Oregon's Health System Transformation

Quarterly Progress Report

Oregon Health Authority

MEASUREMENT PERIOD
Baseline Year 2011 and January-June 2013

PUBLISHING DATE
November 2013

CONTENTS

EXECUTIVE SUMMARY

November 2013 Health System Transformation Quarterly Report

The report highlights statewide performance on key measurements, rates of health care utilization, and costs through the coordinated care organizations that serve Oregon's Medicaid population. These measurements are designed to show how the state is doing in meeting the triple aim of better health, better care and lower costs. Public reporting of this sort is a key element in Oregon's work to transform the state Medicaid system to be more transparent to members, stakeholders and the public.

The report shows where we started, where we are, and where we want to go in improving our health delivery system. Over time, it will show which CCOs are meeting targeted improvements and where improvements are still needed. It also will help us in determining the readiness of the coordinated care model to serve hundreds of thousands of new enrollees into Medicaid over the next few years.

Indicators show emergency department use declining, for example, while primary care is increasing. While progress will not be linear – in the months and years to come there will be movement in the right direction and there will be setbacks – this report is both promising and encouraging. It signals that the state is on the right track with the coordinated care model and shows tangible results of all the work of the local CCOs to improve health and create a more sustainable health care system.

Summary

This report compiles nine months of utilization and cost data based on claims made for payments from the coordinated care organizations. There is a lag time for some claims to be filed so information should be considered preliminary, but most of the claims are complete.

This report also shows six months' worth of several statewide performance metrics. In the months to come, analysis on more metrics will be completed and published. Also, for the first time, this report shows baseline race and ethnicity data for performance measures. This critical information will help highlight areas of greatest disparity and potential improvement.

EXECUTIVE SUMMARY

Highlighted findings

- **Decreased emergency department visits.** Six months of reporting shows that emergency department visits by people served by CCOs has decreased by 9 percent from what it was in 2011. Nine months of expenditure data shows that ED spending is down 18 percent from 2011 as well.
- **Decreased hospitalization for chronic conditions.** CCOs reduced hospital admissions for congestive heart failure by 29 percent, chronic obstructive pulmonary disease by 28 percent and adult asthma by 14 percent.
- **Increased primary care.** Outpatient primary care visits for CCO members increased 18 percent and spending for primary care is up nearly 7 percent. Enrollment in patient-centered primary care homes has increased by 36 percent since 2012, the baseline year for that program.
- **Increased adoption of electronic health records.** Electronic health record adoption among measured providers has doubled. In 2011, 28 percent of eligible providers had EHRs. By June 2013, 57 percent of them had adopted EHRs.

PERFORMANCE METRICS
CCO Incentive Measures

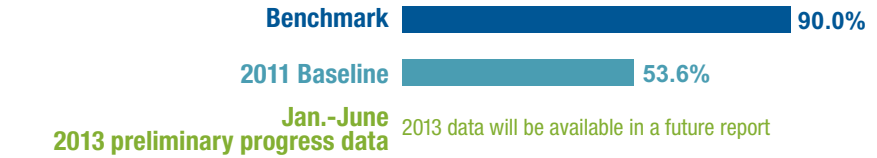
Mental and physical health assessment within 60 days for children in DHS custody

Definition: 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). Children under 4 are only required to have a physical health assessment.

Focus areas: Improving access to effective and timely care and improving behavioral and physical health coordination.

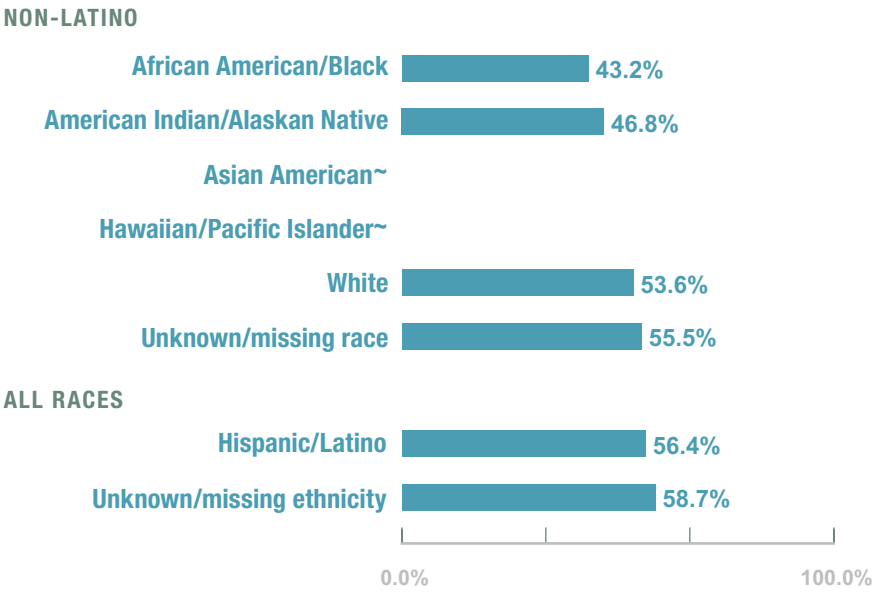
Purpose: Children who have been placed in foster care should have their mental and physical health checked so that an appropriate care plan can be developed. Mental and physical health assessments are a requirement for the foster program because of their importance to improving the health and well-being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

STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA



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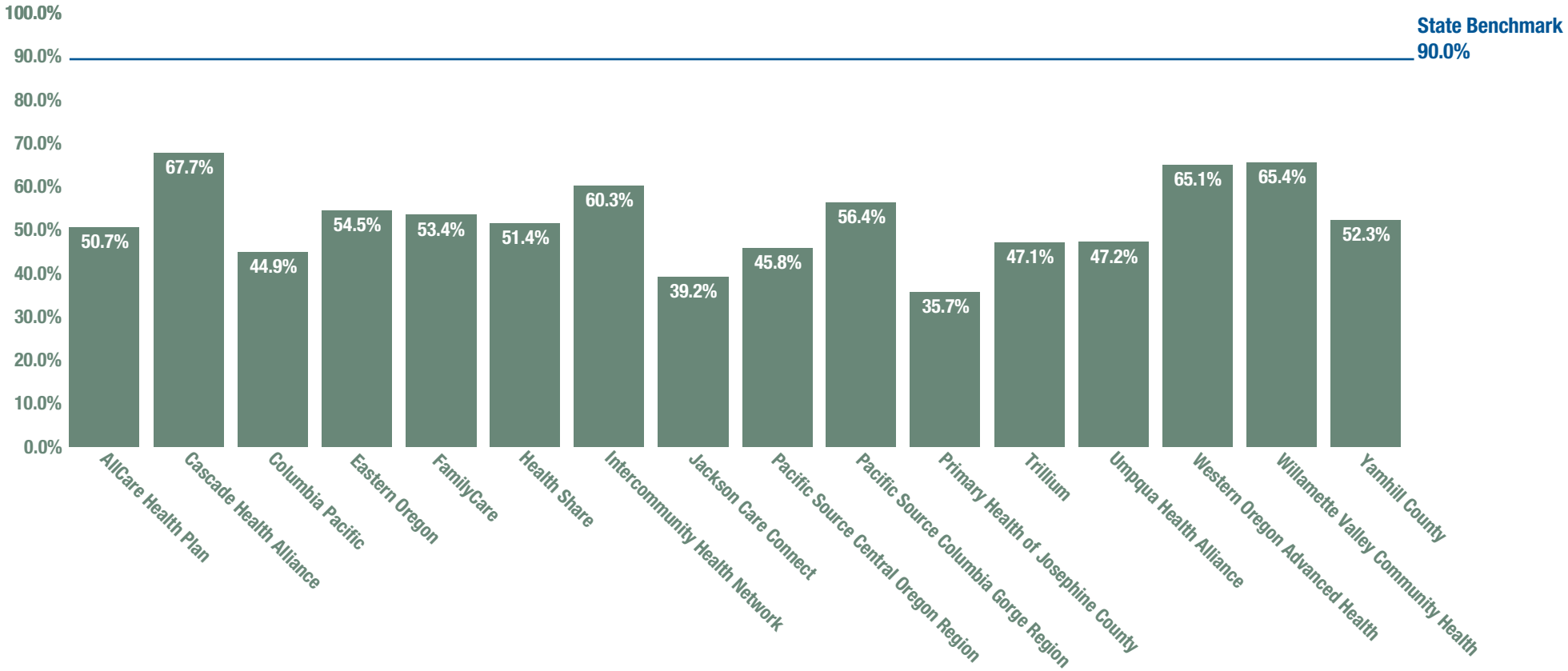
PERFORMANCE METRICS

CCO Incentive Measures

Percentage of children in DHS custody who receive a mental and physical health assessment within 60 days

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

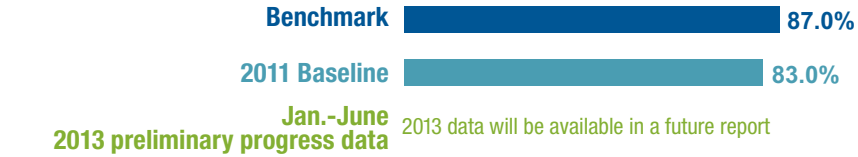
Access to care (CAHPS)

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

Focus areas: Improving access to effective and timely care.

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.

STATEWIDE



Data Source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark Source: 2012 National Medicaid 75th percentile

RACE AND ETHNICITY DATA

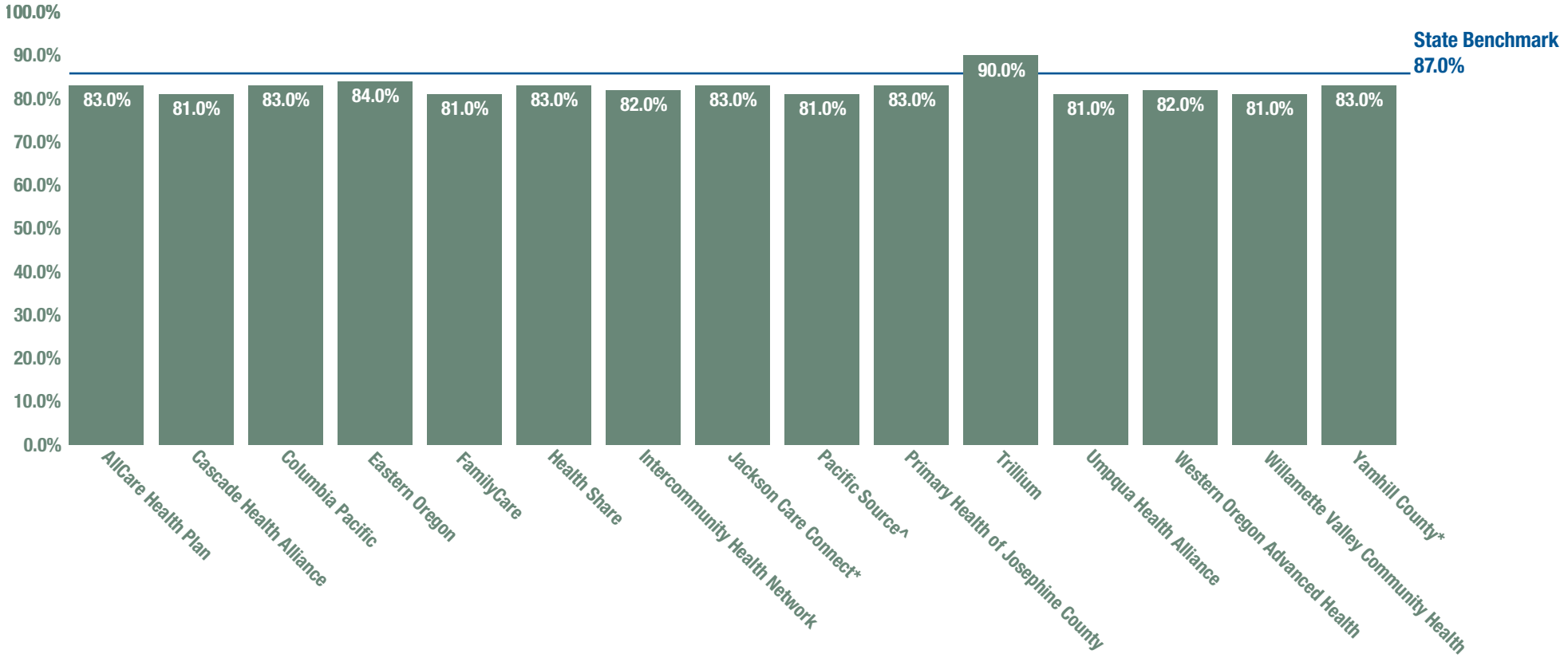
Race and ethnicity data for this measure will be available in a future report

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of patients who thought they received appointments and care when needed

2011 baseline data



*CCO baseline could not clearly be attributed to a past FCHP. Baseline provided is state average.
^Cannot report PacificSource separately for this measure.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Adolescent well-care visits

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

Focus area: Improving primary care for all populations.

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. In 2011, just over half of Oregon's eighth and 11th graders had a well-visit in the past year.

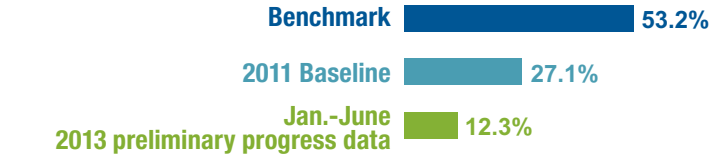
Jan.-June 2013 data

The percentage of adolescents receiving a well-child visit between January and June 2013 represents the visits that have occurred among all eligible adolescents. The percentage will continue to grow across the year as more eligible adolescents receive their well-child visits. It's also important to look at this metric after we have a full year of data.

The percentage through June 2013 shows the progress toward the goal on this metric and should not be compared to the 2011 baseline or benchmark until all visits are counted at the end of 2013, when we have a full year of data.

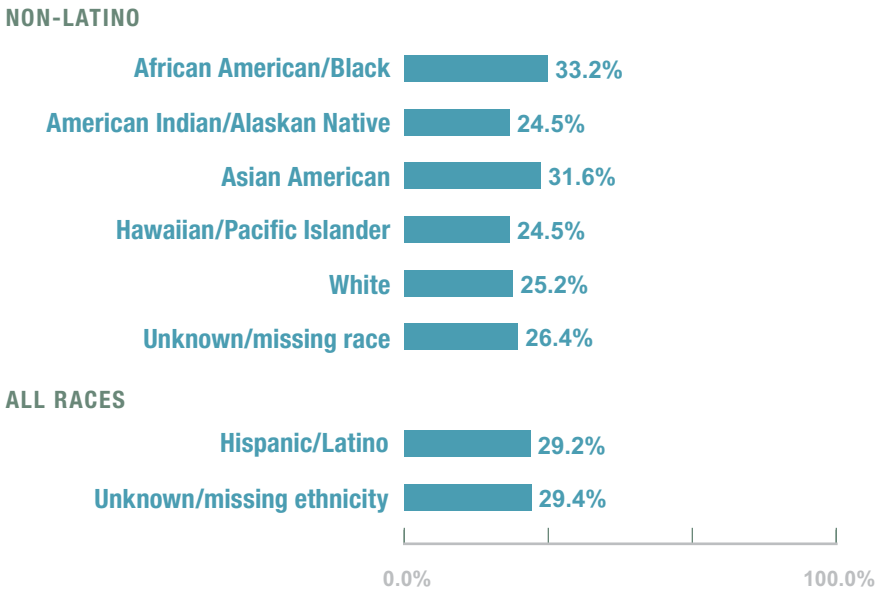
Additionally, this is one metric that varies by season. Generally, more adolescent well-child visits occurring in the summer and fall months. These visits are not counted in the current report that includes data from Jan. – June 2013.

STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA

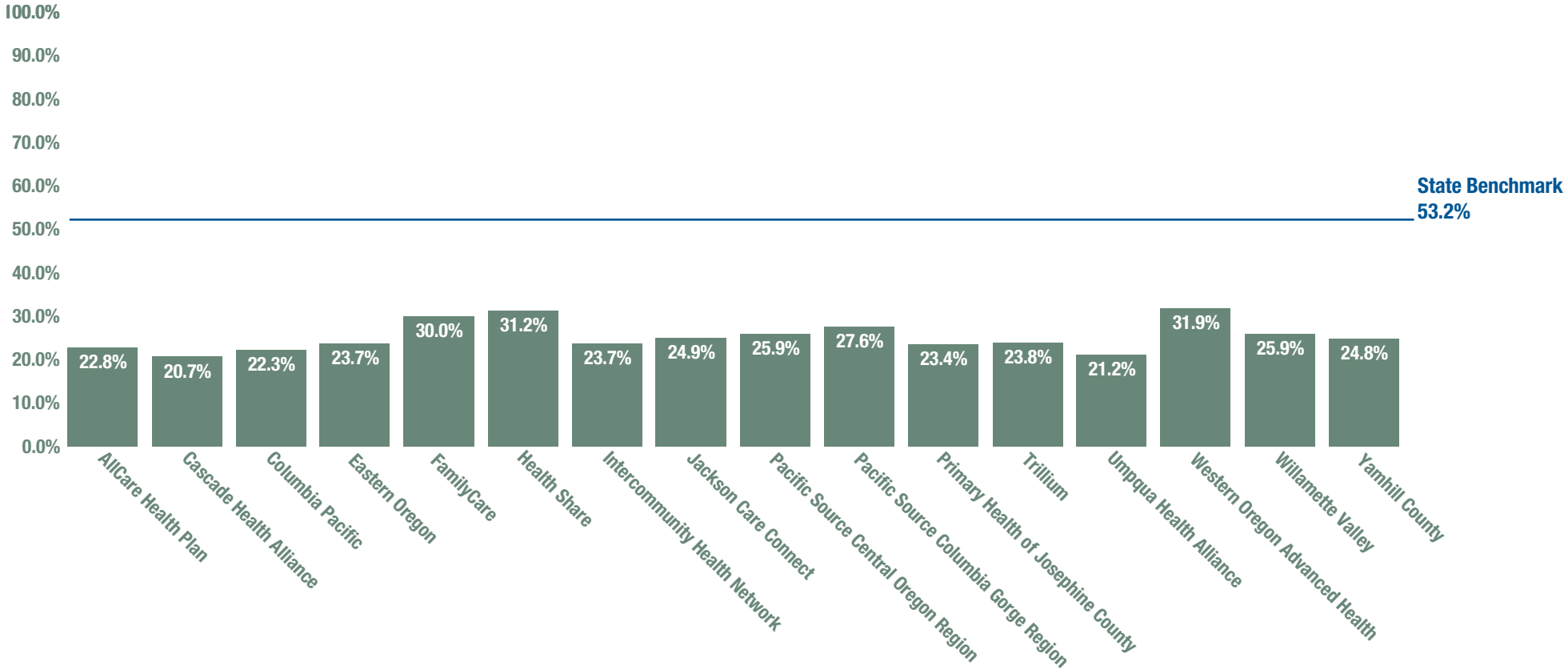


PERFORMANCE METRICS

CCO Incentive and State Performance Measures

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

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Alcohol or other substance misuse (SBIRT*)

Definition: Percentage of adult patients (ages 18 and older) who had appropriate screening and intervention for alcohol or other substance abuse.

Focus area: Improving behavioral and physical health coordination.

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

Jan.-June 2013 data

This metric tracks screening, brief intervention and referral to treatment for alcohol and drug use. The data in this report are what we expect to see at this time, as the guidance document for coding this service and the measure specifications were not final until after June 2013. SBIRT screening rates will likely increase through the second half of the year.

STATEWIDE

*Screening, Brief Intervention, and Referal to Treatment
Data source: Administrative (billing) claims
Benchmark source: Metrics and Scoring Committee consensus

2011 BASELINE RACE AND ETHNICITY DATA

All categories are below one percent.

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of adult patients who had appropriate screening and intervention for alcohol or substance abuse (SBIRT*)

2011 baseline data

CCOs are not charted separately in this quarterly report because they are below 1% for the January to June period.

*Screening, Brief Intervention, and Referal to Treatment

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Ambulatory care: emergency department utilization

Definition: 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.

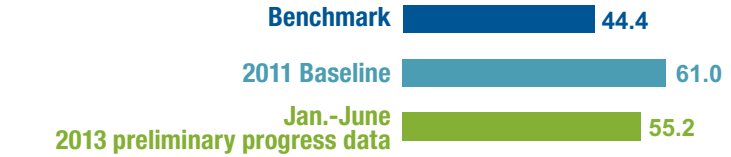
Focus areas: Reducing preventable re-hospitalizations, ensuring appropriate care is delivered in appropriate settings and reducing preventable and unnecessarily costly utilization by super-users.

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.

Jan.-June 2013 data

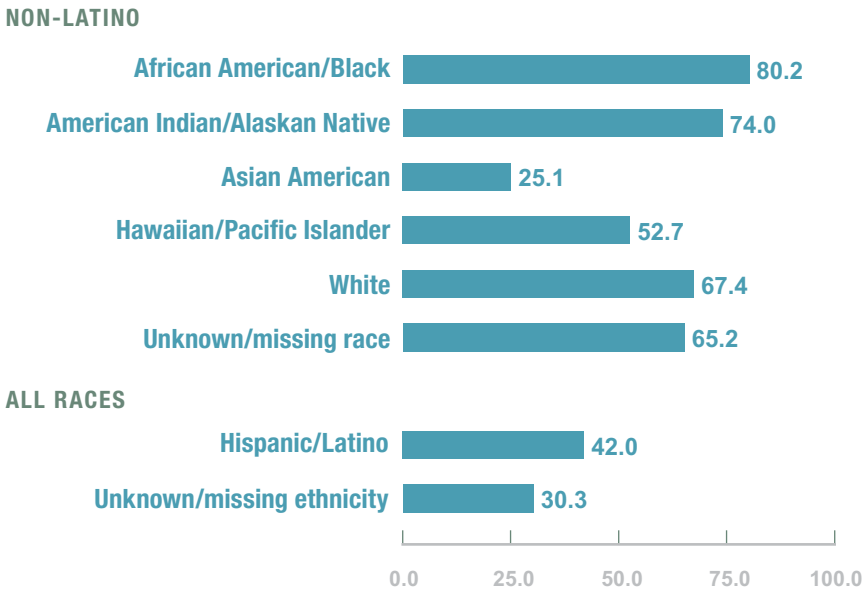
This metric represents emergency department visits between January and June 2013. It shows a preliminary trend toward fewer emergency department visits from January – June 2013. Financial data is consistent in showing reduced emergency department visits. This preliminary data shows a snapshot in time, from the claims information that we have today. Additional data will be coming in and numbers are expected to shift slightly.

STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA

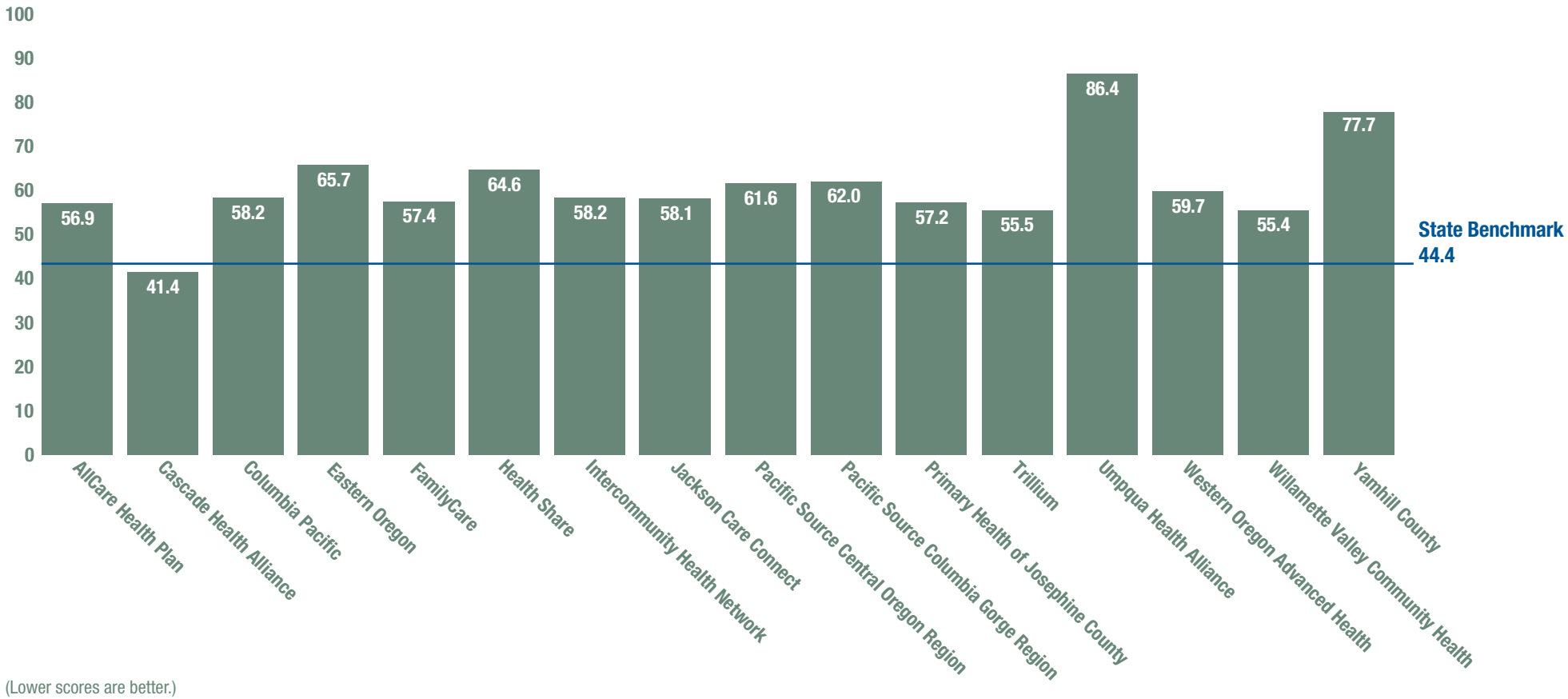


PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Rate of patient visits to an emergency department*

2011 baseline data



(Lower scores are better.)
*Rates are per 1,000 member months

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Ambulatory Care: Outpatient Utilization

Definition: 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.

