oregon Advanced Health: 77.0% (2011) 80.8% (2013)
- Umpqua Health Alliance: 77.2% (2011) 81.1% (2013)
- All Care Health Plan: 76.6% (2011) 81.7% (2013)
- PrimaryHealth of Josephine County: 75.1% (2011) 80.8% (2013)
- Jackson Care Connect: 79.4% (2011) 86.4% (2013)
- Eastern Oregon: 70.9% (2011) 75.8% (2013)
Comprehensive diabetes care: LDL-C screening

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

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

**2013 data** (n=20,105)

This metric tracks the percentage of adult patients with diabetes who received an LDL-C (cholesterol) test during 2013. The 2013 statewide data shows a 5% improvement from baseline.

**Statewide**

Data source: Administrative (billing) claims

Benchmark source: 2012 National Medicaid 75th percentile

**Race and ethnicity data between 2011 & 2013**

Data missing for 3.1% of respondents

<table>
<thead>
<tr>
<th>Race and Ethnicity</th>
<th>2011</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American/Black</td>
<td>66.0%</td>
<td>73.1%</td>
</tr>
<tr>
<td>Hawaiian/Pacific Islander</td>
<td>65.4%</td>
<td>72.3%</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>58.2%</td>
<td>64.1%</td>
</tr>
<tr>
<td>Asian American</td>
<td>71.3%</td>
<td>76.8%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>67.2%</td>
<td>70.2%</td>
</tr>
<tr>
<td>White</td>
<td>67.7%</td>
<td>69.7%</td>
</tr>
</tbody>
</table>

Benchmark 80.0%
Percentage of adult patients (ages 18-85) with diabetes who received an LDL-C (cholesterol) test in 2011 & 2013

- **Trillium**: 55.2% in 2011, 71.4% in 2013
- **Yamhill CCO**: 63.5% in 2011, 73.5% in 2013
- **FamilyCare**: 66.4% in 2011, 72.8% in 2013
- **Health Share**: 68.2% in 2011, 72.0% in 2013
- **Willamette Valley Community Health**: 68.2% in 2011, 73.1% in 2013
- **Columbia Pacific**: 65.6% in 2011, 66.5% in 2013
- **Cascade Health Alliance**: 62.6% in 2011, 63.5% in 2013
- **PacificSource**: 63.2% in 2011, 63.7% in 2013
- **Eastern Oregon**: 61.5% in 2011, 61.5% in 2013
- **All Care Health Plan**: 70.4% in 2011, 70.6% in 2013
- **PrimaryHealth of Josephine County**: 64.6% in 2011, 65.7% in 2013
- **Intercommunity Health Network**: 68.2% in 2011, 70.3% in 2013
- **Umpqua Health Alliance**: 68.6% in 2011, 71.7% in 2013
- **Western Oregon Advanced Health**: 65.9% in 2011, 69.3% in 2013
- **Jackson Care Connect**: 66.8% in 2011, 71.5% in 2013

**Benchmark**: 80%
DEVELOPMENTAL SCREENINGS IN THE FIRST 36 MONTHS OF LIFE

CCO Incentive and State Performance Measure

Developmental screening in the first 36 months of life

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

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

**2013 data (n=20,043)**

The percentage of children who were screened for the risk of developmental, behavioral, and social delays increased from a 2011 baseline of 20.9% to 33.1% in 2013, an increase of 58%.

In 2013, all CCOs exceeded their improvement target and four surpassed the benchmark of 50%. There have been marked gains in this measure across Oregon.

Statewide

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

![Graph showing the increase from 2011 to 2013.]

**Race and ethnicity data between 2011 & 2013**

Data missing for 11.0% of respondents

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>2011</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaskan Native</td>
<td>17.1%</td>
<td>36.0%</td>
</tr>
<tr>
<td>White</td>
<td>22.0%</td>
<td>35.6%</td>
</tr>
<tr>
<td>African American/Black</td>
<td>22.6%</td>
<td>35.2%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>18.7%</td>
<td>28.7%</td>
</tr>
<tr>
<td>Asian American</td>
<td>22.8%</td>
<td>31.2%</td>
</tr>
<tr>
<td>Hawaiian/Pacific Islander</td>
<td>26.6%</td>
<td>32.0%</td>
</tr>
</tbody>
</table>

Benchmark 50.0%
Percentage of children up to three-years-old screened for developmental delays in 2011 & 2013

<table>
<thead>
<tr>
<th>CCO/Plan Name</th>
<th>2011</th>
<th>2013</th>
<th>Improvement</th>
<th>Benchmark 50.0%</th>
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</thead>
<tbody>
<tr>
<td>Western Oregon Advanced Health</td>
<td>1.2%</td>
<td>21.2%</td>
<td>20.0%</td>
<td>57.1%</td>
</tr>
<tr>
<td>Umpqua Health Alliance</td>
<td>6.7%</td>
<td>27.2%</td>
<td>20.5%</td>
<td></td>
</tr>
<tr>
<td>Eastern Oregon</td>
<td>2.0%</td>
<td>23.5%</td>
<td>21.5%</td>
<td></td>
</tr>
<tr>
<td>Jackson Care Connect</td>
<td>2.0%</td>
<td>19.3%</td>
<td>17.3%</td>
<td></td>
</tr>
<tr>
<td>Health Share</td>
<td>12.1%</td>
<td>24.9%</td>
<td>12.8%</td>
<td></td>
</tr>
<tr>
<td>Intercommunity Health Network</td>
<td>16.3%</td>
<td>28.3%</td>
<td>12.0%</td>
<td></td>
</tr>
<tr>
<td>Trillium</td>
<td>19.3%</td>
<td>33.9%</td>
<td>14.6%</td>
<td></td>
</tr>
<tr>
<td>FamilyCare</td>
<td>22.2%</td>
<td>33.1%</td>
<td>10.9%</td>
<td></td>
</tr>
<tr>
<td>Columbia Pacific</td>
<td>19.6%</td>
<td>30.0%</td>
<td>10.4%</td>
<td></td>
</tr>
<tr>
<td>All Care Health Plan</td>
<td>21.0%</td>
<td>30.8%</td>
<td>9.8%</td>
<td></td>
</tr>
<tr>
<td>PacificSource</td>
<td>9.4%</td>
<td>16.8%</td>
<td>7.4%</td>
<td></td>
</tr>
<tr>
<td>Yamhill CCO</td>
<td>19.4%</td>
<td>23.9%</td>
<td>4.5%</td>
<td></td>
</tr>
<tr>
<td>Willamette Valley Community Health</td>
<td>19.4%</td>
<td>23.9%</td>
<td>4.5%</td>
<td></td>
</tr>
<tr>
<td>Cascade Health Alliance</td>
<td>62.7%</td>
<td>60.1%</td>
<td>2.6%</td>
<td></td>
</tr>
<tr>
<td>PrimaryHealth of Josephine County</td>
<td>58.0%</td>
<td>67.1%</td>
<td>9.1%</td>
<td></td>
</tr>
</tbody>
</table>

