

Oregon Quality Measures Description and Methodologies



Information for a Healthy Oregon

Overview:

The goal of this quality measurement initiative is to improve patient care by coordinating and consolidating the information that health plans provide to practitioners. Claims data were submitted by participating health plans and data suppliers to the data services vendor, Milliman, who aggregated the data to calculate results at the practitioner level. *Partner for Quality Care* used clinic-supplied information to link practitioners to the appropriate clinic(s) to create clinic-level and medical group-level results. Reports include results for medical groups with four or more adult primary care practitioners (including nurse practitioners and physician assistants) in Oregon. For most measures, the data represent care provided to commercial and some managed care Medicaid patients between January 1, 2006, and March 31, 2009.

Measure Selection:

An expert committee of physician, plan, purchaser and consumer representatives identified principles for measure selection and the first set of Oregon measures. The measures are a subset of the national Ambulatory Quality Alliance Starter Set endorsed by the Institute of Medicine and the National Quality Forum (NQF). The 11 measures are computed using the Healthcare Effectiveness Data and Information Set (HEDIS) specifications developed and maintained by the National Committee for Quality Assurance (NCQA). Measures will continue to be tested and added or deleted as the effort matures.

Small Numbers of Patients for Some Practitioners:

Despite the large number of claims in the dataset, some practitioners and clinics may have only a small number of patients for some measures. In the aggregation process, patients were 'lost' (about 30%) because only patients who were continuously enrolled in health plans during the measurement period were counted. Additionally, some patients were not captured in the measures because: 1) their condition may not have been coded in a claim, 2) they are not members of a participating health plan, or 3) they don't meet extremely strict inclusion criteria for asthma and depression, or 4) they were assigned to a different practitioner. In some cases, the practitioner may not have had a full-time, full-year experience at the medical group in 2008 or the first quarter of 2009.

The data displays and confidence intervals are intended to help with interpretation when case numbers are small. Reports were sent to all practitioners in eligible clinics regardless of the number of patients in the report in order to increase awareness of the initiative and to solicit feedback.

Measure Name	Numerator: Definition for Compliance of Measure	Denominator: Definition of Condition and Exclusions
Asthma: Use of appropriate medications for people with persistent asthma	Dispensed at least one prescription for a preferred therapy during the measurement year*. Preferred asthma medications include anti-asthmatic combinations, antibody inhibitor, inhaled steroid combinations, inhaled corticosteroids, leukotriene modifiers, mast cell stabilizers, and methylxanthines.	<p>Asthma is defined by: Patients 5–56 years of age during the measurement year* and the year prior who were identified as having persistent asthma because of at least four asthma medication dispensing events, at least one ED visit with asthma as the primary diagnosis, at least one acute patient discharge with asthma as the principal diagnosis, or at least four outpatient asthma visits.</p> <p>Exclude from the eligible population all members diagnosed with emphysema or COPD.</p>
Coronary Artery Disease: Cholesterol management (LDL test) for patients with cardiovascular conditions	Had at least one LDL-C test during the measurement year*.	<p>Coronary artery disease is defined by: 1. Patients 18-75 years discharged alive for AMI, CABG, or PTCA on or between April 1, 2007 – February 1, 2008; or 2. Patients 18-75 years who had a diagnosis of any ischemic vascular disease (IVD) between April 1, 2007 – March 31, 2009. Note: AMI and CABG are from inpatient claims only.</p>
Diabetes: HbA1C testing	Had at least one HbA1c test performed during the measurement year.*	<p>Diabetes is defined by: 1. Patients 18-75 years of age who were dispensed insulin or a hypoglycemic/anti-hyperglycemic on an ambulatory basis; 2. Patients who had two face-to-face encounters with different dates of service in an outpatient setting or non-acute inpatient setting with a diagnosis of diabetes; or, 3. Patients with one face-to-face encounter in an acute inpatient or emergency room setting with a diagnosis of diabetes.</p> <p>Exclusions: Patients with gestational diabetes, steroid-induced diabetes, or polycystic ovaries.</p>
Diabetes: LDL-C test	Had at least one LDL-C screening test done during the measurement year*.	
Diabetes: Eye exam (retinal) performed	Had an eye screening for diabetic retinal disease. This includes those diabetics who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the measurement year*.	
Diabetes: Evidence of nephropathy assessment, treatment, or prevention	Screening for nephropathy or evidence of nephropathy during the measurement year*. Evidence of nephropathy includes a nephrologist visit, a positive urine macroalbumin test as documented by claims, or treatment with ACE inhibitor/ARB therapy.	