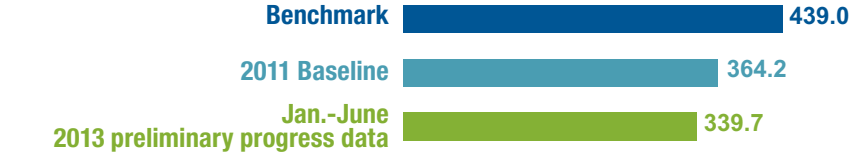
Focus areas: Reducing preventable re-hospitalizations; ensuring appropriate care is delivered in appropriate settings; and reducing preventable and unnecessarily costly utilization by super-users.

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.

Jan-June 2013 data

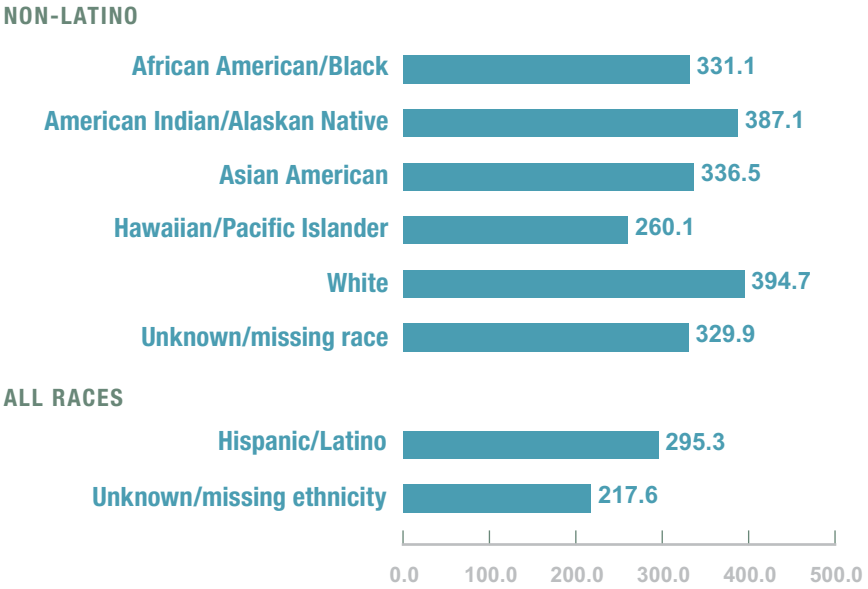
This metric represents outpatient visits that include office visits or routine visits to hospital outpatient departments between January and June 2013. This metric shows a preliminary trend toward fewer outpatient visits from January – June 2013 and may be affected by seasonality and a lag in data submission. Outpatient visits include all visits to primary care and specialists as well as home and nursing home visits.

STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA

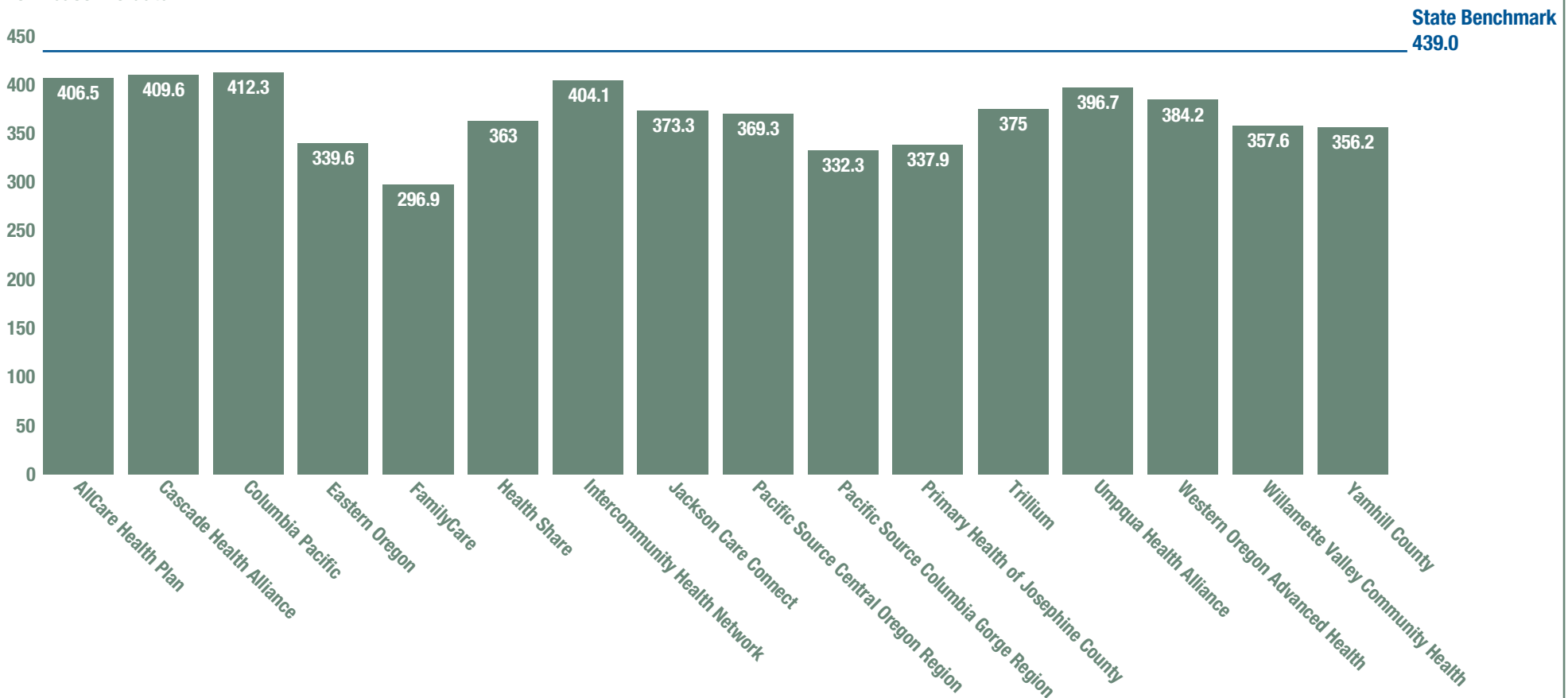


PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Rate of patient visits to a doctor's office or urgent care*

2011 baseline data



*Rates are per 1,000 member months

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Colorectal cancer screening

Definition: 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.

Focus areas: Improving primary care for all populationsl; ensuring appropriate care is delivered in appropriate settings; and improving access to effective and timely care.

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.

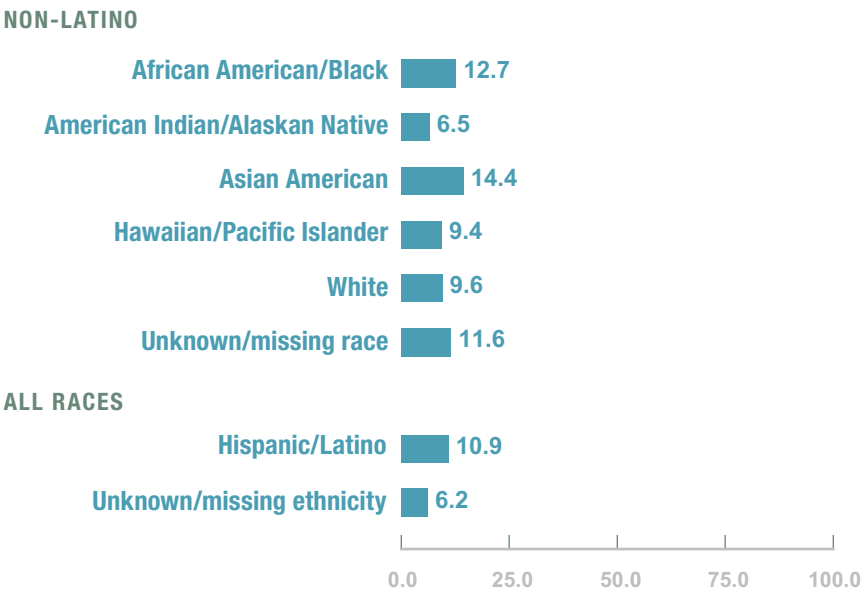
Jan.-June 2013 data

The colorectal cancer screening metric represents screenings that have occurred between January and June 2013 by eligible members (those between 50 and 75 years of age).

STATEWIDE

^Benchmark is 3% improvement target from baseline.
Data source: Administrative (billing) claims
Benchmark source: Metrics and Scoring Committee consensus

2011 BASELINE RACE AND ETHNICITY DATA

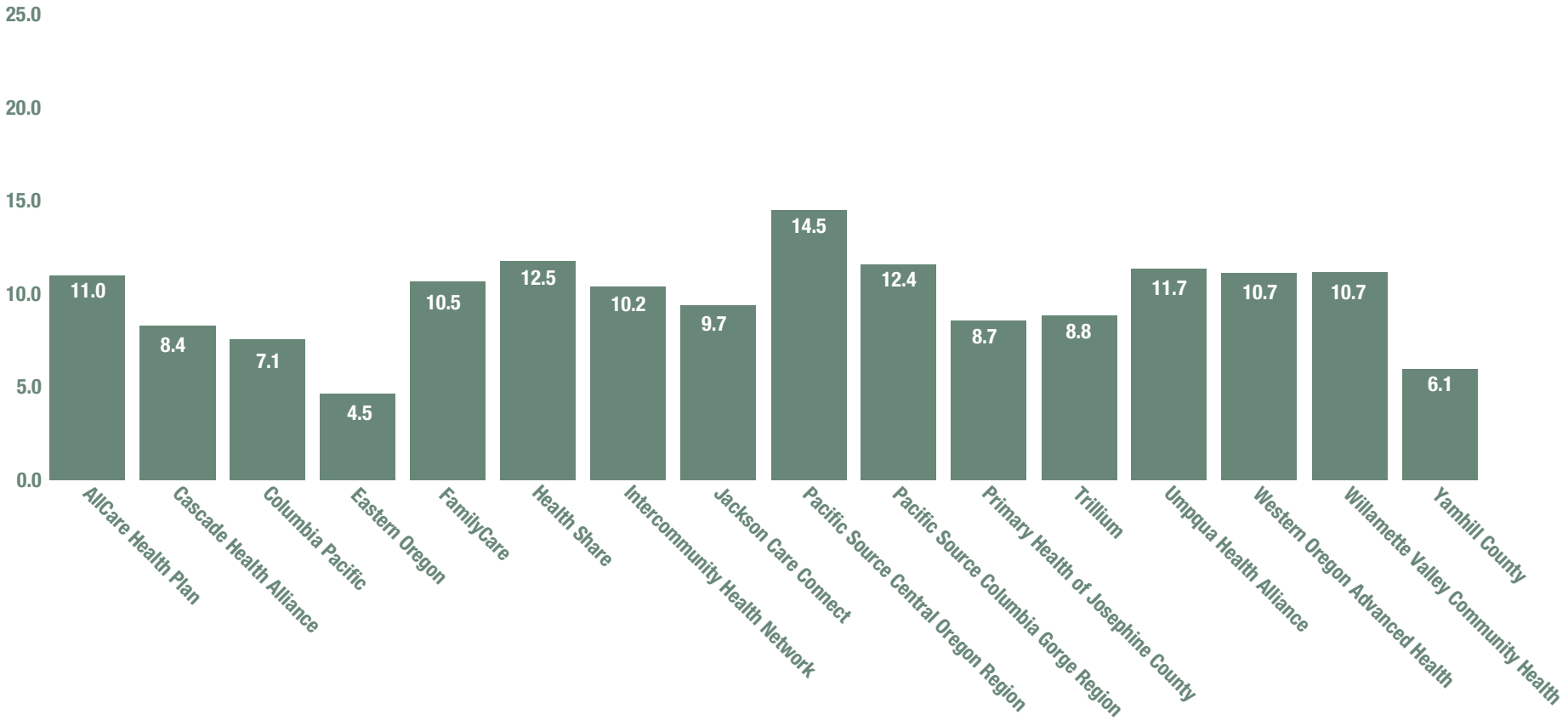


PERFORMANCE METRICS

CCO Incentive and State Performance Measures

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

2011 baseline data



*Rates are per 1,000 member months.
Benchmark is 3% improvement target from baseline

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Developmental screening

Definition: 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.

Focus areas: Improving primary care for all populations; ensuring appropriate care is delivered in appropriate settings; and improving access to effective and timely care.

Purpose: Early childhood screening help 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.

Jan.-June 2013 data

The percentage of children receiving a developmental screening between January and June 2013 represents the visits that have occurred among all the eligible children for the full measurement year. Therefore, the percentage will continue to grow across the year as more screenings occur.

The percentage through June 2013 shows the progress toward the goal on this metric and should not be compared to the 2011 baseline or benchmark until all screenings are counted at the end of 2013, when we have a full year of data.

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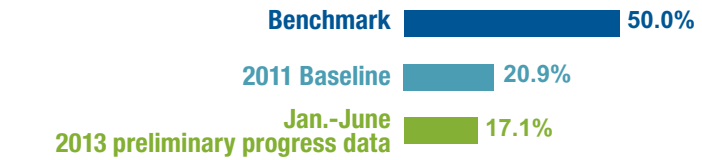
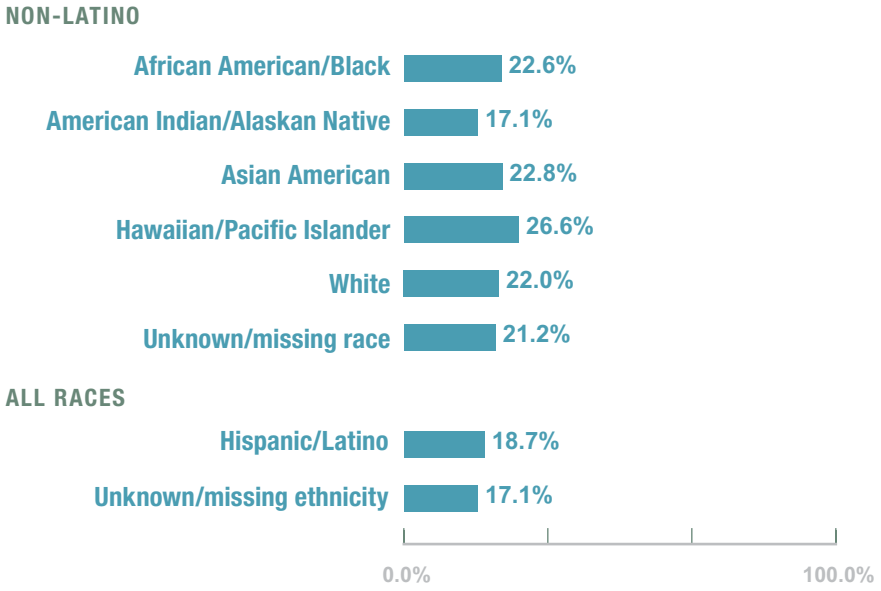


Data source: Administrative (billing) claims
Benchmark source: Metrics and Scoring Committee consensus

2011 BASELINE RACE AND ETHNICITY DATA

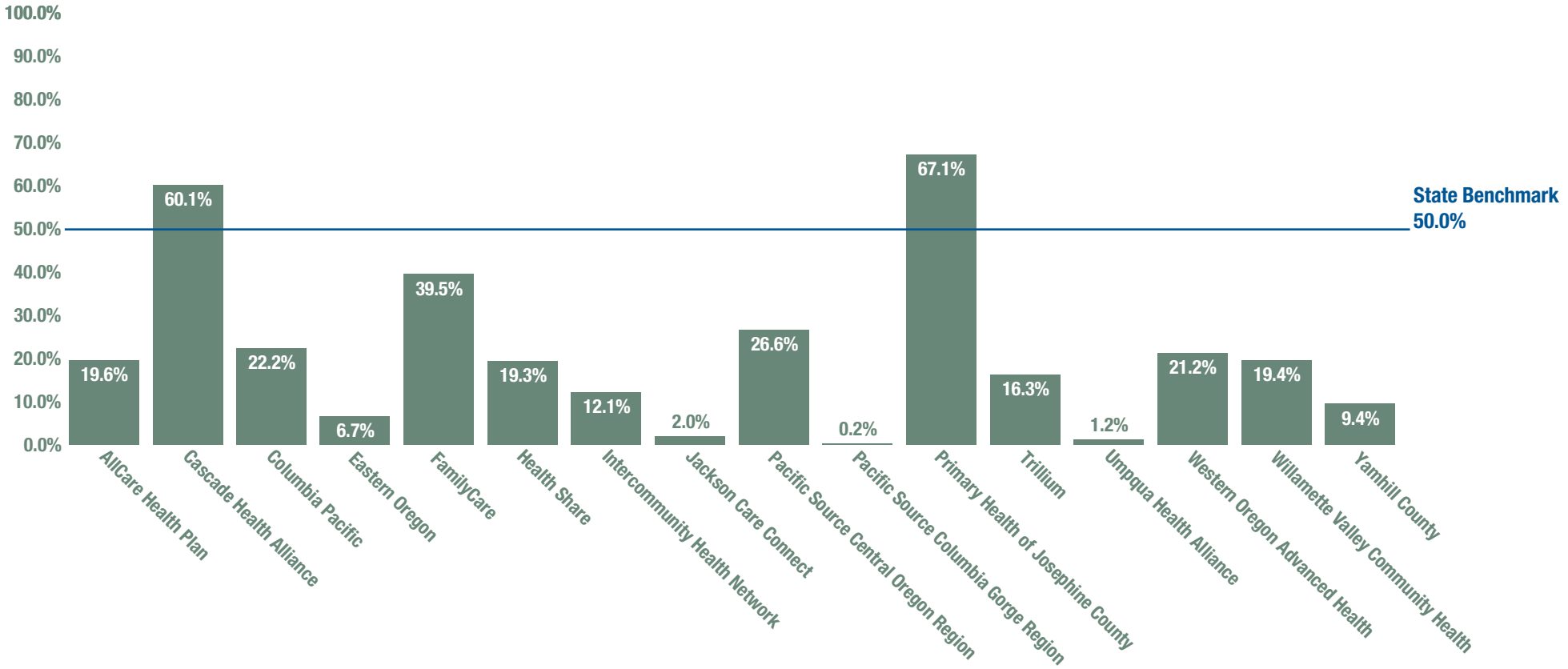


PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of children up to three years old screened for developmental delays

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Electronic Health Record adoption

Definition: Percentage of eligible providers within a CCO's network and service area who qualified for an incentive payment ("meaningful use") during the measurement year through Medicaid, Medicare, or Medicare Advantage EHR Incentive Programs.

Focus areas: Electronic Health Record adoption

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 EHRs have more accurate information on each patient, so they can make the most appropriate clinical decisions.

Jan. – June 2013 data

Electronic Health Record Adoption measures the percentage of eligible providers who received a "Meaningful Use" payment for electronic health record adoption**.** This metric demonstrates an increase in 2013, when compared to the 2011 baseline.

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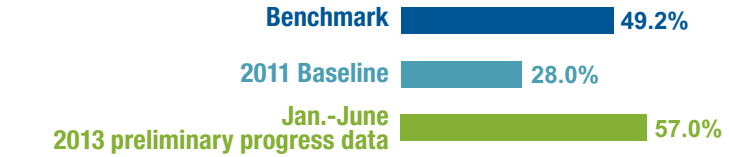


Data source: state and federal EHR Incentive Program
Benchmark source: federal assumed rate for non-hospital based EHR adoption and Meaningful Use by 2014.

RACE AND ETHNICITY DATA

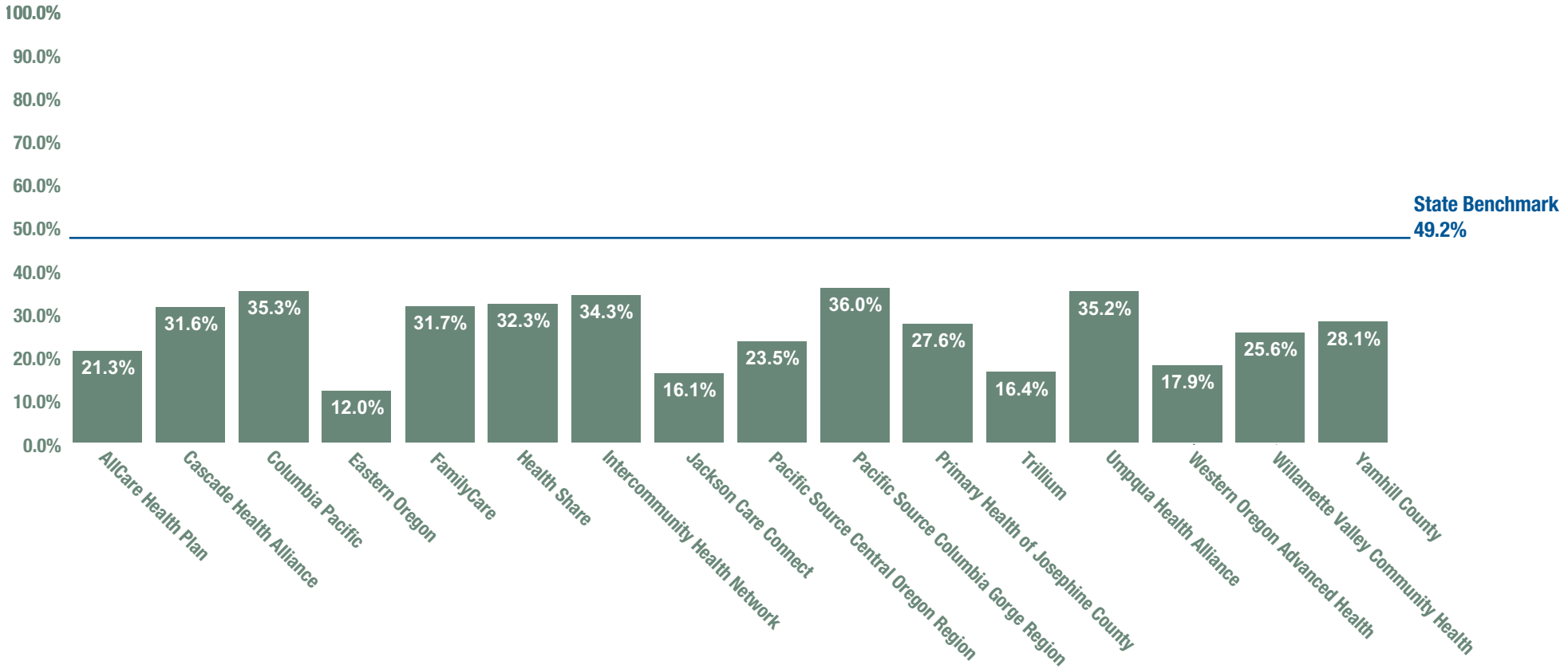
Electronic Health Record adoption will not be stratified by race and ethnicity.

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of providers who qualified for an EHR incentive payment during the measurement year

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Follow-up after hospitalization for mental illness

Definition: Percentage of patients (ages 6 and older) who received a follow-up with a health care provider within 7 days of being discharged from the hospital for mental illness.

Focus areas: Improving behavioral and physical health coordination and reducing preventable re-hospitalizations.

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 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.

Jan.-June 2013 data

This metric represents follow-up visits within seven days after members were discharged from a hospital with a mental health diagnosis between January and June 2013.

Due to a small number of cases for this metric, it is too early to interpret whether or not there are improvements on this measure.

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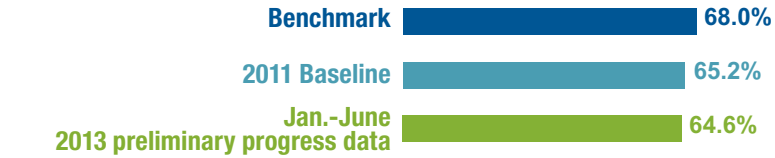
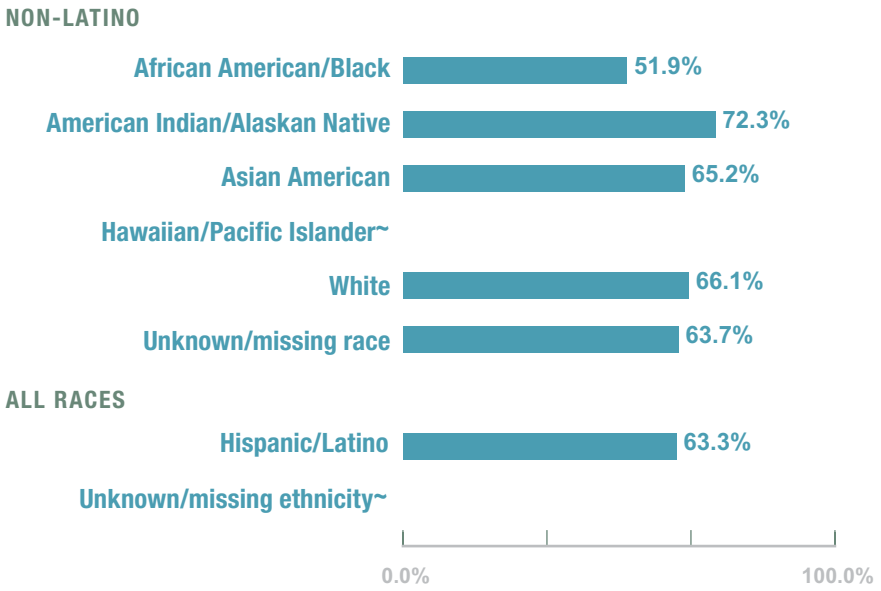


Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

2011 BASELINE RACE AND ETHNICITY DATA



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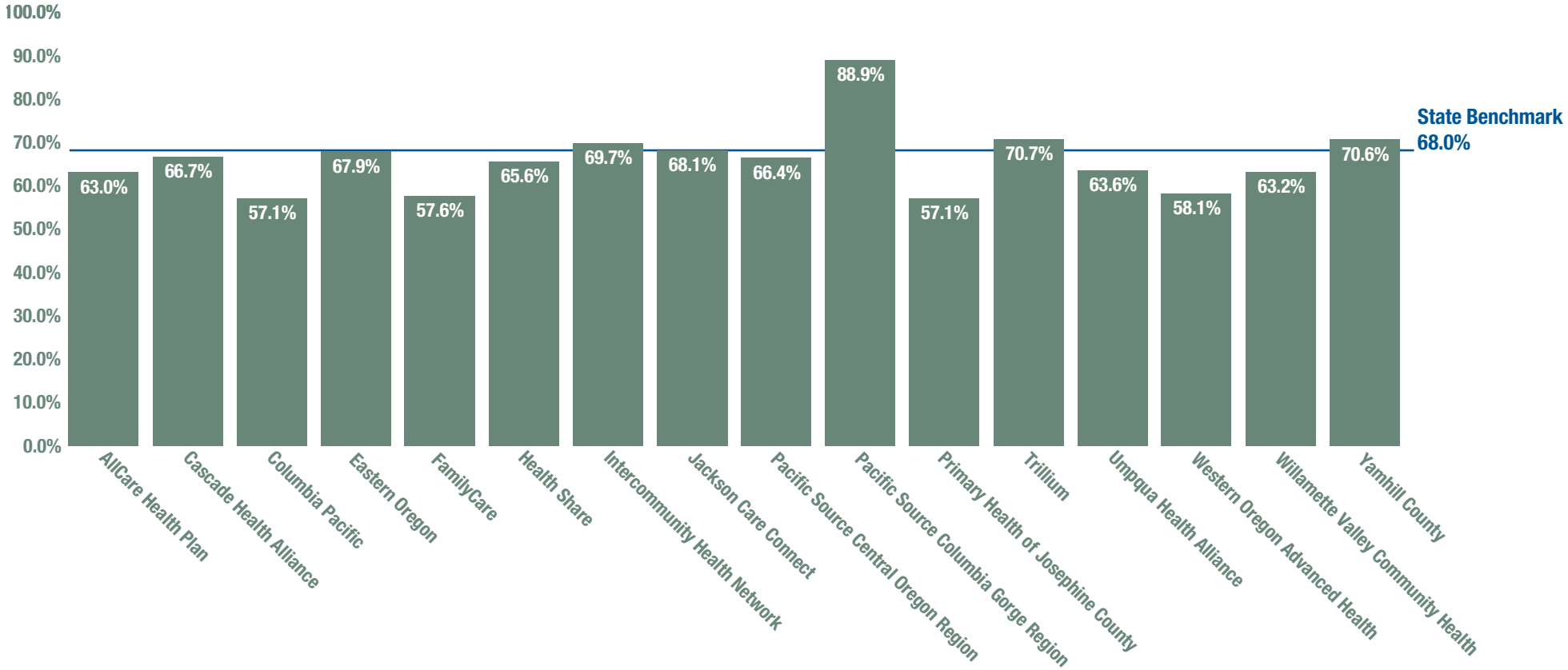
PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of patients who received follow-up care within 7 days of being discharged from the hospital for mental illness

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

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

Definition: 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.