Bolded names met benchmark or improvement target.
**Early Elective Delivery**

**Measure description:** Percentage of women who had an elective delivery between 37 and 39 weeks of gestation. (A lower score is better.)

**Purpose:** There is a substantial body of evidence showing that an infant born at 37 weeks has worse health outcomes than one born at 40 weeks. Specifically, stays at the neonatal intensive care unit are higher in children at 37-38 weeks than children who completed at least 39 weeks. Because of this, it has become a national and state priority to limit elective deliveries to pregnancies that have completed at least 39 weeks gestation.

**2013 data**

Elective deliveries before 39 weeks have decreased 74% across the state, from a 2011 baseline of 10.1% to 2.6% in 2013. All CCOs were below the benchmark of 5% for this measure, showing a success across Oregon for better and safer care for mothers and babies.

---

**Statewide**

(Lower scores are better)

Data source: Administrative (billing) claims, Vital Records, and hospitals

Benchmark source: Metrics and Scoring Committee consensus

<table>
<thead>
<tr>
<th>Year</th>
<th>Elective Deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>10.1%</td>
</tr>
<tr>
<td>2013</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

Benchmark 5.0%

**Race and ethnicity data between 2011 & 2013**

Race and ethnicity data for this measure are not available.
Percentage of women who had an elective delivery between 37 and 39 weeks of gestation in 2011 & 2013

(Lower scores are better)

Bolded names met benchmark or improvement target
Electronic Health Record (EHR) adoption

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

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

2013 data (n=8,236 eligible providers)

Electronic Health Record Adoption measures the percentage of eligible providers who received a “meaningful use” payment for EHR adoption. Electronic health record adoption among measured providers has doubled. In 2011, 28% of eligible providers had adopted certified EHRs. By the end of 2013, 59% of eligible providers had adopted certified EHRs, an increase of 110%.

All CCOs met their improvement target or surpassed the benchmark of 49.2%.
Percentage of providers who qualified for an EHR incentive payment during the measurement year in 2011 & 2013

<table>
<thead>
<tr>
<th>Provider</th>
<th>2011</th>
<th>2013</th>
<th>Benchmark 49.2%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Care Health Plan</td>
<td>21.3%</td>
<td>71.5%</td>
<td></td>
</tr>
<tr>
<td>Western Oregon Advanced Health</td>
<td>17.9%</td>
<td>63.8%</td>
<td></td>
</tr>
<tr>
<td>PrimaryHealth of Josephine County</td>
<td>27.6%</td>
<td>72.5%</td>
<td></td>
</tr>
<tr>
<td>Jackson Care Connect</td>
<td>16.1%</td>
<td>60.5%</td>
<td></td>
</tr>
<tr>
<td>Willamette Valley Community Health</td>
<td>25.6%</td>
<td>68.4%</td>
<td></td>
</tr>
<tr>
<td>Umpqua Health Alliance</td>
<td>35.2%</td>
<td>77.2%</td>
<td></td>
</tr>
<tr>
<td>FamilyCare</td>
<td>31.7%</td>
<td>69.8%</td>
<td></td>
</tr>
<tr>
<td>Eastern Oregon</td>
<td>12.0%</td>
<td>46.0%</td>
<td></td>
</tr>
<tr>
<td>Cascade Health Alliance</td>
<td>11.6%</td>
<td>64.9%</td>
<td></td>
</tr>
<tr>
<td>Trillium</td>
<td>16.4%</td>
<td>48.6%</td>
<td></td>
</tr>
<tr>
<td>PacificSource</td>
<td>25.8%</td>
<td>57.8%</td>
<td></td>
</tr>
<tr>
<td>Columbia Pacific</td>
<td>35.3%</td>
<td>65.6%</td>
<td></td>
</tr>
<tr>
<td>Health Share</td>
<td>32.3%</td>
<td>59.2%</td>
<td></td>
</tr>
<tr>
<td>Yamhill CCO</td>
<td>28.1%</td>
<td>53.9%</td>
<td></td>
</tr>
<tr>
<td>Intercommunity Health Network</td>
<td>34.3%</td>
<td>59.5%</td>
<td></td>
</tr>
</tbody>
</table>
Follow-up after hospitalization for mental illness

**Measure description**: Percentage of patients (ages 6 and older) who received a follow-up with a health care provider within seven days of being discharged from the hospital for mental illness.

**Purpose**: Follow-up care is important to help patients make progress and feel better after being in the hospital for mental illness. This measure addresses an emerging issue for children and adults by suggesting follow up for patients ages 6 and up. Additionally, research shows that follow-up care helps keep patients from returning to the hospital, providing an important opportunity to reduce health care costs and improve health.

**2013 data (n=1,825)**

This metric represents follow-up visits within seven days after patients were discharged from a hospital with a mental health diagnosis. In 2013, the percentage of patients with a follow-up visit was 67.6%, approaching the benchmark of 68.0%. Eight CCOs exceeded the benchmark for this measure, showing progress.

Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

Race and ethnicity data between 2011 & 2013

Data missing for 4.9% of respondents  
~ Data suppressed due to low numbers (n<30)

- **Asian American**: 65.2% in 2011, 74.3% in 2013
- **Hispanic/Latino**: 63.3% in 2011, 67.6% in 2013
- **White**: 66.1% in 2011, 68.9% in 2013
- **African American/Black**: 51.9% in 2011, 52.2% in 2013
- **American Indian/Alaskan Native**: ~
- **Hawaiian/Pacific Islander**: ~
Percentage of patients who received follow-up care within 7 days of being discharged from the hospital for mental illness in 2011 & 2013

Bolded names met benchmark or improvement target

Columbia Pacific
Yamhill CCO
Western Oregon Advanced Health
Willamette Valley Community Health
Primary Health of Josephine County
Cascade Health Alliance
FamilyCare
Umpqua
Health Share
Trillium
PacificSource
Jackson Care Connect
Intercommunity Health Network
All Care Health Plan
Eastern Oregon

Benchmark 68.0%
Follow-up care for children prescribed ADHD medication (initiation phase)

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

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

2013 data (n=2,403)
This metric represents the percentage of children prescribed ADHD medication who had a follow-up visit within 30 days after receiving a new prescription.

In 2013, the benchmark was exceeded statewide (53.3% versus 51.0%). Additionally, over two-thirds of the CCOs exceed the benchmark for this measure.
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (INITIATION PHASE)

CCO Incentive and State Performance Measure

Percentage of children (ages 6-12) who had one follow-up visit with a provider during the 30 days after receiving a new prescription for ADHD medication in 2011 & 2013

**Bolded names met benchmark or improvement target**

- Cascade Health Alliance
- Columbia Pacific
- Jackson Care Connect
- Yamhill CCO
- All Care Health Plan
- Health Share
- Western Oregon Advanced Health
- Trillium
- FamilyCare
- Intercommunity Health Network
- Eastern Oregon
- Umpqua Health Alliance
- Willamette Valley Community Health
- PacificSource
- PrimaryHealth of Josephine County

Benchmark 51.0%

---

2013 Performance Report
June 24, 2014
Oregon Health Authority
Office of Health Analytics
Follow-up care for children prescribed ADHD medication (continuation and maintenance phase)

Measure description: Percentage of children (ages 6-12) who remained on attention deficit hyperactivity disorder (ADHD) medication for 210 days after receiving a new prescription and who had at least two follow-up visits with a provider within 270 days after the initiation phase (see page 47).

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

2013 data (n=1,080)

This metric represents the percentage of children prescribed ADHD medication who remained on the medication for 210 days and had at least two follow-up visits with a provider within 270 days of the prescription. To date, 2013 data are similar to baseline rates.

This measure cannot be reported at the CCO level for

Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

Race and ethnicity data between 2011 & 2013

Data missing for 8.4% of respondents
~Data suppressed due to low numbers (n<30)

- Hispanic/Latino: 58.6% (2011) vs 63.0% (2013)
- African American/Black: 63.6% (2011) vs 65.1% (2013)
- White: 60.4% (2011) vs 61.7% (2013)
- American Indian/Alaskan Native ~
- Asian American ~
- Hawaiian/Pacific Islander ~

Benchmark 63.0%
Immunization for adolescents

**Measure description:** Percentage of adolescents who received recommended vaccines before their 13th birthday.

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

**2013 data (n=6,381)**

The 2013 data shows CCOs are doing better at making sure recommended vaccines are up to date, compared to 2011 baseline. This trend is consistent with the CCOs improvement in providing more adolescent well care visits.

Statewide

Data source: Administrative (billing) claims and ALERT Immunization Information System

Benchmark source: 2012 National Medicaid 75th percentile

<table>
<thead>
<tr>
<th>Race and ethnicity data between 2011 &amp; 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic/Latino</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>African American/Black</td>
</tr>
<tr>
<td>Asian American</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
</tr>
<tr>
<td>Hawaiian/Pacific Islander</td>
</tr>
</tbody>
</table>

Benchmark 70.8%
IMMUNIZATION FOR ADOLESCENTS
State Performance Measure

Percentage of adolescents who received recommended vaccines before their 13th birthday in 2011 & 2013

- Eastern Oregon: 39.1% (2011), 54.8% (2013)
- PacificSource: 46.5% (2011), 59.9% (2013)
- Yamhill CCO: 50.0% (2011), 62.1% (2013)
- Western Oregon Advanced Health: 38.4% (2011), 45.9% (2013)
- FamilyCare: 51.8% (2011), 58.9% (2013)
- PrimaryHealth of Josephine County: 31.6% (2011), 36.5% (2013)
- Intercommunity Health Network: 51.0% (2011), 55.2% (2013)
- Willamette Valley Community Health: 57.2% (2011), 59.9% (2013)
- Health Share: 52.3% (2011), 53.9% (2013)
- Trillium: 35.3% (2011), 37.2% (2013)
- Jackson Care Connect: 46.6% (2011), 49.6% (2013)
- Columbia Pacific: 29.6% (2011), 36.2% (2013)
- Umpqua Health Alliance: 39.4% (2011), 49.7% (2013)
- All Care Health Plan: 34.1% (2011), 61.6% (2013)

Benchmark: 70.8%
Medical assistance with smoking and tobacco use cessation

Component 1: Percentage of adult tobacco users advised to quit by their doctor.

Purpose: Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

2013 data

This set of metrics measures the proportion of adult tobacco users who were advised by their doctor to quit, provided strategies to quit, and recommended medication to quit. All three metrics in this set show improvement in 2013 over baseline.

Statewide

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark source: 2012 National Medicaid 90th percentile

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benchmark</td>
<td></td>
<td>81.4%</td>
</tr>
<tr>
<td>Percentage</td>
<td>50.0%</td>
<td>55.0%</td>
</tr>
</tbody>
</table>

Race and ethnicity data between 2011 & 2013

CAHPS data by race and ethnicity will be available in future reports.
Smoking and tobacco use cessation: Percentage of adults tobacco users advised to quit by a doctor in 2011 & 2013

*CCO baseline could not clearly be attributed to a past FCHP; baseline provided is state average.
Medical assistance with smoking and tobacco use cessation

Component 2: Percentage of adult tobacco users whose doctor discussed or recommended medication to quit smoking.

