Aligning Health Measurement in Oregon

A CHITO Whitepaper to Advance Measurement and Metrics that Work for Oregon

March 24, 2016

"Over the past 20 years as evidence grew about defects in care, there was a sense of alarm. The reaction was to try to turn the lights on, to increase knowledge about the performance of health care in many, many dimensions for many people.

As a result, we began a festival of measurement, an almost measurement mania, where we began to believe that the solution to performance was transparency and measurement. I'm a complete fan of transparency, but we've overshot.

Now, the number of metrics exceeds the ability of any reasonable human being to consume usefully. And, there has been insufficient diligence about the alignment and harmonization of measures." – Don Berwick, Jan. 7, 2016[1]

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Executive Summary

The Collaborative for Health Information Technology in Oregon (CHITO) is a strategic multi-stakeholder alliance created to align and improve the planning, execution, utility, and efficiency of Health Information Technology (HIT) with an emphasis on alignment of efforts around data and analytics in Oregon. The current CHITO entities are Oregon Health Leadership Council (OHLC); Oregon Association of Hospitals & Health Systems (OAHHS); OCHIN; Oregon Health Care Quality Corporation (Q Corp).

CHITO and partner organizations are working with a diverse group of public and private stakeholders to make recommendations in support of aligning a parsimonious set of meaningful measures that allow statewide improvements to be framed around Oregon priority improvement areas. Listening sessions to discuss this critical topic were held in October and November 2015, and leadership from a diverse group of stakeholders has been engaged in discussions about potential opportunities to address this issue.

Over a six month period, the following activities occurred to support this effort: a literature review and measurement inventory were conducted to learn more about the challenges in Oregon and nationally, and possibilities for meaningful alignment; a matrix of measures was developed; and five listening sessions were held to gain insights from a broad array of stakeholders. This whitepaper represents the outcome of that work and is intended for all providers, health plans, health systems, policymakers, consumers, employers and other health and health care stakeholders to serve as a guide in working toward successful measure alignment.

The Situation:

- There are more than 420 reporting measures in Oregon alone
- We aren't always measuring the right things
- Providers and their staff are overwhelmed with the sheer amount of state, federal and commercial transformation initiatives
- Many quality incentive programs have mixed results, are siloed among dozens of sponsors, and don't always make the result available to the public
- Previous efforts to align measures were well-intentioned but had little success, in part because those involved did not have the authority and resources to implement changes

Key Findings:

- The need for alignment is great
- A common vision based on shared goals is essential
- Oregon needs to know if transformation is working
- Measurement must take a wider view than the clinical setting
- The approach to alignment must include all significant stakeholders and leadership
- Existing frameworks may show the way

Our Recommendations:

- The best way to achieve the Triple Aim is through a renewed public-private effort to develop Oregon-specific goals that will improve health while measuring performance success.
- Quality improvement must be driven by a prudent, limited set of measures that aligns with existing goals and potentially replaces existing measure sets.

- The best statewide results will be produced when measures are directed at improving care for all Oregonians regardless of delivery setting, payer, geography, health status, ability to pay, race, ethnicity, etc.
- There must be collaboration with diverse groups representing all those impacted by health care. This will help expand measurement beyond the clinical environment to consider population health, social determinants, and communities where people live, work, and play.
- Measure sets must be responsive to Oregon's unique attributes, while aligning as much as possible with national efforts.

Extended Summary: Key Findings and Recommendations

The need for alignment is great

During five listening sessions that engaged over 100 representatives from all sectors of the health care community, an overwhelming message was that measurement fatigue is real. Participants agreed that as much as Oregon can be proud of the progress we have made in our health system improvement efforts, simplifying and aligning health and health care measurement across public and private sectors would help focus attention, goals and outcomes across the state. Alignment would also offer real relief to health care providers, and real benefit to patients seeking to better understand our health care system. With a typical primary care practice reporting on well over 140 different quality measures, it isn't surprising that Don Berwick, who in many ways began the movement toward measurement alignment, said in his keynote speech "Turtles" at the December 2015 Institute for Healthcare Improvement conference that the number of measures should be cut in half over the next two to three years, then half again. [2]

A common vision based on shared goals is essential

A major theme of the listening sessions was the concern expressed by participants that there is not a shared understanding of what achieving the Triple Aim would mean for Oregon. Participants acknowledged the State of Oregon's efforts at transformation, including a 2009 blueprint laid out by leaders who have since left their positions within state government. Most of the stakeholders in the health care community, including policy and consumer representatives, understand what the Triple Aim is in concept, but do not see a shared Oregon translation or a strong statement of what current "success" would look like over time. A reset to build collective understanding of the vision and its primary objectives will allow appropriate measures to be selected. Stakeholder engagement and "buy-in" to the vision will be vital to its success and help end the proliferation of competing measurement activities.

Oregon needs to know if transformation is working

Every effort thus far at alignment has acknowledged the need to balance measuring data that is feasible to collect, against that data which can point to truly significant trends and improvement. Often this information is collected for state funded programs like the Medicaid Coordinated Care Organizations or the Public Employees Benefit Board, representing segments of Oregonians but not the full population. The listening sessions affirmed what clinicians have said for years: providers do not treat their patients differently based on payer requirements, which underlines the benefit of an aligned multi-stakeholder approach. Work has been undertaken previously in Oregon to align measurement efforts, but the rapid pace of other transformation efforts may well have proved disruptive to the success of those efforts; building on previous work and lessons learned from our transformation efforts, and striving to tie the work of alignment to payment reform and care integration initiatives, for example, should yield results that can truly move us forward.

Measurement must take a wider view than the clinical setting

We have learned a great deal in recent years that should influence alignment activities going forward. For example, the importance of the social determinants of health, or that health is shaped by many

factors beyond clinical interactions, is a more commonly understood concept, yet thus far it remains difficult to measure. Additionally, there is a sense that the health care system is approaching the limits of what it can improve, especially with regard to chronic disease, without turning its focus "upstream" to change at the community and public health level. Many of the large national organizations that are looking at measurement, such as the Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM), are focusing more on these upstream issues. These bodies have recognized that to truly make transformative change to people's health, we must address the areas which affect health outside the health care system. The capacity for health information technology to support the necessary exchange of data for these efforts may be a limiting factor, though it has improved.

The approach to alignment must include all significant stakeholders and leadership

Any attempt to align measurement must be truly inclusive if it is to be successful. Engaging a careful balance of voices from all health care sectors and across stakeholders, including consumers, providers, purchasers, and policymakers, offers the best chance at an outcome that will be carried forward. Our listening session participants told us that one of the best outcomes of health care transformation to date, is improved collaboration among providers and practices seeking to improve care; that spirit may make this task easier. For meaningful change to occur, continued involvement from leadership across all parts of the health care system will be crucial to maintain momentum and make true changes. Certainly the shared desire to reduce measurement fatigue may provide a keener motivation than was present in previous efforts.

Existing frameworks may show the way

The concept of using a framework to guide measurement activity is not new, nor is it easy to achieve across programs. In its 2015 assessment of its own measurement efforts, CMS analyzed over 700 measures across 25 programs and found that only half of the measures were shared across programs, and that nearly half of the measures were developed locally. What the health care community can clearly see now is that though each effort may cite the Triple Aim or the National Quality Strategy—or both—as a guidepost in their work, that has not prevented measure sets from proliferating to a nearly unsustainable degree.

Recent national-scale initiatives, such as the dashboard proposed by the Center for Healthcare Transparency, or the framework for a Culture of Health developed by RWJF, offer two examples of conceptual structures to consider (**see Appendix 3**). Their recommendations reflect an attempt to balance immediately feasible with aspirational measurement; to include measures that are broadly applicable and measures which target specific populations and challenges. These efforts also try to balance measures targeted to elements such as social determinants of health, population health, and patient reported outcomes. In the state of Washington, the recent effort to create a set of measures for use across sectors resulted in a core set and menu approach that was created through a comprehensive multi-stakeholder process – this is a model many listening session participants appreciated.

Table 1: Selected Measure Alignment Sponsors and Initiatives

Centers for Medicare & Medicaid Services	Robert Wood Johnson Foundation "Culture of Health"
Institute of Medicine	National Committee of Quality Assurance
Network for Regional Health Improvement through the Center for Healthcare Transparency	Washington Health Alliance
Oregon Health Authority SB 440 (forthcoming)	Multi-Stakeholder Collaborative (led by AHIP, CMS, NQF)

Conclusion

Oregon health care stakeholders are eager to see a broad, inclusive, community-driven effort at measure alignment. Providers, payers and purchasers are anxious for a path to a measurement system that produces meaningful improvements to health outcomes for Oregonians, and reduces the administrative burden of measurement. Importantly, CHITO research reflects the fact that there are differing measures needed for each part of the system; while CHITO acknowledges that there will always be hundreds of measures, the proposal set forth in this document is to determine an overarching set that can be used to guide health care transformation in Oregon. A simplified and improved measurement system must focus on generating meaningful, useful information to support continued health care transformation efforts.

Project Background

The Collaborative for Health Information Technology in Oregon (CHITO) is a strategic multi-stakeholder alliance created to improve the planning, execution, utility and efficiency of Health Information Technology (HIT) with an emphasis on alignment of efforts around data and analytics in Oregon. The current CHITO entities are Oregon Health Leadership Council (OHLC); Oregon Association of Hospitals & Health Systems (OAHHS); OCHIN; and Oregon Health Care Quality Corporation (Q Corp).

Over the last two years, the topic of measure alignment has consistently emerged as a critical issue with almost universal agreement about its priority status within the health care sector. Hundreds of stakeholders—defined as physical and behavioral health providers, payers, consumers, policy makers, administrators, and public health professionals—across Oregon have told us they are concerned, exhausted and confused by the growing number of health care quality and utilization measures. Primary care groups are being asked to report on over 140 different measure requests by dozens of entities. Consumers, policy makers, health care representatives and employers are asking in duplicitous albeit different ways if overall progress has been made in improving the health and health care of Oregonians.

CHITO-sponsoring organizations were unanimous about the need to address measure alignment. In addition to the thousands of measures already in place, there are over three dozen currently active regional and national initiatives focused on adding new measures and new core measure sets to the health care realm. Meanwhile, stakeholders continue to express overwhelming concerns about the volume, distraction and unintended consequences caused by the proliferation of metrics (**see Appendix 1**).

CHITO and partner organizations worked with a diverse group of public and private stakeholders to make recommendations in support of aligning a parsimonious set of meaningful measures that allow statewide improvements to be framed around Oregon-priority improvement areas. Listening sessions were held in October and November 2015, and leadership from a diverse group of stakeholders has been engaged in discussions about potential opportunities to address this issue.