Focus areas: Improving behavioral and physical health coordination and improving access to effective and timely care.

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.

Jan.-June 2013 data

This metric represents the percentage of children prescribed ADHD medication and had a follow-up visit within 30 days after receiving a new prescription. To date, data are similar to baseline numbers.

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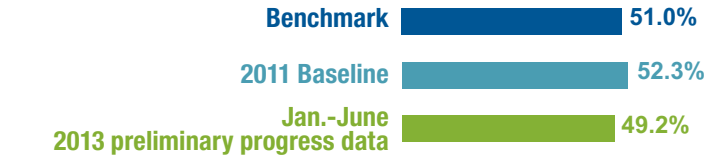
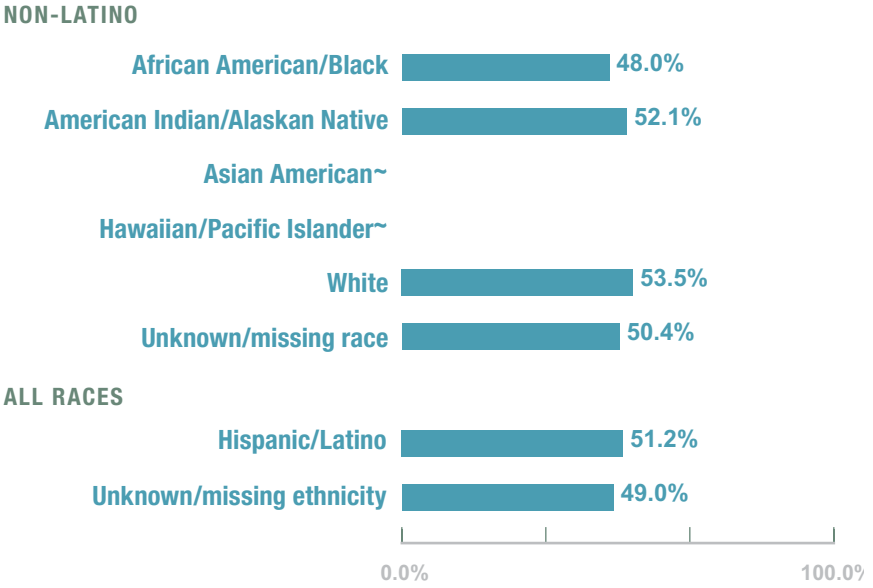


Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

2011 BASELINE RACE AND ETHNICITY DATA



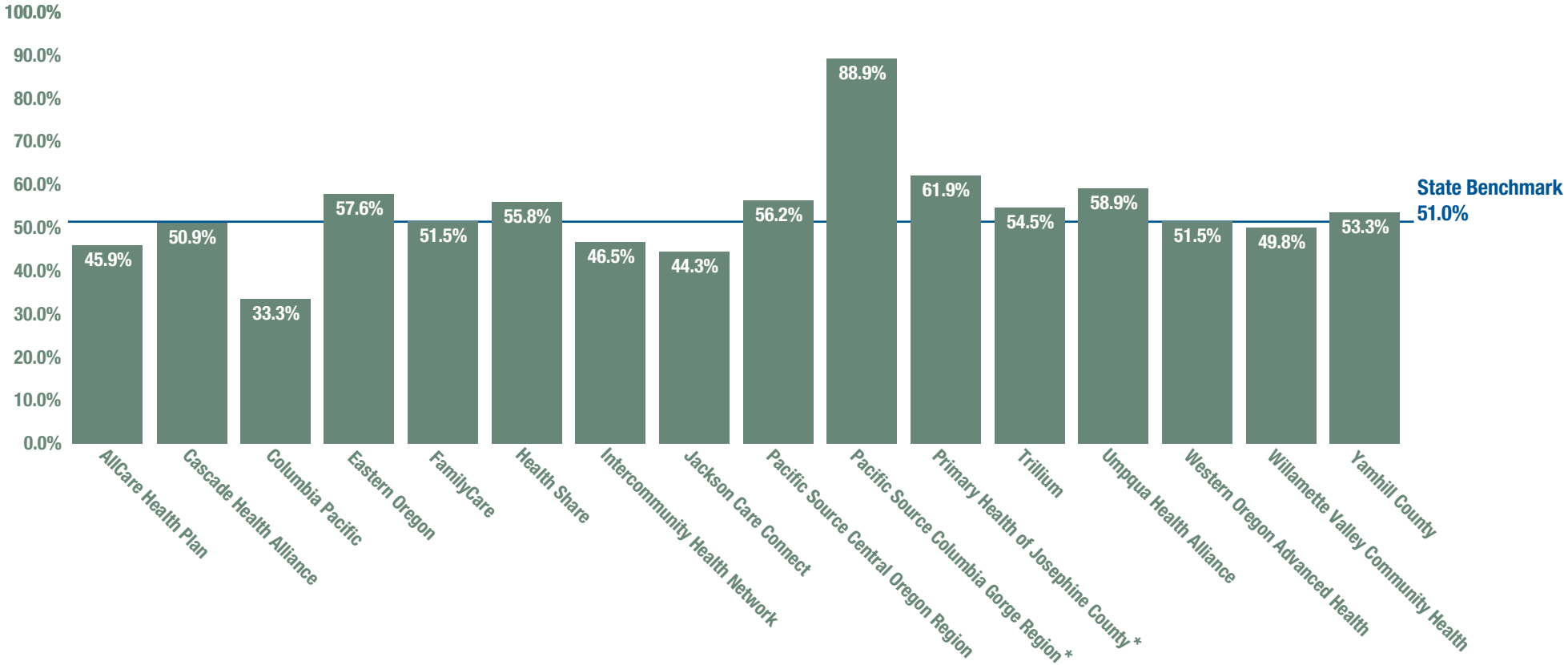
~ Data suppressed due to low numbers (n<30)

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

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

2011 baseline data



*This CCO's rates are based on small denominators (n<30)

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
State Performance Measures

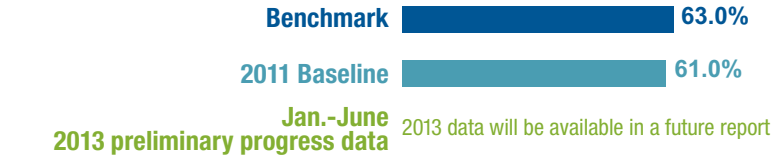
Follow-up care for children prescribed ADHD medication (continuation and maintenance phase)

Definition: 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.

Focus areas: Improving behavioral and physical health coordination and improving access to effective and timely care.

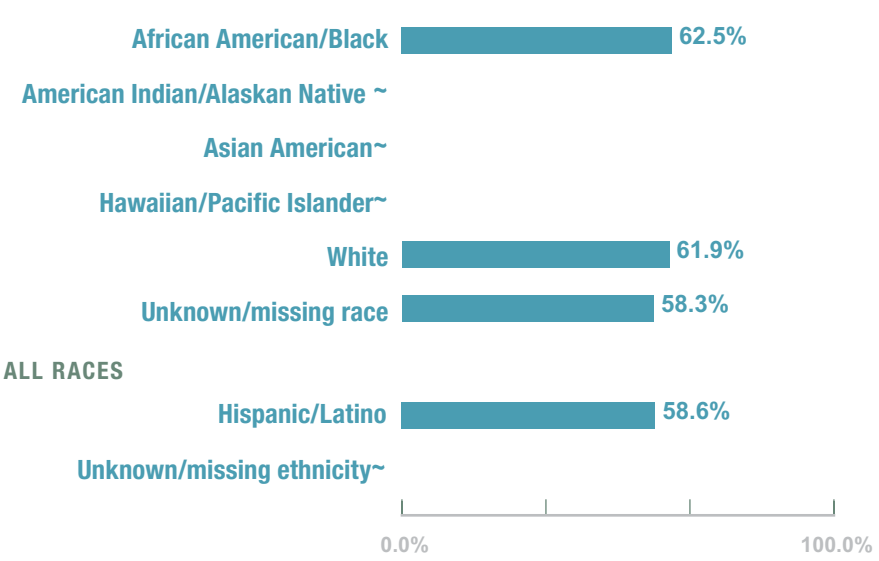
Purpose: Children with attention deficit hyperactivity disorder can be greatly helped by ADHD medication. One critical component of care is that children have follow-up visits once they are on the medication. After a child receives ADHD medication, a primary care provider should continue to assess learning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

STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA



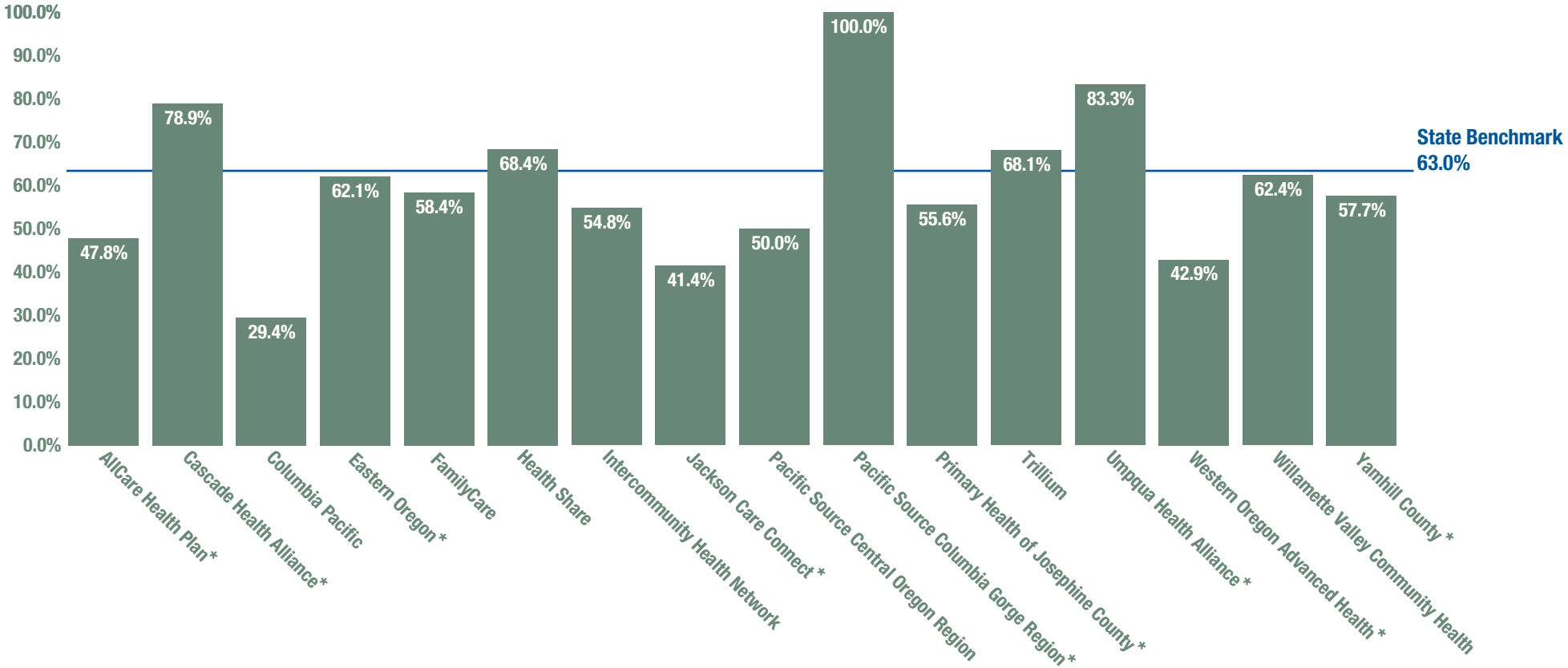
~ Data suppressed due to low numbers (n<30)

PERFORMANCE METRICS

State Performance Measures

Percentage of children (ages 6-12) who remained on ADHD medication for 210 days after receiving a new prescription and who had at least two follow-ups

2011 baseline data



*This CCO's rates are based on small denominators (n<30)

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

Patient-centered primary care home enrollment

Definition: Percentage of patients who were enrolled in a recognized patient-centered primary care home.

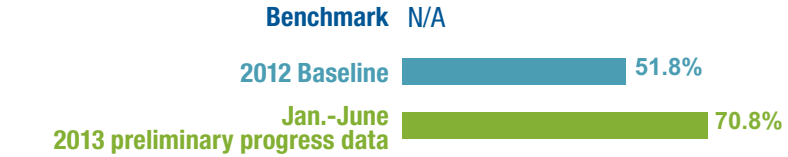
Focus areas: Improving primary care for all populations; ensuring appropriate care is delivered in appropriate settings; and improving access to effective and timely care.

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. The Oregon Health Policy Board estimates that up to $44 million in 3 years, and up to $190 million in 10 years, can be saved when Oregon Health Plan members with one or more chronic conditions receive care through a PCPCH.

Jan.-June 2013 data

This metric tracks the percentage of CCO members who are enrolled in a recognized patient-centered primary care home. The January through June 2013 data shows a trend toward higher enrollment rates compared to 2011 baseline.

STATEWIDE



Data source: CCO quarterly report

RACE AND ETHNICITY DATA

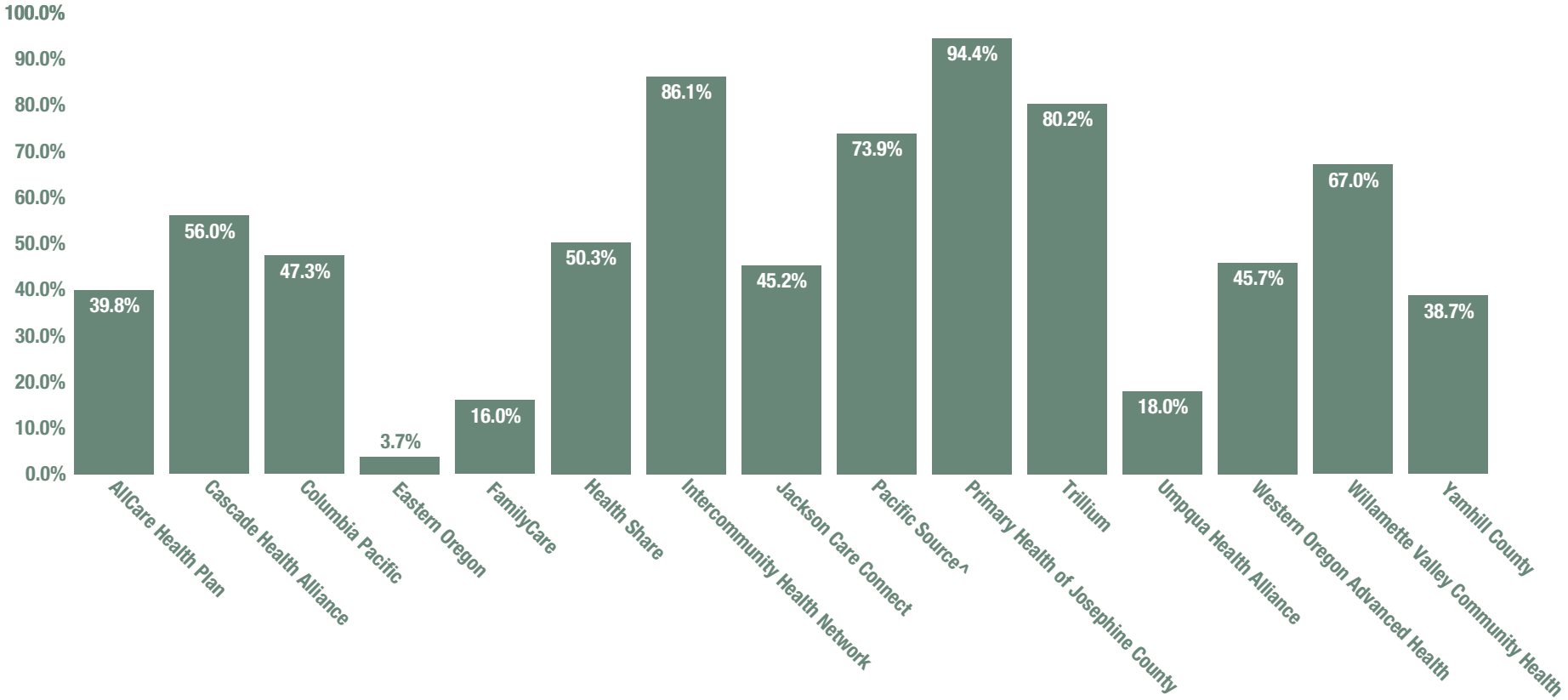
Patient-centered primary care home enrollment will not be stratified by race and ethnicity.

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

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

2012 baseline data



^Cannot report PacificSource separately for this measure.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

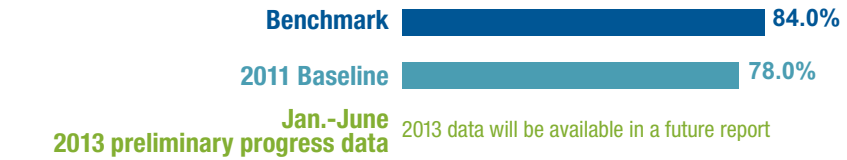
Satisfaction with care (CAHPS)

Definition: 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.

Focus area: Addressing patient satisfaction with health care.

Purpose: A patient's satisfaction and overall experience with their care is a critical component of quality health care. Data shows 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.

STATEWIDE



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

RACE AND ETHNICITY DATA

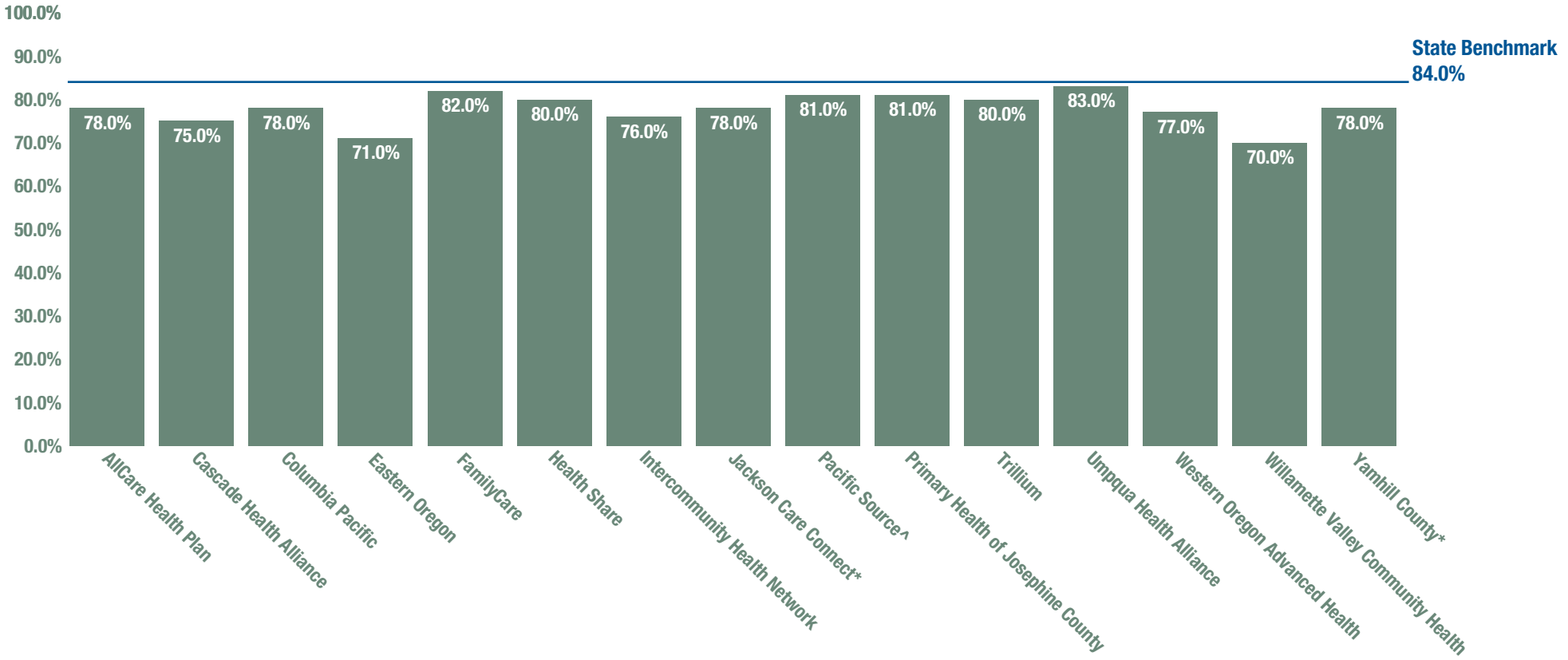
Race and ethnicity data for this measure will be available in a future report.

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

Percentage of patients who received needed information and thought they were treated with courtesy and respect

2011 baseline data



*CCO baseline could not clearly be attributed to a past FCHP. Baseline provided is state average.
^Cannot report PacificSource separately for this measure.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
CCO Incentive and State Performance Measures

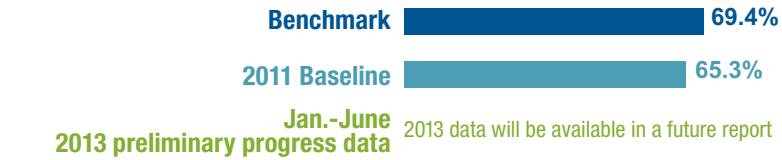
Timeliness of prenatal care

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

Focus areas: Improving overall perinatal and maternity care and improving access to effective and timely care.

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. The timeliness of that care is a critical and sometimes overlooked component. 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% of all babies born in Oregon are covered by Medicaid.

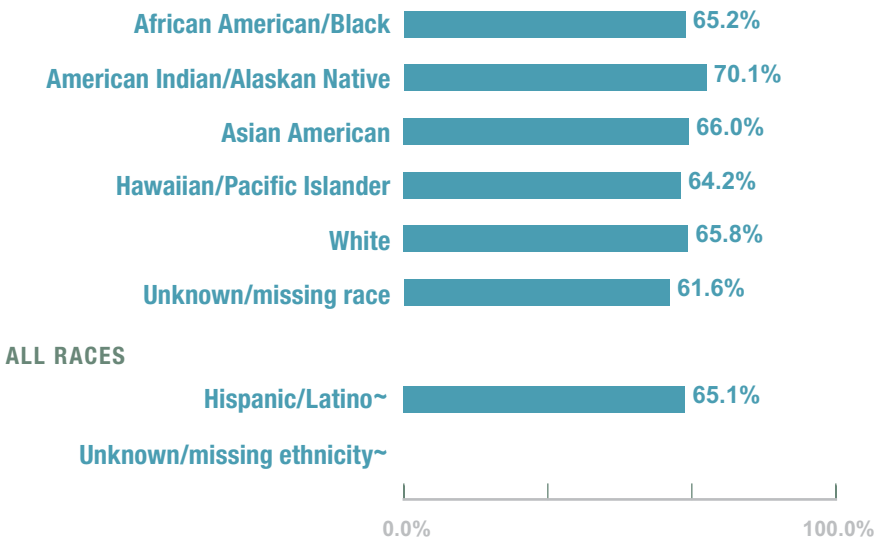
STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA

NON-LATINO



ALL RACES

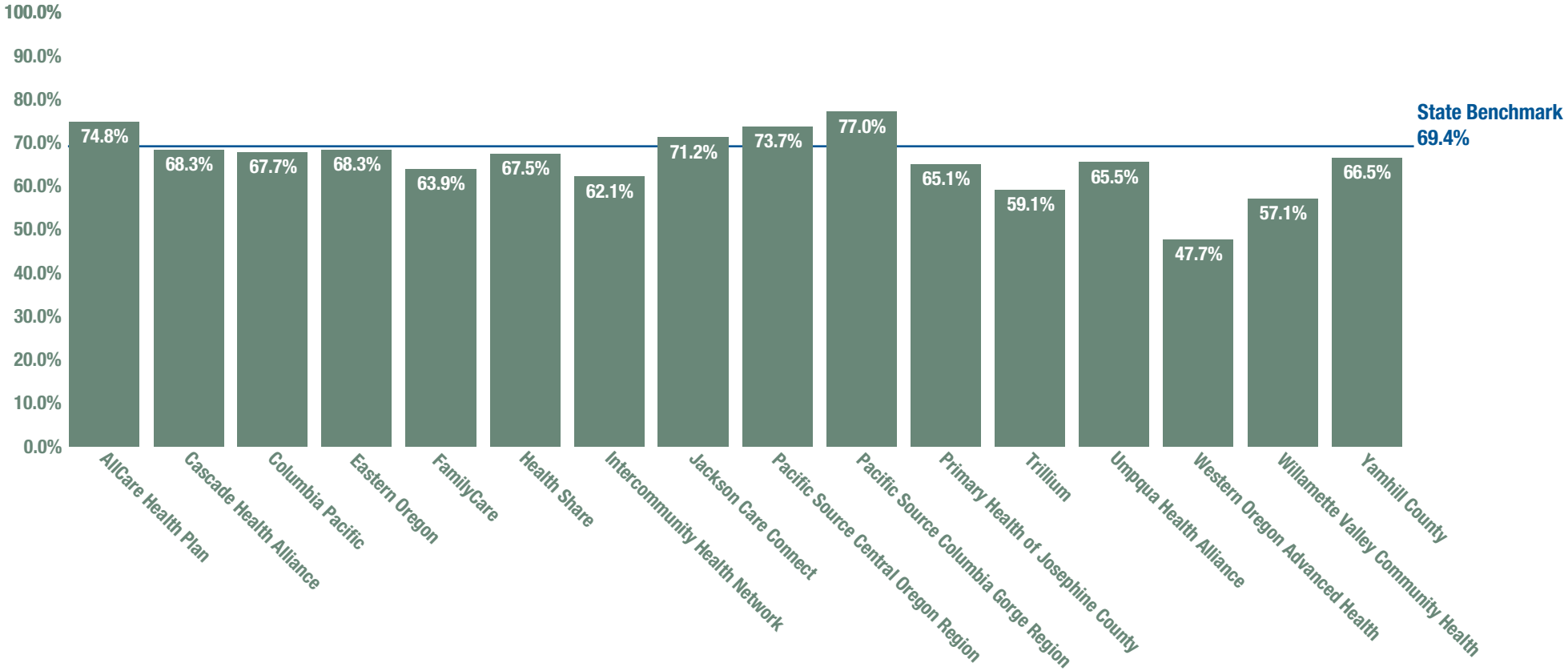
~Data suppressed due to low numbers (n<30)

PERFORMANCE METRICS

CCO Incentive and State Performance Measures

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

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS

State Performance Measures

All-cause readmission

Definition: 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.

