Central Oregon Health Council

**RHIP Clinical Cardiovascular Disease Workgroup**
**PacificSource—Mosaic Conference Room (2nd Floor)**
**2965 NE Conners Avenue, Bend**

**Agenda: July 25, 2017 from 4:00-5:00pm**

## Goals

**Clinical Goal:** Improve hypertension control
**Prevention Goal:** Increase awareness of the risk factors for cardiovascular disease including tobacco use, uncontrolled hypertension, high cholesterol, obesity, physical inactivity, unhealthy diets, and diabetes.

| Health Indicators by 2019 | QIM Measure | State Measure | Healthy People 2020 |
|---|---|---|---|
| 1. Increase the percentage of OHP participants with high blood pressure that is controlled (<140/90mmHg) from 64% to 68% (Baseline: QIM NQF 0018 - Controlling high blood pressure, 2014). | √ | | √ |
| 2. Decrease the prevalence of cigarette smoking among adults from 18% to 16% (Baseline: Oregon BRFSS, 2010-13; QIM Cigarette Smoking Prevalence). | √ | | √ |
| 3. Decrease the prevalence of smoking among 11th and 8th graders from 12% and 6%, respectively to 9% and 3%, respectively (Baseline: Oregon Healthy Teens Survey, 2013). | | | √ |
| 4. Decrease the prevalence of adults who report no leisure time physical activity from 16% in Crook County, 14% in Deschutes County and 17% in Jefferson County to 14%, 12%, and 15 % respectively (Baseline: Oregon BRFSS, 2010-13). | | | |
| 5. Decrease the prevalence of 11th graders and 8th graders who 0 days of physical activity from 11% and 6% to 10% and 5%, respectively (Baseline: Oregon Healthy Teens, 2013). | | | |

1. 4:00-4:05 **Introductions—All**
2. 4:05-4:30 **Smoking Prevalence eCQM Challenges—Beth Quinlan & Workgroup Members**
3. 4:30-4:55 **The Future of the Smoking Prevalence QIM—Ken House & Workgroup Members**
4. 4:55-5:00 **SmokeFree Oregon QIM Proposal LOS Updates—All**
5. 5:00 **Action Items—All**
   - **Next steps**

**Next Meeting: August 30, 2017 from 10-11:30am**
- **Continue A3 Process**


| Cardiovascular Disease - Clinical (10) | Organization |
|---|---|
| Mark Backus, MD, FACP | Cascade Internal Medicine Specialists |
| Megan Bielemeier, MSN, BSN, RN, CCM | St. Charles Medical Group |
| Stevi Bratschie, MPH | PacificSource |
| David Huntley, MPH | Epidemiologist - Community Member |
| Alison Little, MD, MPH | PacificSource |
| Penny Pritchard, MPH | Deschutes County Health Services |
| Robert Ross, MD, MScED, FAAFP | St. Charles Health System/St. Charles Medical Group |
| Divya Sharma, MD, MS | Central Oregon IPA & Mosaic Medical |
| Shiela Stewart, RN, BSN | Central Oregon IPA |
| Kris Williams | Crook County Health Department |

# Cigarette Smoking Prevalence Metric – FAQ

May 12, 2016

This document provides frequently asked questions and answers regarding the new cigarette smoking prevalence metric, and is designed to accompany the measure specification sheet.

Please direct any additional questions to Metrics.Questions@state.or.us.

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**Are the measure specifications posted online final?**

OHA updated the cigarette smoking prevalence measure specifications on May 12th – these are the most current specifications available. OHA does not intend to publish further "final" specifications, although reserves the right to update these specifications for CY 2016 if additional clarification is needed, or errors found.

**Is the measure based on Meaningful Use Core Objective "Record Smoking Status" or Meaningful Use NQF 0028 "Tobacco Use Assessment & Cessation Intervention"?**

The measure is based on the Meaningful Use Core Objective "Record Smoking Status." Please note that the new measure does not directly align with the Core Objective, which looks for the percent of patients who have their status recorded. While this is one component (Rate 1) of the CCO measure, the CCO measure then looks at of those who have their status recorded, how many are cigarette smokers (Rate 2) and/or tobacco users (Rate 3).

However, some EHRs may already have functionality to be able to report on prevalence in line with the CCO measure specifications based on a custom query from NQF 0028, rather than the Core Objective.