*The results are based on administrative claims data with dates of service between January 1, 2006, and March 31, 2009, and the measurement year of April 1, 2008 – March 31, 2009.

Depression: Antidepressant medication management: acute phase	Patients who remained on an antidepressant medication for at least 84 days (12 weeks) as determined by prescription fills.	Depression is defined by: Patients aged 18 and older diagnosed with a new episode of major depression during the measurement year* and prescribed antidepressant medication. Exclusions: Patients who had an acute inpatient stay with a principal diagnosis of mental health or substance abuse during the 245 days after the episode start date. Patients with brief depressive reaction are excluded since the diagnosis includes grief reaction.
Depression: Antidepressant medication management: continuous phase	Patients who remained on an antidepressant medication for at least 180 days (6 months) as determined by prescription fills.	
Breast cancer screening	Women who had a mammogram during the measurement year* and the year prior.	Women eligible for breast cancer screening include: Women 40-69 years of age. Exclusions: Women who had a bilateral mastectomy or 2 separate mastectomies billed in 2005 – first quarter of 2009.
Cervical cancer screening	Women who had a Pap test during the measurement year* and two years prior.	Women eligible for a Pap test include: Women 21-64 years of age. Exclusions: Women who had a hysterectomy billed in 2005 – first quarter of 2009.
Chlamydia screening	Women who had a Chlamydia test during the measurement year*.	Women eligible for a Chlamydia screen include: Sexually active women 16-24 years of age. Sexually active women are identified by either having filled a prescription for contraceptives during the measurement year* or had at least 1 claim with a code to identify sexually active women. Exclusions: Women who had a pregnancy test during the measurement year followed within 7 days by either a prescription for Accutane or an x-ray are excluded.

Achievable Benchmark of Care (ABC): The ABC Benchmark, developed at the University of Alabama at Birmingham, indicates the mean rates of best performing Oregon clinics providing care to at least 10% of the patient population. The achievable benchmark for each measure was calculated using data from this initiative. The ABC provides an objective method for identifying benchmark performance levels *already achieved* by "best-in-class" clinics within Oregon. For detailed information, see the website: <http://main.uab.edu/show.asp?durki=14503>

Methodology for Assigning Patients to Practitioners and Clinics: An expert committee of physician, plan, purchaser and consumer representatives selected the method for assigning patients to a primary care practitioner (PCP). This method attributed the patient to the PCP who

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was seen the most frequently during the measurement period* and the year prior. If a tie occurs, the most recently seen PCP was attributed. Each patient was attributed to only one PCP.

Accuracy of Claims Data: Through the validation process, errors and omissions in data were identified as stemming from multiple sources including both the health plans and the delivery system. After extensive refinement, test clinics determined that 98% of their patients were correctly attributed to their PCP. Remaining sources of error were varied and often specific to the medical group or health plan. For some conditions, such as diabetes, the denominator was extremely accurate; while for others, such as Pap tests, the denominator occasionally included women who'd had a hysterectomy prior to 2005. Evidence of services is not always captured in claims and is usually due to coding issues. Attending physicians who serve in residency programs may have patients attributed to them who were seen and followed by a resident physician. However, validation clinics determined that billing data can provide useful patient-level information to clinics including prescription fills, ER visits, and evidence of diagnostic tests.

Data Missing in this Round: The dataset contains information from eight health plans. Claims data from United Health Care and additional Medicaid claims will be added in the next round of data submission. Claims for Medicare patients are not included nor are claims from Aetna, Cigna, other non-domestic insurers, and some managed care Medicaid plans. Denied claims and self-pay visits are not included.

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