Purpose: Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

2013 data
This set of metrics measures the proportion of adult tobacco users who were advised by their doctor to quit, provided strategies to quit, and recommended medication to quit. All three metrics in this set show improvement in 2013 over baseline.
Smoking and tobacco use cessation: Percentage of adults tobacco users whose doctor discussed or recommended medication to quit smoking in 2011 & 2013

*CCH baseline could not clearly be attributed to a past FCHP; baseline provided is state average.
Medical assistance with smoking and tobacco use cessation

Component 3: Percentage of adult tobacco users whose doctor discussed or recommended strategies to quit smoking.

Purpose: Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

2013 data
This set of metrics measures the proportion of adult tobacco users who were advised by their doctor to quit, provided strategies to quit, and recommended medication to quit. All three metrics in this set show improvement in 2013 over baseline.
Smoking and tobacco use cessation: Percentage of adults tobacco users whose doctor discussed or recommended strategies to quit smoking in 2011 & 2013

*CCO baseline could not clearly be attributed to a past FCHP; baseline provided is state average.
MENTAL AND PHYSICAL HEALTH ASSESSMENT WITHIN 60 DAYS FOR CHILDREN IN DHS CUSTODY

CCO Incentive Measure

Mental and physical health assessment within 60 days for children in DHS custody

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

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

2013 data (n=137)

This metric has systematic challenges that can make it difficult to measure. For example, CCOs are still building relationships with local field offices to quickly identify children that enter the foster care system. OHA and the CCOs are continuing to work together on the methodology to improve data collection and reporting for this measure. Nonetheless, 12 CCOs exceeded the benchmark or their improvement target for this measure, showing progress.

Statewide

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Mental Health Assessment</th>
<th>Physical Health Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>53.6%</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>63.5%</td>
<td></td>
</tr>
</tbody>
</table>

Benchmark 90%

Race and ethnicity data between 2011 & 2013

Data missing for 60.0% of respondents

- **White**: 53.6% → 63.1%
- **Hispanic/Latino**: 56.4%
- **American Indian/Alaskan Native**: 46.8%
- **African American/Black**: 43.2%
- **Asian American**:
- **Hawaiian/Pacific Islander**:

Benchmark 90.0%
MENTAL AND PHYSICAL HEALTH ASSESSMENT WITHIN 60 DAYS FOR CHILDREN IN DHS CUSTODY

CCO Incentive Measure

Percentage of children in DHS custody who received a mental and physical health assessment within 60 days in 2011 & 2013

Bolded names met benchmark or improvement target

<table>
<thead>
<tr>
<th>CCO</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trillium</td>
<td>47.1%</td>
<td>80.9%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Primary Health of Josephine County</td>
<td>35.7%</td>
<td>75.0%</td>
<td></td>
</tr>
<tr>
<td>Western Oregon Advanced Health</td>
<td>47.2%</td>
<td>75.0%</td>
<td></td>
</tr>
<tr>
<td>Cascade Health Alliance</td>
<td>47.2%</td>
<td>75.0%</td>
<td></td>
</tr>
<tr>
<td>Umpqua Health Alliance</td>
<td>47.2%</td>
<td>75.0%</td>
<td></td>
</tr>
<tr>
<td>Yamhill CCO</td>
<td>47.2%</td>
<td>75.0%</td>
<td></td>
</tr>
<tr>
<td>FamilyCare</td>
<td>47.2%</td>
<td>75.0%</td>
<td></td>
</tr>
<tr>
<td>Columbia Pacific</td>
<td>47.2%</td>
<td>75.0%</td>
<td></td>
</tr>
<tr>
<td>Health Share</td>
<td>47.2%</td>
<td>75.0%</td>
<td></td>
</tr>
<tr>
<td>Willamette Valley Community Health</td>
<td>47.2%</td>
<td>75.0%</td>
<td></td>
</tr>
<tr>
<td>Jackson Care Connect</td>
<td>39.2%</td>
<td>50.0%</td>
<td></td>
</tr>
<tr>
<td>PacificSource</td>
<td>47.9%</td>
<td>50.0%</td>
<td></td>
</tr>
<tr>
<td>All Care Health Plan</td>
<td>47.1%</td>
<td>50.0%</td>
<td></td>
</tr>
<tr>
<td>Intercommunity Health Network</td>
<td>23.1%</td>
<td>60.3%</td>
<td>60.3%</td>
</tr>
</tbody>
</table>

Benchmark 90.0%
PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT (PCPCH)

CCO Incentive and State Performance Measure

Patient-centered primary care home enrollment

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

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

2013 data (n=528,689)

This metric tracks the percentage of CCO members who are enrolled in a recognized patient-centered primary care home. Enrollment in patient-centered primary care homes has increased by 52% since 2012, the baseline year for this program.

Fourteen CCOs show an increase in members enrolled in a patient-centered primary care home.

Statewide

Data source: CCO quarterly report
Benchmark source: n/a

Goal: 100% of members are enrolled in a Tier 3 PCPCH

Race and ethnicity data between 2012 & 2013

Patient-centered primary care home enrollment will not be stratified by race and ethnicity

Data source: CCO quarterly report
Benchmark source: n/a

2012: 51.8%
2013: 78.6%
PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT (PCPCH)

CCO Incentive and State Performance Measure

Percentage of patients who were enrolled in a recognized patient-centered primary care home in 2012 & 2013

Goal: 100% of members are enrolled in a Tier 3 PCPCH

Eastern Oregon 3.7% 63.3%
FamilyCare 16.0% 74.1%
Umpqua Health Alliance 18.0% 73.5%
Yamhill CCO 38.7% 75.5%
Health Share 50.3% 81.2%
Columbia Pacific 47.3% 76.1%
Willamette Valley Community Health 45.7% 67.0%
Western Oregon Advanced Health 39.8% 50.0%
All Care Health Plan 65.0% 50.0%
PacificSource 56.0% 73.9%
Cascade Health Alliance 56.0% 65.0%
Trillium 80.2% 85.3%
Intercommunity Health Network 86.1% 87.6%
Primary Health of Josephine County 94.4% 95.6%
Jackson Care Connect 45.2% 45.2%
**Diabetes Short Term Complications Admission Rate (PQI 01)**

**State Performance Measure**

---

**Diabetes short term complications admission rate**

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

PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

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

**2013 data** (n=2,672,059 member months)

This metric tracks hospital use for adult patients with diabetes who could be better treated with good disease management. The rates for this measure are reported per 100,000 member years and a lower rate is better.