**Are there technical specifications available for the Meaningful Use Core Objective "Record Smoking Status"?**

The Core Objective is *not* an eCQM and there are not equivalent specifications or logic flows available.

Documentation of the Objective is available online here: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2013DefinitionEP_9_Record_Smoking_Status.pdf

CEHRT criteria are available online here: https://www.healthit.gov/sites/default/files/commonclinicaldataset_ml_11-4-15.pdf

**According to CMS, the Core Objectives are going away. What does this mean for CCOs' ability to leverage existing reporting?**

OHA's understanding of CMS' guidance for Modified Stage 2 and Stage 3 Meaningful Use is that while smoking status goes away as a Core Objective, it was removed with the assumption that all EHRs will maintain the ability to record smoking status as a basic functionality.

The same guidance also notes that CMS is removing "record demographics" and "record vital signs" as core objectives, but again with the understanding that EHRs will continue to support these basic functions.

**The measure specifications reference the Clinical Practice Guidelines: Treating Tobacco Use and Dependence (2008). What information from the Guidelines is needed for the measure?**

The Clinical Practice Guidelines were used to create the minimum cessation benefit requirements for the pharmacotherapy products. The Guidelines are included in the specifications as a reference, and while they include helpful suggestions for clinic and health plan interventions, they are not needed to implement the measure specifications.

**Appendix 2 of the measure specifications states that CCOs must use one of the following options (if Meaningful Use reports are available versus if unavailable). Does the CCO need to select a single option for use across all clinics that will be reporting?**

No. OHA anticipates that each clinic will have their own approach and is not requiring CCOs to standardize across their entire data submission for this measure. This will be something that will be identified as part of the Year Four Data Proposal documentation for each clinic that will be submitting data.

**What if tobacco use is recorded in the EHR in a structured way, but not according to the Meaningful Use Standard Criteria?**

The measure can include any cigarette smoking and/or tobacco use status recorded as structured data (i.e., fields in the EHR that can be queried – not chart review, or open text chart notes). As long as the status is recorded as structured data and can be queried, it does not need to align with the Standard Criteria.

**The specifications refer to "provider" – does this mean Meaningful Use Eligible Providers?**

Yes. The preference is to limit this reporting to those Eligible Provider types.

**Will OHA provide SNOMED codes to identify cigarette smoking and tobacco use?**

There is considerable variance in how each EHR reports tobacco use – despite the Meaningful Use Core Objective and Standards Criteria, this is not very standardized. The measure is designed to allow as much flexibility across EHRs as possible; therefore OHA will not require specific SNOMED codes to be used for numerator compliance.

However, if using the Standards Criteria, there are SNOMED codes for each status. The SNOMED codes have been cross-walked to our measure specifications in the table below:

| Status | SNOMED | SMOKING STATUS RECORDED | SMOKING PREVALENCE | TOBACCO PREVALENCE |
|---|---|---|---|---|
| Current every day smoker | 449868002 | Y | Y | Y |
| Current some day smoker | 428041000124106 | Y | Y | Y |
| Former smoker | 8517006 | Y | | |
| Never smoker | 266919005 | Y | | |

| Status | SNOMED | SMOKING STATUS RECORDED | SMOKING PREVALENCE | TOBACCO PREVALENCE |
|---|---|---|---|---|
| Smoker, current status unknown | 77176002 | Y | Y | Y |
| Unknown if ever smoked | 266927001 | | | |
| Heavy tobacco smoker | 428071000124103 | Y | Y | Y |
| Light tobacco smoker | 428061000124105 | Y | Y | Y |

There are additional SNOMED CT codes that may be helpful in designing reports, but again, will be dependent on each individual EHR's functionality. OHA would be interested in hearing from any CCOs / clinics that have mapped their tobacco use recording to these SNOMED codes.