Focus area: Reducing preventable re-hospitalizations.

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.

Jan. –June 2013 data

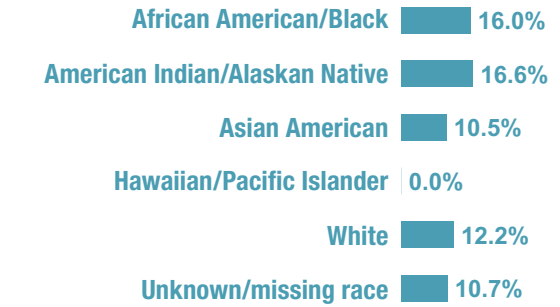
This metric tracks the percentage of adult patients who had a hospital stay and were readmitted for any reason within 30 days of discharge. The January through June 2013 data shows a preliminary trend toward lower readmission rates.

STATEWIDE

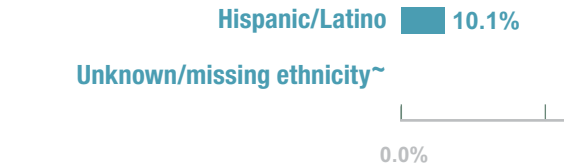
Data source: Administrative (billing) claims
Benchmark source: Average of 2012 Commercial and Medicare 75th percentiles

2011 BASELINE RACE AND ETHNICITY DATA

NON-LATINO



ALL RACES



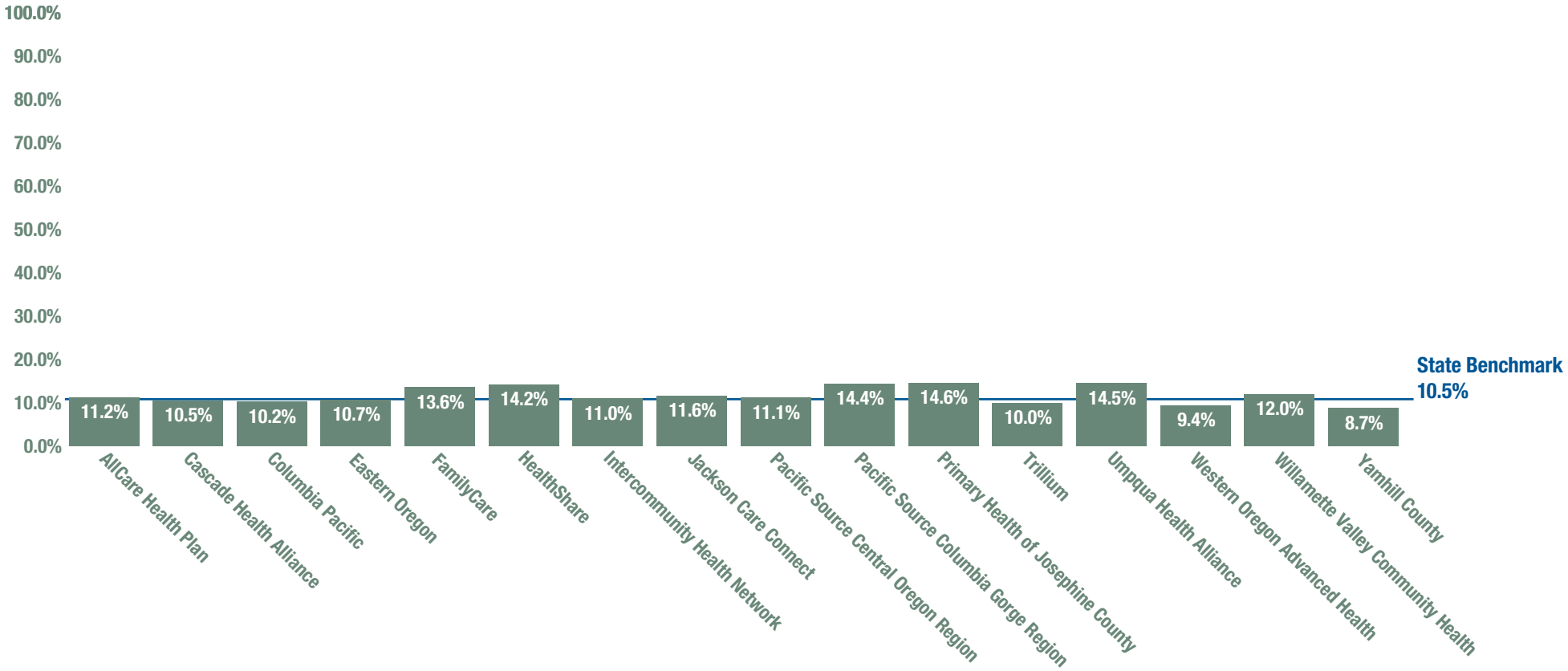
~Data suppressed due to low numbers (n<30)

PERFORMANCE METRICS

State Performance Measures

Percentage of adult patients who had a hospital stay and were readmitted for any reason within 30 days of discharge

2011 baseline data



(Lower score is better)

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

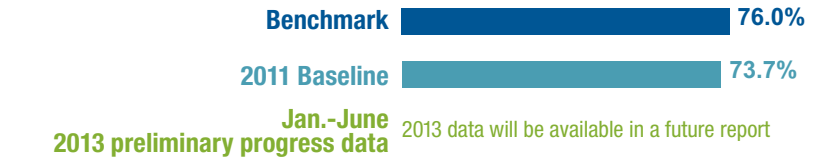
Appropriate testing for children with pharyngitis

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

Focus areas: Improving primary care for all populations and ensuring appropriate care is delivered in appropriate settings.

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.

STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA

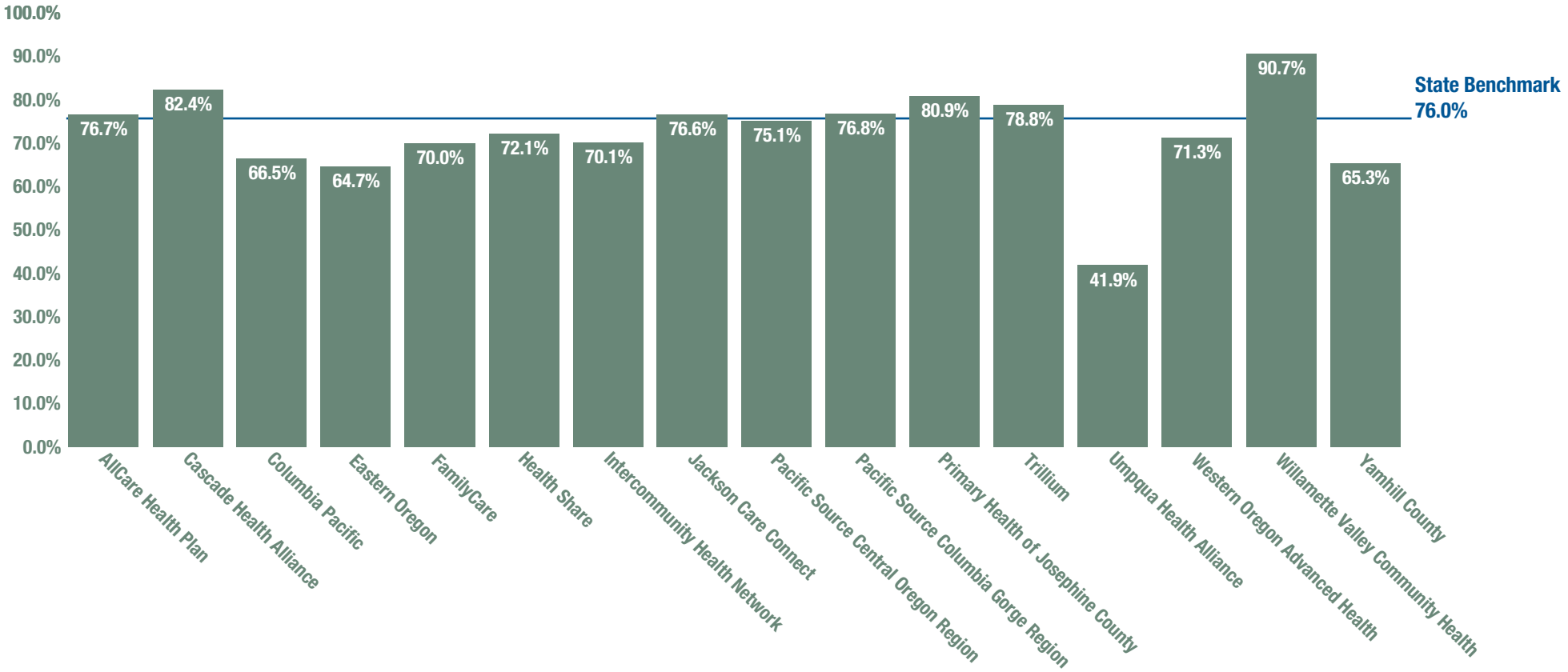
Race and ethnicity data for this measure will be available in a future report

PERFORMANCE METRICS

State Performance Measures

Percentage of children with a sore throat who were given a strep test before getting an antibiotic

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
State Performance Measures

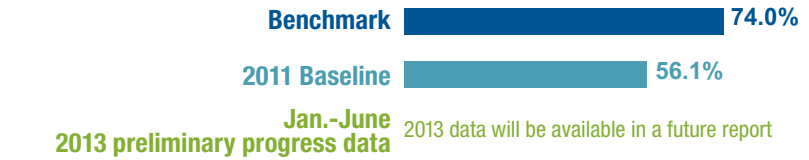
Cervical cancer screening

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

Focus area: Improving access to effective and timely care.

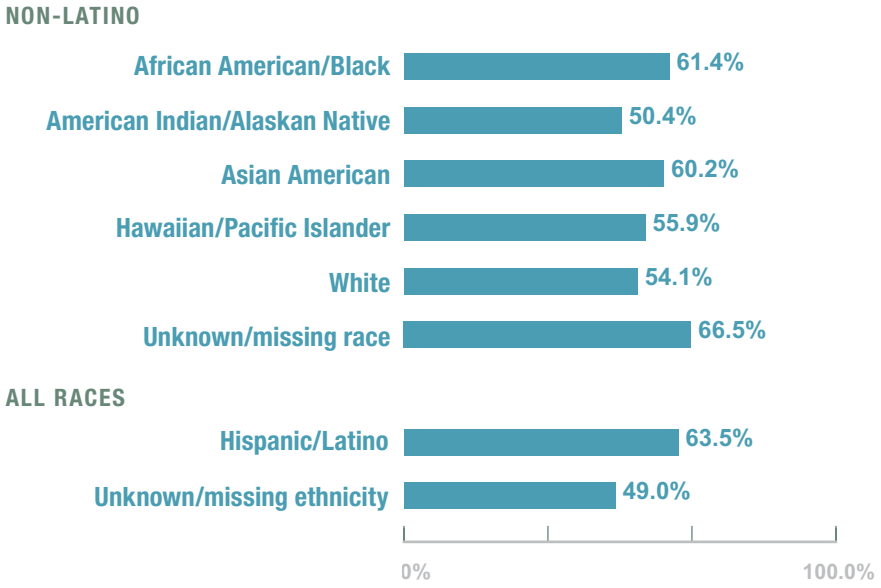
Purpose: A Pap test helps find early signs of cancer in the cervix when the disease is easier and less costly to treat. Treating cervical cancer in its earliest stages also increases the five-year survival rate to 92 percent, according to the American Cancer Society.

STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA

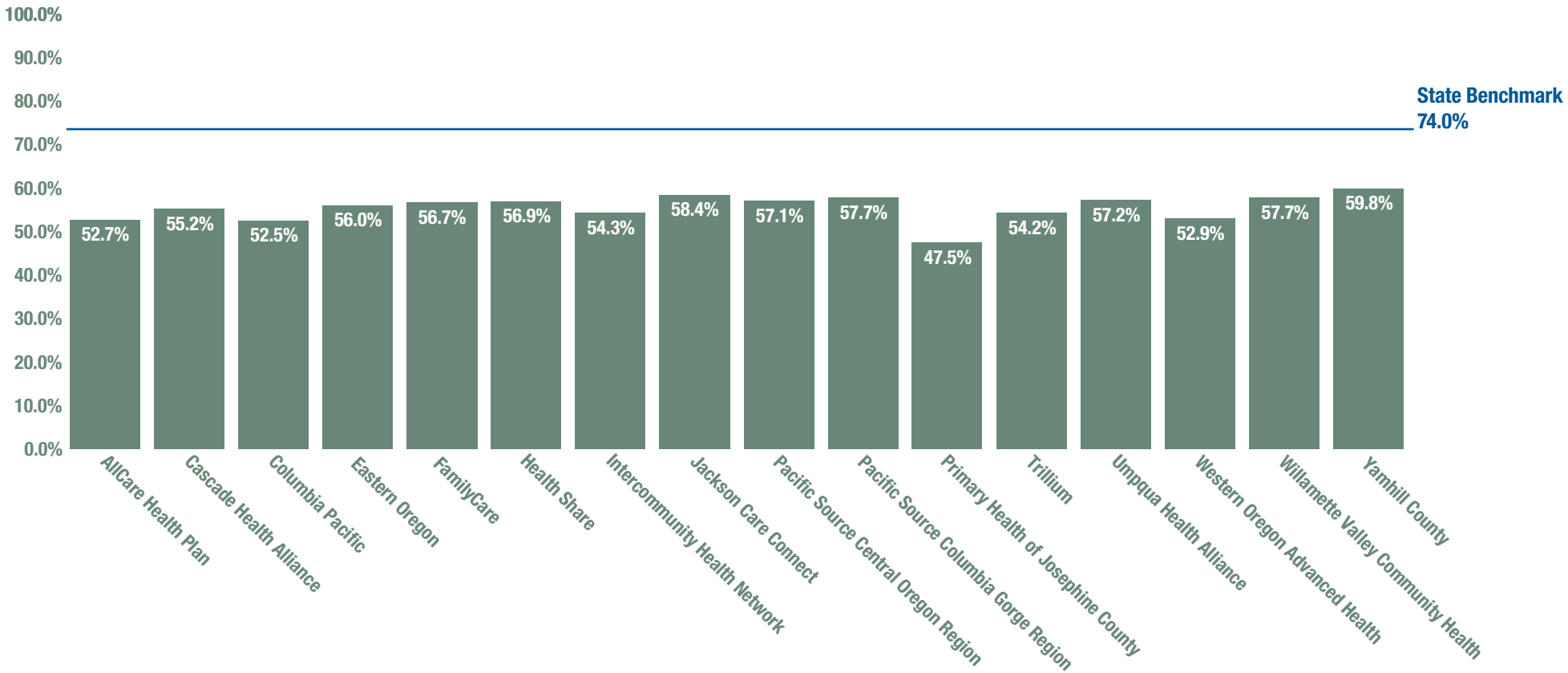


PERFORMANCE METRICS

State Performance Measures

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

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Child and adolescent access to primary care providers, all ages

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

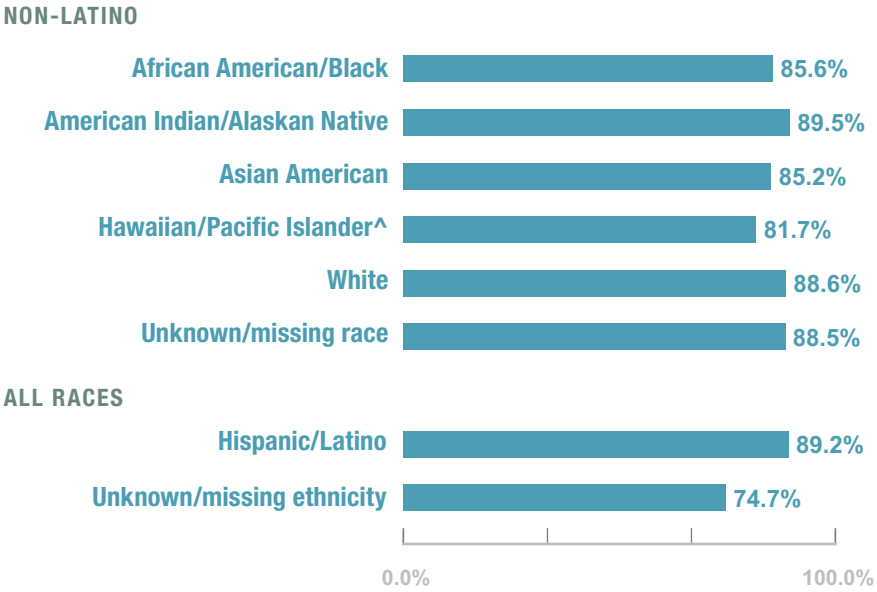
Focus areas: Improving access to effective and timely care and improving primary care for all populations.

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.

STATEWIDE

Data source: Administrative (billing) claims

2011 BASELINE RACE AND ETHNICITY DATA

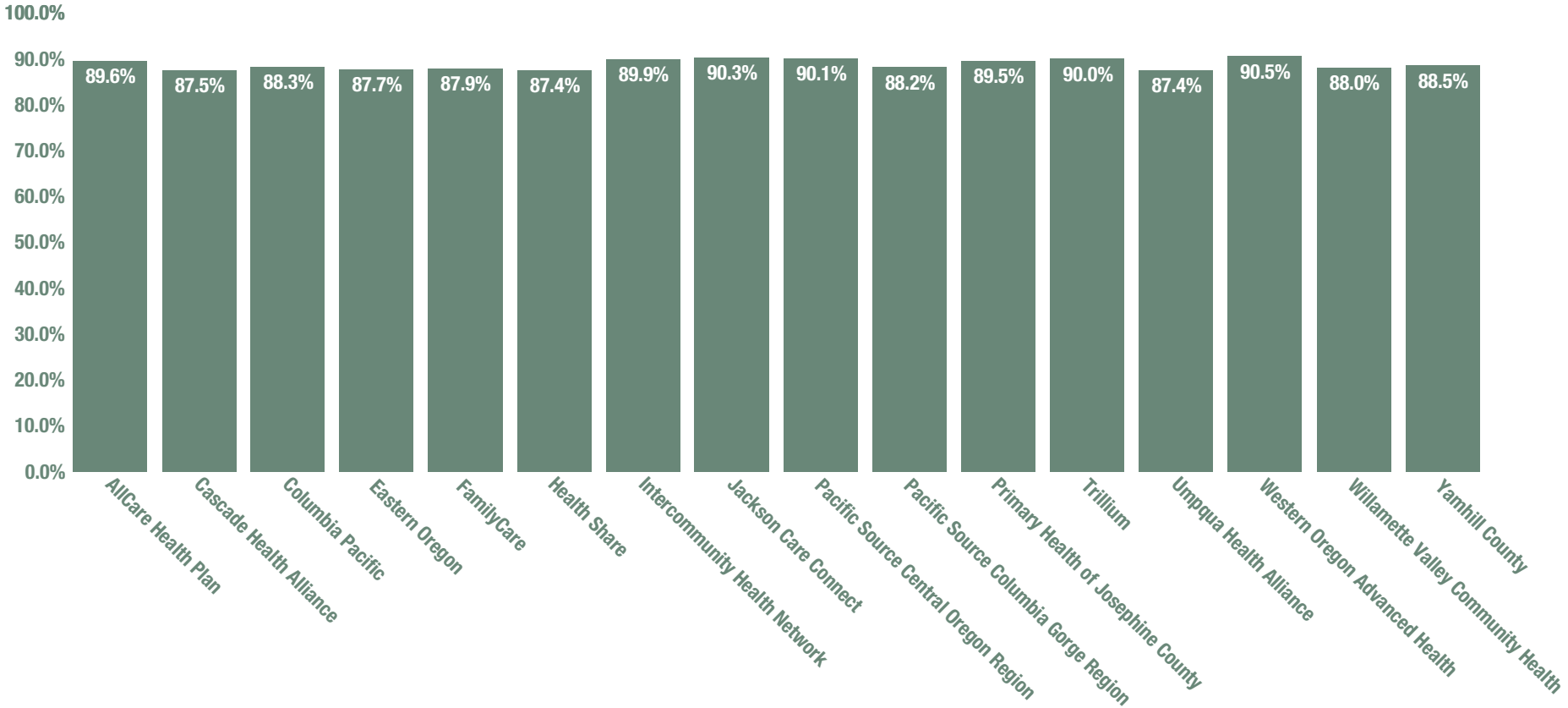


PERFORMANCE METRICS

State Performance Measures

Percentage of children who had a visit with a primary care provider

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

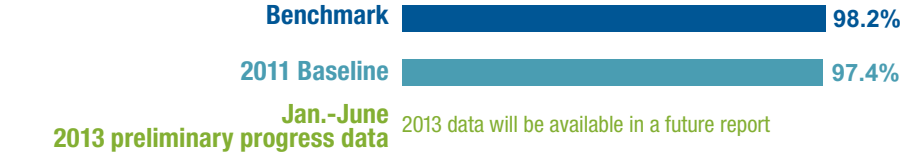
Child and adolescent access to primary care providers, 12-24 months

Definition: Percentage of toddlers (ages 12–24 months) who had a visit with a primary care provider.

Focus areas: Improving access to effective and timely care and improving primary care for all populations.

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.

