Public Health Division

John A. Kitzhaber, M.D., Governor

Oregon Health Authority

800 NE Oregon Street
Portland, OR 97232
971-673-1222 Phone
971-673-1299 FAX
971-673-1222 TTY - TDD

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Oregon Health Authority
State Innovation Model Year 2 Operational Plan Update
Attestation for Section E, Population Health Plan Roadmap

Background and capacity
The Oregon Health Authority (OHA) has invested SIM funding in core population health integration activities. The following population health activities have been underway since the start of Oregon's SIM grant.

- **Enhanced public health data and surveillance capacity.** In Demonstration Year 1, OHA began fielding a Behavioral Risk Factor Surveillance System Survey (BRFSS) of Medicaid members. In Years 2 and 3, SIM funds will support a general population BRFSS race/ethnic oversample and the Oregon Healthy Teens survey of 8th and 11th graders. In addition, in Demonstration Year 1 OHA conducted analyses of key population health indicators by coordinated care organization (CCO) region and by race/ethnicity. OHA is also directing SIM funds toward enhancing the Oregon Public Health Assessment Tool (OPHAT), which provides users with access to a queriable public health database. OPHAT users can create customizable queries to conduct community health assessments and track progress on population health goals. The intent behind investing in these core public health surveillance systems is to provide CCOs, local public health authorities, hospitals, community-based organizations and other partners with timely information on the health status of their population in order to develop, implement and monitor community health improvement plans.
- **Support for population health and coordinated care organization (CCO) integration.** In Demonstration Year 1, OHA released a competitive Request for Grant Applications for local public health authorities and CCOs to implement evidence-based population health interventions in both the health system and community settings. As a result, four unique community prevention programs are underway, collectively supporting six of 16 CCOs and 20 of 34 local public health authorities. As grantees were required to align their proposals with local community needs, CCO incentive measures and performance improvement plans, funded initiatives are diverse and include prevention of opioid-related overdose deaths, tobacco control and maternal and child health promotion.

These two project areas are currently supported by 2.0 FTE funded by SIM; one research analyst leading the development of OPHAT and one operations and policy analyst managing the community prevention grant program and serving as a liaison between OHA's Public Health Division and other OHA offices and programs on health system transformation.

In addition to the SIM funds directly managed by OHA's Public Health Division, population health is integrated throughout Oregon's SIM grant activities and has been an intentional part of Oregon's health system transformation since its inception. Improving population health has been a core component of every health system transformation strategy that Oregon has developed in recent years; notably the 2008 Oregon Health Fund Board's *Aim High: Building a Healthy Oregon* report and the 2010 Oregon Health Policy Board's *Action Plan for Health*. Some specific ways population health is integrated in Oregon's overall approach include the following initiatives.

- **Quality metrics.** OHA's Public Health Division has provided technical support to other OHA staff in the development of specifications for certain health system transformation measures; OHA Public Health Division staff have provided content area expertise in the development of measure specification documents in order to help CCOs achieve their goals. In addition, in April 2014, the State Health Officer proposed six options for population health measures to the Metrics and Scoring Committee for their consideration as a part of the 2015 measure set. The Metrics and Scoring Committee will be considering these population health measures among other suggestions, with a goal to finalize the 2015 measure set in Fall 2014. See Attachment A for more information about alignment between various measure sets in Oregon.
- **Learning collaboratives and other technical assistance support.** Staff from OHA's Public Health Division meet routinely with staff from the OHA Transformation Center to plan and execute learning collaboratives and other technical assistance opportunities for CCOs, providers, Community Advisory Councils and others. For example, local public health experts have presented on panels during the Transformation Center's Complex Care Learning Collaborative; the aforementioned community prevention grantees led a discussion about population health integration at the June 2014 CCO learning collaborative; several public health-led sessions were offered at the first annual Community Advisory Council Summit; and the SIM-funded operations and policy analyst in OHA's Public Health Division serves on the Community Advisory Council Steering Committee. OHA's Transformation Center, Office of Equity and Inclusion and Public Health Division are working collaboratively to provide technical assistance and support CCOs as they begin implementing their community health improvement plans. Finally, in conjunction with the Coordinated Care Model Summit in December 2014, the OHA Transformation Center and Public Health Division will facilitate a meeting between local public health administrators and CCO leadership about opportunities to leverage population health approaches in local health system transformation efforts.
- **Patient-centered primary care home support.** Staff from OHA's Public Health Division have provided evidence-based resources to the Patient-Centered Primary Care Home Institute and program to assist providers in effectively delivering preventive health services and linking to community-based population health resources such as the Stanford Chronic Disease Self-Management Program and the Oregon Tobacco Quit Line. In addition, the OHA Public Health Division's School-Based Health Center (SBHC) Program is providing support to SBHCs interested in becoming recognized as Patient-Centered Primary Care Homes.
- **Traditional health workers.** Staff from OHA's Public Health Division have provided information about training programs appropriate for traditional health workers, such as health education and health promotion programs that can be used for traditional health worker continuing education credit. OHA's Public Health Division and local public health authority partners will continue to support the launch of traditional health worker certification and training.
- **Mental health integration.** OHA's Public Health Division has partnered with the OHA Addictions and Mental Health Division to fund performance improvement projects with adolescent providers to implement screening, brief intervention and referral to treatment (SBIRT) for