Use of these SNOMED CT codes are not officially required as part of the measure specifications, but a crosswalk to our specifications is provided in the table below for reference:

| Category | SNOMED | SMOKING STATUS RECORDED | SMOKING PREVALENCE | TOBACCO PREVALENCE |
|---|---|---|---|---|
| Tobacco use and exposure – finding | 365980008 | Y | | Y |
| Ex-tobacco user | 702975009 | Y | | |
| Finding relating to moist tobacco use | 228499007 | Y | | Y |
| Finding related to tobacco chewing | 228509002 | Y | | Y |
| Maternal tobacco abuse | 16994006 | Y | | Y |
| Maternal tobacco use | 427189007 | Y | | Y |
| Never used tobacco | 702979003 | Y | | |
| No known exposure to tobacco smoke | 711563001 | Y | | |
| Passive smoker | 43381005 | Y | | |
| Snuff use – finding | 365983005 | Y | | Y |
| Tobacco consumption unknown | 160614008 | | | |
| Tobacco smoking behavior – finding | 365981007 | Y | Y | Y |
| Tobacco user | 110483000 | Y | | Y |

**How should "Unknown if ever smoked" from the Standards Criteria be reported / counted in the measure?**

Unknown if ever smoked is likely designed for obtunded / demented / non-history given patients and is expected to be a low percentage of the overall denominator. "Unknown if ever smoked" should be counted as missing.

If any CCOs are interested in tracking any usage of "unknown if ever smoked" in their reporting, OHA is interested in the results, as this may be more appropriate as an exclusion in future versions of the measure.

**If a member has their tobacco use status recorded multiple times, potentially from several providers, which status should be included in the measure?**

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

If tobacco use status has been recorded multiple times *across multiple practices*, reporting is dependent on the ability to de-duplicate individuals across multiple practices in the data submission. As OHA is not yet requiring all of the data to be submitted at the individual level, OHA will not be requiring de-duplication across all practices in the Year Four data submission. If reporting this at the practice level, the individual will be in the denominator and numerator once per practice, although they may be in multiple practices' data.

**Can marijuana be included in the prevalence report if it is *not* recorded separately from cigarette smoking in the EHR?**

No. This would not meet the measure specifications or the Core Measure. The EHR should work to separate out cigarette and marijuana smoking into discrete fields before developing a report and being included in a CCO's data submission.

**Will OHA provide codes / value sets to exclude individuals on nicotine replacement therapy (NRT)?**

No. If the measure is based on the Meaningful Use Core Measure "Record Smoking Status" – there should not be a problem in developing reports based on how / where smoking status is collected, without querying anything related to nicotine replacement therapy.

The exclusion related to nicotine replacement therapy is added to clarify that NRT should not be treated as equivalent to cigarette smoking or tobacco use *nor* should it be taken as a given that an individual with NRT is a non-smoker.

It is possible that a member is both on NRT and still documented as a tobacco user (in the fields where cigarette smoking / tobacco use status are recorded). In this case, the member would be counted as a tobacco user, despite the use of NRT. Individuals should only be counted as non-tobacco users when they have successfully quit, which would then be reflected in updated tobacco use status at subsequent visits.

**If NRT is being excluded from the measure, should non-nicotine prescriptions for tobacco cessation also be excluded?**

No. The measure is not about cessation services being provided, or percent of individuals who received medical assistance for smoking cessation. The measure is a measure of prevalence. Providers who write prescriptions for patients (NRT or non-nicotine) should not translate that prescription to mean the member is now a non-smoker.

**How should a report determine if individuals are both on NRT and still smoking or using tobacco?**

If an individual is still smoking, or using tobacco, despite NRT, they should be included in the numerator as this is a measure of prevalence.

The NRT exclusion was added to the specifications to clarify how / what status should be documented in the EHR, not to remove all NRT users from the measure entirely.

**If an individual is a former cigarette smoker and on NRT, but took up chewing tobacco, how should they be counted in the measure?**

The NRT would not be a factor in this individual's inclusion or exclusion in the measure. In this scenario, the individual is not included in Rate 2 (cigarette smoking prevalence), but would be included in Rate 3 (tobacco use prevalence).

**Do existing Meaningful Use reports apply the "eligible as of the last date of the reporting period" or is this a new concept for clinics reporting Meaningful Use?**

Meaningful Use is designed for clinics to measure their patients; eligibility is a health plan reporting construct. The specifications ask for this eligibility criteria "where possible" to reflect that some CCOs have integrated data warehouses and can look at eligibility and clinical data in conjunction. This is not expected of every practice in a CCO's data submission, especially as this is not part of standard Meaningful Use reporting.