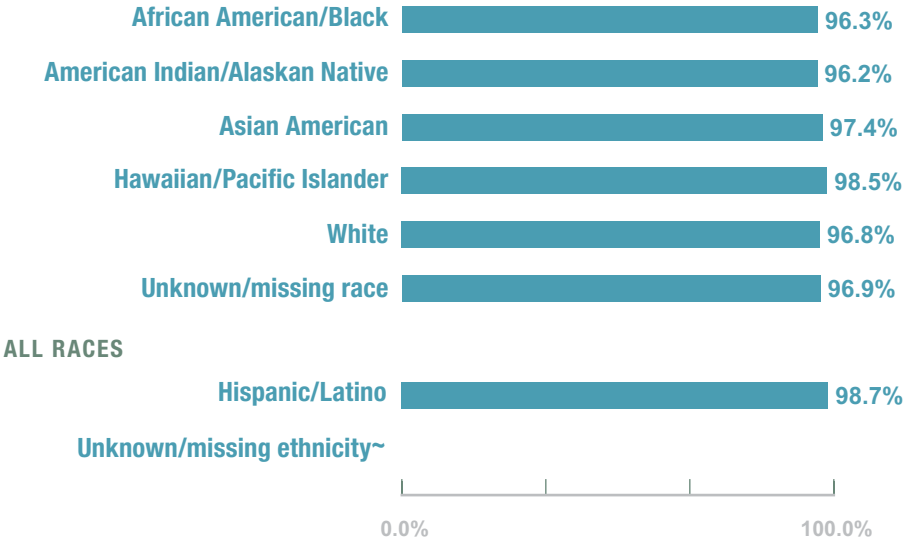
STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA

NON-LATINO



ALL RACES

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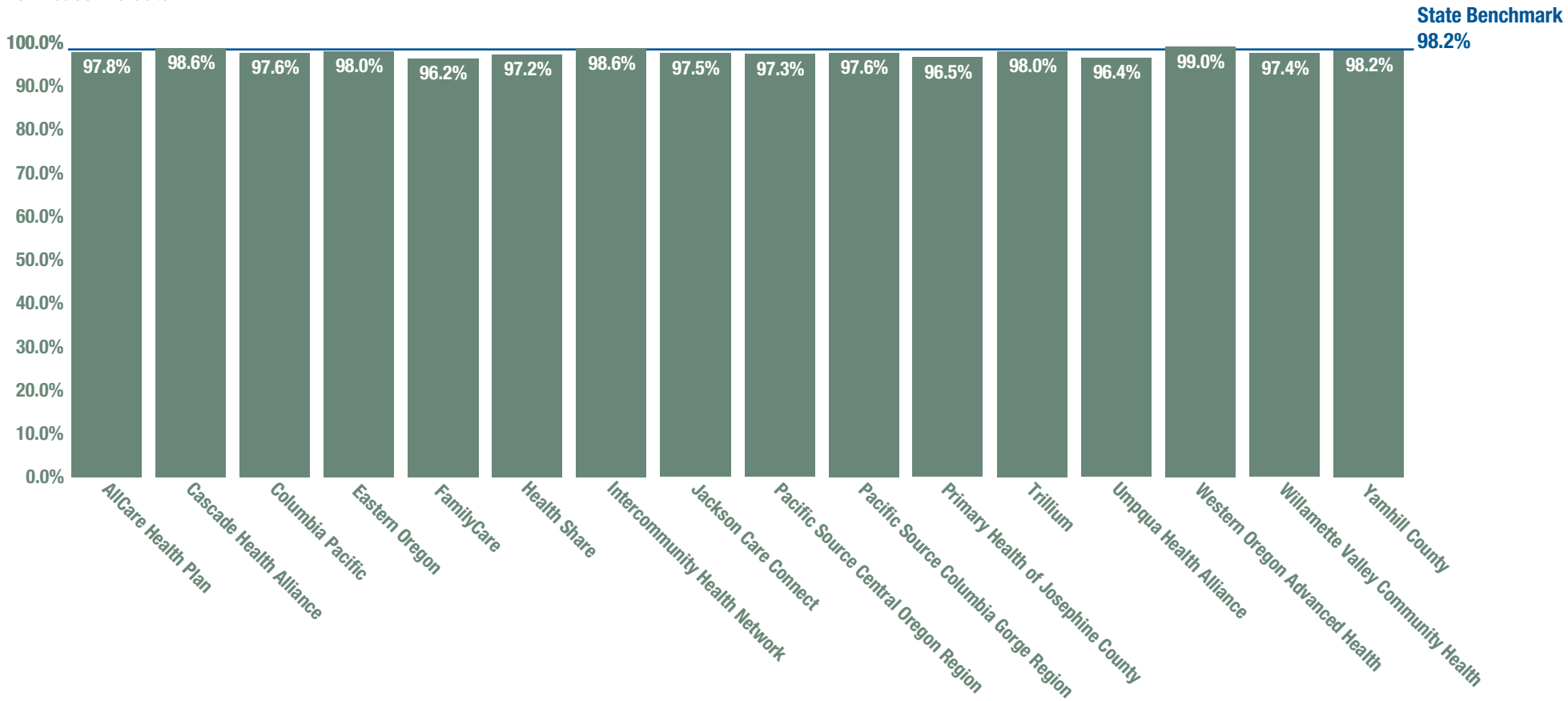
PERFORMANCE METRICS

State Performance Measures

Percentage of toddlers (ages 12–24 months) who had a visit with a primary care provider

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

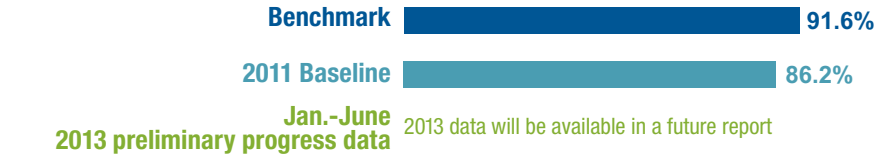
Child and adolescent access to primary care providers, 25 months – 6 years

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

Focus areas: Improving access to effective and timely care and improving primary care for all populations.

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.

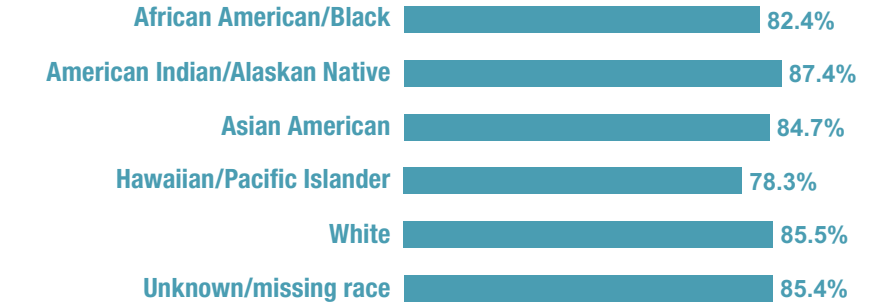
STATEWIDE



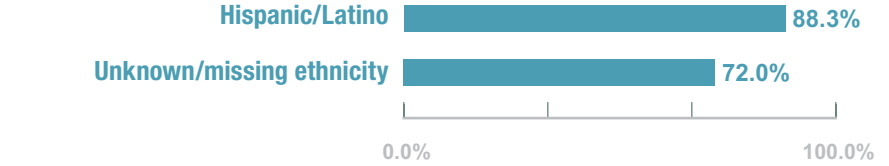
Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 75th percentile

2011 BASELINE RACE AND ETHNICITY DATA

NON-LATINO



ALL RACES

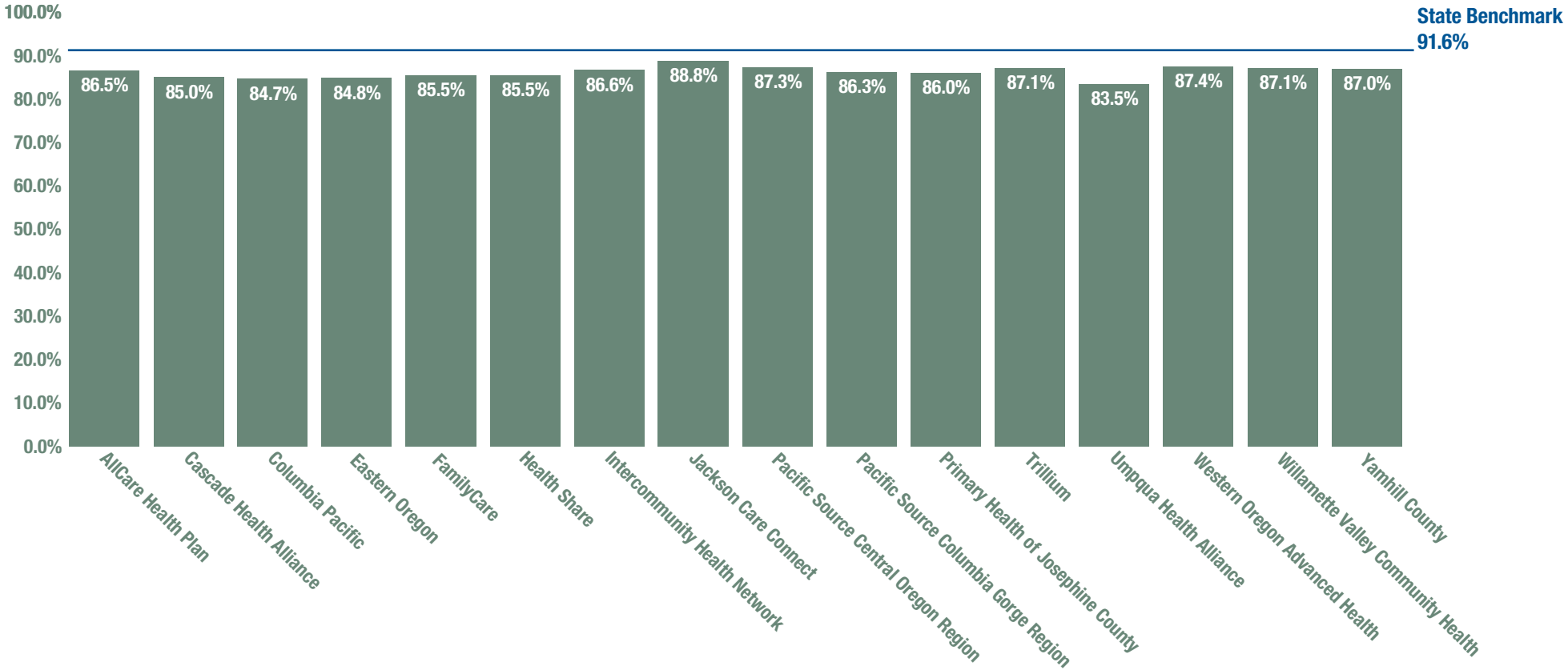


PERFORMANCE METRICS

State Performance Measures

Percentage of children (ages 25 months – 6 years years) who had a visit with a primary care provider

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

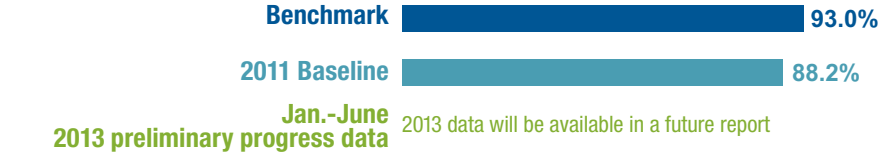
Child and adolescent access to primary care providers, 7-11 years

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

Focus areas: Improving access to effective and timely care and improving primary care for all populations.

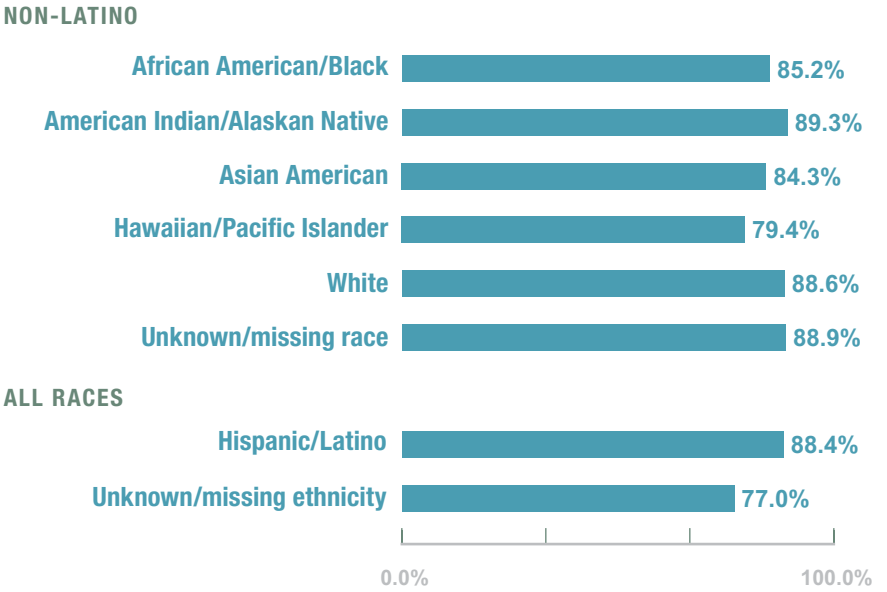
Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA

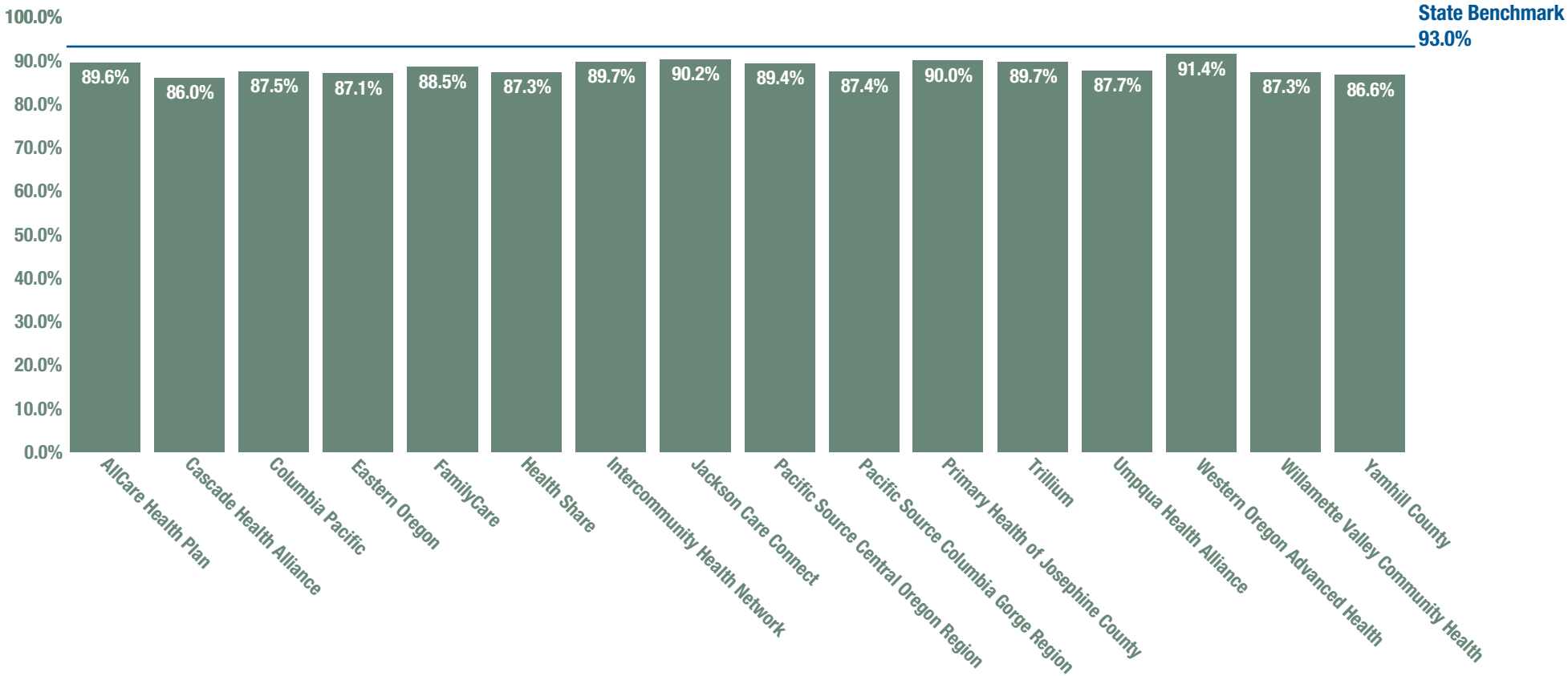


PERFORMANCE METRICS

State Performance Measures

Percentage of children and adolescents (ages 7–11 years) who had a visit with a primary care provider

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

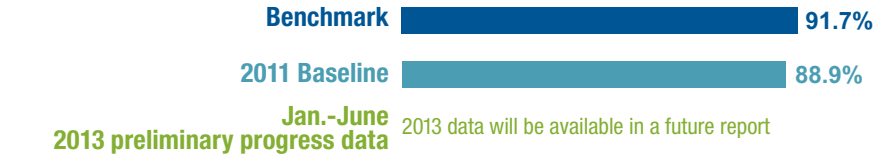
Child and adolescent access to primary care providers, 12-19 years

Definition: Percentage of adolescents (ages 12–19 years) who had a visit with a primary care provider.

Focus areas: Improving access to effective and timely care and improving primary care for all populations.

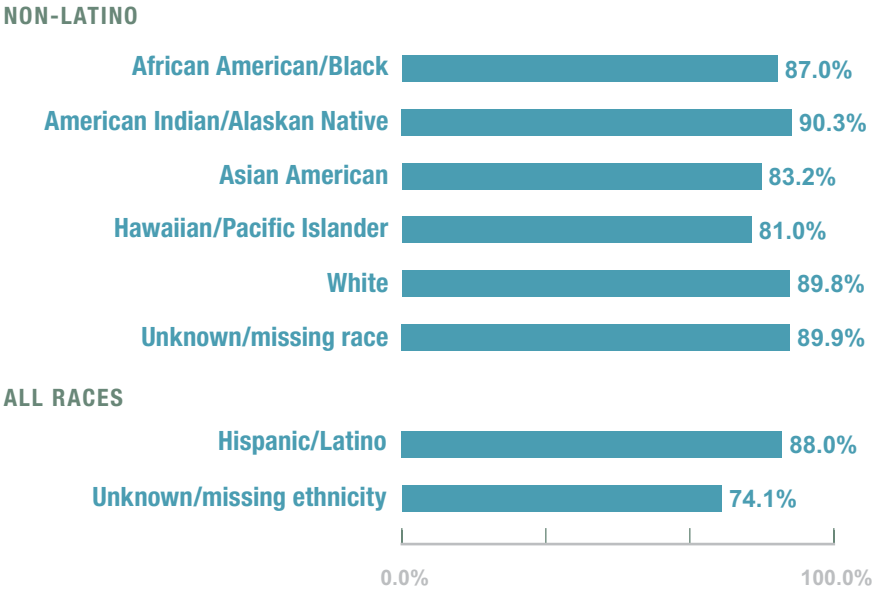
Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA

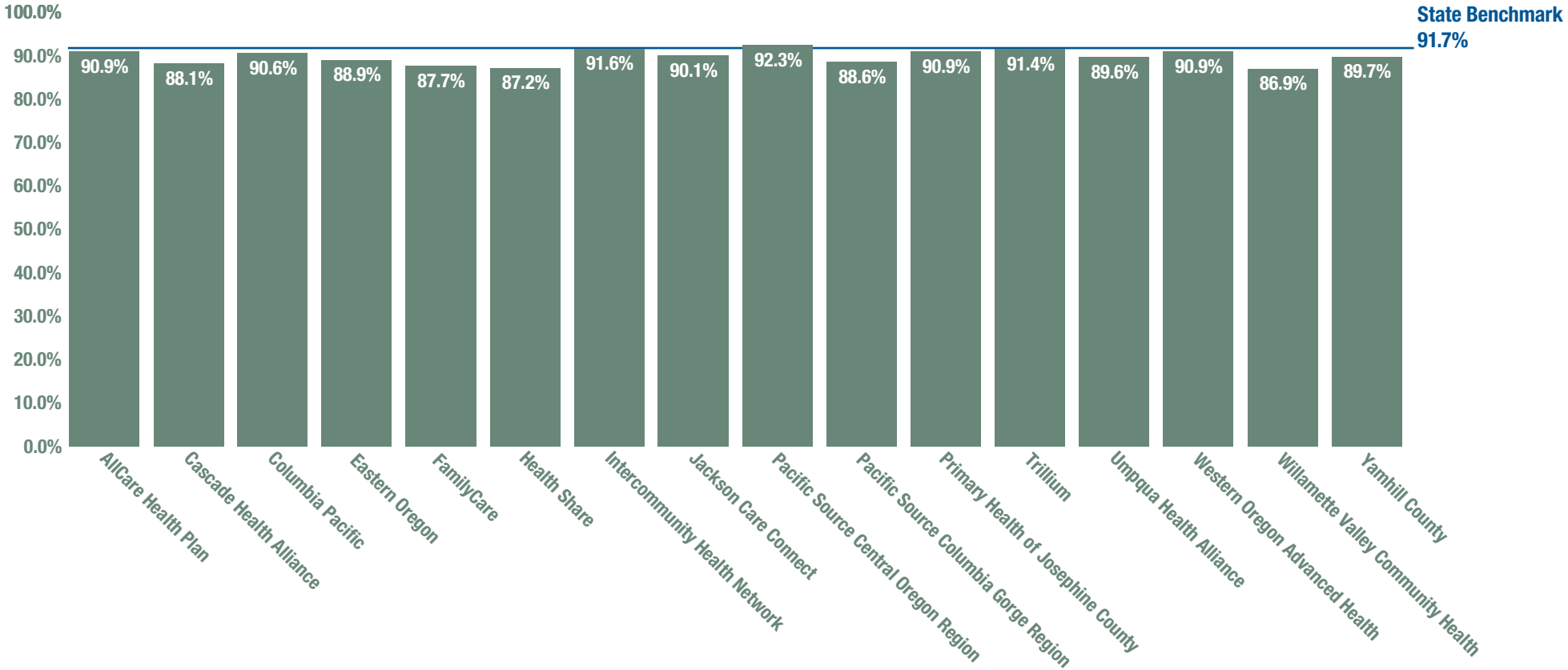


PERFORMANCE METRICS

State Performance Measures

Percentage of adolescents (ages 12–19 years) who had a visit with a primary care provider

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
State Performance Measures

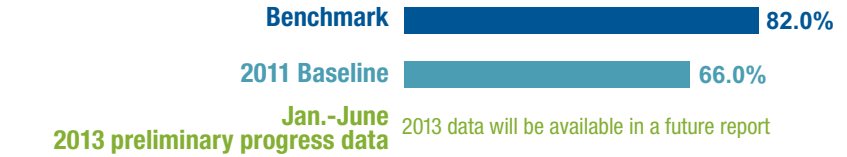
Childhood immunization status

Definition: Percentage of children who received recommended vaccines before their 2nd birthday.

Focus areas: Improving primary care for all populations and ensuring appropriate care is delivered in appropriate settings.

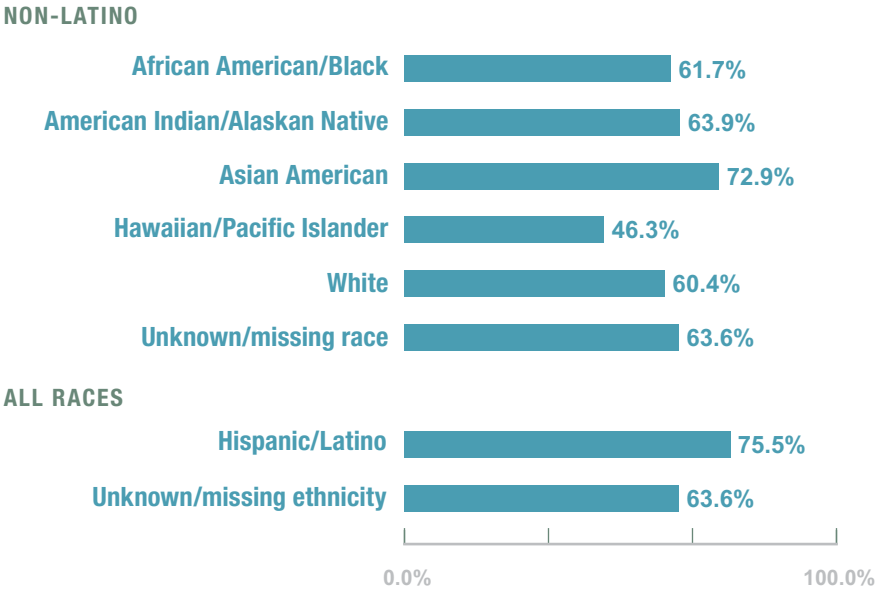
Purpose: Vaccines are one of the safest, easiest and most effective ways to protect children from potentially serious diseases. Vaccines are also cost-effective tools that help to prevent the spread of serious diseases which can sometimes lead to widespread public health threats.

STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA

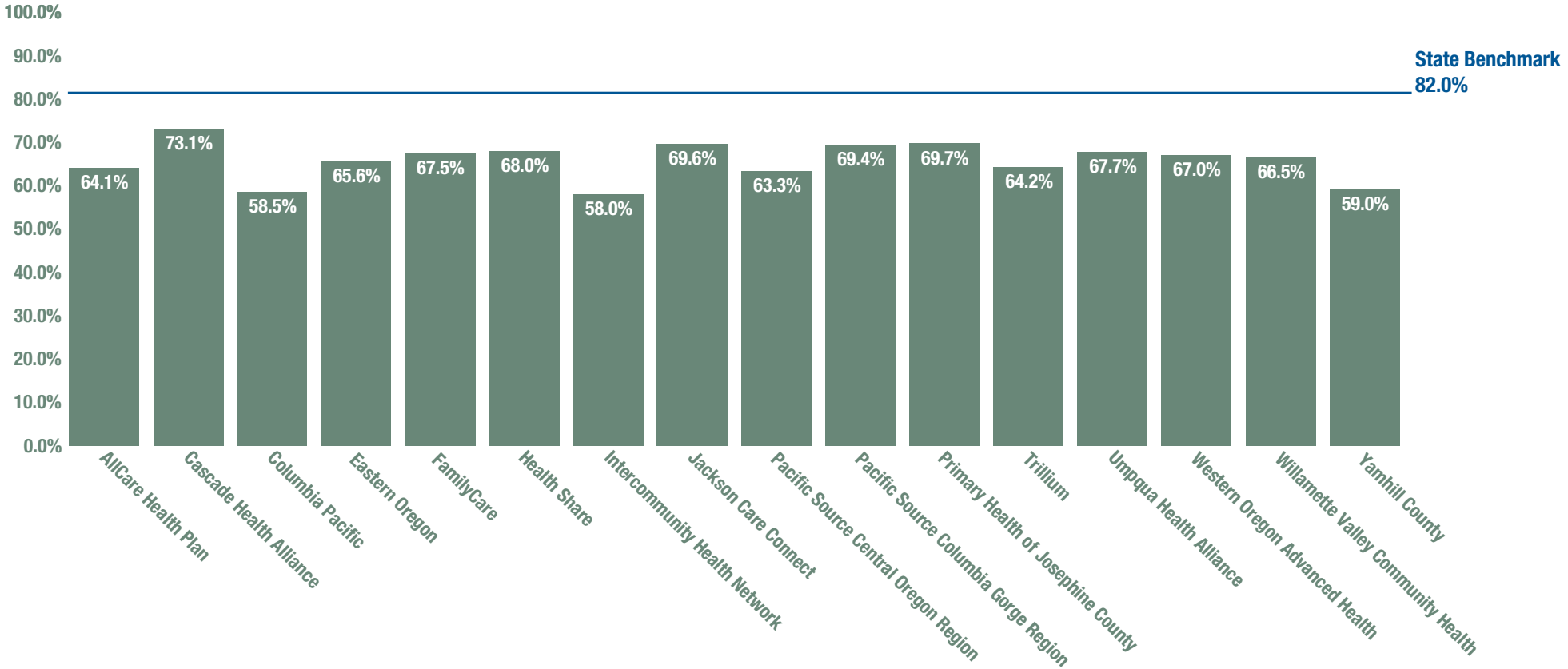


PERFORMANCE METRICS

State Performance Measures

Percentage of children who received recommended vaccines before their 2nd birthday

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
State Performance Measures

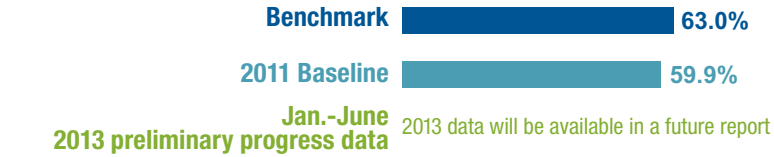
Chlamydia screening

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

Focus area: Improving access to effective and timely care.