CHITO convened the listening sessions as candid conversations to bring together a cross-section of stakeholders in the health care community who are working on or with quality measurement in Oregon; to assess the alignment of common statewide goals and agenda(s); and to help inform the pilot project with diverse views and perspectives. CHITO has approached this pilot as a way to bring the community together to discuss the issue and determine common areas of understanding and work to be done moving forward.

Over 100 representatives from all stakeholders in the health care community participated in five in-person and one virtual listening session. Their feedback, along with information gathered from an extensive literature review (**see Appendix 2**), serve to inform this document along with the recommendations it contains. This whitepaper represents the outcome of that work and is intended for all health care system partners, policy makers and consumers to serve as a guide to support ongoing efforts toward successful measure alignment.

A Brief History of Oregon's Measurement Efforts

Health care transformation has been an area of sustained focus for Oregon health care and policy professionals for over a decade. During that time, several efforts have been planned or launched that would advance the value of health care quality and cost reporting. However, a variety of factors have led to those efforts being as fractured and duplicative as they are in communities across the country. In some cases, efforts did not succeed because sponsors began with divergent goals and disparate populations to address. In other cases, Oregon's Medicaid-driven health care transformation efforts necessarily absorbed resources and attention. Multiple efforts among multi-stakeholder groups, especially since 2009, more than once resulted in agreement on a core set of measures and implementation plans, but little real change occurred around alignment.

In 2000, the Oregon Coalition of Healthcare Purchasers recognized the need to begin measuring health care quality and cost in an effort to support businesses trying to cope with a surge in the cost of health care and health insurance. They created the Oregon Health Care Quality Corporation (Q Corp) to convene a collaborative group of stakeholders who would foster projects to support quality health care. Now in its eighth year of quality reporting, the measures in Q Corp's measure set are reviewed annually to ensure that they produce relevant and actionable information for Oregon.

In 2005, the Oregon Association of Hospitals and Health Systems (OAHHS) collaborated with the state Office for Oregon Health Policy and Research to develop public reporting websites on hospital cost and quality. The data repository, managed by a subsidiary of OAHHS, contains a wealth of information hospitals use to support their reporting efforts. Legislation passed in 2013 created the Hospital Transformation Performance Program, which identified a set of incentivized performance measures to assess the impact of health care reform on hospital quality, cost reduction, and patient safety.

Since 2008, the Triple Aim of improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care has emerged as a clearly articulated set of goals around which the entire health care community can organize.[3] Aligning the efforts to achieve the Triple Aim, however, has continued to be difficult for some of the same reasons that made alignment challenging before.

House Bill 2009, passed in June 2009, included a host of provisions to advance health care transformation, including the creation of a consolidated Oregon Health Authority (OHA), and the Oregon Health Policy Board which serves to help drive the strategy behind Oregon's ongoing health reform efforts.

In 2010, OHA released the Action Plan for Health, which included a draft scorecard to be finalized in 2011, which was to include standard quality measures. That group identified measures to support the broad categories of the Triple Aim, with the narrower focus on incidence of lifestyle-sensitive health conditions, access, hospital and acute care quality, prevention and chronic disease care quality, avoidable cost drivers, and access. The scorecard would have drawn data from a variety of in-state and national sources. With the passage of House Bill 2009, and the subsequent focus on implementation of the CCO model, the scorecard was not finalized.

Passed during the 2013 legislative session, House Bill 2118 called for a work group to recommend a core set of health outcomes and quality measures for use by CoverOregon, OHA, the Oregon Educators

Benefit Board (OEBB), and the Public Employees' Benefit Board (PEBB). The group presented its recommendations to the Oregon Health Policy Board in May 2014. That recommendation report outlined two phases, with 13 immediately possible measures in Phase I and 15 measures that required further development of data sources for Phase II.

At the same time, CoverOregon identified a need to create a set of measures to rate health plans and help consumers navigate the health insurance exchange in advance of the launch of the exchange, and partnered with Q Corp to lead the development of that measure set. Those measures were selected based on principles derived from four entities, including the National Committee for Quality Assurance (NCQA) and the Commonwealth Fund, and the potential for the measures to align with national efforts, among a handful of other criteria. This effort was the first time in Oregon that health plan measures were to be reported publically to consumers on such a wide scale. When the decision was made to move to using the Federal Exchange, and operations of CoverOregon were transferred to the Department of Consumer and Business Services, the opportunity for evaluation of Oregon's health plans at the carrier level was delayed. The Federal Exchange program has developed the Quality Rating System for Qualified Health Plans offered on the exchange, which evaluates those plans based on relative quality and price; those ratings are publicly reported through each Marketplace website.[4]

Also in 2013, the first Coordinated Care Organizations (CCOs) began enrolling patients. Pursuant to the Section 1115 waiver from the Centers for Medicare and Medicaid Services (CMS), OHA formed the Metrics & Scoring Committee, which began meeting in 2012 and was tasked with selecting, maintaining and retiring the list of performance and incentive measures the CCOs must report. The Committee has met regularly for over three years. For 2016, there are 18 incentive measures in a set of 37 total measures the State is reporting to CMS. These measures have significant alignment with PEBB and OEBB measure sets and have been mostly well received.

In the same year, the Legislature passed House Bill 2348 to guide efforts to modernize Oregon's Public Health Division. The recommendation report was released in September 2014, and contained a conceptual framework for the delivery of public health services intended to modernize the provision of public health prevention and infection control services at the local level, and to better integrate the provision of public health services with the rest of the health care infrastructure in the state.[5]

After a decade of active work in health care transformation, in 2015 the Oregon Business Council worked to draft a new Oregon Business Plan, which will include a "scorecard" to support its framework. The group hopes the "scorecard," which would include a common set of quality and cost measures, will influence continued health care transformation in the coming years, and that it will be part of a set of data tools and resources so that consumers, employers, providers and insurers make the best health, purchasing, and clinical coverage decisions.

Oregon's "Healthiest State" Initiative was formally launched in 2014 by then-Governor John Kitzhaber and a coalition of business and community leaders, including the Oregon Business Council. The effort, which looks at a cross-section of indicators, including financial and community factors, is driven by the desire to "make the healthy choice the easy choice," and most factors being measured currently are derived from nationally fielded surveys. This public-private effort seeks to focus on upstream, population-level interventions to address the factors that contribute to poor physical well-being and are primarily reflected in rates of obesity, tobacco usage, and substance abuse. This initiative is also

associated with the "Blue Zones" project, which is active in Klamath Falls, Oregon, and is affiliated with Healthways, a national provider of wellness programs (**see Appendix 2**).[†]

During Oregon's 2015 legislative session, Senate Bill 440 was sponsored by a group of health care stakeholders, including Service Employees International Union, Providence Health Plans, Kaiser Permanente, Moda Health, Oregon State Public Interest Research Group, HealthShare of Oregon and GlaxoSmithKline. The legislation requires OHA, over a period of 18 months, to create a strategic plan governing the collection and use of health care data going forward, which will then inform a workgroup that will select a specific menu of measures to be used across public health insurance programs, as well as OEBB and PEBB.

[†] Cambia Health Foundation is a prominent sponsor of both the Oregon Healthiest State initiative and the Blue Zones Project.

National Initiatives Approaching Measure and Metric Alignment

The early part of the 21st century saw the expansion and proliferation of measurement activity for quality improvement, transparency, and cost-containment purposes. In 2011, the Agency for Healthcare Research and Quality (AHRQ) published the National Quality Strategy (NQS), which institutionalized the concept of the Triple Aim of providing better, more affordable care for individuals and communities, six priorities to guide efforts, and nine business and policy levers to align health care's operations to drive progress. Since 2011, several alignment efforts have referenced the NQS as a roadmap guiding their efforts.

A 2015 Bipartisan Policy Center report discusses seven measure alignment efforts on a national scale.[6] The Federal government, through CMS, has enormous influence in shaping measurement activity by tying payment incentives to performance around a set of measures. Through the ongoing work of health care transformation, those measure sets have proliferated as pilot programs, and reform initiatives have expanded. CHITO analysis included eight different comprehensive measure sets sponsored by federal agencies among the more than 30 efforts selected for study.[†]

RWJF sponsored multiple rounds of funding to 16 communities around the country for seven years through "Aligning Forces for Quality," including Oregon; their latest large-scale initiative is supporting and mobilizing a Culture of Health, which seeks to organize how the U.S. thinks of health in domains beyond health care, which would be tracked by capturing cross-sector data from education to voting to economic performance, and linking them to health.

The Network for Regional Health Improvement (NRHI) is an organization with 40 members across the country; a majority of these participate in health care quality or cost reporting activities. A recent survey of members found that among the eight communities that responded, more than 220 measures are currently being produced. NRHI has sponsored the Center for Healthcare Transparency, which pulled together expertise from member organizations around the country to strategize around the creation of a dashboard of measures that could be in place and available to 50 percent of the U.S. population by 2020. That dashboard includes a mix of measures based on claims-, clinical-, and patient-generated data.

America's Health Insurance Plans (AHIP) convened health plans, CMS, the National Quality Forum (NQF), specialty societies, employers and consumers for the Core Quality Measures Collaborative, to develop a core set of measures in selected clinical areas. In June 2015, the group published a progress report that included measure selection criteria and principles the group used as they aligned public and private quality measures to harmonize with the NQS. Their measure set was released Feb. 16, 2016, and the intent is that these measures will be incorporated into federal efforts through the Physician Fee Schedule and Proposed Rules, while private payers will phase the measures in through the contract renewal process.

The Joint Commission (JC) has been rating hospitals for 13 years. Its 2015 annual report includes data on 49 accountability measures in 12 measure sets, and rated 3,300 hospitals, approximately one-third of

[†] Our analysis did not cover nursing home care, end-stage renal disease, or e-prescribing, nor did we explore meaningful use in detail after the January 13, 2016 announcement that meaningful use would be restructured within the Merit-Based Incentive Program (MIPS) as it is implemented.

which earned *Top Performer* scores. Shortly after they released their rankings in November 2015, the JC announced that it would suspend rankings for 2016 as it re-evaluates hospital quality as measurement efforts evolve nationally. Over time, the JC's measure set has diverged from Medicare measurement, and in announcing the rating suspension, the CEO cited a mismatch between chosen measures and data-collection methodologies.

Alignment at the state level outside Oregon

One of the projects funded by the RWJF AF4Q initiative was to develop a Community Tool to Align Measurement, hosted by NQF. The tool itself launched in 2012, and is still available via the NQF website. All AF4Q communities, including Oregon, participated in the project; once the tool was developed, it was put into use in several communities. Notably, the Greater Detroit Area Health Council took the results from using the alignment tool to work with other AF4Q communities and Beacon programs in the area on aligning their efforts. The Cheyenne Regional Medical Center in Cheyenne, Wyoming, used a CMS Innovation Grant to work with the tool and physician champions across the state to create a set of 13 quality measures to use in Patient Centered Medical Home (PCMH) pilot practices.