**Will clinics be able to submit data for a partial year if they implemented a change to their EHR or workflow?**

Yes. Clinics will be able to submit data for a partial year. OHA has an exception process as part of the Data Proposal where CCOs will indicate which clinics would be reporting partial years and why.

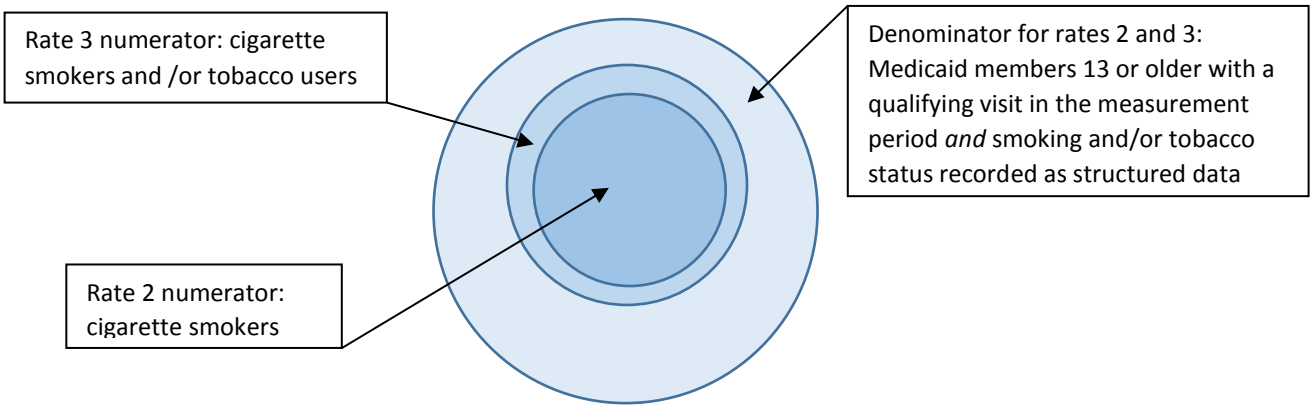
Please note that pending determination of the population threshold for this measure for 2016 it may be preferable to not include some clinics if the reporting capacity is not built out, although each CCO will need to make this determination given their collective ability to report, as well as the potential 'cherry picking' that this may create for their baseline. That is, including fewer clinics may result in an artificially lower baseline, which would then make it harder to meet improvement targets / benchmarks in subsequent years when more clinics are included.

# Additional FAQ on cigarette smoking prevalence measure

November 2016

**Background to questions**

These questions involve the numerators for rate 2 and rate 3. The rate 2 numerator is Medicaid members 13 or older who had a qualifying visit during the measurement period, had smoking and/or tobacco use recorded as structured data, AND are cigarette smokers. The rate 3 numerator is Medicaid members 13 or older who had a qualifying visit during the measurement period, had smoking and/or tobacco use recorded as structured data, AND are cigarette smokers *and/or* tobacco users.




Ideally, it would be possible to measure both cigarette smoking and other forms of tobacco use to support reductions in overall tobacco prevalence. Reporting data on rate 3, however, is not possible from many EHRs.

Before finalizing the cigarette smoking prevalence measure, OHA fielded a survey to better understand how tobacco use status is collected and reported out of EHRs. http://www.oregon.gov/oha/analytics/MetricsTAG/May%2028,%202015%20Materials.pdf (survey results begin on p5 of the PDF) Based on the survey, OHA expected that practices would be able to produce the data for rate 2, and so the benchmark and improvement targets for this measure are compared to rate 2.

Measure specifications and an earlier set of FAQs can be found here: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

**Question 1: If a practice is able to produce numerator data for rate 2 but not rate 3, can the CCO report that data in its data submission?**

Yes, OHA will accept data submissions that include rate 2 but not rate 3. Although complete reporting is preferred, the prevalence rate for the measure is calculated based on rate 2.

**Question 2: If a practice is able to produce numerator data for rate 3 but not for rate 2, can the CCO report that data in its data submission?**

OHA will accept data submissions that lack rate 2 only in exceptional circumstances. The CCO would need to request approval from OHA prior to submitting data and receive approval through the Data Proposal process. This discussion should begin as early as possible.