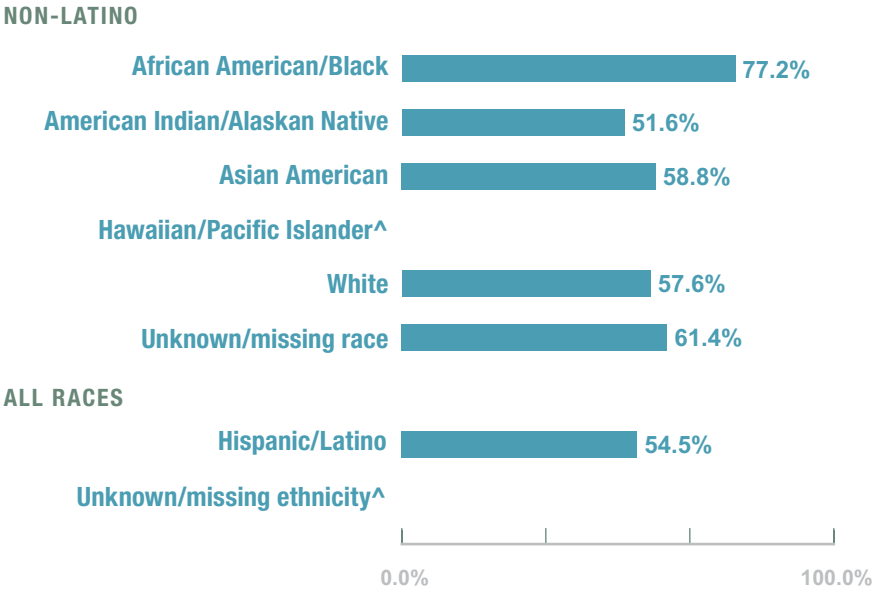
Purpose: Chlamydia is the most common reportable illness in Oregon. Since there are usually no symptoms, routine screening is important to find the disease early so that it can be treated and cured with antibiotics. If Chlamydia is not found and treated, it can lead to pelvic inflammatory disease, which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

STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA



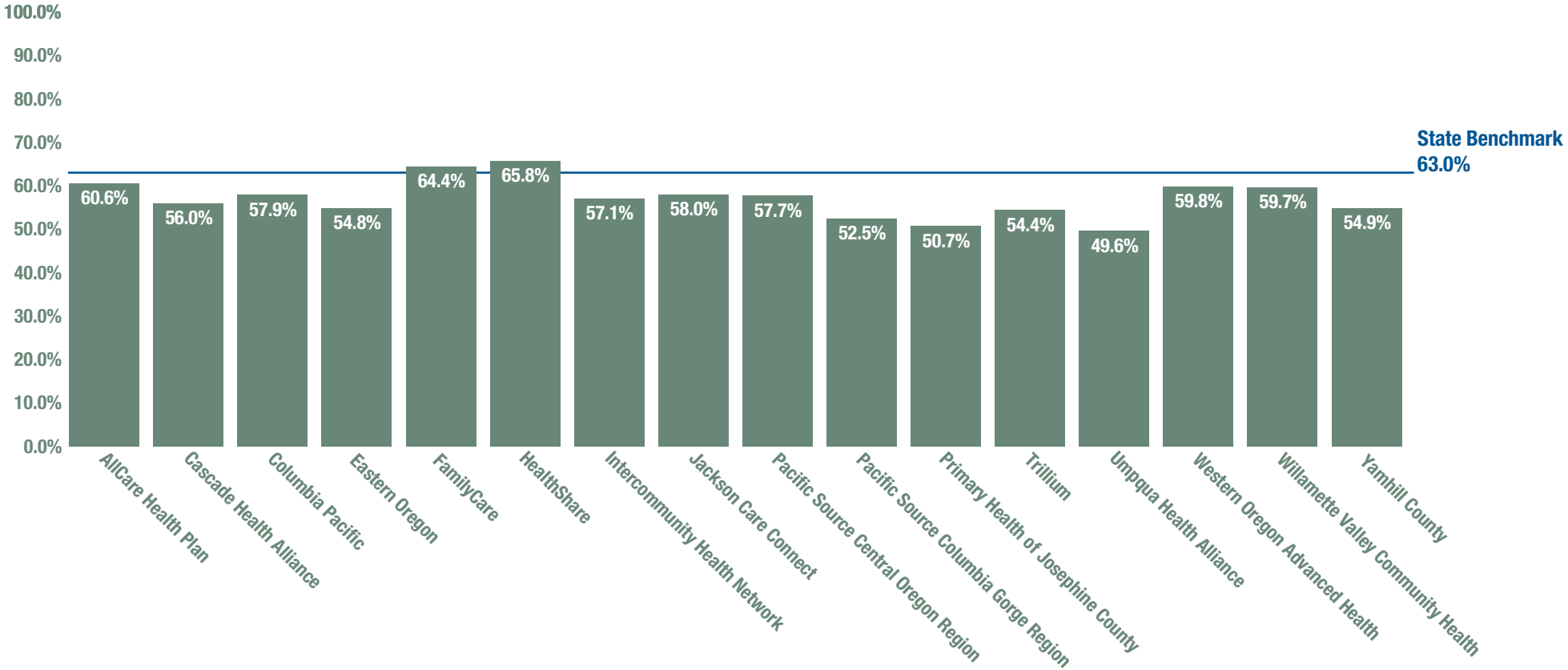
^Data suppressed due to low numbers (n<30)

PERFORMANCE METRICS

State Performance Measures

Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

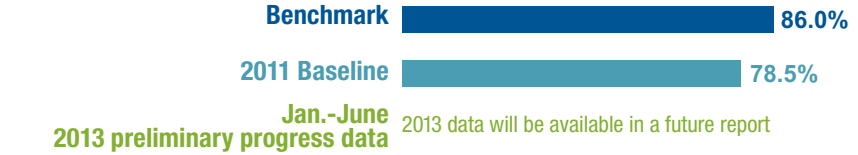
Comprehensive diabetes care: Hemoglobin A1c testing

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

Focus area: Addressing discrete health issues.

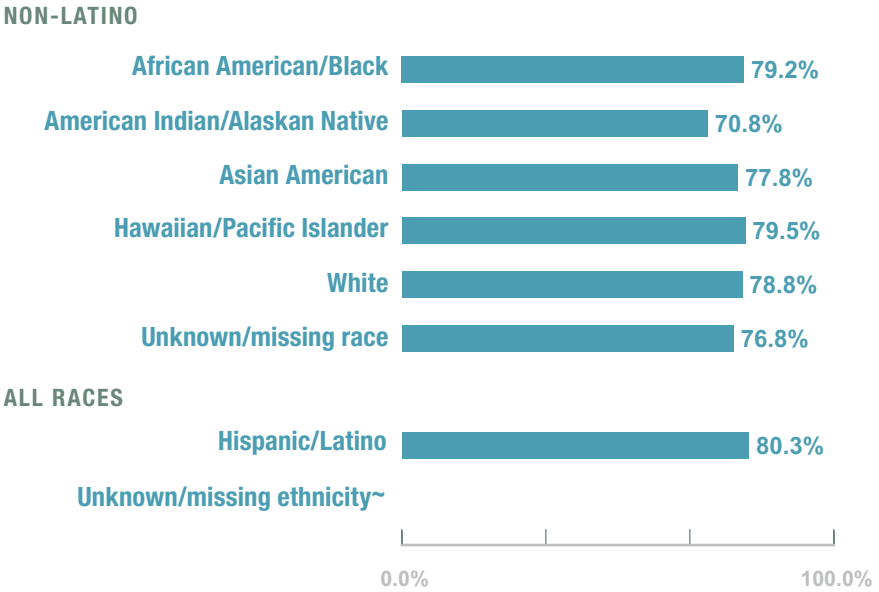
Purpose: Controlling blood sugar levels is important to help people with diabetes manage their disease. It is also a key way to assess the overall effectiveness of diabetes care in Oregon. By improving the quality of care for diabetes, Oregon can help patients avoid complications and hospitalizations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

STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA



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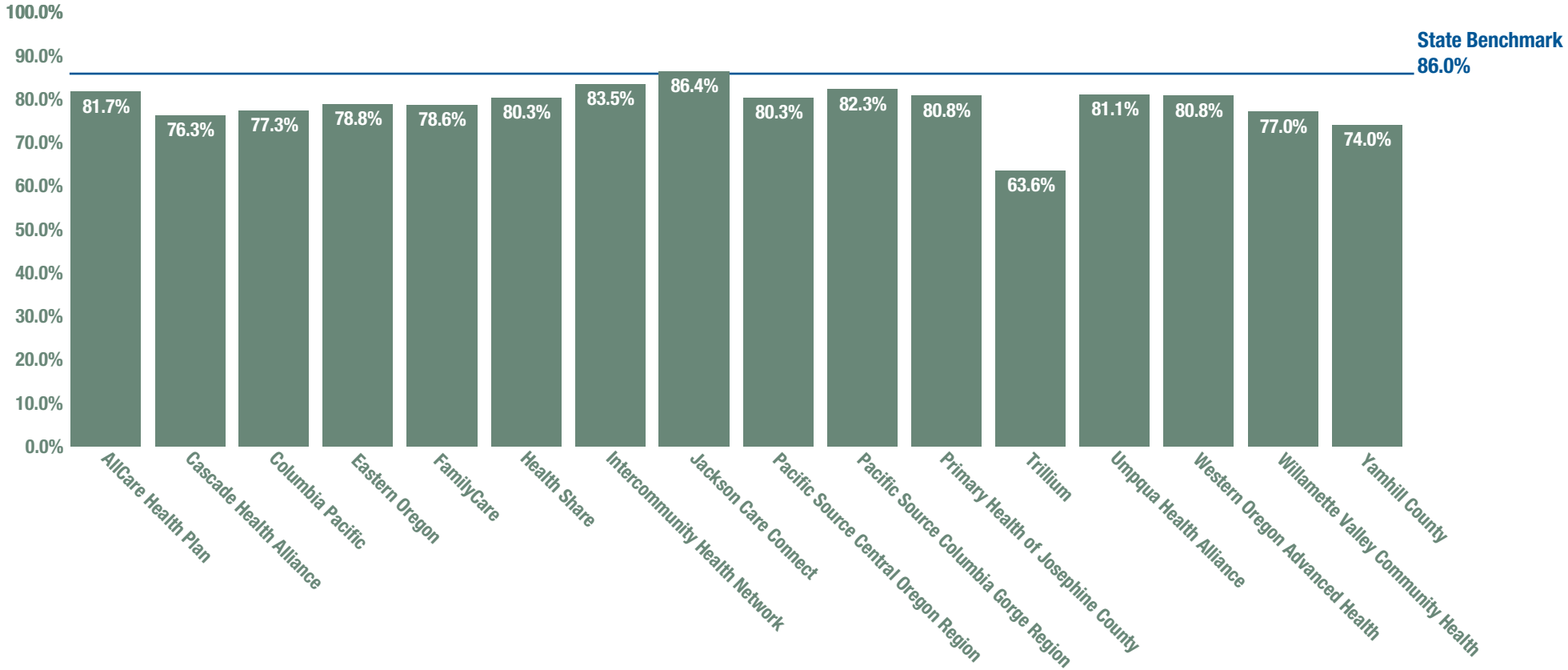
PERFORMANCE METRICS

State Performance Measures

Percentage of adult patients with diabetes who received at least one A1c blood sugar test

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

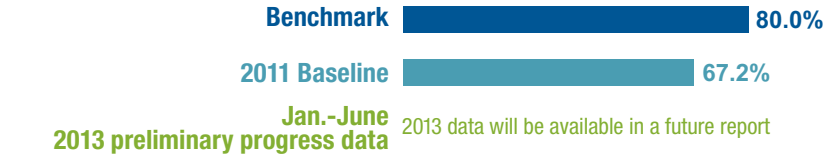
Comprehensive diabetes care: LDL-C screening

Definition: Percentage of adult patients (ages 18-75) with diabetes who received a LDL-C (cholesterol) test.

Focus area: Addressing discrete health issues.

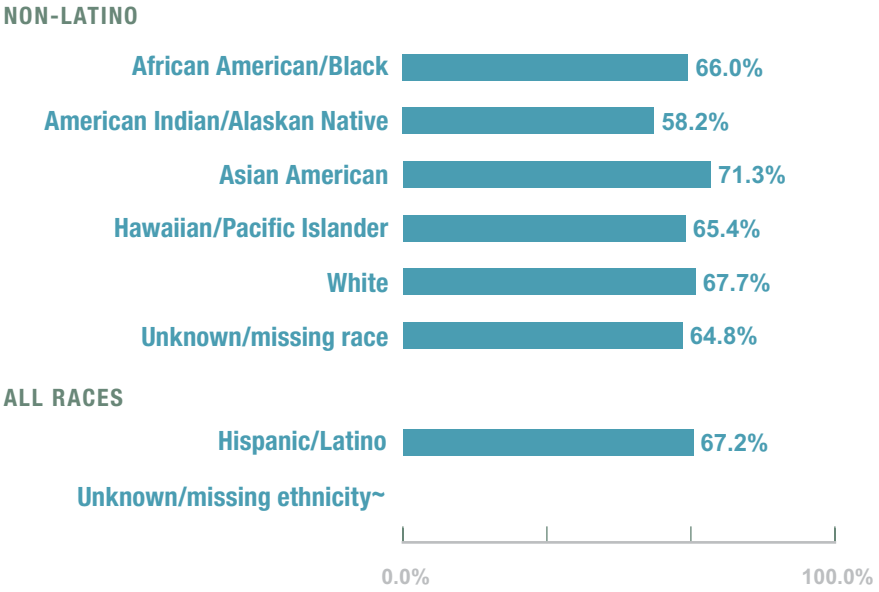
Purpose: This test helps people with diabetes manage their condition by measuring the level of 'bad cholesterol' (LDL-C) in the blood. Managing cholesterol levels can help people with diabetes avoid problems such as heart disease and stroke.

STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA



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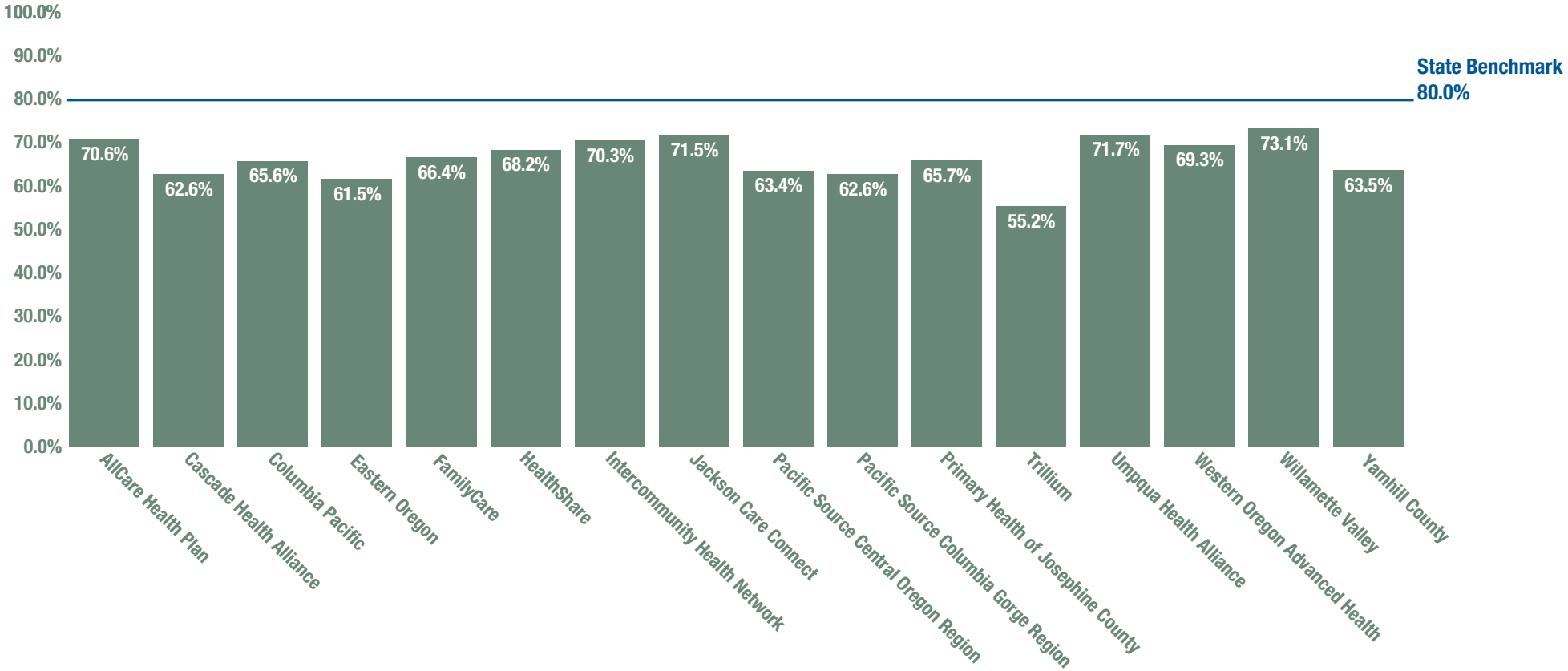
PERFORMANCE METRICS

State Performance Measures

Percentage of adult patients with diabetes who received an LDL-C (cholesterol) test

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
State Performance Measures

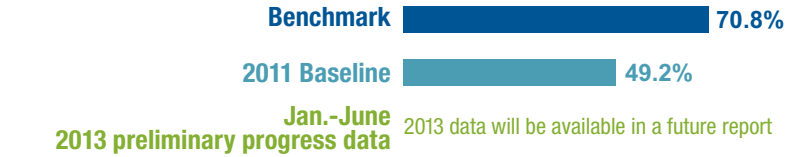
Immunizations for adolescents

Definition: Percentage of adolescents who received recommended vaccines before their 13th birthday.

Focus areas: Improving primary care for all populations and ensuring appropriate care is delivered in appropriate settings.

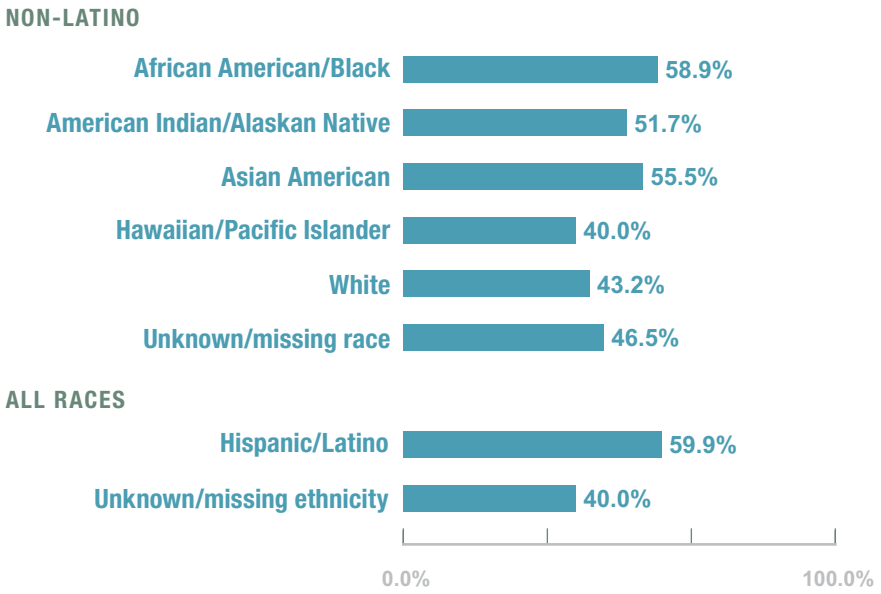
Purpose: Like young children, adolescents also benefit from immunizations. Vaccines are a safe, easy and cost-effective way to prevent serious disease. Vaccines are also cost-effective tools that help to prevent the spread of serious and sometimes fatal diseases.

STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA

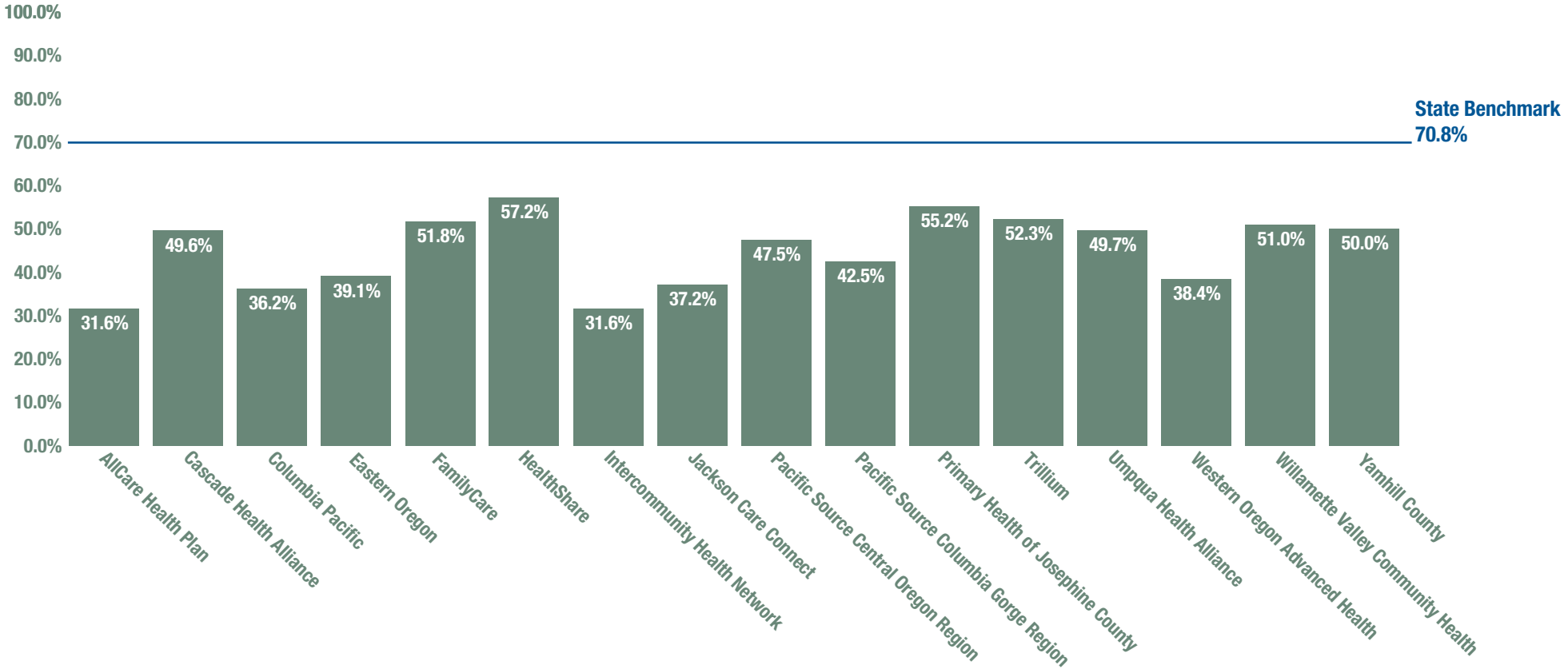


PERFORMANCE METRICS

State Performance Measures

Percentage of adolescents who got recommended vaccines before their 13th birthday

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

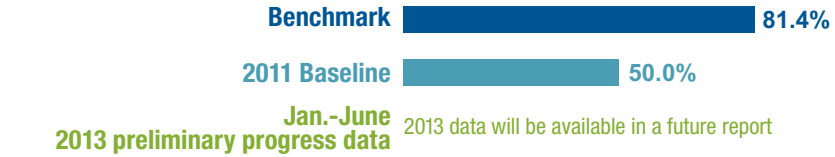
Medical assistance with smoking and tobacco use cessation

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

Focus areas: Improving primary care for all populations and ensuring appropriate care is delivered in appropriate settings.

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.

STATEWIDE



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

RACE AND ETHNICITY DATA

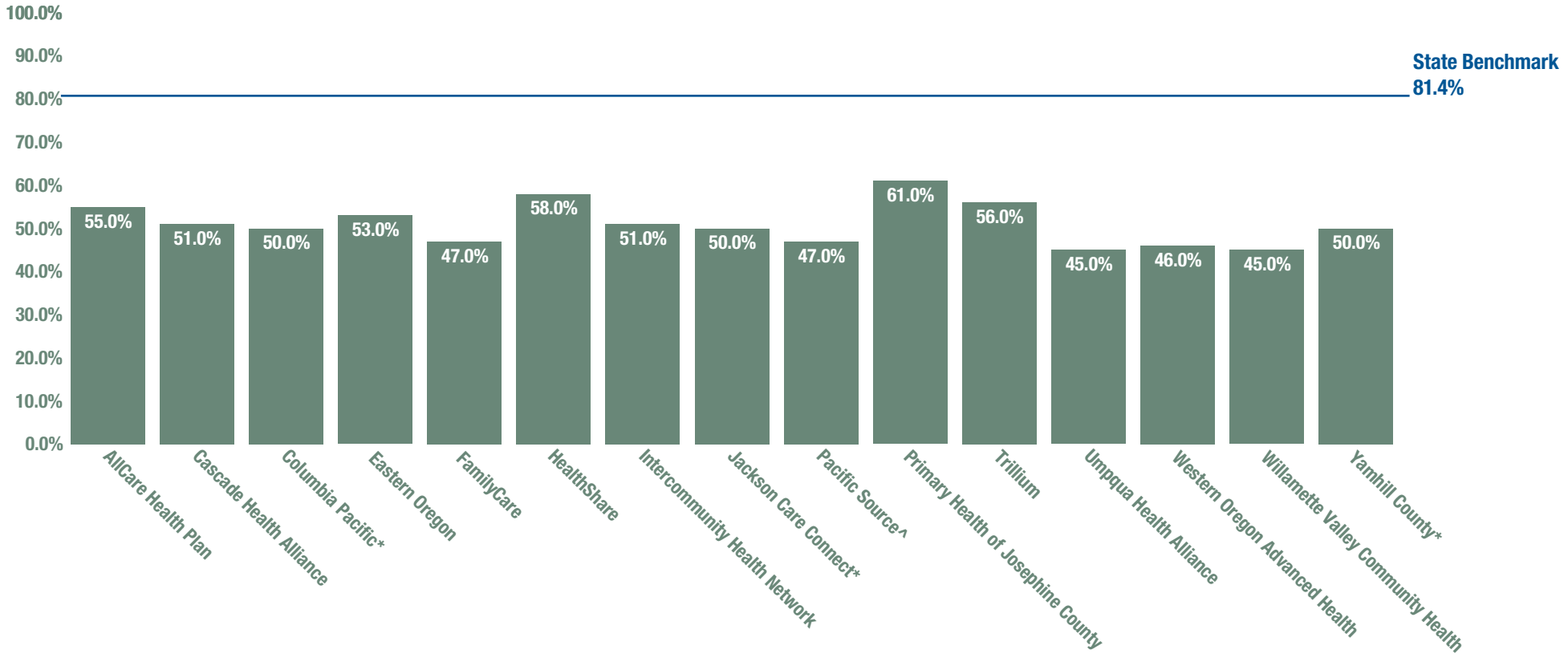
Race and ethnicity data for this measure will be available in a future report

PERFORMANCE METRICS

State Performance Measures

Smoking and tobacco use cessation: Percentage of adult tobacco users advised to quit by their doctor

2011 baseline data



*CCO baseline could not clearly be attributed to a past FCHP. Baseline provided is state average.
^Cannot report PacificSource separately for this measure.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

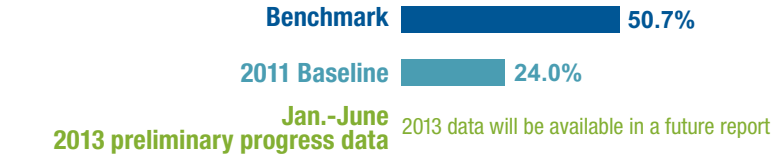
Medical assistance with smoking and tobacco use cessation

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

Focus areas: Improving primary care for all populations and ensuring appropriate care is delivered in appropriate settings.