The 2013 rate shows an increase compared to 2011, suggesting an area of care that could benefit from better management.

---

### Statewide

**Lower scores are better**  
Data source: Administrative (billing) claims  
Benchmark source: OHA consensus, based on prior performance trend

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate per 100,000 member years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>192.9</td>
</tr>
<tr>
<td>2013</td>
<td>211.5</td>
</tr>
</tbody>
</table>

**Benchmark:** 10% reduction from statewide baseline

---

### Race and ethnicity data between 2011 & 2013

**Lower scores are better**  
Data missing for 5.6% of respondents

<table>
<thead>
<tr>
<th>Group</th>
<th>2011 Rate</th>
<th>2013 Rate</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaskan Native</td>
<td>466.3</td>
<td>627.4</td>
<td>10%</td>
</tr>
<tr>
<td>African American/Black</td>
<td>114.7</td>
<td>227.7</td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>101.1</td>
<td>131.0</td>
<td></td>
</tr>
<tr>
<td>Asian American</td>
<td>70.5</td>
<td>89.5</td>
<td></td>
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<tr>
<td>Hawaiian/Pacific Islander</td>
<td>0.0, 0.0</td>
<td>0.0, 0.0</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>213.6</td>
<td>233.9</td>
<td></td>
</tr>
</tbody>
</table>

**Benchmark:** 10% reduction from statewide baseline
**DIABETES SHORT-TERM COMPLICATION ADMISSION RATE (PQI 01)**

State Performance Measure

**PQI 01: Rate of adult patients with diabetes who had a hospital stay because of a short-term problem with their disease in 2011 & 2013**

(Lower scores are better)
Rates are per 100,000 member years
PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators

- **FamilyCare**: 185.1 - 203.8
- **Western Oregon Advanced Health**: 16.7 - 109.0
- **All Care Health Plan**: 117.0 - 205.6
- **Columbia Pacific**: 148.9 - 209.4
- **Umpqua Health Alliance**: 213.4 - 249.9
- **Health Share**: 183.8 - 185.1
- **Jackson Care Connect**: 243.1 - 279.7
- **Cascade Health Alliance**: 360.8 - 417.3
- **PacificSource**: 185.7 - 247.5
- **Trillium**: 281.3 - 344.3
- **PrimaryHealth of Josephine County**: 227.5 - 290.5
- **Yamhill CCO**: 115.7 - 193.0
- **Intercommunity Health Network**: 151.1 - 237.0
- **Willamette Valley Community Health**: 172.5 - 260.2
- **Eastern Oregon**: 143.8 - 254.4

**Benchmark:** 10% reduction from statewide baseline
**Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate**

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

PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

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

**2013 data (n=2,672,059 member months)**

This metric tracks hospital use for older adults with chronic obstructive pulmonary disease or asthma - diseases that could be better treated with good disease management. The rates for this measure are reported per 100,000 member years and a lower rate is better. Statewide, CCOs performed below the benchmark for 2013, showing improvement in disease management care.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI 05)

State Performance Measure

PQI 05: Rate of adult patients (age 40 and older) who had a hospital stay because of asthma or chronic obstructive pulmonary disease in 2011 & 2013

(Lower scores are better)
Rates are per 100,000 member years
PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators

Benchmark: 10% reduction from statewide baseline

Yamhill CCO 42.9 396.9
All Care Health Plan 202.9 509.7
Western Oregon Advanced Health 268.0 644.9
Umpqua Health Alliance 243.3 602.6
Intercommunity Health Network 181.1 821.1
FamilyCare 356.6 447.2
PacificSource 430.9 544.9
Cascade Health Alliance 435.3 602.6
Willamette Valley Community Health 238.5 402.0
Trillium 226.1 421.0
Columbia Pacific 281.3 421.0
Health Share 368.3 350.6
Eastern Oregon 364.7 421.0
PrimaryHealth of Josephine County 292.5 322.8
Jackson Care Connect 364.7 421.0

(Orange indicates reduction from baseline)
CONGESTIVE HEART FAILURE ADMISSION RATE (PQI 08)
State Performance Measure

Congestive heart failure admission rate

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

PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

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

**2013 data** (n=2,672,059 member months)

This metric tracks hospital use for adults with congestive heart failure that could be better treated with good disease management. The rates for this measure are reported per 100,000 member years and a lower rate is better.

Statewide, CCOs performed below the benchmark for 2013, showing improvement in disease management care.

**Statewide**

(Lower scores are better)

Data source: Administrative (billing) claims

Benchmark source: OHA consensus, based on prior performance trend

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>336.9</td>
</tr>
<tr>
<td>2013</td>
<td>247.0</td>
</tr>
</tbody>
</table>

**Race and ethnicity data between 2011 & 2013**

(Lower scores are better)

- **American Indian/Alaskan Native**
  - 2011: 233.1
  - 2013: 672.3

- **African American/Black**
  - 2011: 688.4
  - 2013: 950.5

- **Hawaiian/Pacific Islander**
  - 2011: 166.4
  - 2013: 355.0

- **White**
  - 2011: 242.4
  - 2013: 355.0

- **Hispanic/Latino**
  - 2011: 101.1
  - 2013: 189.2

- **Asian American**
  - 2011: 235.2
  - 2013: 294.0

**Benchmark:** 10% reduction from statewide baseline
CONGESTIVE HEART FAILURE ADMISSION RATE (PQI 08)
State Performance Measure

PQI 08: Rate of adult patients who had a hospital stay because of congestive heart failure in 2011 & 2013
(Lower score is better)
Rates are per 100,000 member years
PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators

(Orange = 2011, Gray = 2013)

Benchmark: 10% reduction from statewide baseline
**ADULT ASTHMA ADMISSION RATE (PQI 15)**

State Performance Measure

**Adult (ages 18-39) asthma admission rate**

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

PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

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

**2013 data** (n=2,672,059 member months)

This metric tracks hospital use for adults with asthma that could be better treated with good disease management. The rates for this measure are reported per 100,000 member years and a lower rate is better.