substance use, as well as depression screening and follow-up within the context of an adolescent well visit. SBIRT, depression screening and adolescent well visits are all CCO incentive measures (see Attachment A); this project aims to support CCOs in achieving three of their 17 incentive measures.

- **Public Employees' Benefit Board (PEBB) benefit design.** Staff from OHA's Public Health Division have provided support to PEBB in the design of its Health Engagement Model and chronic disease self-management benefits. OHA Public Health Division staff work with PEBB to field the Behavioral Risk Factor Surveillance System Survey of State Employees (BSSE); these survey results are used to track behavioral risk factors of PEBB members and to make informed decisions about benefit design.

Plans for SIM Demonstration Years 2 and 3

Over the course of Demonstration Year 2 and throughout the term of the SIM grant, OHA will continue to integrate population health in its overall approach to spreading the coordinated care model.

OHA's Public Health Division has planned to revise the State Health Improvement Plan (SHIP), which was developed in 2012 as a part of the state's accreditation efforts, in order to receive additional stakeholder input on Oregon's priorities and strategies for improving population health. OHA's Public Health Division also acknowledges the need to revise the SHIP in light of Oregon's rapidly transforming health system.

Between May and August 2014, leadership from OHA's Public Health Division are meeting with local public health authorities, CCOs and Community Advisory Councils, academic partners, local elected officials, providers and community-based organizations across the Oregon to obtain feedback on:

1. What health issues should be included in the SHIP (based on leading causes of death, areas where Oregon falls below the national ranking, areas where Oregon is trending in the wrong direction and/or where an issue is one of CDC's Winnable Battles);
2. Where there is overlap between the SHIP and community health improvement plans; and
3. How to leverage shared population health strategies in the SHIP and in community health improvement plans to achieve maximum impact.

Once stakeholder meetings are complete, feedback will be compiled and an achievable number of strategic priorities will be identified for inclusion in the new SHIP which will range from 2015-2020. When priorities are identified, OHA Public Health Division staff will convene working groups to draft strategies to meaningfully impact priority health areas by 2020. Strategies will be vetted through OHA leadership and programs before being shared back with external stakeholders for review and comment. OHA's Public Health Division will finalize the SHIP by December 2014.

In developing the strategies to achieve each priority area, OHA Public Health Division staff will align strategies in three areas:

1. Policy, systems and environmental change interventions;
2. Interventions that link the health system with communities; and
3. Health system interventions.

This approach will clearly articulate the synergy between public health and health care delivery systems in addressing prevention and population health.

For each strategic priority selected, measures will also be identified and will align to the greatest extent possible with Oregon's existing and proposed measure sets and CDC's recommended population health

measures. In addition, OHA will consider opportunities for SHIP measures to align with the new Child and Family Well-being Measurement Workgroup, which seeks to identify high impact areas that cross Oregon's health system and early learning transformation efforts.

Employing CDC technical assistance
OHA staff will participate in all required CDC-supported technical assistance initiatives, including those offered via monthly conference calls, site visits, webinars and other venues.

Tracking of tools/templates and resources
Once the SHIP is developed, OHA's Public Health Division will leverage its Performance Management Program and quality improvement resources to track the progress of SHIP objectives and related population health metrics. OHA's Public Health Division will coordinate with appropriate entities for monitoring of any selected measures that are already being collected and reported.

Other tools, templates and resources that are developed will be posted to the OHA Transformation Center and Public Health Division websites and to the Conference of Local Health Officials' website.