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.

STATEWIDE



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

RACE AND ETHNICITY DATA

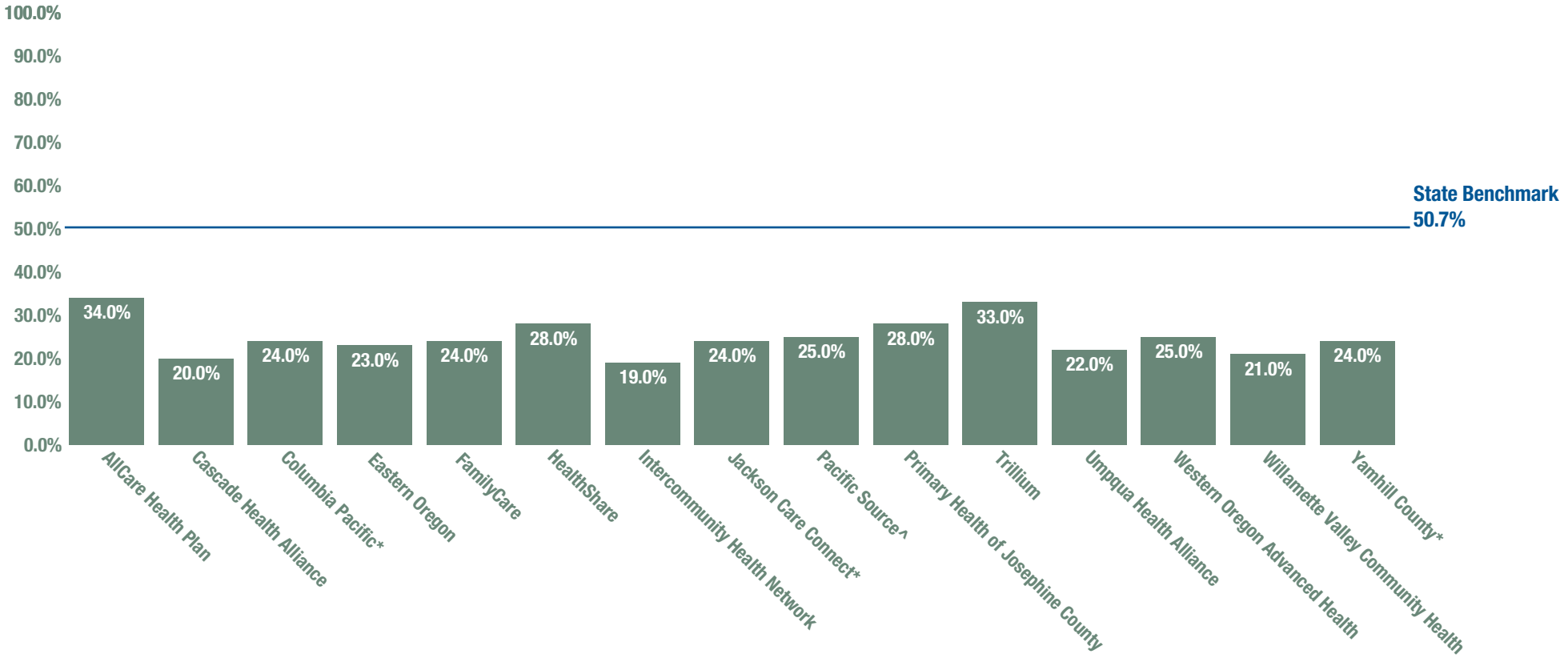
Race and ethnicity data for this measure will be available in a future report

PERFORMANCE METRICS

State Performance Measures

Smoking and tobacco use cessation: Percentage of adult tobacco users whose doctor discussed or recommended medications to quit smoking

2011 baseline data



*CCO baseline could not clearly be attributed to a past FCHP. Baseline provided is state average.
^Cannot report PacificSource separately for this measure.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

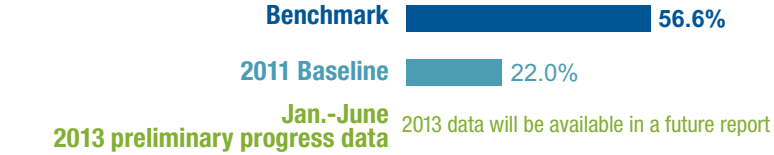
Medical assistance with smoking and tobacco use cessation

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

Focus areas: Improving primary care for all populations and ensuring appropriate care is delivered in appropriate settings.

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.

STATEWIDE



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

RACE AND ETHNICITY DATA

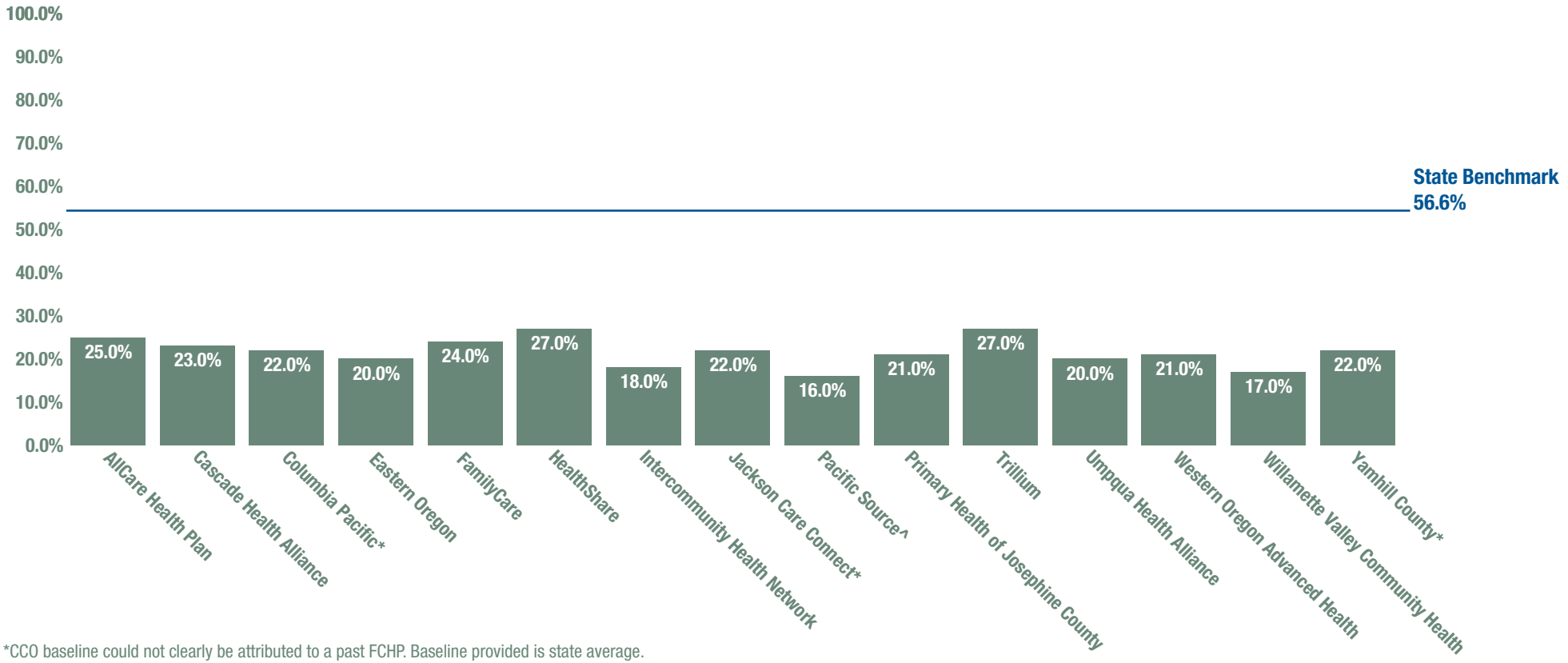
Race and ethnicity data for this measure will be available in a future report

PERFORMANCE METRICS

State Performance Measures

Smoking and tobacco use cessation: Percentage of adult tobacco users whose doctor discussed or recommended strategies to quit smoking

2011 baseline data



*CCO baseline could not clearly be attributed to a past FCHP. Baseline provided is state average.
^Cannot report PacificSource separately for this measure.

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
State Performance Measures

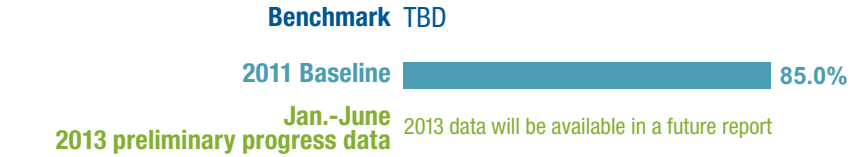
Extent to which primary care providers are accepting new Medicaid patients*

Definition: Percentage of primary care providers that are accepting new Medicaid/Oregon Health Plan patients as of 2011. This information comes from the Oregon Physician Workforce Survey.

Focus area: Improving access to effective and timely care.

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.

STATEWIDE



*Accepting new Medicaid/OHP patients with both no limitations and some restrictions
Data source: Physician Workforce Survey

RACE AND ETHNICITY DATA

Physician Workforce Survey results cannot be stratified by race and ethnicity

PERFORMANCE METRICS
State Performance Measures

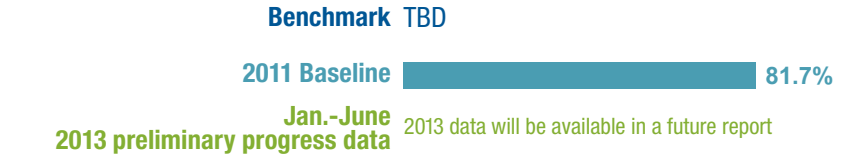
Extent to which primary care providers currently see Medicaid patients*

Definition: Percentage of primary care providers that currently care for Medicaid/Oregon Health Plan patients. This information comes from the Oregon Physician Workforce Survey.

Focus area: Improving access to effective and timely care.

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.

STATEWIDE



*Excludes 'don't know' and missing
Data source: Physician Workforce Survey

RACE AND ETHNICITY DATA

Physician Workforce Survey results cannot be stratified by race and ethnicity

PERFORMANCE METRICS
State Performance Measures

Diabetes short term complications admission rate (PQI 1)*

Definition: 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.

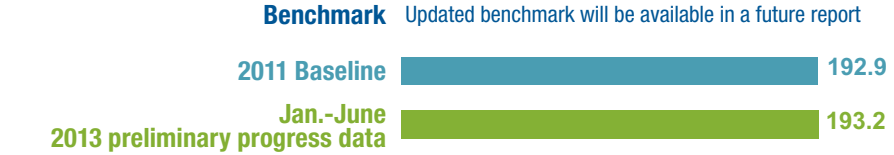
Focus area: Addressing discrete health issues.

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 the costs of health care.

Jan-June 2013 data

This metric tracks hospital use for adult patients with diabetes that could be better treated with good disease management. The rates for this measure are reported per 100,000 member years, which means the January through June 2013 data is directly comparable to annual data, including the 2011 baseline.

STATEWIDE



*Agency for Healthcare Research and Quality, Prevention Quality Indicators
Data source: Administrative (billing) claims

RACE AND ETHNICITY DATA

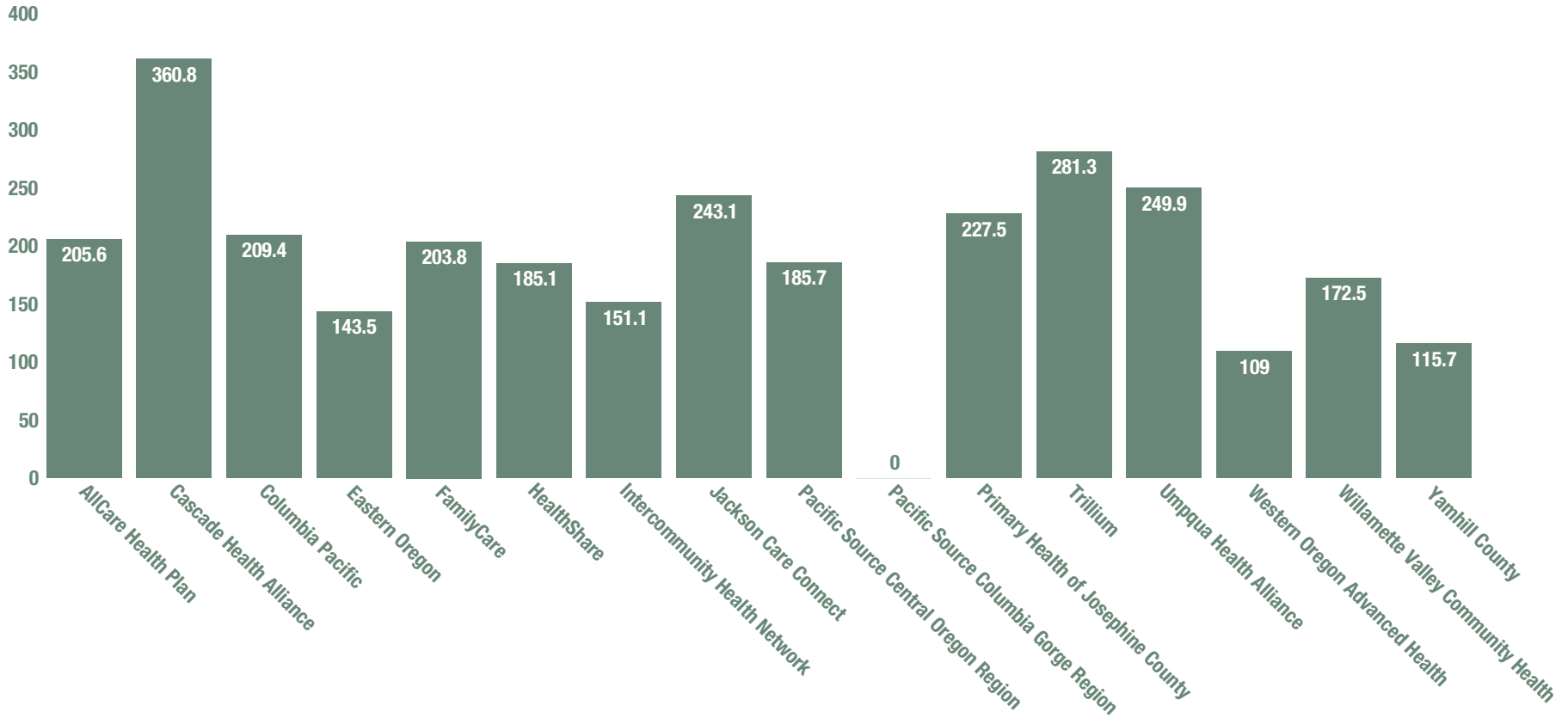
Race and ethnicity data for this measure will be available in a future report

PERFORMANCE METRICS

State Performance Measures

PQI 1*: Rate of adult patients with diabetes who had a hospital stay because of a short-term problem from their disease

2011 baseline data



(Lower score is better.)
Rates are per 100,000 member years
Updated benchmark will be available in a future report
*Agency for Healthcare Research and Quality, Prevention Quality Indicators

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate (PQI 5)*

Definition: 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.

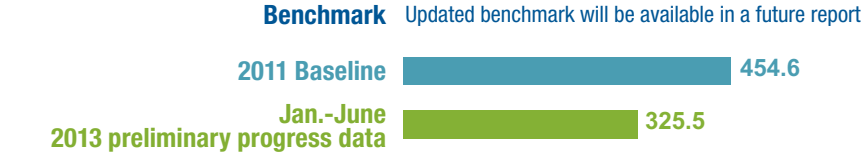
Focus area: Addressing discrete health issues.

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 the costs of health care.

Jan.-June 2013 data

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, which means the January through June 2013 data is directly comparable to annual data, including the 2011 baseline. This metric shows a preliminary trend toward lower hospital utilization for this chronic condition.

STATEWIDE



*Agency for Healthcare Research and Quality, Prevention Quality Indicators
Data source: Administrative (billing) claims

RACE AND ETHNICITY DATA

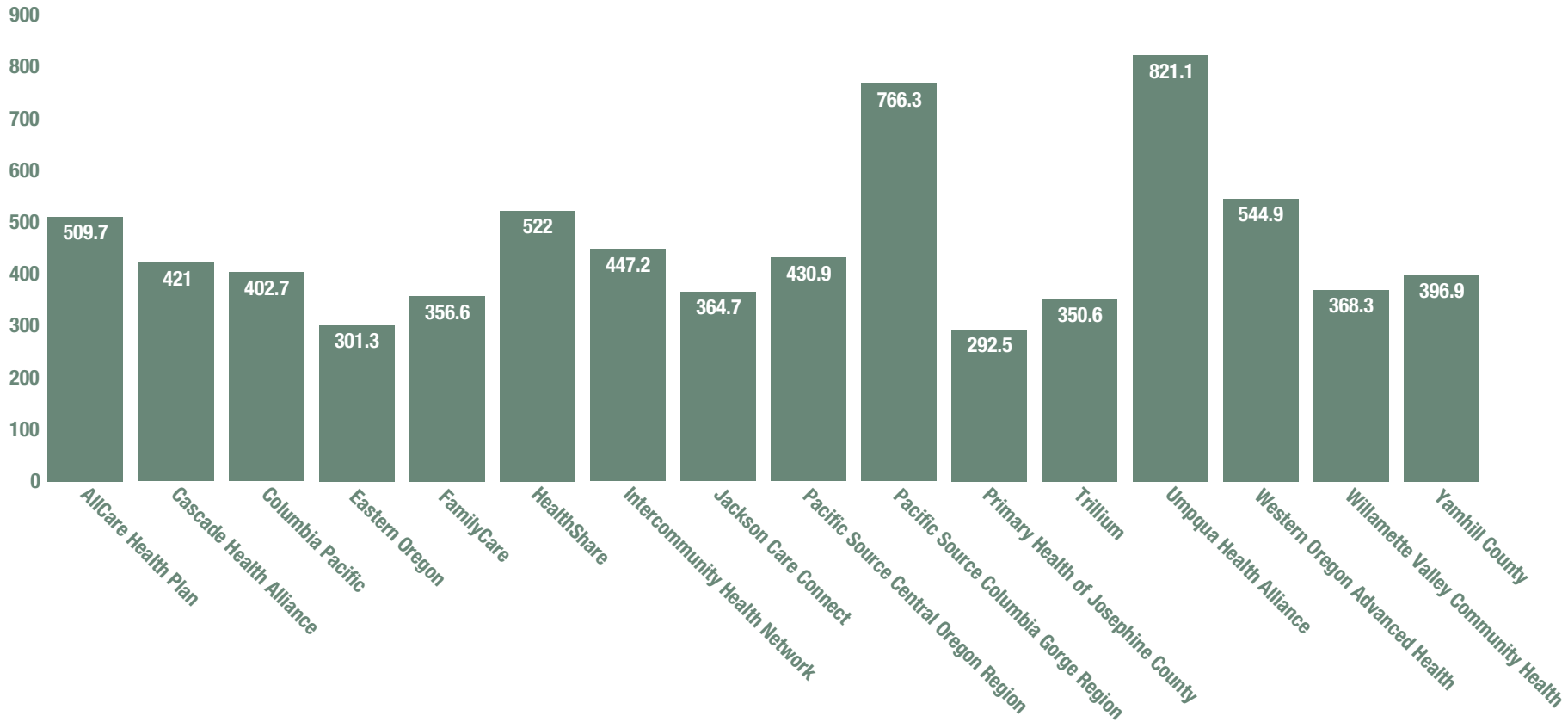
Race and ethnicity data for this measure will be available in a future report

PERFORMANCE METRICS

State Performance Measures

PQI 5*: Rate of adult patients (ages 40 and older) who had a hospital stay because of asthma or chronic obstructive pulmonary disease

2011 baseline data



(Lower score is better.)
Rates are per 100,000 member years
Updated benchmark will be available in a future report
*Agency for Healthcare Research and Quality, Prevention Quality Indicators

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
State Performance Measures

Congestive heart failure admission rate (PQI 8)*

Definition: 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.

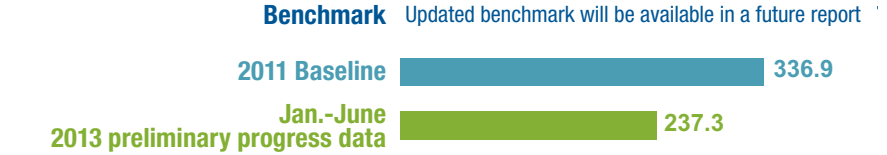
Focus area: Addressing discrete health issues.

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 the costs of health care.

Jan.-June 2013 data

This metric tracks hospital use for adults with congestive health failure that could be better treated with good disease management. The rates for this measure are reported per 100,000 member years, which means the January through June 2013 data is directly comparable to annual data, including the 2011 baseline. This metric shows a preliminary trend toward lower hospital utilization for this chronic condition.

STATEWIDE



*Agency for Healthcare Research and Quality, Prevention Quality Indicators
Data source: Administrative (billing) claims

2011 BASELINE RACE AND ETHNICITY DATA

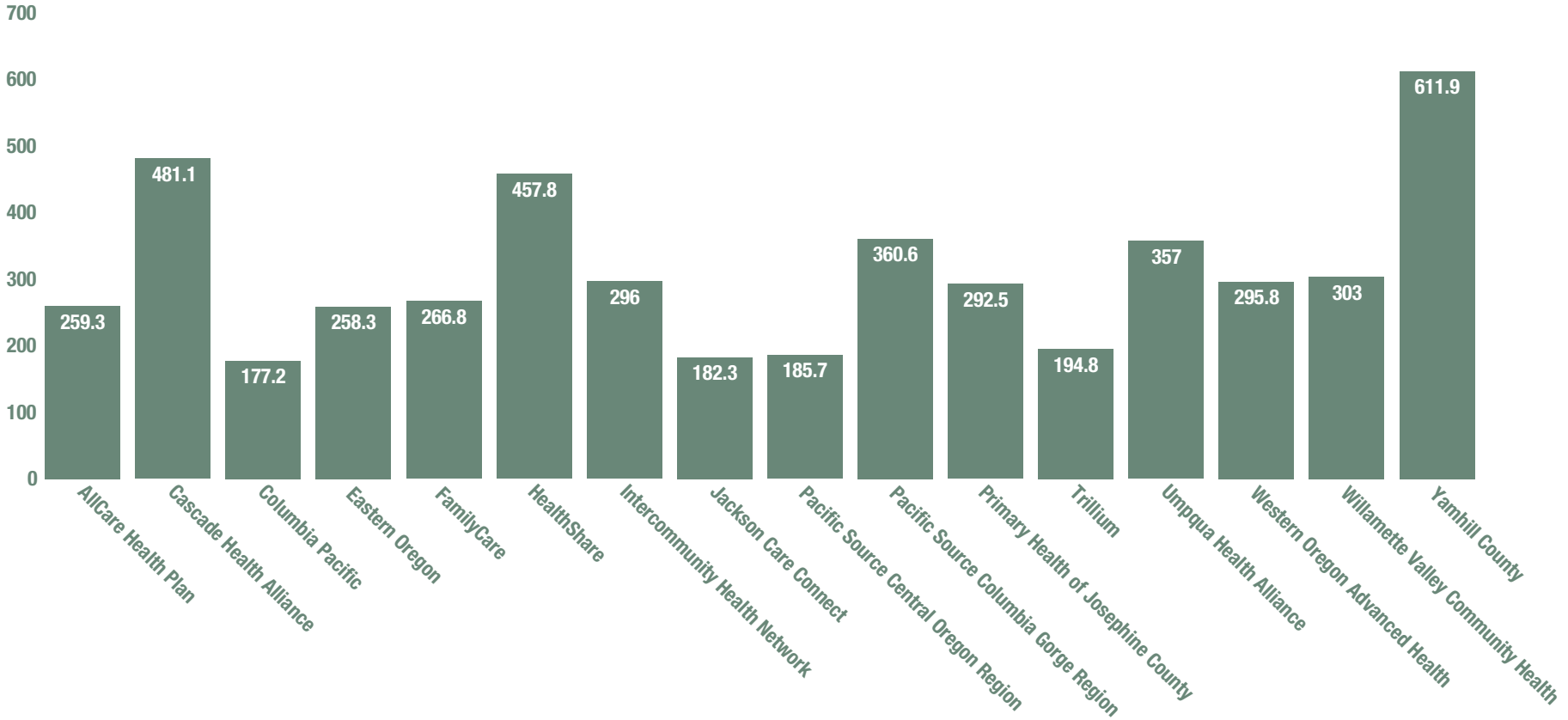
Race and ethnicity data for this measure will be available in a future report

PERFORMANCE METRICS

State Performance Measures

PQI 8*: Rate of adult patients who had a hospital stay because of congestive heart failure

2011 baseline data



(Lower score is better.)
Rates are per 100,000 member years
Updated benchmark will be available in a future report
*Agency for Healthcare Research and Quality, Prevention Quality Indicators

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
State Performance Measures

Adult (ages 18-39) asthma admission rate (PQI 15)*

Definition: 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.