A recent example of an entire state's health care community collaborating to achieve consensus on measures comes from Washington, where the Washington Health Alliance (WHA) worked with the Washington State Health Care Authority to identify a set of core measures for use in their health reform work in 2015. The measures in that set were considered by the listening session attendees, and are included in the matrix in **Appendix 4**.

Alignment Goals and Principles for Oregon

Among the national alignment efforts, most sponsors clearly articulate a set of goals or domains that offer structure to their chosen measure sets (see Table 2), and some also identify principles or intentions to guide their work. During the CHITO-sponsored listening sessions, many participants described the achievement of the Triple Aim as the ultimate goal that measure alignment should help achieve; discussion revealed a variety of ideas for what that might look like. Some participants emphasized reduced measurement and administrative burden so that providers could focus on care; others hoped for measurement that is truly meaningful for improving patient experience; still others wanted to prioritize improved health for all Oregonians, and emphasized that issues of health equity and disparities—not currently measured well—must be addressed.

These perspectives are critical in helping to inform what possible goals might guide alignment work in Oregon. CHITO partners felt, and the literature affirms, that without a shared understanding of the goals and objectives of health care reform, measure alignment would not be possible.

Table 2: High-level Domains for Measurement in National Efforts

Institute of Medicine	National Quality Strategy	RWJF
- Healthy people - Care quality - Care cost - Engaged people	- Patient and family engagement - Patient safety - Care coordination - Population/public health - Efficient use of healthcare resources - Clinical process/effectiveness	- Making health a shared value - Fostering cross-sector collaboration to improve well-being - Creating healthier, more equitable communities - Strengthening integration of health services and systems - Improved population health, well-being and equity

In these conversations, participants clearly felt that any work toward alignment should include careful reflection and broad stakeholder engagement and consensus. It is essential for our community to think about why we are doing this work, and start from a common understanding of our goals.

Many of the initiatives analyzed for this whitepaper refer to the NQS, which articulates principles included in Table 3. Comparing NQS principles to other efforts such as the Core Quality Measures Initiative (CQMI) reveals a range of possible focuses and perspectives for alignment in Oregon. For example, the NQS principles focus on how measurement can make care better for patients, their families, and their communities, whereas the CQMI principles are predominantly focused on impact to providers. Both efforts agree that the proposed measures should capture efforts toward the Triple Aim and be reflective of patient health outcomes.

Table 3: National Initiatives Guiding Principles	
NQS Guiding Principles	**Core Quality Measures Initiative Governing Principles**
- Work with communities to promote wide use of best practices to enable healthy living and well-being. - Promote the most effective prevention, treatment, and intervention practices for the leading causes of mortality, starting with cardiovascular disease. - Ensure person- and family-centered care. - Make care safer. - Promote effective communication and care coordination. - Make quality care affordable for people, families, employers, and governments.[7]	- Measure sets must be aimed at achieving the three-part aim of the National Quality Strategy: better care, healthier people and communities, and more affordable care. - NQF-endorsed measures are preferred. * In the absence of NQF endorsement, measures must be tested for validity and reliability in a manner consistent with the NQF process where applicable. - Data collection and reporting burden must be minimal. - Overuse and underuse measures should both be included. - Measure sets for clinicians should be limited to fewer than 15 measures when possible. - Measures that are currently in use by physicians, measure patient outcomes, and have the ability to drive improvement are preferred. - Measures that are cross-cutting across multiple conditions to reflect a domain of quality (e.g., patient experience with care, patient safety, functional status, managing transitions of care, medication reconciliation) are preferred. - Measures should be meaningful to and usable by consumers, and also applicable to different patient populations. - Patient outcome measures should allow careful and prudent physicians to attain success. - As with all measures, those which reform payment or delivery systems should measure clinical quality, patient experience, and costs.[8]

Based on feedback from CHITO stakeholders, as well as research from similar alignment efforts, CHITO offers the following considerations that encompass alignment goals and principles.

1) Reducing Reporting Burden on Providers

Across every listening session, CHITO stakeholders were quite vocal about the need to reduce the burden of reporting for providers in care settings. With one Portland primary care practice telling CHITO that they are tracking 140 measures, and with Medicare sponsoring 25 different initiatives and over 700 measures by its own reckoning, the source of measurement fatigue is clear. Nationally, the problem is still larger. One study published in 2015 cited an analysis of 48 initiatives covering 25 states and including over 1,300 measures.[9]

Analysis of the degree to which measure sets overlap show similarly distressing variation, as different initiatives modify measure specifications to meet specific needs. Thus, one clinic might be expected to report measures on mammography specifically, or breast cancer screening more broadly, covering different age groups. Additionally, listening session participants expressed frustration with the lack of timely and actionable data as well as the enormous costs of collecting and analyzing data that are born primarily by practices and health plans. For many, there are concerns about the rewards of investing in systems to support measurement while the return on investment remains unclear.

Stakeholders had several recommendations about how to reduce the burden currently placed on providers to report measures. Some noted that in an ideal situation, each patient would know about metrics and be knowledgeable enough to track their own care and data (**see Appendix 1**). Others argued for the ability for providers and staff to only have to report once to a central repository. Any additional

report generation would be the responsibility of payers who might have the ability to pull and push data to that repository. Additionally, stakeholders noted that electronic health records need to be fully interoperable, and health information technology and exchange infrastructure should be better balanced throughout the state.

2) Focusing Attention on Meaningful Measurement

The Core Quality Measures Collaborative articulates the "three Rs" as a goal for their efforts: reduce the number of measures, refine the measures, and relate the measures to patient health outcomes, focusing on "measures that matter."[9] This goal highlights an important problem with measure proliferation: measurement should focus on what changes health most; measuring too much diminishes the value of the results. A recent impact assessment of 25 CMS measurement activities echoes this principle in its recommendation that sponsors should determine what degree of alignment with state and federal programs would benefit patients and providers. Measure alignment not only reduces provider burden but also supports a multi-payer approach to transforming health care.[10]

CHITO stakeholders agreed that not all measures are suited to all populations, but that Oregon should push toward better care for all through any measurement effort. Some voiced a desire to align around measures to help the most vulnerable Oregonians despite the acknowledged difficulty caused by limited benchmarks. It was noted that our current measures do not account for culture, and that measurement needs to be developed with commonly held views of what health is and should be, though Healthcare Effectiveness Data and Information Set (HEDIS) measures could provide a good base to work from. Stakeholders also expressed concerns that measurement activities cannot be done in isolation; efforts should be coupled with best practices and tools to help achieve expected outcomes.

Some stakeholders felt progress as measured by the Triple Aim has slowed, while others felt the concept is inadequate to address core issues like equity and health disparities in our communities. Stakeholders in the sessions felt that continual, multi-directional change to measurement is inevitable, and that agreeing on a single set of measures was unlikely to ever happen. Others felt that meeting the Triple Aim is not the only or perhaps even best area of focus. Stakeholders also mentioned Oregon's public health modernization efforts to focus more on preventive care, though they also voiced the need to determine what other organizations think public health should be concerned with measuring.

Some stakeholders in the listening sessions thought it would be best to identify a broadly accepted measure set, aligned between the public and private sector, with clear indicators of care quality, although these were not defined. The ideal outcome in that scenario would be an aligned set of core measures to be shared and agreed upon, with opportunities for flexibility that allow for consideration of innovation and population or regional health differences.

3) Working toward core and flexible measure sets

Additionally, stakeholders expressed that they wanted an agreed upon, aligned set of measures that are shared, and an optional menu set. This optional menu set would accommodate innovation and account for population or regional health differences. They agreed that not all measures are suited to all populations, care settings and purposes, but that Oregon should push toward better care for all through any measurement effort. Stakeholders also expressed concerns that measurement activities cannot be done in isolation; efforts should be coupled with best practices or tools to help achieve expected

outcomes. In order to accomplish this balance, a framework would need to stratify measures, which will add complexity to the process, but is necessary for a fuller picture of progress toward the Triple Aim.

Recommendations

1) A common vision based on shared goals is essential

The stakeholders at the CHITO listening sessions were clear that the Triple Aim remains an important guiding principle for health care improvement. However, participants were also clear that the Triple Aim was not specific enough to help organize overall goals for health care and health in Oregon. Participants saw its value as a founding principle but generally thought public and private stakeholders in Oregon need to articulate a renewed, shared vision of a successfully transformed health care system. In addition, participants generally responded favorably to examples of organizing alignment efforts within domains such as IOM, RWJF and other efforts as a way to offer more concrete guidance to the wider community of stakeholders that will continue to work with measurement in some way. Assessing the articulated goals and outcomes of existing measurement programs in Oregon to look for areas of harmony is an important first step.

2) A prudent, limited set of measures must align with existing goals and potentially replace existing measure sets

As much as the listening session participants expressed their wish for a simpler system, many cautioned that no single set of measures would be a realistic goal. The core-set-and-menu system, such as WHA's system, has merits to consider in this respect. Additionally, the IOM cites composite measures as one tactic for harmonizing measurement across dimensions, allowing for adjustment of the underlying measures over time while tracking on the composite can continue.[11] As Don Berwick said, "The reality is we won't wave a wand and remove a thousand measures, but the biggest gift we could do now is to restate the goals, focus on a parsimonious set – acknowledge that parties at different times will need to focus on different things that are more granular."[12]

3) Alignment is iterative; implementation is essential to any plan

Our listening session participants and the literature suggest that alignment efforts are successful in large part because of the strength of the partnership and commitment of the participants. Those at work on alignment must establish strong partnerships in order to be successful in selecting measures and championing the results.

Articulating a rationale for the process of selecting and maintaining the set of measures is critical to success, in large part because it is not feasible to assume that a single alignment effort will be sufficient indefinitely or even for three years. Some of the most important work an alignment workgroup can do is determine a clear process for how new measures will be selected. Similarly, it is critical to help the community shape, and then understand when and why measures will be retired. Careful attention to these factors can help guard against the potential to frustrate or demoralize people who feel like they are striving to achieve results, and that the reward for their performance improvement is that the finish line is moved.

Identifying and agreeing upon criteria for measure selection, ongoing evaluation, retirement of measures, and engaging leadership and decision makers in the ongoing implementation and reporting of results will help minimize "drift" of efforts over time; such maintenance work offers the benefit of the

opportunity to check in and reaffirm the goals of alignment. The work toward alignment must include a process for sustainably revisiting measures periodically.

Similarly, achievements in improvement anywhere in the community should be celebrated, studied and shared. Ensuring that the health care system at large has appropriate infrastructure to spotlight successful improvement efforts can help support one of the elements of health care transformation that stakeholders in our listening sessions found most positive: collaboration and community learning.