Statewide, CCOs performed below the benchmark for 2013 showing improvement in asthma care.

**Statewide**

(Lower scores are better)

Data source: Administrative (billing) claims

Benchmark source: OHA consensus, based on prior performance trend

**Race and ethnicity data between 2011 & 2013**

(Lower scores are better)

Data missing for 5.6% of respondents

**African American/ Black**

2011: 95.6

2013: 148.5

**Hispanic/ Latino**

2011: 18.4

2013: 29.1

**White**

2011: 36.8

2013: 45.3

**Hawaiian/ Pacific Islander**

2011: 0.0

2013: 0.0

**Asian American**

2011: 0.0

2013: 23.5

**American Indian/ Alaskan Native**

2011: 156.9

2013: 532.9

Benchmark 10% reduction from baseline
ADULT ASTHMA ADMISSION RATE (PQI 15)
State Performance Measure

PQI 15: Rate of adult patients (age 18-39) who had a hospital stay because of asthma in 2011 & 2013

(Lower score is better)
Rates are per 100,000 member years
PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>2011 Rate</th>
<th>2013 Rate</th>
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<td>0.0</td>
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<tr>
<td>PrimaryHealth of Josephine County</td>
<td>0.0</td>
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<tr>
<td>Western Oregon Advanced Health</td>
<td>33.5</td>
<td>62.2</td>
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<tr>
<td>FamilyCare</td>
<td>52.6</td>
<td>71.3</td>
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<tr>
<td>Health Share</td>
<td>57.3</td>
<td>75.9</td>
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<tr>
<td>Cascade Health Alliance</td>
<td>22.0</td>
<td>40.1</td>
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<tr>
<td>PacificSource</td>
<td>27.5</td>
<td>44.6</td>
</tr>
<tr>
<td>Umpqua Health Alliance</td>
<td>25.1</td>
<td>36.7</td>
</tr>
<tr>
<td>All Care Health Plan</td>
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<tr>
<td>Eastern Oregon</td>
<td>28.3</td>
<td>28.7</td>
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<tr>
<td>Columbia Pacific</td>
<td>16.1</td>
<td>16.5</td>
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<td>Yamhill CCO</td>
<td>16.5</td>
<td>21.4</td>
</tr>
<tr>
<td>Trillium</td>
<td>38.9</td>
<td>47.3</td>
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<tr>
<td>Intercommunity Health Network</td>
<td>25.1</td>
<td>33.9</td>
</tr>
<tr>
<td>Willamette Valley Community Health</td>
<td>23.3</td>
<td>47.7</td>
</tr>
</tbody>
</table>

Benchmark:
10% reduction from statewide baseline
Prenatal and Postpartum Care: Timeliness of Prenatal Care

CCO Incentive and State Performance Measure

Timeliness of prenatal care

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

Purpose: Care during a pregnancy (prenatal care) is widely considered the most productive and cost-effective way to support the delivery of a healthy baby. This measure helps ensure timeliness by tracking the percentage of women who receive an early prenatal care visit (in the first trimester). Improving the timeliness of prenatal care can lead to significantly better health outcomes and cost savings - as more than 40 percent of all babies born in Oregon are covered by Medicaid.

2013 data (n=5,598)

This metric tracks the percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days or enrollment in Medicaid. The 2013 data show an improvement over baseline and are approaching the statewide benchmark. Twelve CCOs met their improvement target or exceeded the benchmark for this measure.

Race and ethnicity data between 2011 & 2013

Data missing for 7.2% of respondents

- Asian American: 66.0% (25%) - 75.7% (75%)
- African American/Black: 65.2% - 68.7%
- White: 65.8% - 68.3%
- American Indian/Alaskan Native: 70.1% - 72.5%
- Hispanic/Latino: 65.1% - 66.2%
- Hawaiian/Pacific Islander: 55.9% (25%) - 64.2% (50%) - 75% (75%)
Percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days of enrollment in Medicaid in 2011 & 2013

Bolded names met benchmark or improvement target

**Eastern Oregon**
- Western Oregon Advanced Health: 47.7% - 57.4%
- Primary Health of Josephine County: 66.5% - 71.9%
- Family Care: 62.1% - 66.8%
- Intercommunity Health Network: 65.1% - 69.8%
- Yamhill CCO: 66.5% - 70.3%
- Cascade Health Alliance: 68.3% - 70.2%
- PacificSource: 74.0%
- Willamette Valley Community Health: 57.1% - 58.8%
- Health Share: 67.5%
- Umpqua Health Alliance: 65.5% - 66.3%
- All Care Health Plan: 73.4%
- Columbia Pacific: 64.8%
- Trillium: 56.0% - 59.1%
- Jackson Care Connect: 67.5% - 71.2%

**Benchmark**: 69.4%
**Postpartum care**

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

**Purpose:** Having a timely postpartum care visit helps increase the quality of maternal care and reduces the risks for potential health complications associated with pregnancy. Women who have a visit between 21 and 56 days after delivery can have their physical health assessed and can consult with their provider about infant care, family planning and breastfeeding.

**2013 data** (n=13,385)

This metric tracks the percentage of women who had a timely postpartum care visit after delivery. Results for 2013 show a decrease in this measure when compared to 2011.

This measure cannot be reported at the CCO level for 2013.

**Statewide**

Data source: Administrative (billing) claims

Benchmark source: 2012 National Medicaid 75th percentile (administrative data only, adjusted)

**Race and ethnicity data between 2011 & 2013**

Data missing for 7.1% of respondents

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>2011</th>
<th>2013</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American/Black</td>
<td>34.8%</td>
<td>38.4%</td>
<td>38.4%</td>
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<td>Hispanic/Latino</td>
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<td>38.9%</td>
<td>38.9%</td>
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<td>Asian American</td>
<td>43.7%</td>
<td>48.3%</td>
<td>48.3%</td>
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<tr>
<td>American Indian/Alaskan Native</td>
<td>30.3%</td>
<td>36.2%</td>
<td>36.2%</td>
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<tr>
<td>White</td>
<td>33.1%</td>
<td>40.6%</td>
<td>40.6%</td>
</tr>
<tr>
<td>Hawaiian/Pacific Islander</td>
<td>23.9%</td>
<td>33.9%</td>
<td>33.9%</td>
</tr>
</tbody>
</table>
Component 1: Extent to which primary care providers are accepting new Medicaid patients

Measure description: Percentage of primary care providers who are accepting new Medicaid/Oregon Health Plan patients.