Incorporation of population health core measures of diabetes, tobacco and obesity
Tobacco use and obesity are the leading causes of death in Oregon and thus are likely to be included as priorities in the SHIP. Attachment A highlights the degree to which OHA has already adopted measures related to tobacco, obesity, diabetes and related risk factors. In Year 2, OHA will continually update the existing measure crosswalk with other CDC-required measure sets, particularly those for new CDC funding opportunities for which OHA is applying, and will ensure the matrix is updated with ongoing changes to the existing measure sets. This crosswalk will then be used to identify appropriate measures to track OHA's progress towards health outcomes prioritized for inclusion in the SHIP. Existing relevant measures include diabetes: HbA1c control; comprehensive diabetes care: HbA1c testing and LDL-C screening; tobacco use prevalence for members; obesity prevalence for members; and medical assistance with smoking cessation.

Outreach to state health officials and providers
Oregon's Public Health Director, Lillian Shirley, participates on the SIM Operations team and numerous other executive leadership groups. Ms. Shirley was formerly vice-chair of the Oregon Health Policy Board and she served on the Board of Directors for Health Share of Oregon CCO during her tenure as the Director of the Multnomah County Health Department.

In the development of the SHIP, OHA Public Health Division staff have invited CCOs, Community Advisory Councils and local health care providers to community meetings; additional input from the health care community will be sought through outreach to professional organizations and through existing meetings with key partners.

As referenced above, OHA's SIM grant funds two full-time positions in the OHA Public Health Division; these staff participate in SIM operations meetings and partner on the above-listed initiatives to integrate population health in Oregon's health system transformation efforts.

Communication strategy
OHA uses the Transformation Center's communication systems and learning collaboratives to spread best practices for incorporating population health in all communities and non-clinical settings. In June 2014, SIM-funded community prevention grantees presented at the CCO learning collaborative and

began a discussion about population health integration. A half-day, facilitated meeting is scheduled in conjunction with the Coordinated Care Model Summit to assist CCOs and local public health authorities in developing plans for working collaboratively to advance population health.

SIM-funded community prevention grantees are required to continually share their work through local, state and national conferences and other venues. To date, webinars, meeting and conference presentations as well as local news stories have all featured the preliminary work of the community prevention grantees.

The SIM-funded operations and policy analyst in the OHA Public Health Division staffs the Health System Transformation Committee of the Conference of Local Health Officials. This committee meets monthly and shares emerging best practices for leveraging health system transformation to achieve population health.

Internally, a cross-cutting team of staff from the OHA Public Health Division meet monthly to align work related to health system transformation; other OHA initiative staff regularly attend these meetings to identify best practices as well as opportunities to continue collaboration.

Attachment A: Oregon Measure Alignment

Measures	CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	Medicaid Adult Quality Measures	CHIPRA Measures	PEBB/OEBB 2013 Measures	HB 2118 Recommended Measures (CoverOregon)	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	OID	CMMI Core Measures	CDC State Public Heath Actions/1305 Measures	SIM Suggested Population Health Measures	Proposed CCO Incentive Measures – Population Health	Alignment Score
30-day mortality rate, risk adjusted (NQF 0229, 0230)											x				1
3-item care transition measure (NQF 0228)											x				1
Ability for providers with HIT to receive lab data electronically directly into their EHR system as discrete searchable data (NQF 0489)											x				1
ACE inhibitor or ARB therapy – diabetes and/or LVSD (NQF 0066)											x				1
Activity measure for post-acute care (AM-PAC) – CMS DOTPA short term, public domain version (NQF 0429, 0430)											x				1
Adherence to antipsychotics for individuals with schizophrenia (NQF 1879)				x											1
Adolescent well care visits	x	x			x	x			x						5

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Adoption of Health Information Technology (NQF 0488)											x[1]				1
Adoption of medication e-prescribing (NQF 0486)											x				1
Adult BMI assessment				x		x									2
Adult weight screening and follow up (NQF 0421)									x		x				2
Adults ever screened for HIV														x	1
Adults who met aerobic and muscle strengthening guidelines													x		1
Alcohol or other substance misuse (SBIRT)	x	x	x				x		x[2]						5
All-cause readmission (NQF 1789)			x					x			x				3
Ambulatory Care: Outpatient and Emergency Department Utilization *indicates ED utilization only	x*	x	x		x	x	x*								6
Ambulatory-care sensitive hospital admissions (PQI #1, 14, NQF 272, 678)			x												1
Annual HIV/AIDS medical visit				x											1

[1] Conceptually similar to OHA's EHR Adoption measure.