Likewise, there is some evidence to suggest that the most deliberately undertaken process improvement will fail if insufficient attention is paid to the motivation behind that effort. For example, if surgical checklists improved outcomes in most locations that implemented it, but not all, it will be important to examine the implementation behind the failed sites as well as the successful ones.

4) Measurement must take a wider view than the clinical setting

The focus in measurement thus far has been on process because in a fee-for-service health care landscape, it is easy to count services. Yet even as evidence bases for various approaches to health care may change (screening frequencies, standard drug therapies, target LDL levels, surgical interventions) the desired outcome from this measurement is the same: improved outcomes.

The IOM report asserted a preference for outcomes measures unless process or composite measures were clearly better at reflecting system impact.[13] Yet, listening session participants warned that relentless focus on outcomes measures can leave the sickest behind, and again, ignore significant health status improvements that fall "below the line." Likewise, stakeholders expressed the concern that an overly narrow focus incentivizes providers and payers to select the healthiest and richest patients–a detriment to true population health improvement. A balance between the two is essential and would require a stratified model of measures–a complex task to be sure.

Patient experience data is critical to capture and incorporate into our understanding of health system performance, but extremely costly to collect and analyze. Consumer behavior has changed rapidly regarding phone survey participation versus mail survey participation, and collection mode seems to have some impact on results.[14] Mobile and web technology stands to further disrupt this mode of studying care; though results could be faster, controlling for validity will be essential.

Oregon has yet to find a sustainable way to collect, aggregate and publically report patient experience data across payers and clinical settings, though survey activity is ongoing. While Oregon's CCO metrics require some measures from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and private-sector payers are increasingly including such data in their quality programs, this data is not accessible to study and may be resulting in duplicated use of resources.

5) Match measurement to available data, while simultaneously pursuing better data

CHITO listening session stakeholders imagined a future where the capture of data was almost effortless and invisible; the IOM predicts that development of information technology will result in faster measurement with less effort. However, the reality is that capturing the most meaningful measurements of health may depend upon technology or data that is not yet readily available. Some initiatives, recognizing this, imagine a phased approach. The Center for Healthcare Transparency

imagines adding measures that rely on more complex or hard-to-source data to its dashboard each successive year. The IOM recognized that in some of the areas they advocate improving, highly reliable measures do not yet exist, and so advise the choice of the "best current measure" in those areas.[15]

6) The approach to alignment must include all significant stakeholders and leadership

Listening session participants were quite clear that alignment efforts need to include an accurate, broad representation of the community, while acknowledging that consensus can be more difficult to achieve as decision-making groups grow larger.

One of the factors in transformation fatigue in any industry is that failed or abandoned efforts can result in a sense of wasted time. A frequent comment from the listening session participants was that stakeholders working on measurement must commit to shared goals and to using whatever common measure set is developed. Thus, care must be taken to ensure that decision-makers as well as subject matter experts are included in the effort; clarifying goals of measurement and alignment can help attract committed participants with the subject matter expertise required to succeed.

7) Coordinate with other efforts

At least twice in the last decade, significant state resources and community effort have been expended to create a measure set for use by a collaborative of stakeholders, but shifting priorities for other transformation efforts resulted in that work being set aside.

Through 2016, it will be essential for any group working on measure alignment in Oregon to consider how the Medicaid waiver is likely to evolve, what the health care community is working on with respect to payment reform (which often is built on performance), and what trends quality data can help the community track (e.g., what impact is health system expansion and integration having on quality?). Similarly, efforts aimed at improving health care cost transparency are a greater area of focus. The stakeholder group should consider whether measurement activities can support that work. According to the 2015 Catalyst for Payment Reform's state price transparency report, Oregon (like most states) earned an F. Ideally, quality measurement efforts should work in harmony with cost measurement.[16]

As much as possible, state-level alignment efforts should also align with Federal efforts. Significant investments in payment transformation and in quality improvement will continue, and it is clear that the era of divergent public and private measurement priorities has not succeeded. In addition, to help drive the health care system toward greater value-based purchasing – rather than continuing to reward volume regardless of quality of care delivered – CMS has set a goal to have 30 percent of Medicare payments in alternative payment models by the end of 2016 and 50 percent in by the end of 2018. They plan to achieve this through investment in alternative payment models such as Accountable Care Organizations (ACOs), advanced primary care medical home models, new models of bundling payments for episodes of care, and integrated care demonstrations for beneficiaries that are Medicare-Medicaid enrollees.[17]

Conclusion

Oregon health care stakeholders are eager to see a successful and sustainable, inclusive community-driven effort at measure alignment. Providers, payers and purchasers are anxious for a path to a measurement system that produces meaningful outcomes in the health of Oregonians and reduces the administrative burden of measurement. While CHITO acknowledges that there will always be hundreds of measures, the recommendations set forth in this document are meant to inform the creation of an overarching set that can be used to guide health care transformation in Oregon. Listening session participant feedback and the literature reviewed reflects the fact that there are differing measures needed for each part of the system. However, a simplified system must focus on generating meaningful, useful information to support continued health care transformation efforts.

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Aligning Health Measurement in Oregon
Appendix 1: Narrative Summary of Listening Sessions

Background

CHITO is a strategic multi-stakeholder alliance created to align and improve the planning, execution, utility, and efficiency of Health Information Technology (HIT) with an emphasis on alignment of efforts around data and analytics in Oregon. The CHITO entities are Oregon Health Leadership Council (OHLC); Oregon Association of Hospitals & Health Systems (OAHHS); OCHIN; Oregon Health Care Quality Corporation (Q Corp); and other partners as interested.

Over the last two years, Measure and Metric alignment has consistently emerged as a critical issue with almost universal agreement about its priority status. CHITO sponsoring organizations were unanimous about the need to address this issue. In addition to the thousands of measures already in place, there are over three dozen new regional and national initiatives focused on adding potential new measures and new core measure sets. Stakeholders have expressed overwhelming concerns about the volume, distraction and unintended consequences caused by the proliferation of metrics.

CHITO convened the listening sessions as a way to bring together a cross-section of stakeholders in the health care community who are working on or with quality measurement in Oregon for candid conversations; assess the alignment of common statewide goals and agenda; and to help inform the pilot project by the contribution of diverse views and perspectives. CHITO has approached this pilot as a way to bring the community together to discuss the issue and determine common areas of understanding and work to be done moving forward.

The factors that led to the convening included:

- Stakeholders from across Oregon have told Q Corp and CHITO partners that they are concerned, exhausted and confused by the growing number of health care quality and utilization measures.
- There are now over 2,000 endorsed and validated quality measures that have been endorsed by various accredited organizations.
- Primary care groups in Oregon are being asked to focus on over 140 different measures requested by dozens of payers, plans and purchasers. In addition, citizens, policy makers, health care industry representatives and employers are asking if we have made overall progress in improving the health and health care of Oregonians.
- Significant progress has been made in improving the quality of health care in several targeted areas over the last years; however, there are unintended consequences to the endless proliferation of measures and fragmented focus, and more measures being created and implemented each day.

Five CHITO listening sessions were convened during October and November to discuss several factors related to quality and cost measurement and reporting efforts identified as problematic for Oregon. Over 100 attendees from a diverse group of stakeholders attended those sessions. The goal of these listening sessions was to bring together a cross-section of stakeholders in the Oregon health care community who are working on or with quality measurement for a candid conversation that would help inform the CHITO Pilot Project #2 on measure alignment, and provide diverse perspectives to help shape the ultimate result of the pilot, the whitepaper. The listening sessions helped illuminate the common themes that are outlined below.

Listening Session Structure

The majority of the listening sessions were structured so that participants offered feedback on a set of questions about measure alignment:

- What are the overall Oregon health care goals for 2015 and 2016?
- What is working?
- What could be improved?
- Are we "there" in terms of measure alignment?
- What's the best outcome we can imagine if we "get to" alignment?
- What is the biggest concern you have?
- What suggestions do you have for how we get "there"?

During the in-person sessions, participants discussed the questions in small facilitated groups, and then reconvened to share their perspectives together. Though as in any group, perspectives varied, the stakeholders in these sessions had similar views on many common themes.

Is there a common goal for health care in Oregon?

Participants agreed that the Oregon health care community frequently refers to an intention to pursue the Triple Aim[1] originally defined as improving patient experience of care, improving population health, and reducing health care costs. When the groups were asked to provide some examples of what that meant in their experience, the diversity of answers made it clear that Oregon's health care community does not currently share a common set of defined goals for how to achieve the Triple Aim in Oregon. In every session, participants agreed Oregon could benefit from a clarified and refreshed vision for the statewide goals for health and health care

In general, stakeholders feel that Oregon is a leader in meaningful measurement, and is doing better than many other states in this area. Participants acknowledged the Coordinated Care Organization (CCO) metrics and incentive program as an indication of significant progress. One participant's comment was that "Oregon should be proud of its progressiveness and is much further along than many other states."

Attendees noted that more medical practices are using data, and are getting comfortable doing so. That this has led to care and practice improvements and collaboration. Participants noted greater comfort with the use of benchmarks. However, there is still plenty of work to be done. The discussion of what information we still lack to achieve transformation goals revealed dynamic tension between two dominant viewpoints – one, that measures must be broad in order to capture the breadth of necessary data, and two, that metrics needed to be fewer and more streamlined. What the majority of participants agreed upon was that alignment was needed and should focus on measurement efforts that are most meaningful for producing better statewide outcomes.

[1] The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim": Improving the patient experience of care (including quality and satisfaction); Improving the health of populations; and Reducing the per capita cost of health care.
http://www.ihi.org/engage/initiatives/tripleaim/

What is Working?

When discussing what has been working in measure alignment, the stakeholders generally viewed HEDIS measures and hospital safety metrics favorably, and mentioned the alignment of CCO, Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) measurement efforts as a useful step. Measures that crossed the continuum of care and reflect best practices and national standards were viewed as meaningful. Stakeholders also said that they see a shift towards adoption of emerging outcome measures, and it was mentioned that incentives and penalties, or "carrots and sticks," were useful for driving change. The participants noted the effectiveness of Oregon's monetary incentives in producing improved results. Those stakeholders who are working to comply with measurement efforts appreciated the spirit of collaboration that this work has fostered, and were very positive about the areas where payers and government are working together to align measures.

What Could be Improved?

Participants had lively discussions about the potential to improve measurement activities in Oregon. Many noted that expectations for measurement have risen sharply, and that the volume and complexity of measures in use is leading to metric fatigue.