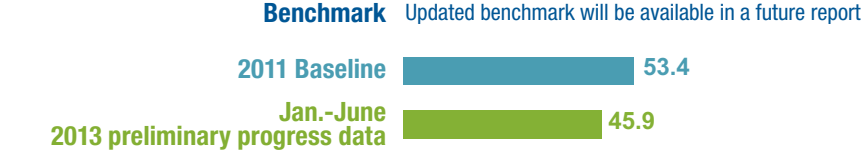
Focus area: Addressing discrete health issues.

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 the costs of health care.

Jan.-June 2013 data

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, which means the January through June 2013 data is directly comparable to annual data, including the 2011 baseline. This metric shows a preliminary trend toward lower hospital utilization for this chronic condition.

STATEWIDE



*Agency for Healthcare Research and Quality, Prevention Quality Indicators
Data source: Administrative (billing) claims

RACE AND ETHNICITY DATA

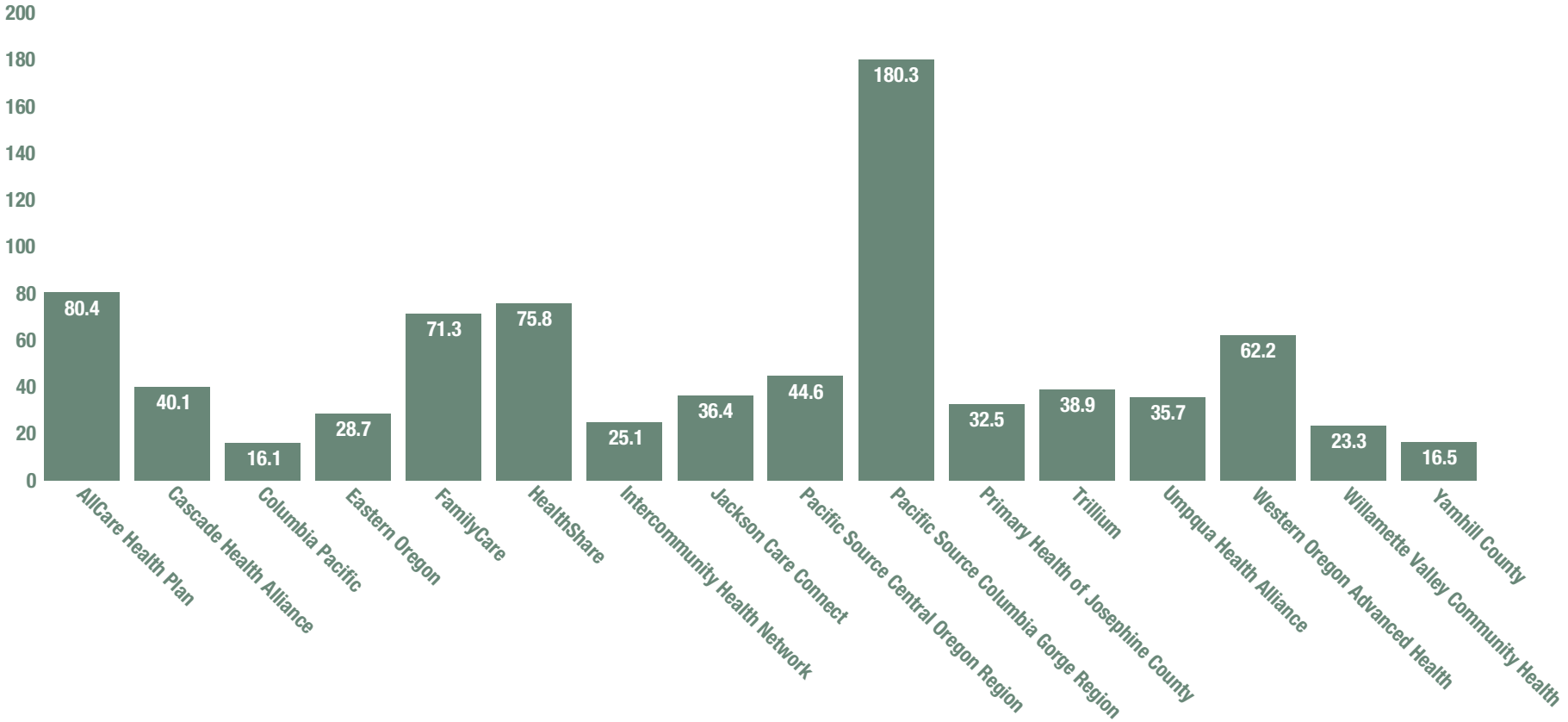
Race and ethnicity data for this measure will be available in a future report

PERFORMANCE METRICS

State Performance Measures

PQI 15*: Rate of adult patients (ages 18-39) who had a hospital stay because of asthma

2011 baseline data



(Lower score is better.)
Rates are per 100,000 member years
Updated benchmark will be available in a future report
*Agency for Healthcare Research and Quality, Prevention Quality Indicators

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

PERFORMANCE METRICS
State Performance Measures

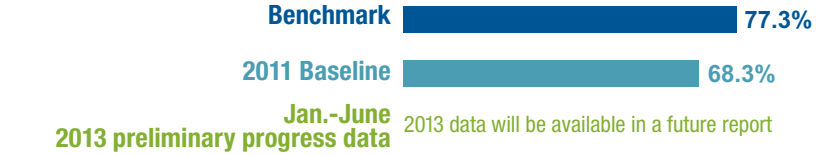
Well-child visits in the first 15 months of life

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

Focus areas: Improving access to effective and timely care; improving primary care for all populations; and ensuring appropriate care is delivered in appropriate settings.

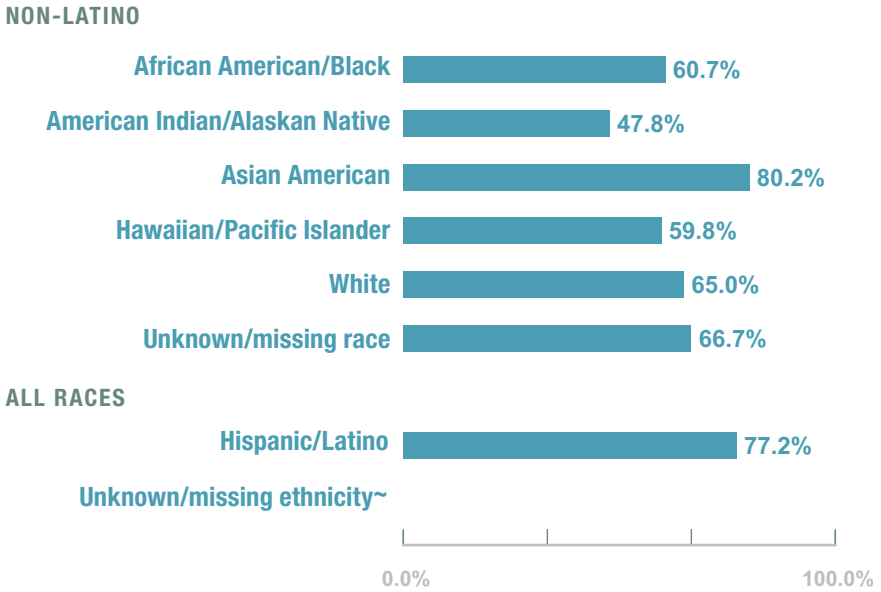
Purpose: Regular well-child visits are one of the best ways to detect physical, developmental, behavioral and emotional problems in infants. They are also an opportunity for providers to offer guidance and counseling to parents.

STATEWIDE



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

2011 BASELINE RACE AND ETHNICITY DATA



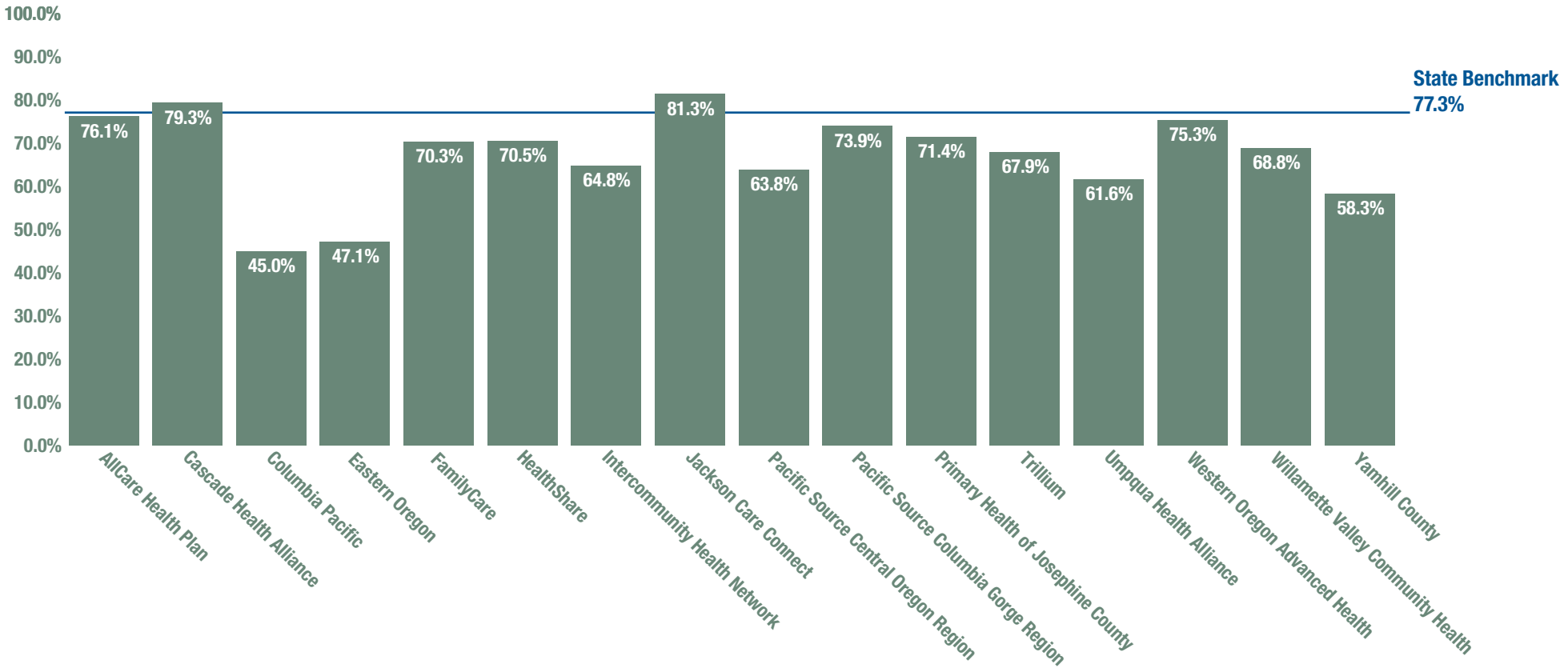
~Data suppressed due to low numbers (n<30)

PERFORMANCE METRICS

State Performance Measures

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

2011 baseline data



2011 baselines are pre-CCO and are based on data from the predecessor care organization.

COST AND UTILIZATION DATA

Quarterly Data

UTILIZATION DATA

CATEGORY	OREGON PRE-CCO BASELINE**	BENCHMARK	OCT-DEC 2012 *	JAN-MAR 2013 *	APR-JUN 2013 *	OCT 2012 - JUN 2013 AVERAGE
UTILIZATION DATA (ANNUALIZED / 1000 MEMBERS)						
Inpatient – Medical / General – Patient Days	161.1	***	163.4	184.8	143.6	163.9
Inpatient – Medical / Rehabilitation – Patient Days	3.0	***	3.4	3.0	1.9	2.7
Inpatient – Surgical – Patient Days	81.5	***	79.0	74.1	61.1	71.4
Inpatient – Maternity / Normal Delivery – Patient Days	45.8	***	39.1	42.7	42.3	41.4
Inpatient – Maternity / C-Section Delivery – Patient Days	27.5	***	20.7	22.0	18.5	20.4
Inpatient – Maternity / Non-Delivery – Patient Days	9.0	***	6.5	7.1	7.0	6.9
Inpatient – Newborn / Well – Patient Days	40.0	***	35.4	38.5	36.2	36.7
Inpatient – Newborn / With Complications – Patient Days	51.7	***	45.2	34.2	33.5	37.6
Inpatient – Mental Health / Psychiatric – Patient Days	53.1	***	50.8	43.7	37.4	44.0
Inpatient – Mental Health / Alcohol and Drug Abuse – Patient Days	5.7	***	6.5	5.0	5.1	5.5
Outpatient – Primary Care Medical Visits (Includes Immun/Inject)	2,655.2	***	3,103.4	3,363.2	2,934.1	3,133.6
Outpatient – Specialty Care Visits	4,163.5	***	3,980.4	3,896.1	3,560.8	3,812.4
Outpatient – Mental Health Visits	885.4	***	973.8	765.3	704.8	814.6
Outpatient – Dental Visits (preventative)	475.5	***	416.8	484.2	452.4	451.1
Outpatient – Emergency Dept Visits	See Ambulatory Care ED utilization metric in CCO Incentive and State Performance Measures section of this report					
Outpatient – Pharmacy Prescriptions Filled	9,490.9	***	8,902.2	9,410.6	8,555.8	8,956.2
Outpatient – Labs and Radiology (Service Units)	4,858.9	***	4,607.7	4,937.5	4,785.1	4,776.7
Outpatient – Freestanding ASC Procedures	25.4	***	21.9	24.5	24.7	23.7

For footnote explanations, see page 82.

COST AND UTILIZATION DATA

Quarterly Data

COST DATA

CATEGORY	OREGON PRE-CCO BASELINE**	BENCHMARK	OCT-DEC 2012 *	JAN-MAR 2013 *	APR-JUN 2013 *	OCT 2012 - JUN 2013 AVERAGE
COST PER MEMBER PER MONTH (PMPM)						
Inpatient – Medical / General	$25.51	***	$24.94	$28.24	$23.13	$25.44
Inpatient – Medical / Rehabilitation	$0.27	***	$0.27	$0.23	$0.15	$0.22
Inpatient – Surgical	$20.99	***	$19.38	$18.87	$17.44	$18.56
Inpatient – Maternity / Normal Delivery	$6.47	***	$5.77	$6.01	$6.15	$5.98
Inpatient – Maternity / C-Section Delivery	$4.36	***	$3.26	$3.51	$3.04	$3.27
Inpatient – Maternity / Non-Delivery	$1.21	***	$0.82	$0.94	$0.85	$0.87
Inpatient – Newborn / Well	$2.12	***	$2.16	$2.37	$2.30	$2.28
Inpatient – Newborn / With Complications	$7.21	***	$5.59	$4.97	$4.58	$5.05
Inpatient – Mental Health / Psychiatric	$3.97	***	$3.27	$2.98	$2.63	$2.96
Inpatient – Mental Health / Alcohol and Drug Abuse	$0.52	***	$0.54	$0.42	$0.43	$0.46
Outpatient – Primary Care	$34.41	***	$35.95	$38.13	$35.91	$36.66
Outpatient – Specialty Care	$25.46	***	$24.28	$24.82	$23.52	$24.21
Outpatient – Mental Health	$23.19	***	$21.56	$20.79	$19.77	$20.71
Outpatient – Dental	$12.20	***	$7.08	$8.20	$7.80	$7.69
Outpatient – Emergency Department	$9.71	***	$7.85	$8.40	$7.74	$8.00
Outpatient – Pharmacy Prescriptions	$32.40	***	$32.35	$33.56	$31.47	$32.46
Outpatient – Labs and Radiology	$21.72	***	$18.93	$20.09	$18.83	$19.28
Outpatient – Freestanding ASC Procedures	$1.60	***	$1.56	$1.80	$1.68	$1.68
Outpatient – Health Related Services	$0.00	***	$0.00	$0.00	$0.00	$0.00
Outpatient – Other Hospital Services	$29.00	***	$24.38	$27.13	$25.40	$25.64
Outpatient – All Other	$21.00	***	$21.10	$22.22	$21.31	$21.54

For footnote explanations, see page 82.

FINANCIAL DATA
Footnotes

* Includes claim data received and processed through 9/27/13. At this point, there is no data on services that have happened, but have yet to be recorded or invoiced. This dashboard is also incomplete due to lags in submitting data to OHA. As a result, this data is very preliminary. The values will be recalculated and reported as additional data becomes available. This is the first step in collecting and sharing data, and future dashboards will be updated when more complete data is submitted.

** Oregon baseline measures are state-wide values from CY 2011 and are based on data before health transformation began and CCOs were formed.

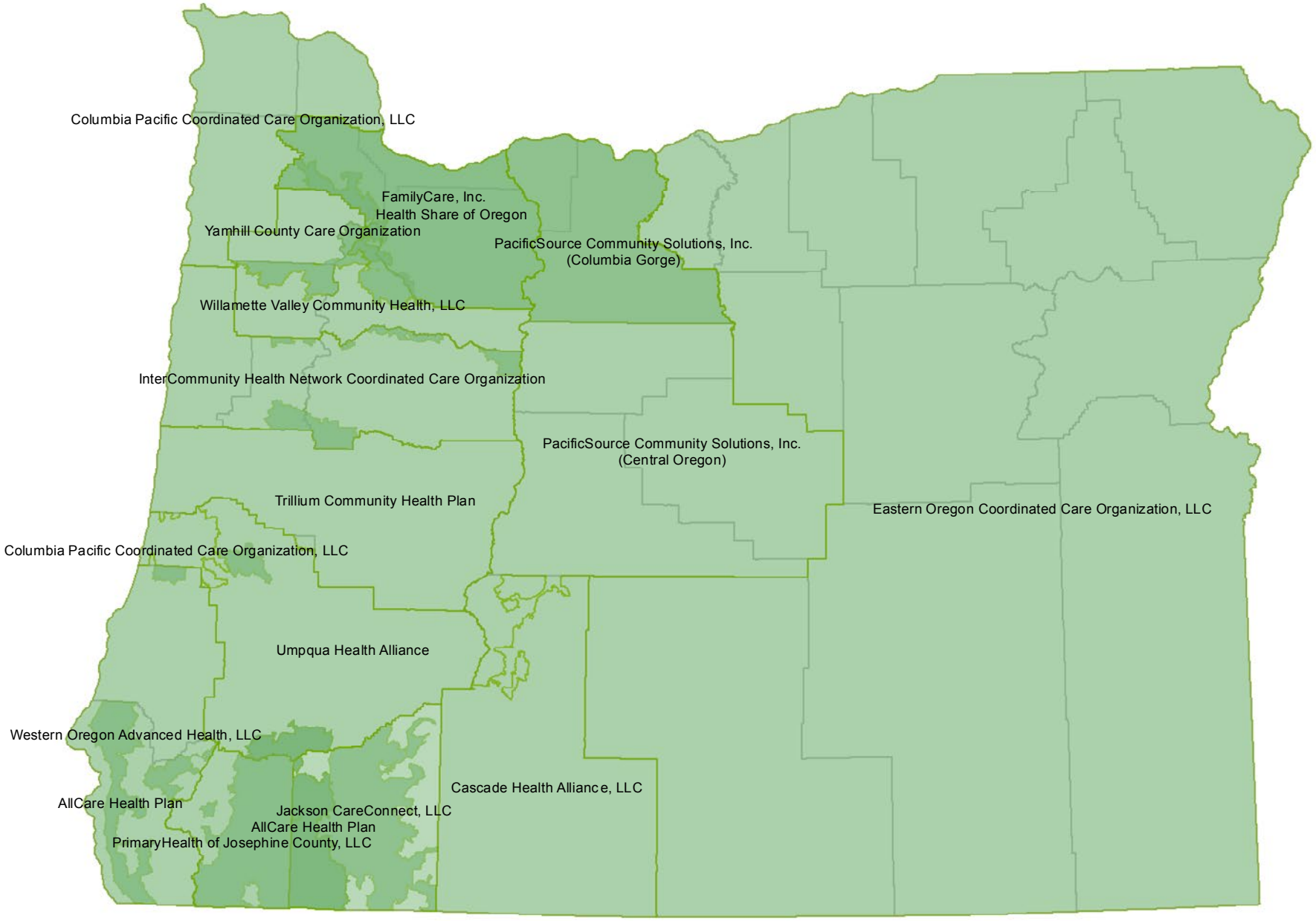
*** Benchmark in development

APPENDICES
Coordinated Care Organizations Service Areas

CCO Name	Service Area by County
AllCare Health Plan	Curry, Josephine, Jackson, Douglas (partial)
Cascade Health Alliance	Klamath County (partial)
Columbia Pacific Coordinated Care Organization	Clatsop, Columbia, Coos (partial), Douglas (partial), Tillamook
Eastern Oregon Coordinated Care Organization	Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union Wallowa Wheeler
FamilyCare	Clackamas, Marion (partial), Multnomah, Washington
Health Share of Oregon	Clackamas, Multnomah, Washington
Intercommunity Health Network CCO	Benton, Lincoln, Linn
Jackson Care Connect	Jackson
PacificSource Community Solutions (Central Oregon Region)	Crook, Deschutes, Jefferson, Klamath (partial)
PacificSource Community Solutions (Columbia Gorge Region)	Hood River, Wasco
PrimaryHealth of Josephine County	Douglas (partial), Jackson (partial), Josephine
Trillium Community Health Plan	Lane
Umpqua Health Alliance	Douglas (most)
Western Oregon Advanced Health	Coos, Curry
Willamette Valley Community Health	Marion, Polk (most)
Yamhill County CCO	Clackamas (partial), Marion (partial), Polk (partial), Yamhill

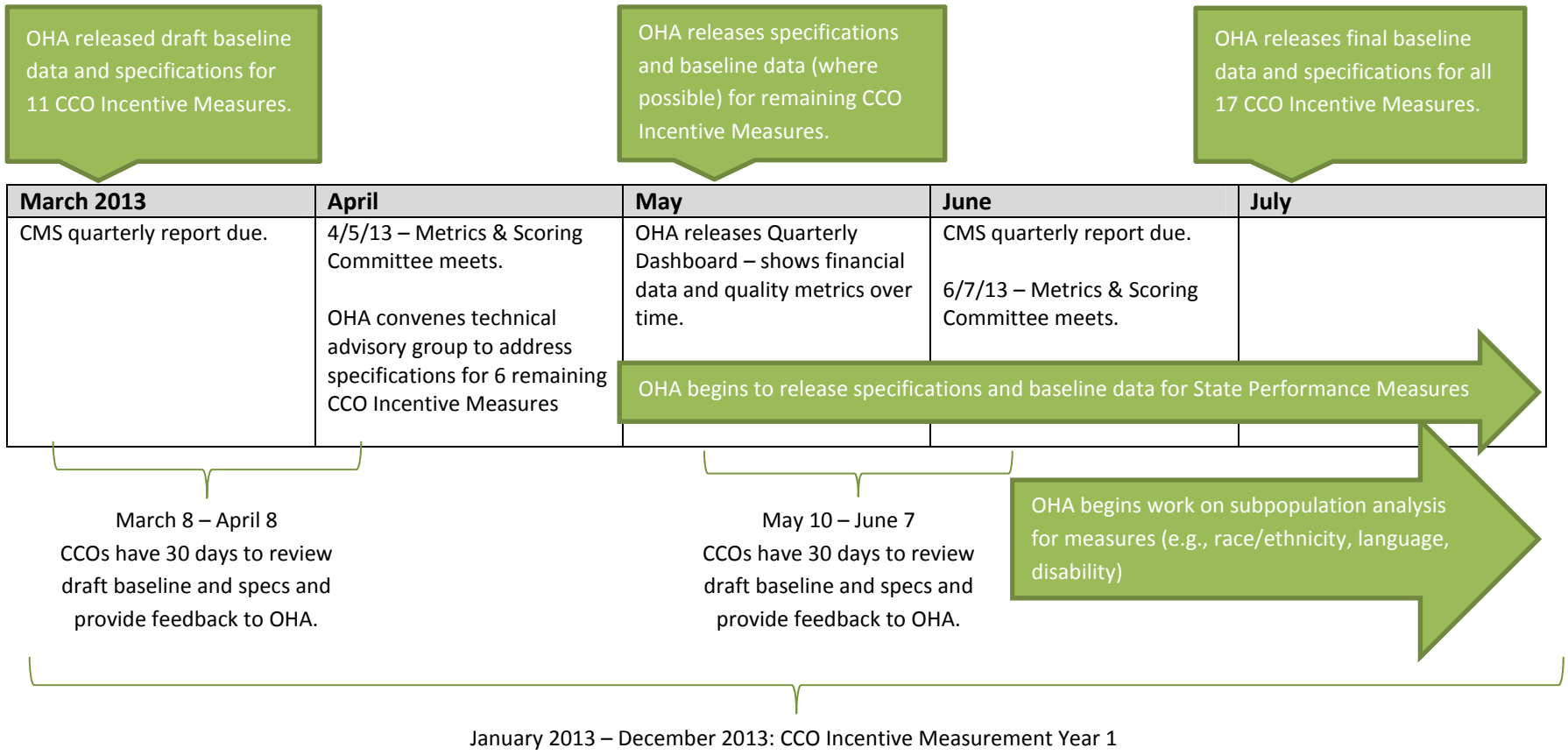
APPENDICES

Coordinated Care Organizations Service Areas



APPENDICES

Timeline: CCO Incentive Measures and Quality Pool Year 1



APPENDICES

Timeline: CCO Incentive Measures and Quality Pool Year 1

August 2013	September	October	November	December
OHA Quarterly Dashboard released.	CMS quarterly report due.		OHA Quarterly Dashboard released.	CMS quarterly report due.

OHA continues work on subpopulation analysis for measures. Releases analysis for CY 2011 baseline.

January 2013 – December 2013: CCO Incentive Measurement Year 1

OHA releases CY 2013 results for 17 CCO Incentive Measures.

Quality Pool funding is disbursed.

January 2014	February	March	April	May	June
	OHA Quarterly Dashboard released.	CMS quarterly report due.		OHA Quarterly Dashboard released.	CMS quarterly report due.

Critical period for CY 2013 claims submission. If claims are not submitted by March, OHA cannot include them in analysis to meet the June deadline.

OHA analyzes CY 2013 data for CCO Incentive Measurement Year 1.

January 2014 – December 2014: CCO Incentive Measurement Year 2

APPENDICES

OHA Contacts and Online Information

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For more information about baseline data and technical specifications for measures, visit:

http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

For more information about coordinated care organizations, visit:

www.health.oregon.gov

Oregon Health Authority

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OHA 8115 C (11/2013)