[2] RAND specifications; unclear if this measure will align with OHA measures.

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Annual monitoring for patients on persistent medications				x											1
Antidepressant medication management (NQF 0105)				x		x[3]		x							3
Appropriate opioid dose							x								1
Appropriate testing for children with pharyngitis (NQF 0002)		x			x				x						3
Appropriate treatment for children with upper respiratory infection (NQF 0069)						x									1
Asthma assessment (NQF 0001)											x				1
Asthma pharmacologic therapy (NQF 0047)											x				1
Asthma related ED visits (ages 2-20) (NQF 1381)					x										1
Avoidance of antibiotic treatment in adults with acute bronchitis (NQF 0058)						x									1
Breast cancer screening (NQF 0031)				x[4]		x		x[5]							3

[3] Effective continuation phase only.
[4] For women ages 42-69. May not be comparable to other measures.
[5] EHR-based quality measure. May not be comparable to PEBB/OEBB and CoverOregon measures.

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CAHPS adult and child composite: Access to care	x	x	x	x			x[6]				x				6
CAHPS adult and child composite: Satisfaction with care	x	x	x	x			x[7]				x				6
CAHPS: Rating of Health Plan							x								1
CAHPS adult member health status			x								x				2
CAHPS Surveys (NQF 0005-0009, 0517, 0691-0697, 0285)											x				1
Care transition record transmitted to health care professional (NQF 0648)											x				1
Care transition: transition record transmitted to health care professional				x											1
CARE-F and CARE-C assessment tools for nursing facilities, day rehabilitation programs, and other ambulatory settings in the community											x				1
Cervical cancer screening (NQF 0032)		x		x		x			x						4

[6] Only adult members who "always" got care as soon as needed.

[7] Only adult members who "always" were treated with courtesy and respect from customer service and who "always" got the information or help they needed.

Measures	CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	Medicaid Adult Quality Measures	CHIPRA Measures	PEBB/OEBB 2013 Measures	HB 2118 Recommended Measures (CoverOregon)	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	OID	CMMI Core Measures	CDC State Public Heath Actions/1305 Measures	SIM Suggested Population Health Measures	Proposed CCO Incentive Measures – Population Health	Alignment Score
Cesarean rate for low-risk first birth women (NQF 0471)											x				1
Child and adolescent access to primary care practitioners		x			x										2
Childhood immunization status (NQF 0038)		x			x	x	x		x		x		x		7
Chlamydia screening in women ages 16-24 (NQF 0033)		x		x	x	x	x								5
Cholesterol management for patients with cardiovascular conditions: LDL-C screening						x									1
Cholesterol management for patients with cardiovascular conditions: LDL-C control						x									1
Colorectal cancer screening	x	x				x[8]	x	x[9]	x[10]		x[11]		x		8
Comfortable dying: pain brought to a comfortable level within 48 hours of initial assessment (NQF 0209)											x				1

[8] HEDIS specifications. OHA specifications for the CCO incentive measures and "test" measure deviate significantly from HEDIS for CY 2013. These data will not be comparable.

[9] NQF 0034. EHR-based quality measure. These data will not be comparable to OHA and PEBB/OEBB measures.

[10] NQF 0034. These data will not be comparable to OHA and PEBB/OEBB measures.

[11] NQF 0034. These data will not be comparable to OHA and PEBB/OEBB measures.

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Comprehensive diabetes care: Eye exams (NQF 0055)						x	x				x	x	x		5
Comprehensive diabetes care: Foot exams (NQF 0056)											x				1
Comprehensive diabetes care: HbA1c control (NQF 0575)							x		x			x			3
Comprehensive diabetes care: HbA1c testing (NQF 0057)		x		x		x	x		x	x			x		7
Comprehensive diabetes care: LDL-C Screening (NQF 0063		x		x		x			x						4
Comprehensive diabetes care: nephropathy assessment (NQF 0062)						x	x				x	x	x		5
Continuity assessment record and evaluation (CARE) tool											x				1
Controlling high-blood pressure (NQF 0018)	x	x		x			x	x[12]	x[13]		x[14]	x			8
COPD: bronchodilator therapy (NQF 0102)											x				1
Coronary Artery Disease (CAD)									x		x[15]				2

[12] EHR-based quality measure. These data will not be comparable to OHA measures.
[13] EHR-based quality measure. These data will not be comparable to OHA measures.
[14] EHR-based quality measure. These data will not be comparable to OHA measures.