When the conversation turned to what could be improved, stakeholders stated that there was a misconception that the data was the ultimate outcome, when the real outcome is to provide tools to support improved care and achieve improved population health. Some voiced a sense that our current system encourages "teaching to the test," so to speak, so that some process improvements are only maintained so long as it is measured (and incented). Many stakeholders felt that progress needed to be made in the area of measurement to support more patient engagement in care and a reduction of health disparities, again reflecting a confused sense of the *goals* of measurement. If measures could be more directed at patients, and patients could access meaningful clinical and provider performance information at key decision points in their care, many felt it would be an important positive step. Many said that work on cost transparency and information sharing must continue so that patients and primary care providers can help drive the cost reduction component of the Triple Aim. This was viewed as an excellent area to take advantage of better technology and data. Patient engagement in this work could make the connection between health and health care and increase the personal accountability for health care professionals.

Provider participants did not feel that they have control over their data or a voice in choosing the measures. Generally, participants agreed that coordination between the public and private health plans is a positive, but the stakeholders also felt that measure development needs to have more realistic intent, value and implementation. Currently, new measurement programs typically include new measures, leading again to fatigue and confusion about purpose. Something needs to change. Stakeholders called for explicit understanding of the tradeoffs from standardization of measures, and fundamental platforms for data and analytics.

Additionally, participants noted the need to improve the efficiency of the data collection process and the need for better integration of data collection into workflows and technology. Stakeholders wondered if it was possible to have a statewide data and analytics source that could be kept current with what was happening nationally and in the health insurance industry, although it was acknowledged that what would be politically possible might not lead to significantly improved outcomes.

It is clear that there is still huge variation in care across the state; measurement efforts should help to rectify those discrepancies. Everyone felt that it was important to identify the most valuable measures, but generally acknowledged that is difficult because priorities differ significantly depending on the goals and intentions for measurement efforts. Some expressed the feeling that politics and economics were driving the process, rather than a desire to achieve the best outcomes.

For example, national payers might match priority measures to their larger improvement efforts, which differ from local payers. Each specialty and clinical setting has its own measures based on a variety of factors, while state agencies might prioritize others based on populations served, so determining which are the "right" measures to look at is a challenge. Integrating population and behavioral health into the larger health care context will require measures that may not yet exist.

Participants also acknowledged risks in measure selection: if we measure what is easy, and there are already clinics scoring over 90 percent on a given measure, then is it useful to incentivize that measure further? Over-emphasis on outcomes measures might lead to situations where patients in most need get less clinical focus than those whose health is most likely to improve to a benchmark. If performance varies among providers, there are usually complex reasons, making it difficult to generate meaningful change from complex data. Retiring measures as "achieved" can seem capricious; performance improvement is a process rather than an endpoint, and providers can feel that policymakers using measurement to set policy or payment don't value the improvement goals that *are* met. Depending on process measures can risk the loss of innovation and research that might result in real care breakthroughs.

Where Are We in Terms of Measure Alignment?

The Triple Aim is a commonly used phrase, but it became clear through the listening sessions that a shared approach for how best to achieve this goal is missing. Some stakeholders felt progress as measured by the Triple Aim has slowed, while others felt the concept is inadequate to address core issues like equity and health disparities in our communities. Stakeholders in the sessions felt that continual, multi-directional change to measurement is inevitable, and that agreeing on one set of measures was unlikely ever to happen. Others felt that meeting the Triple Aim is not the only or perhaps best area of focus.

Many participants acknowledged that appropriate levels of measurement for hospitals, providers, health systems, public health systems, or policy makers will always differ. Stakeholders also mentioned Oregon's public health modernization efforts to focus more on preventive care, though they also cited that as an example of the need to coordinate efforts between private and public initiatives. Everyone agreed that outcome measures were part of the next evolution but also recognized the importance of clinical, cost and utilization data.

In several sessions, participants talked about the politics of measurement including the sense that measurement is supporting what one called the "economic juggernaut of health care industry." Another participant noted "politics and economics drive process but not the best outcomes."

In these conversations, participants clearly felt that any work toward alignment should include careful reflection. It is essential for our community to think about *why* we are doing this work, and start from a

common understanding of our goals. Without that focus, participants felt we may lose the human element of care when we incentivize performance through measurement. Are we trading the personal judgment of the clinician? Are we encouraging unintended consequences or adverse selection? These concerns have existed since the beginning of quality improvement efforts, but remain an issue today. The key to mitigating this concern is the development of a common understanding of community goals, especially if consensus builds toward a focus on outcomes measures, which seem to carry additional risks to some participants. Many felt that just reaching alignment on claims measures would be enough.

What is the Best Outcome?

Stakeholders' vision for best outcomes varied, but all entailed a reduction in the administrative burden of measurement, and a focus on meaningful measurement that would prioritize some common measures while allowing for flexibility to match local needs and interests. Conversation touched on specialty and hospital quality, but mostly focused on the burden on primary care. Some noted that in an ideal situation, each patient would be familiar with some metrics and be knowledgeable enough to track their own care and data. Reporting could then be more tailored to patients' needs and experience, and there would be more transparency throughout the health care system. If this could be achieved, the burden of tracking measures would be reduced on providers and plans, and efforts could be better coordinated.

Stakeholders also wanted to report once to a central repository and enable insurers to pull and push data to that repository, taking the responsibility off the clinicians and support staff. Some thought it would be best to identify a broadly-accepted measure set, aligned between the public and private sector, with clear indicators of care quality, although these were not defined. Session participants were unsure how these could be financed and whether performance would still be incentivized. Stakeholders did note that electronic health records needed to be fully interoperable, and health information technology infrastructure would need to be able to support efforts throughout the state, now and in the future.

Stakeholders said that, ideally, they wanted an aligned set of measures to be shared and agreed upon, but have flexibility and allow for consideration of innovation and population or regional health differences. They agreed that not all measures are suited to all populations, but that Oregon should push toward better care for all through any measurement effort. Some voiced a desire to align around measures to help the most vulnerable Oregonians, even though this would be difficult if there were benchmarks to meet. It was noted that our current measures do not account for culture, and that measurement needs to be developed with commonly held views of what health is and should be, though HEDIS measures could provide a good base to work from. Stakeholders also expressed concerns that measurement activities cannot be done in isolation; efforts should be coupled with best practices or tools to help achieve expected outcomes.

What is the Biggest Concern About Alignment?

Stakeholders were worried about being able to overcome measurement and health care reform fatigue. Some felt that the current efforts require too much effort on measurement activities for not enough benefit, and that alignment might not focus on sustainability. Others expressed a worry that alignment would remain elusive; they felt that there was not enough consensus on which measures are most valuable, or how many there should be, or how they could capture non-traditional care, especially in the absence of robust health IT systems outside medical clinics. Some existing measures would have to be

cut, and this would no doubt alienate some providers and lead to underrepresentation of legitimate improvement goals. Participants suggested that this could best be managed by applying quality improvement principles to measure selection and retirement. The community would need to assess what is working, surfacing examples from across the population that could be shared with others working toward the same goals.

Others voiced the concern that, given the increased overhead required for measurement activities, reimbursement rates would not be sustainable without continued incentives as the industry moves to alternative payment methodologies, especially for the Medicaid population which is the focus of so much transformation effort. Some worried that technology would not be good enough to make the process streamlined or that the data to support care would not be available when needed. Others worried about the impact of clinic size on the ability to succeed, or how the unique needs of different populations would be accounted for and met. Some felt that some of the more important aspects of improved care, like care coordination, do not have commercial appeal and may be abandoned.

Participants in the listening sessions noted that in order to use metrics to truly improve health, inequities needed to be understood. Though Oregon has made gains in improving health disparities, more progress is needed. Our community might consider a framework such as the Robert Wood Johnson Foundation's Culture of Health initiative, which includes assessments of civic engagement among other factors, and uses data from sources outside health care to ask questions that get at the health of the community. Stakeholders felt that it is important not to let alignment diminish our ability to address health disparities. Measures need to be carefully developed in order capture what needs to be measured for key sub-populations. In addition, as health care's emphasis moves to prevention, measurement must evolve to capture avoided care, such as avoiding unintended pregnancy.

How Do We Get There?

Attendees emphasized the need for truly collaborative conversation around resetting and articulating statewide health care goals and selecting measures to support them. Stakeholders viewed the lessons learned from participation in a CCO model of shared collaboration as a potential platform to use to make the conversation easier. They called for a large-scale discussion over common language to talk about what better health looks like and should mean, and shared goals across the state and among different organization types. In such a process, clinics could share their examples of what is working in their measurement efforts, and highlight areas that need further consideration to be shared through ongoing communication efforts. It is essential to balance logistical feasibility with inclusiveness, and to make the conversation as inclusive as possible to get buy-in from clinicians and team members and open lines of communication. Simplification efforts should be as broadly applicable as possible. The needs of Medicare, Medicaid, state and private purchasers, and health systems should all be considered and addressed.

Many attendees pointed to what the State of Washington has done as a good platform to consider as a starting point. Working from an understanding of what data is available, and identifying a framework and outcomes to shape a reasonable core set of measures that include claims-based, clinical, and population-health measures would be a good start.

Ultimately, many stakeholders felt that it would be best to have a core set of outcome-based priorities with a subset of measures based on population or practice specific needs. Participants seek a reasonably-sized, fairly incentivized set of measures that combines qualitative and quantitative

approaches. Importantly, stakeholders also emphasized a need to create a clear path to implementation.

Wrap-Up

At each listening session, time was set aside to allow stakeholders to share their thoughts beyond the main questions discussed above. The wrap-up discussions focused on the prospect of alignment in broader terms. Some mentioned that it would be instructive to take advantage of the available performance data since measurement began, and look to see where improvements have emerged. It was acknowledged that there is a lot of energy to pursue alignment work, but not a lot of coordination or organization.

Participants asked many questions related to the passage in spring 2015 of Senate Bill 440, the groups did discuss the role of the state in this work. Some asked for clarification about how their input would inform CHITO's alignment plans, which are distinct from the state's. Many expressed a strong sense of urgency to move as quickly as feasible. While many stakeholders felt that the state, as a key stakeholder, should be brought into CHITO's work as early as possible, others were concerned that momentum might be lost given the timeline laid out in the legislation.

Conclusion

The views shared in these listening sessions reflected the expertise of the range of stakeholders in health care, from policymakers to providers and patients. Their lived experience working with measures generated a lot of great directions for work moving forward. There appears to be consensus in many areas of this work, such as the need to expand collaboration and communication. The work being done in Oregon and elsewhere has informed us, and now the goal seems to be a push to make alignment happen in a real way.

Listening Session Attendee Breakdown

Some attendees may be listed in more than one category.

Behavioral health – 1
Clinic representatives – 6
Providers - 8
Consultants – 6
Oregon Health Insurance Marketplace – 1
Employers/Purchasers – 4
FQHC assn – 2
Health plan – 37
Hospital – 2
Hospital Assn- 4
IPAs – 5
OEBB – 1
PEBB – 1
OHA – 6
OHPB members – 3
Patient advocates – 2
Public health- 2
QIOs/Policy orgs -23

Aligning Health Measurement in Oregon
Appendix 2: Literature Review

Introduction

Staff from CHITO partners reviewed over 25 measure initiatives, policy papers or care guidelines over a two-month period to provide background and broad-based understanding of the measurement activities that are currently occurring at local, state, regional and national levels. The literature included in the review was compiled from a wide range of organizations. Staff identified a diverse set of measurement activities to review that by no means encompass the entire breadth of work being done. The following literature review will provide an overview of the commonalities and differences that were found while completing the review. A complete bibliography of this work has also been compiled.