Component 2: Extent to which primary care providers currently see Medicaid patients

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

Component 3: Current payer mix at primary care practices

Definition: This measure will provide a breakdown of payer mix at primary care practices. This data will be available in a future report.

Purpose: Access to primary care leads to better health outcomes and more affordable health care. Improving primary care access for low-income Oregonians can also help reduce health disparities and overall health care costs

2013 data

The Oregon Physician Workforce Survey was not fielded in 2013. Updated data from the 2014 survey will be available in early 2015.

This measure cannot be stratified by race and ethnicity, nor reported at the CCO level.
SATISFACTION WITH CARE (CAHPS)

CCO Incentive and State Performance Measure

Satisfaction with care (CAHPS)

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

Purpose: A patient's satisfaction and overall experience with their care is a critical component of quality health care. Data show that healthier patients tend to report being more satisfied with the care they receive. Patients who are not satisfied with their care may miss appointments.

2013 data

The percentage of individuals reporting satisfaction with their health plan increased from 78% in 2011 to 84% in 2013, an increase of six percentage points. Overall, the statewide rate reached the benchmark for 2013. Additionally, seven of the 15 CCOs met the benchmark for this measure.

Statewide

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark source: 2012 National Medicaid 90th percentile

Benchmark 84.0%

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<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>78.0%</td>
</tr>
<tr>
<td>2013</td>
<td>84.0%</td>
</tr>
</tbody>
</table>
Race and ethnicity data between 2011 & 2013

CAHPS data by race and ethnicity will be available in future reports
Satisfaction with Care (CAHPS)
CCO Incentive and State Performance Measure

Percentage of patients who received needed information and thought they were treated with courtesy and respect by customer service staff in 2011 & 2013

Bolded names met benchmark or improvement target

- Willamette Valley Community Health: 70.0% in 2011, 83.5% in 2013
- Eastern Oregon: 71.0% in 2011, 83.7% in 2013
- Intercommunity Health Network: 76.0% in 2011, 97.2% in 2013
- Columbia Pacific: 79.0% in 2011, 94.7% in 2013
- Primary Health of Josephine County: 78.0% in 2011, 88.2% in 2013
- All Care Health Plan: 77.0% in 2011, 95.1% in 2013
- Jackson Care Connect: 78.0% in 2011, 94.7% in 2013
- Cascade Health Alliance: 75.0% in 2011, 81.6% in 2013
- Trillium: 80.0% in 2011, 94.2% in 2013
- Western Oregon Advanced Health: 77.0% in 2011, 80.3% in 2013
- Yamhill CCO: 76.0% in 2011, 81.0% in 2013
- PacificSource: 81.0% in 2011, 83.5% in 2013
- FamilyCare: 82.0% in 2011, 83.8% in 2013
- Health Share: 79.5% in 2011, 80.0% in 2013
- Umpqua Health Alliance: 81.9% in 2011, 83.0% in 2013

Benchmark: 84.0%

- Bolded names met benchmark or improvement target.
Well-child visits in the first 15 months of life

Measure description: Percentage of children up to 15 months old who had at least six well-child visits with a health care provider.

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

2013 data (n=4,120)

This metric tracks the percentage of children up to 15 months old who had at least six well-child visits with a health care provider. The 2013 percentage shows a decrease in this metric when compared to 2011.

Two CCOs increased the percentage of children who had at least six well child-visits, providing an opportunity to learn about their best practices.
WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

State Performance Measure

Percentage of children up to 15 months old who had at least six well-child visits with a health care provider in 2011 & 2013

- Eastern Oregon: 47.1% - 69.2%
- Columbia Pacific: 45.0% - 61.0%
- Western Oregon Advanced Health: 75.3%
- Willamette Valley Community Health: 64.2% - 68.8%
- Cascade Health Alliance: 73.2% - 79.3%
- Umpqua Health Alliance: 55.0% - 61.6%
- Jackson Care Connect: 73.6% - 81.3%
- PacificSource: 57.6% - 66.0%
- Health Share: 61.3% - 70.5%
- Trillium: 57.9% - 67.9%
- FamilyCare: 60.1% - 70.3%
- Intercommunity Health Network: 51.0% - 64.8%
- All Care Health Plan: 58.3% - 76.1%
- Yamhill CCO: 45.7% - 71.4%
- PrimaryHealth of Josephine County: 45.0% - 61.6%

Benchmark: 77.3%
Approach
In order to reduce administrative burden and improve quality, OHA intends to leverage increasing capabilities for electronic reporting of clinical quality measure data. These capabilities are enabled through the use of Electronic Health Records (EHRs). OHA is pursuing a phased-in approach to electronic reporting of three CCO incentive measures: depression screening and follow up plan, diabetes HbA1c poor control, and controlling hypertension. In 2013, OHA required CCOs to submit a year one technology plan and proof of concept data in order to earn quality pool payments associated with these three measures.

Year One Technology Plans
The technology plans provide an environmental scan of the CCOs current technological capacity, including EHR adoption, health information exchange (HIE), and health information technology (HIT) projects underway. The technology plans also outline how CCOs will develop infrastructure to support electronic reporting of clinical quality data. CCOs received an advance distribution of quality pool funds (equaling 75 percent of 3/17ths of their quality pool total) once OHA had reviewed and approved their technology plans.

Proof of Concept Data
The proof of concept data submission is a sample of electronic clinical quality data, representing at least 10 percent of CCO membership, for each of the three clinical measures. CCOs received credit for the measure once OHA had reviewed and approved the submitted proof of concept data. The following page provides an overview of CCO results.