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composite (NQF 0055, 0067, 0070, 0074)															
Cost measures: *Total care (excluding PBM Rx, chiro, CAM, behavioral health) *Inpatient facility *Outpatient total (e.g., imaging, lab, other) *Professional total *Primary care *Specialty care/referral *Other								x[16]		x					1
Developmental screening in the first 36 months of life (NQF 1448)	x	x	x		x		x		x	x					7
Diabetes long-term complications (NQF 0274)											x				1
Diabetes: Blood Pressure Control <140/90 (NQF 0061)								x[17]	x						2
Diabetes: HbA1c Poor Control (NQF	x	x				x		x[18]							4

[15] Reported as separate measures.

[16] May have some overlap with OHA cost/utilization reporting in the Health Systems Transformation Quarterly Progress report. Need additional details on the measure to confirm.

[17] EHR-based quality measure.

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0059)															
Diabetes: LDL-C Control (NQF 0064)						x		x[19]	x						3
Driving after drinking													x		1
Effective contraceptive use among women not desiring pregnancy			x				x								2
Electronic Health Record adoption	x	x													2
Falls: screening for future falls risk (NQF 0101)								x							1
Family evaluation of hospice (NQF 0208)											x				1
Fibrinolytic therapy received within 30 minutes of ED arrival (NQF 0288)											x				1
Fibrinolytic therapy received within 30 minutes of hospital arrival (NQF 0164)											x				1
Flu shots for adults age 50-64 (NQF 003)				x			x						x	x[20]	4
Follow-up after hospitalization for mental illness (NQF 0576)	x	x	x	x	x	x				x	x				8
Follow-up care for children prescribed ADHD medications (NQF 0108)	x				x	x			x						3

[18] EHR-based quality measure. These data will not be comparable to OHA measures.
[19] EHR-based quality measure.
[20] Includes all children and adults age six months and older.

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Frequency of ongoing prenatal care (NQF 1391)					x				x		x				3
HbA1c testing for pediatric patients ages 5017 (NQF 0060)					x										1
Health care coverage													x		1
Health care associated infections													x		1
Health related quality of life – physically and mentally unhealthy days													x		1
Healthy term newborn (NQF 0716)											x				1
Heart failure: beta blocker therapy for left ventricular systolic dysfunction (NQF 0083)								x[21]			x				2
HIV viral suppression at most recent viral load test													x		1
Hospital ED visit rate that did not result in hospital admissions, by condition											x				1
HPV vaccination among females 13-17														x	1
Immunization for adolescents (NQF 1407)		x			x	x	x		x						5
Influenza immunization (NQF 0041)								x[22]	x		x				3

[21] EHR-based quality measure.
[22] EHR-based quality measure.

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Initiation and engagement of alcohol and other drug treatment (NQF 0004)			x	x							x				3
Ischemic vascular disease: complete lipid profile and LDL control (NQF 0075)								x[23]			x				2
Lipid control (NQF 0075)													x		1
Median intake of fruits and vegetables													x		1
Median time to transfer to another facility for acute coronary intervention (NQF 0290)											x				1
Medical assistance with smoking and tobacco use cessation (CAHPS) (NQF 0027)		x		x		x[24]	x						x		5
Medicare spending per beneficiary, risk-adjusted, and price standardized											x				1
Medication for high blood pressure control												x	x		2
Medication management for people with asthma							x								1
Medication reconciliation (NQF 0097)											x				1
Medication reconciliation post-			x												1

[23] EHR-based quality measure.

[24] Measure is a roll up of three CAHPS questions: advising smokers to quit, discussing smoking cessation medications, and discussing smoking cessation strategies.

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discharge (NQF 0554)															
Mental and physical health assessment within 60 days for children in DHS custody	x		x[25]												2
Optimal diabetes care (NQF 0729)											x				1
Otitis Media with Effusion – Avoidance of Inappropriate Use of Systemic Antimicrobials in Children (ages 2-12) (NQF 0657)					x										1
Patient safety for selected indicators (NQF 0531)											x				1
Patient-Centered Primary Care Home (PCPCH) enrollment	x	x													2
PC-01: Elective delivery before 39 weeks (NQF 0469)	x	x		x							x				4
PC – 02: Cesarean section							x								1
PC-03: Antenatal Steroids (NQF 0476)				x											1
Pediatric Central-line Associated					x										1

[25] Mental health assessments only.