Staff began the review by identifying themes to look for in the items reviewed, and determined the following should be included:

- Steward - who created the measures/guidelines; who funded or sponsored the work
- Approach – the stakeholder group represented or the population covered by the measures/guidelines
- Domains – the categories of measurement/care included (i.e. population health, chronic care, acute care etc.)
- Goals – the stated goals of the measures/guidelines
- Gaps – the health indicators or populations not covered
- Data Sources – where is the data coming from to run the measures
- Certification – are the measures/guidelines certified or endorsed

This review will summarize the measure/guidelines activities by the themes listed above.

Steward

During the literature review a variety of measure stewards were identified and are categorized as follows:

Federal agencies:

- Health & Human Services Administration
- Centers for Medicare & Medicaid Services

National organizations:

- Robert Wood Johnson Foundation
- Institutes of Medicine
- National Committee for Quality Assurance
- Network for Regional Healthcare Improvement
- America's Health Insurance Plan
- Center for Health Care Transparency

State agencies & organizations (outside Oregon):

- Washington State Health Care Authority
- Washington Health Alliance
- Massachusetts Health Quality Partners

Oregon state agencies and organizations:

- Oregon Health Authority
- Oregon Business Council
- Oregon Healthiest State
- Q Corp

Approach

The focus of the initiatives vary immensely by the role of the steward in the health care system in the United States. These include providers, clinics, hospitals, the health care "system" (including: providers, clinics, hospitals, payers, employers and public health), patients, public health, populations and large geographic areas. A large portion of the initiatives focused on patients, clinics and the systems supporting individuals enrolled in Medicaid and Medicare. This dominance is largely due to the number of initiatives tied to CMS funding made available after the passage of the Affordable Care Act. The approach taken by the various initiatives showcases one of many sources of confusion among the initiatives: health care is being measured at varying levels and for a multitude of audiences. Because the approaches vary so widely in the stakeholders they cover, it is difficult to group the initiatives together to see where they overlap by this theme alone.

Domains

The literature review uncovered a variety of domains which are developed and tied specifically to the stakeholder group covered by the initiative. As there are a multitude of stakeholder groups for which the initiatives were developed, the domains are not as cross-cutting as one might hope. There are however a few areas that do show up in a number of the initiatives. Predominantly, these domains included cost - both the financial effect on the patient and the cost to the health care system. Clinical care measures are also a large part of many of the initiatives; these include both process and outcomes measures in a variety of settings from clinics to hospitals. A third area frequently seen in the domains is improving population health and reducing disparities. Many of the initiatives seem to be placing an increased emphasis on prevention and community health as measurement areas. The National Quality Strategy outlines five domains: Safety, Patient Engagement, Care Coordination, Effective Treatment, Healthy Communities, and Affordable Care. A review of CMS quality measurement activities determined there are still significant gaps particularly in the Affordable Care and Care Coordination domains.

Goals

Overall, the goals of the initiatives reviewed fell into two broad categories: achieving the Triple Aim and aligning measures. Many of the initiatives are specifically focused on, and designed to, align measures across settings and reduce the reporting and measurement burden across the system. The initiatives that are not focused on measure alignment are by and large working to achieve the Triple Aim, whether

explicitly stated or generally implied. These initiatives are largely focused on improving health, improving care and reducing costs.

Gaps

The gaps identified in the review are numerous. In many of the reviewed efforts, there is a desire to measure various topics but either no current measures exist or there is no way to collect the necessary data. This appeared repeatedly throughout the initiatives as a reason why certain domains and areas either were not included in the measure set, or where no results were available. Other large gaps include variation in the measurement of the initiative. For example, in several efforts the recommendations allow providers to choose from an extensive list of measures to report on. The threat of this recommendation to allow choice is that the number of providers reporting on the measures is smaller than if a smaller set of measures was required to be reported by all providers making the data less valid because the denominator or "N" is smaller, and more difficult to evaluate in a comparative way.

Data Sources

Unsurprisingly, the data for the proposed measure sets/guidelines can be collected from claims, clinical sources (e.g. EHRs, Registries, etc.) and/or surveys. While many entities acknowledge the need to engage patients more actively in measurement efforts, survey modalities remain expensive and cumbersome; some initiatives are calling for innovation in gathering patient experience data. Many initiatives use a variety of data sources in order to fill in gaps that single data sources have.

Certification

Most of the initiatives use groups of experts to create measures/guidelines lists. Some, but not all, of the initiatives are accredited by a national body. The recognition given by these entities is seen as the gold standard or national benchmark. However, the systems of review and certification criteria are not aligned themselves, which is abundantly apparent throughout the initiatives reviewed, with many initiatives taking standard measures and making adjustments to meet their own goals and objectives. Tension between desire for credibility of certification and the need for measurement to be nimble enough to support innovation.

Conclusion

The disparate goals, domains and certification of measurement and practice guideline initiatives are extensive and need to be addressed in order to reduce the burden on the providers of care and the community in which they practice. Many of the activities have similar motivations but have varying avenues of achieving the goals of the Triple Aim as they may understand them. This diversity has led to a proliferation of measures and measurement activities that may not be doing enough to improve care, lower costs and improve patients' health.

Aligning Health Measurement in Oregon
Appendix 3: Listening Session Discussion Guide and Materials

Background:
CHITO is convening this conversation in response to several factors in Oregon.

- Over the last two years, hundreds of stakeholders across Oregon have told us they are concerned, exhausted and confused by the growing number of health care quality and utilization measures.
- There are now over 2,000 endorsed and validated quality measures that have been endorsed by various accredited organizations.
- Primary care groups in Oregon are being asked to focus on over 140 different measures requested by dozens of payers, plans and purchasers. In addition citizens, policy makers, health care industry representatives and employers are asking if we have made overall progress in the health and healthcare of Oregonians.
- The good news is that significant progress has been made in improving the quality of care in several targeted areas over the last years! The bad news is there are unintended consequences of the endless proliferation of measures and fragmented focus and more measures being created and implemented each day.

Goals: This discussion will:

- Bring together a cross-section of stakeholders in the health care community who are working on or with quality measurement in Oregon for candid conversation
- Check in on alignment of our common goals and agendas – are we really all pointing in the same direction?
- Help inform the CHITO Pilot Project #2 on measure and metric alignment with diverse perspectives to help shape the next steps

Once the listening sessions are complete, CHITO partners will draft a whitepaper offering interested stakeholders and policymakers in Oregon a view of the current measurement landscape, and suggestions and options for better alignment that reflects our common goals.

Agenda:

Time	Topic	Lead
1:00p.m.	Welcome and introduction	Mylia Christensen and CHITO partners
1:10p.m.	Group discussion	Small groups
1:55p.m.	CHITO Overview	Mylia Christensen
2:10p.m.	Further discussion and next steps	Group
2:25p.m.	Wrap-up and adjourn	Mylia Christensen

Discussion Guide:

The questions to explore include the following:

- In the science of healthcare quality improvement, you typically select the overall goals to be accomplished and then select measures to track specific targeted improvements. What are the overall Oregon healthcare goals for 2015 and 2016? Are we all on the same page?
- Thinking about the last five years of measurement development in Oregon, what would you say is working? What could be improved?
- What is the best outcome you can imagine for measurement alignment work? What is your biggest concern?
- With so many sets of measures for different aims in play (e.g., process, outcome, population health, hospital, payment reform), it can be difficult to find a common language or context to talk about what these measures do, and what goal they are moving us to. Ideally, alignment of measures and metrics should reflect the alignment of overall public and private goals for Oregon.
    - Looking ahead to 2016, do you believe we are "there" in terms of alignment? Why or why not?
    - What suggestions do you have to help get us there? What other information or participation would be critical to alignment?
    - Looking at a few samples in your packet, would any of these frameworks be useful in trying to find a common language and framework for all the levels of measures and metrics? Why? Other suggestions?