Because the numerator for rate 3 includes both cigarette smokers and tobacco users, it always will be at least equal to and generally will be higher than the numerator for rate 2, which includes cigarette smokers only. When performance is calculated, therefore, the smoking prevalence rate will appear to be higher (worse) if the calculation includes rate 3 numerator data.

Reporting on rate 3 one year and rate 2 the following year would appear to create an improvement in performance, regardless of any actual decline in smoking prevalence from year to year. If a CCO submits data on rate 3 and not rate 2 for some or all of its key practices in a given year, then for the following year, OHA reserves the right to assess the CCO's performance against the benchmark only, with no improvement target.

# RHIP Workgroup Updates: June

**Behavioral Health: Identification & Awareness (Support: Rebeckah Berry & Mike Franz)**

- This group meets the fourth Tuesday of every month from 8:15-9:30am and currently has 21 members.
- In June, the group continued their A3 process with the aim of identifying and engaging 100% of individuals in Central Oregon that have a behavioral health need, and ensure an effective and timely response.

**Behavioral Health: Substance Use and Chronic Pain (Support: Rebeckah Berry & Rick Treleaven)**

- This group meets the third Wednesday of every month from 3:45-5pm and currently has 27 members.
- In June, the group continued the work of evaluating how to measure their metrics for the Substance Use & Chronic Pain area of focus. Once this group completes this process, they will begin their first A3 (likely in August).

**Cardiovascular Disease—Clinical (Support: Rebeckah Berry & Shiela Stewart)**

- This group meets the fourth Tuesday of every month from 3:45-5pm and currently has 10 members.
- In June, this workgroup agreed to continue the focus of their A3 around eliminating all youth tobacco use in Central Oregon in addition to submitting for QIM funds around a SmokeFree media campaign to raise awareness of targeted tobacco advertising.

**Diabetes—Clinical (Support: Rebeckah Berry & Therese McIntyre)**

- This group meets the second Thursday of every month from 9-10:30am and currently has 12 members.
- In June, this workgroup continued their A3 process with the aim of 95% of Central Oregonians with Type 2 Diabetes will have an HbA1c of < 9%.

**CVD & Diabetes: Prevention (Support: MaCayla Arsenault, Sarah Worthington, & Steve Strang)**

- This group meets the fourth Tuesday of every month from 3:30-5pm and currently has 26 members.
- In June, this workgroup dug deeper into the data for their metrics and shared information on current pay to play fees and scholarship programs in the region. They also continued their work on their A3 around removing barriers for students participating in physical activities. Next month they will continue to put their experiments through the PICK chart. However, they have determined their first step is to build relationships and partnerships with schools and invite them to participate in the A3 process.

# RHIP Workgroup Updates: June

## Oral Health (Support: Donna Mills & Mary Ann Wren)

- This group meets the third Tuesday of every month from 11-12pm and currently has 23 members.
- The Oral Health Workgroup heard a presentation from Heather Simmons of PacificSource regarding Oral Health metrics compared across CCO's. The group will resume work on the A3 process at the July meeting.

## Reproductive Health/Maternal Child Health (Support: Donna Mills & Muriel DeLaVergne-Brown)

- This group meets the second Tuesday of every month from 4-5pm and currently has 22 members.
- The Reproductive Maternal/Child Health Workgroup worked through their Problem Statement and Aim on their A3. In July they will move on to Box 2 and 3, initial and target states.

## Social Determinants of Health

- This group meets the third Friday of every month from 10:30-11:30am and currently has 26 members in Kindergarten Readiness and 37 members in Housing.

### Education & Health (Support: Donna Mills & Desiree Margo)

- The Kindergarten Readiness workgroup broke into the three subgroups identified during the process they completed in May; Literacy, Social and Emotional Supports, and Integration of Services/Access. Each group worked on Box 1 of their respective A3s.

### Housing (Support: Bruce Abernethy & MaCayla Arsenault)

- In June, the workgroup reviewed and refined their drafted A3 around addressing the problem that Central Oregon communities do not have a comprehensive understanding of the current housing/homeless needs which results in missed opportunities for additional funding, unaligned efforts, and a lack of commitment to act. In their gap analysis, they decided to start with completing a Housing Needs Assessment. Their second A3 addresses the problem that Central Oregon has a population of chronically homeless and high utilizers of government, public, and private services whose health and housing needs are not being met by current approaches, continuing the cycle of homelessness and illness.