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Bloodstream Infections–Neonatal Intensive Care Unit and Pediatric Intensive Care Unit (NQF 0139)															
Percentage of adult smokers that have made a quit attempt in the past year													x		1
Percentage of population living in food deserts													x		1
Plan all-cause readmission (NQF 1768)		x		x	x	x	x								5
Pneumococcal immunization for older adults (NQF 0043, 0044)									x		x				2
Post-discharge continuing care plan created (NQF 0557)											x				1
Post-discharge continuing plan transmitted to next level of care provider upon discharge (NQF 0558)											x				1
Potentially avoidable emergency department visits (Medi-Cal methodology)			x												1
PQI 01: Diabetes, short term complication admission rate (NQF 0272)		x		x											2
PQI 05: Chronic obstructive pulmonary		x		x				x			x				4

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disease admission rate (NQF 0275)															
PQI 08: Congestive heart failure admission rate (NQF 0277)		x		x				x			x				4
PQI 11: Bacterial pneumonia admission rate (NQF 0279)											x				1
PQI 12: Urinary tract infection admission rate (NQF 0281)											x				1
PQI 15: adult asthma admission rate		x		x							x				3
PQI 9: Low birth weight (NQF 0278)			x		x								x		3
PQI 92 – Prevention quality chronic composite							x								1
Pregnancy among females 15-17														x	1
Prenatal and postpartum care: Postpartum care rate (NQF 1517)		x		x		x[26]	x		x						5
Prenatal and postpartum care: Timeliness of prenatal care (NQF 1517)	x	x			x	x	x		x						6
Preventive Dental Services for children ages 1-20					x										1
Primary PCI received within 90 minutes											x				1

[26] Unclear if PEBB/OEBB measure is including both the prenatal and postpartum care elements of this measure. Documentation only lists "timeliness of prenatal care".

Measures	CCO Incentive Measures	Quality and Access "Test" Measures	OHA Core Performance Measures	Medicaid Adult Quality Measures	CHIPRA Measures	PEBB/OEBB 2013 Measures	HB 2118 Recommended Measures (CoverOregon)	Comprehensive Primary Care Initiative Measures	PCPCH Quality Measures	OID	CMMI Core Measures	CDC State Public Heath Actions/1305 Measures	SIM Suggested Population Health Measures	Proposed CCO Incentive Measures – Population Health	Alignment Score
of hospital arrival (NQF 0163)															
Prophylactic antibiotics discontinued within 24 hours after surgery end time (NQF 0529)											x				1
Proportion of days covered: 5 rates by therapeutic category (NQF 0541)											x				1
Provider access questions (3) from the Physician Workforce Survey		x													1
Rate of obesity among members			x				x					x	x	x	5
Rate of tobacco use among members			x				x							x	3
Reminder system for mammograms (NQF 0509)									x						1
Screening for clinical depression and follow-up plan (NQF 0418)	x	x		x			x	x	x		x				7
Smokefree indoor air legislation													x		1
State 3 (AIDS) at time of diagnosis of HIV infection													x		1
Students in >=95th percentile for BMI												x	x		2
Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post-surgery (NQF 0218)											x				1
Surgical site infection (NQF 0299)											x				1

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Tobacco use assessment and tobacco use cessation intervention (NQF 0028)								x	x		x				3
Total Medicare Part A and B cost calculation recommendations											x				1
Transition record with specified elements received by discharged patients (NQF 0647) / Timely transmission of transition record							x				x				2
Use of appropriate medications for people with asthma (NQF 0036)						x		x	x						3
Use of aspirin or another antithrombotic (NQF 0068)											x				1
Use of imaging studies for low back pain (NQF 0052)						x									1
Utilization buckets: *ED utilization/1,000 *ED utilization/1,000 by top 10 diagnoses *Inpatient med/surg days/1,0000 *Advanced imaging (i.e., PET, CT, MRI, nuclear medicine) *Primary care visits/1,000 *Specialty care visits/1,000								x		x					2

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Weight assessment and counseling for nutrition and physical activity in children/ adolescents (NQF 0024)					x	x	x	x	x		x				6
Well-child visits in the 3rd, 4th, 5th and 6th years of life (NQF 1516)					x				x		x				3
Well-child visits in the first 15 months of life (NQF 1392)		x			x				x		x				4
Youth cigarette smoking													x		1