APPENDIX

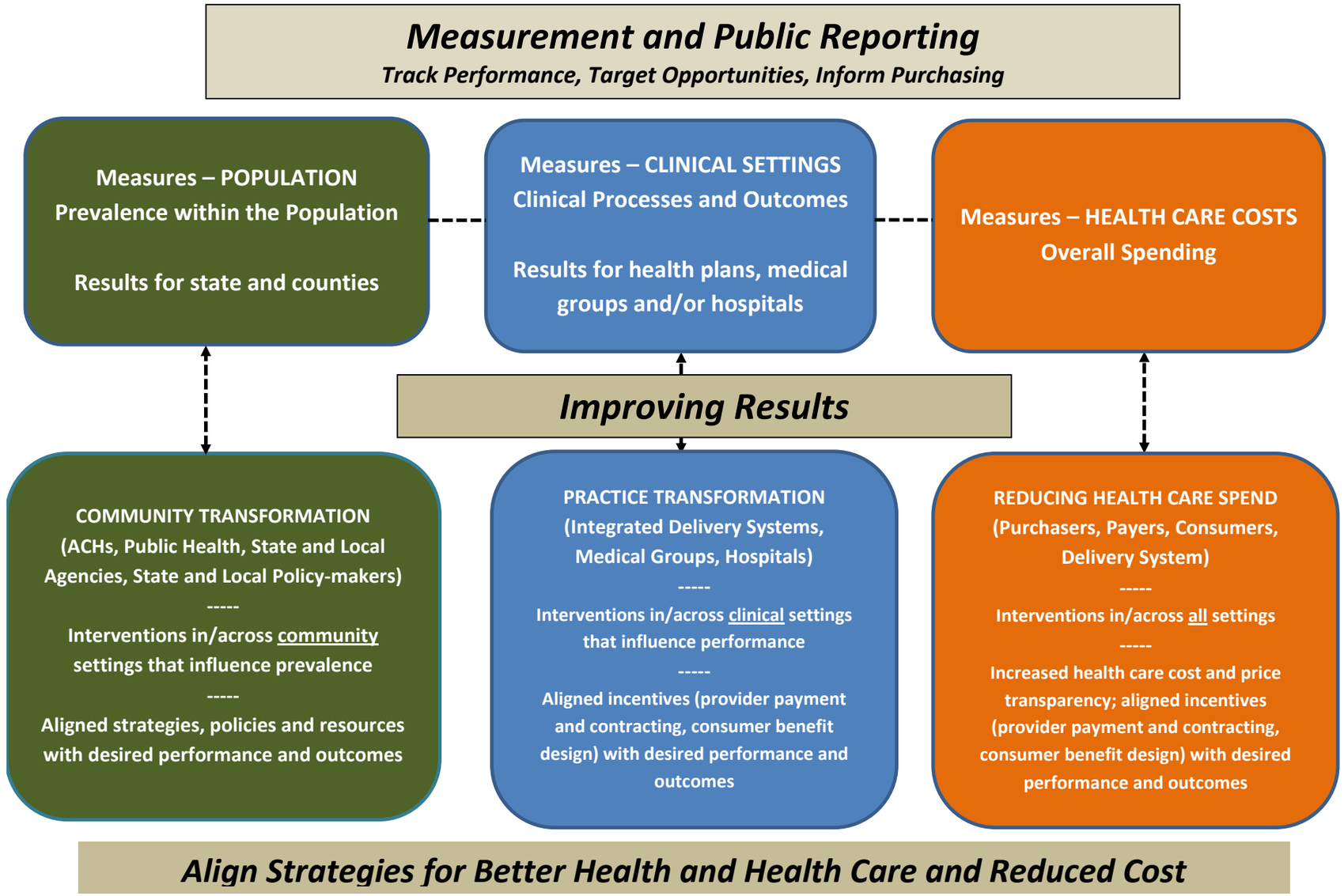
CULTURE OF HEALTH ACTION FRAMEWORK

ACTION AREAS	DRIVERS	MEASURES
1 MAKING HEALTH A SHARED VALUE	MINDSET AND EXPECTATIONS	Value on health interdependence
		Value on well-being
		Public discussion on health promotion and well-being
	SENSE OF COMMUNITY	Sense of community
		Social support
	CIVIC ENGAGEMENT	Voter turnout
		Volunteer engagement
2 FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING	ENUMERATION AND QUALITY OF PARTNERSHIPS	Local health department collaboration
		Opportunities to improve health for youth at schools
		Business support for workplace health promotion and Culture of Health
	INVESTMENT IN CROSS-SECTOR COLLABORATION	U.S. corporate giving
		Federal allocations for health investments related to nutrition and indoor and outdoor physical activity
	POLICIES THAT SUPPORT COLLABORATION	Community relations and policing
		Youth exposure to advertising for healthy and unhealthy food and beverage products
		Climate resilience
		Health in all policies
3 CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES	BUILT ENVIRONMENT/PHYSICAL CONDITIONS	Housing affordability
		Access to healthy foods
		Youth safety
	SOCIAL AND ECONOMIC ENVIRONMENT	Residential segregation
		Early childhood education
		Public libraries
	POLICY AND GOVERNANCE	Complete Streets policies
		Air quality
4 STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS	ACCESS	Access to public health
		Access to stable health insurance
		Access to mental health services
		Dental visit in past year
	CONSUMER EXPERIENCE AND QUALITY	Consumer experience
		Population covered by an Accountable Care Organization
	BALANCE AND INTEGRATION	Electronic medical record linkages
		Hospital partnerships
		Practice laws for nurse practitioners
		Social spending relative to health expenditure

OUTCOME	OUTCOME AREAS	MEASURES
IMPROVED POPULATION HEALTH, WELL-BEING, AND EQUITY	ENHANCED INDIVIDUAL AND COMMUNITY WELL-BEING	Well-being rating
		Caregiving burden
	MANAGED CHRONIC DISEASE AND REDUCED TOXIC STRESS	Adverse child experiences
		Disability associated with chronic conditions
	REDUCED HEALTH CARE COSTS	Family health care cost
		Potentially preventable hospitalization rates
		Annual end-of-life care expenditures


LIFE EXPECTANCY
COMMUNITY ENGAGEMENT
WELL-BEING
INDIVIDUAL ENGAGEMENT
OVERWEIGHT & OBESITY
POPULATION SPENDING BURDEN
ADDICTIVE BEHAVIOR
VITAL SIGNS
Core Metrics for Health and Health Care Progress
INDIVIDUAL SPENDING BURDEN
UNINTENDED PREGNANCY
CARE MATCH WITH PATIENT GOALS
HEALTHY COMMUNITIES
EVIDENCE-BASED CARE
PREVENTIVE SERVICES
PATIENT SAFETY
CARE ACCESS

STATEWIDE COMMON MEASURES – "STARTER SET"



Overview of Measures:

MEASURES – POPULATION
Prevalence within the Population
Results for State, Counties/Accountable Communities of Health
(Note: Many, but not all, measures shown to the right will also have results at the state and/or county levels).

1. **Immunization: Influenza**
2. **Unintended Pregnancies**
3. **Tobacco: % of Adults who Smoke Cigarettes**
4. **Behavioral Health: % of Adults Reporting 14 or more Days of Poor Mental Health**
5. **Ambulatory Care Sensitive Hospitalizations for COPD**

MEASURES – HEALTH CARE COSTS

50. **Annual State-purchased Health Care Spending Relative to State's GDP**
51. **Medicaid Spending per Enrollee**
52. **Public Employee and Dependent Spending per Enrollee (Include Public Schools)**

MEASURES – CLINICAL SETTINGS
Clinical Processes or Outcomes
Results for Health Plans, Medical Groups and/or Hospitals

Health Plan (Only)	Primary Care Medical Groups (4 or more Providers)	Hospitals
Children/Adolescents 6. Access to Primary Care 7. Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life 8. Youth Obesity: BMI Assessment/Counseling 9. Oral Health: Primary Caries Prevention/ Intervention	**Children/Adolescents** 19. Immunization: Childhood Status 20. Immunizations: Adolescent Status 21. Immunizations: HPV Vaccine for Adolescents 22. Appropriate Testing for Children with Pharyngitis	40. Patient Experience: Communication about Medications and Discharge Instructions 41. 30-day All Cause Readmissions* 42. Potentially Avoidable ED Visits* 43. Patients w/ 5 of More ED Visits *without* Care Guidelines 44. C-Section NTSV 45. 30-day Mortality: Heart Attack 46. Catheter-associated Urinary Tract Infection 47. Stroke: Thrombolytic Therapy 48. Falls with Injury per Patient Day 49. Complications/Patient Safety Composite (11 components)
Adults 10. Access to Primary Care 11. Adult Obesity: BMI Assessment/Counseling 12. Medical Assistance with Smoking and Tobacco Use Cessation 13. Colorectal Cancer Screening* 14. Diabetes Care: Blood Pressure Control 15. Diabetes Care: HbA1c Poor Control 16. Hypertension: Blood Pressure Control 17. Follow-up After Hospitalization for Mental Illness @ 7 days, 30 days 18. 30-day Psychiatric Inpatient Readmission **Results available for medical groups starting in 2016.*	**Adults** 23. Patient Experience: Provider Communication 24. Screening: Cervical Cancer 25. Screening: Chlamydia 26. Screening: Breast Cancer 27. Immunizations: Pneumonia (Older Adults) 28. Avoidance of Antibiotics for Acute Bronchitis 29. Avoidance of Imaging for Low Back Pain 30. Asthma: Use of Appropriate Medications 31. Cardiovascular Disease: Use of Statins 32. COPD: Use of Spirometry in Diagnosis 33. Diabetes: HbA1c Testing 34. Diabetes: Eye Exams 35. Diabetes: Screening for Nephropathy 36. Depression: Medication Management 37. Medication Adherence: Proportion of Days Covered 38. Medication Safety: Annual Monitoring for Patients on Persistent Medications 39. Medications: Rate of Generic Prescribing	**Results also available for medical groups.*

Aligning Health Measurement in Oregon
Appendix 4: Selected Matrix of Measures

Selected Quality Measures Matrix	NQF ID	Measure Steward		RWJF	WHA	CHT	CCO Incentive	CCO Performance	Oregon HTPP	CMS 5 Star C&D	PCPCH Quality Measures	IOM Priority Mesures	Oregon Q-Corp	AHIP/CMS Core set: OB/GYN	AHIP/CMS Core Set: ACO and PCMH
Count of 2-4 Count of 5+	67		**Count**	2	51	11	14	15	10	10	33	17	23	8	20
Pharyngitis Testing - Children	0002	NCQA	**3**		x						x		Y		
Initiation and engagement of alcohol and other drug treatment	0004	NCQA	**1**					x							
Controling High BP	0018	NCQA	**6**		x	x		x			x	x			x
Rate of obesity among members			**1**					x							
Rate of tobacco use among members			**3**		x			x				x			
BMI Child (Weight assessment and Counseling for Nutrition and Physical Activityh for Children/Adolescents)	0024	NCQA	**2**		x						x				
Advise Smokers to Quit (Medical Assistance with Smoking and Tobacco Use Cessation)	0027	NCQA	**1**		x										
Tobacco Assessment	28a	AMA	**2**								x				x
Tobacco Intervention	28b	AMA	**0**												
Prevention screening composite - BC, CCA, ColoCA Screening		CA OPA	**1**			x									
Breast CA Screen	0031	NCQA	**4**		x					x	x		Y		
Cervical CA Screen	0032	NCQA	**5**		x						x		Y	x	x
Chlamydia Screen	0033	NCQA	**2**		x								Y		
Chlamydia screening and follow up	1395	NCQA	**1**											x	
Colorectal CA Screen	0034	NCQA	**6**		x		x			x	x	x			x
Asthma Medications	0036	NCQA	**2**								x		Y		
Child Immunizations	0038	NCQA	**2**		x						x				
Influenza Immunization	0041	AMA	**4**		x					x	x	x			
Pneumonia Vaccine Older Adults	0043	NCQA	**2**		x						x				
Pneumonia vaccine	0044	NCQA	**1**								**x**				

Selected Quality Measures Matrix	NQF ID	Measure Steward		RWJF	WHA	CHT	CCO Incentive	CCO Performance	Oregon HTPP	CMS 5 Star C&D	PCPCH Quality Measures	IOM Priority Mesures	Oregon Q-Corp	AHIP/CMS Core set: OB/GYN	AHIP/CMS Core Set: ACO and PCMH
Count of 2-4 Count of 5+	67		**Count**	2	51	11	14	15	10	10	33	17	23	8	20
Imaging for Low Back Pain	0052	NCQA	**2**		x										x
Osteoporosis management in women who have had a fracture	0053	NCQA	**1**							x					
DM Care: Eye Exam	0055	NCQA	**4**		x					x			Y		x
DM: Foot Exam	0056	NCQA	**1**												x
DM Care: HbA1c Testing	0057	NCQA	**4**		x						x		Y		x
Avoidance of Antibiotics Adults with Bronchitis	0058	NCQA	**2**		x										x
DM Care: HbA1c Poor Control	0059	NCQA	**3**		x		x								x
DM Care: BP Control <140/90	0061	NCQA	**2**		x						x				
DM Care: Med Attention for Nephropathy	0062	NCQA	**4**		x					x			Y		x
DM Care: LDL-C Screening	0063	NCQA	**2**								x		Y		
DM Care: LDL-C Control <100 mg/dL	0064	NCQA	**1**								x				
CAD: ACE Inhibitor or ARB Therapy–Diabetes or LVSD	0066	ACC	**1**								x				
CAD: Antiplatelet Therapy	0067	ACC	**1**								x				
IVD: Use of Aspirin	0068	NCQA	**1**												x
CAD: Beta-blocker therapy	0070		**1**								x				
Beta-Blockers after Heart Attack	0071	NCQA	**1**												x
Heart Attack Therapy Protocol			**1**									x			
Cardiovascular risk reduction			**1**									x			
Stroke Therapy Protocol			**2**		x							x			
Statin therapy for pts with coronary artery disease	0543	CMS	**1**		x										
CAD: Lipid Control	0074	ACC	**1**								x				