Additional Information
Supporting documentation for the year one technology plans and proof of concept data submission is available online at: http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx
## TECHNOLOGY PLAN AND CLINICAL QUALITY MEASURES

### Proof of Concept Data Approved

<table>
<thead>
<tr>
<th>Coordinated Care Organization</th>
<th>Year One Technology Plan Approved</th>
<th>Depression Screening</th>
<th>Diabetes Control</th>
<th>Hypertension Control</th>
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<tr>
<td>All Care Health Plan</td>
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<td>Jackson Care Connect</td>
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<td>✓</td>
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</tr>
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<td>PacificSource</td>
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<td>✓</td>
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<tr>
<td>PrimaryHealth of Josephine County</td>
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<td>✓</td>
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<tr>
<td>Trillium</td>
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<td>Umpqua Health Alliance</td>
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</tbody>
</table>
Overview

OHA implemented a new software system used for grouping various claims into specific categories in the spring of 2014. Working with OHA’s contractor, Milliman, we are using the MedInsight HCG (Health Cost Guidelines) Grouper. This is a proprietary classification system developed by Milliman. This is the same grouping software that is used to classify Commercial and Medicare Advantage claims in the All-Payer, All-Claims database system. Using the same software allows us to integrate reporting of CCO and other Medicaid data with the reports produced from All-Payer, All-Claims, database making the data comparable.

As a result, this report is generally not comparable with previous Health System Transformation Quarterly Reports. This report includes twelve quarters of data, using the new grouping system, which has been characterized in a similar manner to enable comparison of data over time.

Notes

This report includes claims data received and processed by OHA through 5/30/14. At this point, there are no data on services that have happened, but have yet to be recorded or invoiced. This dashboard may be incomplete due to lags in submitting data to OHA. Future dashboards will be updated when more complete data is submitted.

The cost and utilization information includes data from before health transformation began and CCOs were formed. Calendar year 2013 is the first full year of CCO data.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient -- Medical / General -- Patient Days</td>
<td>202.8</td>
<td>176.3</td>
<td>160.8</td>
<td>156.1</td>
<td>173.7</td>
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<tr>
<td>Inpatient -- Surgical -- Patient Days</td>
<td>98.5</td>
<td>88.4</td>
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<td>87.1</td>
</tr>
<tr>
<td>Inpatient -- Maternity / Normal Delivery -- Patient Days</td>
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<td>47.4</td>
<td>47.0</td>
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<tr>
<td>Inpatient -- Maternity / C-Section Delivery -- Patient Days</td>
<td>27.2</td>
<td>27.7</td>
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<td>Inpatient -- Maternity / Non-Delivery -- Patient Days</td>
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<td>9.7</td>
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<tr>
<td>Inpatient -- Newborn / Well -- Patient Days</td>
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<td>42.6</td>
<td>41.8</td>
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<td>$ 7.25</td>
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<tr>
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<td>$ 23.52</td>
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<td>$ 22.75</td>
<td>$ 23.23</td>
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## Cost data statewide (table 3 of 3)

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<tbody>
<tr>
<td><strong>Cost Per Member Per Month (PMPM)</strong></td>
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<td>Inpatient -- Medical / General</td>
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<td>Inpatient -- Surgical</td>
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<tr>
<td>Inpatient -- Maternity / Normal Delivery</td>
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<tr>
<td>Inpatient -- Maternity / C-Section Delivery</td>
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<td>Inpatient -- Newborn / Well</td>
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<td>Inpatient -- Newborn / With Complications</td>
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<td>Inpatient -- Mental Health / Psychiatric</td>
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<td>Inpatient -- Mental Health / Alcohol and Drug Abuse</td>
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<td>Outpatient -- Pharmacy Prescriptions</td>
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<td>Outpatient -- Labs (Professional and Technical)</td>
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<td>$7.59</td>
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<td>Outpatient -- All Other</td>
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## Coordinated Care Organization Service Areas

<table>
<thead>
<tr>
<th><strong>CCO Name</strong></th>
<th><strong>Service Area by County</strong></th>
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</thead>
<tbody>
<tr>
<td>AllCare Health Plan</td>
<td>Curry, Josephine, Jackson, Douglas (partial)</td>
</tr>
<tr>
<td>Cascade Health Alliance</td>
<td>Klamath County (partial)</td>
</tr>
<tr>
<td>Columbia Pacific CCO</td>
<td>Clatsop, Columbia, Coos (partial), Douglas (partial), Tillamook</td>
</tr>
<tr>
<td>Eastern Oregon CCO</td>
<td>Bauer, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler</td>
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<tr>
<td>FamilyCare</td>
<td>Clackamas, Marion (partial), Multnomah, Washington</td>
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<tr>
<td>Health Share of Oregon</td>
<td>Clackamas, Multnomah, Washington</td>
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<tr>
<td>Intercommunity Health Network</td>
<td>Benton, Lincoln, Linn</td>
</tr>
<tr>
<td>Jackson Care Connect</td>
<td>Jackson</td>
</tr>
<tr>
<td>PacificSource Community Solutions - Central Oregon</td>
<td>Crook, Deschutes, Jefferson, Klamath (partial)</td>
</tr>
<tr>
<td>PacificSource Community Solutions - Gorge</td>
<td>Hood River, Wasco</td>
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<tr>
<td>PrimaryHealth of Josephine County</td>
<td>Douglas (partial), Jackson (partial), Josephine</td>
</tr>
<tr>
<td>Trillium Community Health Plan</td>
<td>Lane</td>
</tr>
<tr>
<td>Umpqua Health Alliance</td>
<td>Douglas (most)</td>
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<tr>
<td>Western Oregon Advanced Health</td>
<td>Coos, Curry</td>
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<tr>
<td>Willamette Valley Community Health</td>
<td>Marion, Polk (most)</td>
</tr>
<tr>
<td>Yamhill CCO</td>
<td>Clackamas (partial), Marion (partial), Polk (partial), Yamhill</td>
</tr>
</tbody>
</table>
For questions about performance metrics, contact:

Lori Coyner  
Director of Health Analytics  
Oregon Health Authority  
Email: lori.a.coyner@state.or.us

For questions about financial metrics, contact:

Jeff Fritsche  
Finance Director  
Oregon Health Authority  
Email: jeffrey.p.fritsche@state.or.us

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

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