Selected Quality Measures Matrix	NQF ID	Measure Steward		RWJF	WHA	CHT	CCO Incentive	CCO Performance	Oregon HTPP	CMS 5 Star C&D	PCPCH Quality Measures	IOM Priority Mesures	Oregon Q-Corp	AHIP/CMS Core set: OB/GYN	AHIP/CMS Core Set: ACO and PCMH
Count of 2-4 Count of 5+	67		**Count**	2	51	11	14	15	10	10	33	17	23	8	20
IVD: Lipid Panel and LDL Control <100	0075	NCQA	**1**										x		
Diabetes control composite			**1**									x			
Falls: Risk Assess and Plan of Care	0101	NCQA	**1**							x					
Falls with injury per patient day	0202	ANA	**1**		x										
Behavioral Health And substance Abuse															
Antidepressant Med Mgmt	0105	NCQA	**2**		x								Y		
Follow-up after hospitalization for mental illness	0576	NCQA	**4**		x		x	x	x						
% of adults reporting 14 or more days of poor mental health			**1**		x										
Depression remission at 6 months	0711	MNCM	**1**			x									
Depression remission at 12 months	0710	MNCM	**1**												x
Depression response at 12 months - progress towards remission	1885	MNCM	**1**												x
Utilization of the PHQ-9 to monitor depression symptoms for adolescents and adults	0712	MNCM	**1**			x									
Clinical Depression Screening	0418	CMS	**3**				x	x			x				
Preventative: BMI Screening	0421	NCQA	**4**		x					x	x				x
PC-01 Elective delivery before 39 weeks	0469	TJC	**1**											x	
PC-02 Cesarean rate for low-risk first birth women	0471	TJC	**2**		x									x	
Incidence of episiotomy	0470	CCHC	**1**											x	
Care for older adults: Medication review	0553	NCQA	**1**							x					

Selected Quality Measures Matrix	NQF ID	Measure Steward		RWJF	WHA	CHT	CCO Incentive	CCO Performance	Oregon HTPP	CMS 5 Star C&D	PCPCH Quality Measures	IOM Priority Mesures	Oregon Q-Corp	AHIP/CMS Core set: OB/GYN	AHIP/CMS Core Set: ACO and PCMH
Count of 2-4 Count of 5+	67		**Count**	2	51	11	14	15	10	10	33	17	23	8	20
Proportion of days covered: 3 rates by therapeutic coverage	0541	PQA	**1**		x										
DM Care: HbA1c Control <8.0%	0575	NCQA	**1**								x				
Use of Spirometry testing in the assessment and diagnosis of COPD	0577	NCQA	**1**		x										
Annual Dental Visit	1388	NCQA	**1**	x											
Dental sealants on permanent molars for children	2508	ADA-DQA	**1**				x								
Primary caries prevention/intervention			**1**		x										
Well-Child First 15 Mo	1392	NCQA	**2**								x		Y		
Frequency of prenatal care	1391	NCQA	**1**											x	
Immunizations for Adolescents	1407	NCQA	**2**		x						x				
Prenatal and postpartum care: postpartum care rate	1517	NCQA	**1**								x				
Prenatal and postpartum care: Timeliness of prenatal care	1517	NCQA	**2**				x				x				
Human papillomavirus vaccine for female adolescents	1959	NCQA	**1**		x										
Developmental screening in the first 3 years of life	1399	NCQA	**2**								**x**		x		
Developmental screening in the first 36 months of life	1448	OHSU	**2**				x	x							
Well-Child 3,4,5,6 Yrs	1516	NCQA	**3**		x						x		Y		
Asthma: Medication Management	1799	NCQA	**2**		x										x
Annual Monitoring: persistent medications	2371	NCQA	**1**		x										
Breast Cancer Screening	2372	NCQA	**3**									x		x	x

Selected Quality Measures Matrix	NQF ID	Measure Steward		RWJF	WHA	CHT	CCO Incentive	CCO Performance	Oregon HTPP	CMS 5 Star C&D	PCPCH Quality Measures	IOM Priority Mesures	Oregon Q-Corp	AHIP/CMS Core set: OB/GYN	AHIP/CMS Core Set: ACO and PCMH
Count of 2-4 Count of 5+	67		**Count**	2	51	11	14	15	10	10	33	17	23	8	20
SBIRT			**5**				x	x	x		x		x		
Non-recommended Cervical Cancer Screening in Adolescent Females			**2**											x	x
Ambulatory care: Outpatient and Emergency Department Utilization			**3**				x	x					x		
Effective Contraception use among women not desiring pregnancy	NA		**3**				x	x				x			
Unintended pregnancy			**1**		x										
PQI 01: Diabetes, short term complication admission rate	0272	AHRQ	**1**					x							
PQI 05: Chronic obstructive pulmonary disease admission rate	0275	AHRQ	**1**		x										
PQI 09: Low birth weight	0278	AHRQ	**1**					x							
PQI 14: uncontrolled diabetes admission rate	0638	AHRQ	**1**					x							
Hospitalization for potentially avoidable complications			**1**	x											
Total resource use population based PMPM index		HP	**1**			x									
Access to care															
Reminder system for mammograms	0509	AMA	**1**								x				
Child and adolescents' access to primary care practitioners (CAP)	NA	NCQA	**1**		x										

Selected Quality Measures Matrix	NQF ID	Measure Steward		RWJF	WHA	CHT	CCO Incentive	CCO Performance	Oregon HTPP	CMS 5 Star C&D	PCPCH Quality Measures	IOM Priority Mesures	Oregon Q-Corp	AHIP/CMS Core set: OB/GYN	AHIP/CMS Core Set: ACO and PCMH
Count of 2-4 Count of 5+	67		**Count**	2	51	11	14	15	10	10	33	17	23	8	20
Adults' access to preventive/ambulatory health services	NA	NCQA	**1**		x										
PCPCH enrollment			**1**				x								
Adolescent Well-Care Visits			**3**				x				x		x		
Usual Source of Care			**1**									x			
Delay of needed care			**1**									x			
Rate of Generic prescribing			**1**		x										
Generic Rx Fills: Statins			**1**										x		
Generic Rx Fills: SSRIs and antiD			**1**										x		
Cost															
Total Cost of Care			**2**			x						x			
Medicaid spending per enrollee			**1**		x										
Public employee and dependedt			**1**		x										
Annual state-purchased health care			**1**		x										
Hospital/safety measures															
Procedure volume - THR, TKR, PCI Stents, CABG, Bariatric, Cholecystectomy, high risk delivery, carpal tunnel, brca surgery, colorectal ca surgery		CIVHC	**1**			x									
Potentially Avoidable ED: Per 100			**2**					x					Y		
Potentially Avoidable ED: % total			**2**		x								Y		
Patients with 5 or more ED visits without care guidelines			**1**		x										
30-day psychiatric inpatient readmission			**1**		x										

Selected Quality Measures Matrix	NQF ID	Measure Steward		RWJF	WHA	CHT	CCO Incentive	CCO Performance	Oregon HTPP	CMS 5 Star C&D	PCPCH Quality Measures	IOM Priority Mesures	Oregon Q-Corp	AHIP/CMS Core set: OB/GYN	AHIP/CMS Core Set: ACO and PCMH
Count of 2-4 Count of 5+	67		**Count**	2	51	11	14	15	10	10	33	17	23	8	20
Adverse drug events due to opioids		ISMP	**1**						x						
Hypoglycemia in Patients receiving insulin		ASHSP [SUI]	**1**						X						
Hosp Admints for Amb Conditions			**1**										Y		
Excessive anticoagulation with Warfarin		ISMP	**1**						x						
Hospital-Wide All-Cause Readmission Measure	1789	CMS	**2**			x			x						
30-Day All-Cause Readmit	1768	NCQA	**4**		x	x				x			Y		
Hospital 30 day mortality - AMI	0230	CMS	**1**		x										
CLABSI	0139	CDC	**1**						x						
AHRQ PSI-90 Composite	0531	AHRQ	**1**			x									
CAUTI	0754	CDC (138)	**2**		x				x						
Medication reconciliation post-discharge	0097	NCQA	**1**												x
Wrong-site surgery			**1**									x			
Pressure Ulcers			**1**									x			
Complications/Patient Safety Composite (11 components)			**1**		x										
HF 1 Discharge instructions			**1**		x										
HCAHPS	0166	CMS	**1**						x						
Care Coordination															
Shared Decision Making			**2**			x						x			
End--of-Life/advanced care planning			**1**									x			
Hospitals share ED visit information with primary care providers and other hospitals	NA	NA	**1**						x						

Selected Quality Measures Matrix	NQF ID	Measure Steward		RWJF	WHA	CHT	CCO Incentive	CCO Performance	Oregon HTPP	CMS 5 Star C&D	PCPCH Quality Measures	IOM Priority Mesures	Oregon Q-Corp	AHIP/CMS Core set: OB/GYN	AHIP/CMS Core Set: ACO and PCMH
Count of 2-4 Count of 5+	67		**Count**	2	51	11	14	15	10	10	33	17	23	8	20
Mental, physical and dental health assessments within 60 days for children in DHS custody			**2**				x	x							
Follow-up care for children prescribed ADHD medications	0108	NCQA	**1**								x				
Objective Measures															
EHR Adoption			**1**				x								
Board certification			**1**	x											
Transitions of care - summary	P124		**1**									x			
CAHPS Adult & Child	0005	AHRQ	**2**			x									x
Consumer assessment of healthcare providers and systems (CAHPS) HP - Medicaid and Commercial	0006	AHRQ	**2**							x		x			
Consumer assessment of healthcare providers and systems (CAHPS) Health plan survey 5.0	0006	AHRQ	**1**	x											
CAHPS adult and child composite: Access to care			**3**				x	x		x					
CAHPS adult and child composite; Satisfaction with care			**2**				x	x							
patient experience: Provider communication			**1**		x										
CAHPS adult/child health status			**1**					x							