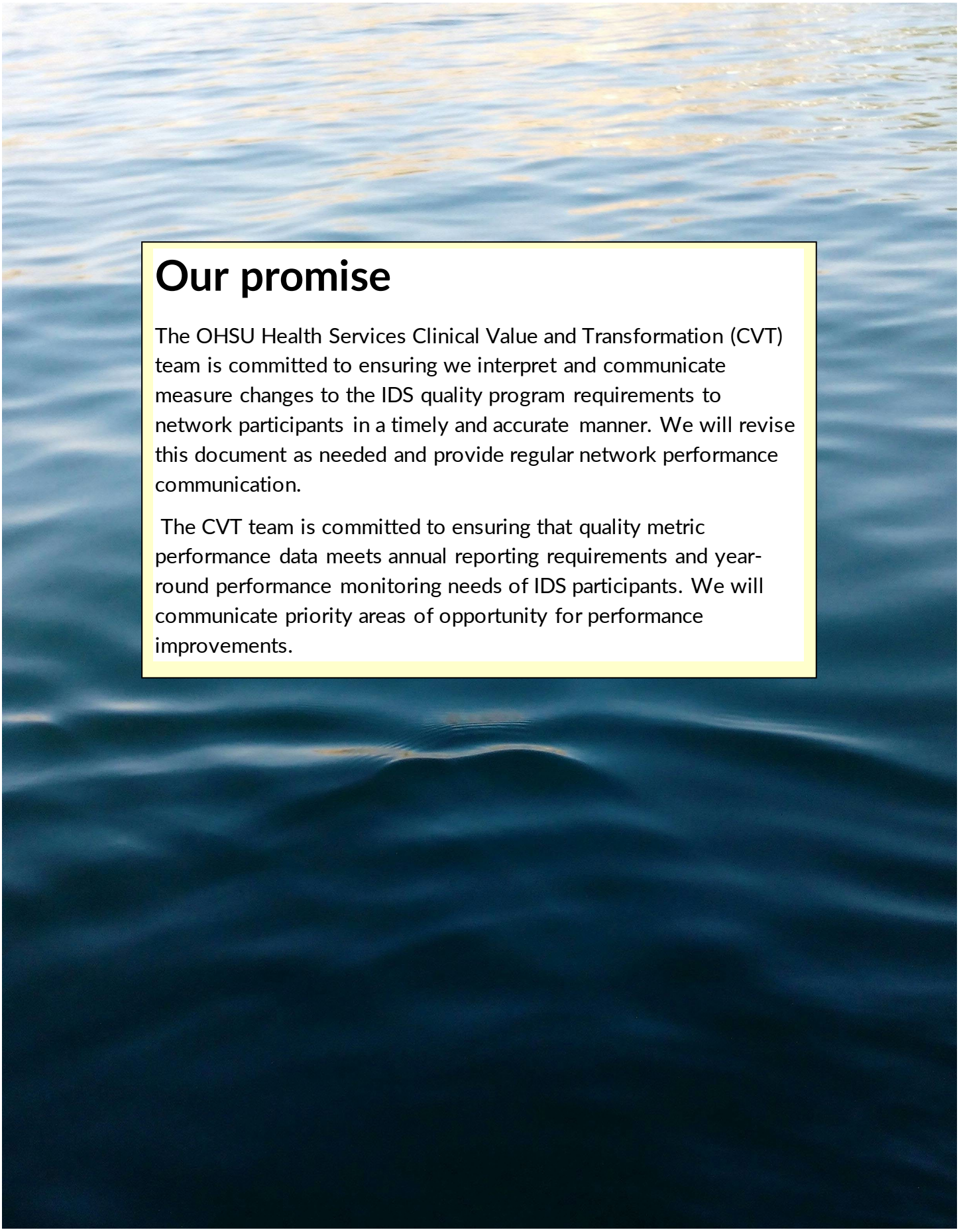

INTEGRATED DELIVERY SYSTEM
Quality Incentive Program
Performance Year 2025
OHSU
Health



Our promise

The OHSU Health Services Clinical Value and Transformation (CVT) team is committed to ensuring we interpret and communicate measure changes to the IDS quality program requirements to network participants in a timely and accurate manner. We will revise this document as needed and provide regular network performance communication.

The CVT team is committed to ensuring that quality metric performance data meets annual reporting requirements and year-round performance monitoring needs of IDS participants. We will communicate priority areas of opportunity for performance improvements.

Introduction

This booklet outlines the 2025 OHSU Health IDS quality reporting requirements, performance expectations and key metrics.

OHSU Health Integrated Delivery System (IDS) is a member of Health Share of Oregon Coordinated Care Organization (CCO), a network of physical, behavioral and dental clinicians who have agreed to work together to provide coordinated, high-quality care to Medicaid members enrolled in the Oregon Health Plan (OHP).

OHSU Health IDS launched Jan. 1, 2020, in alignment with the OHA CCO 2.0 initiative. As a founding partner of Health Share of Oregon (HSO), OHSU collaborated with Moda Health to establish the IDS through a joint venture designed to assume full financial risk for Medicaid members in the Portland metropolitan region. The two organizations share operational leadership. OHSU manages the clinician network and oversees clinical quality and care transformation efforts. Moda Health manages administrative functions, such as claims processing, member services and financial operations

The IDS model emphasizes whole-person care, integrating physical, behavioral and social health supports to meet the complex needs of Medicaid members. A core priority of our IDS is addressing social and structural barriers that influence health outcomes, including housing instability, food insecurity, transportation barriers and health literacy.

Contact information

OHSU Health Services, Clinical Value and Transformation Team

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For quality information, visit

OHSU Health IDS Quality Metric Navigator

For the latest version of this document:

OHSU Health Services for Providers and Clinics under the provider resources tab.

Our names

Our legal corporate name is registered as OHSU Health IDS, LLC. We are internally referred to as OHSU Health IDS or the IDS.

Health Share member ID Cards will list us as OHSU Health. Our patient-facing name is OHSU Health Services.

Our network

The IDS supports a diverse and integrated network of more than **3,000** employed and community-based providers, collectively serving about **63,000** Medicaid members focusing on equity, prevention and high-quality outcomes.

Acronyms

CCO: Coordinated Care Organization

CMS: Centers for Medicare and Medicaid Services

CVT: Clinical Value and Transformation

eCQM: Electronic Clinical Quality Measure

(Different from Medicare Shared Savings Program eCQMs)

EMR: Electronic Medical Record

HSO: Health Share of Oregon

IDS: Integrated Delivery System

MLA: Meaningful Language Access

MSC: Metrics and Scoring Committee

OHA: Oregon Health Authority

OHP: Oregon Health Plan

QHOC: Quality Health Outcomes Committee

QIP: Quality Incentive Program

REAL-D: Race, Ethnicity and Language, Disability

SDoH: Social Drivers of Health

(also known as Social Determinants of Health)

SEH: Social-Emotional Health

SUD: Substance Use Disorder

TAG: Technical Advisory Group

Contents

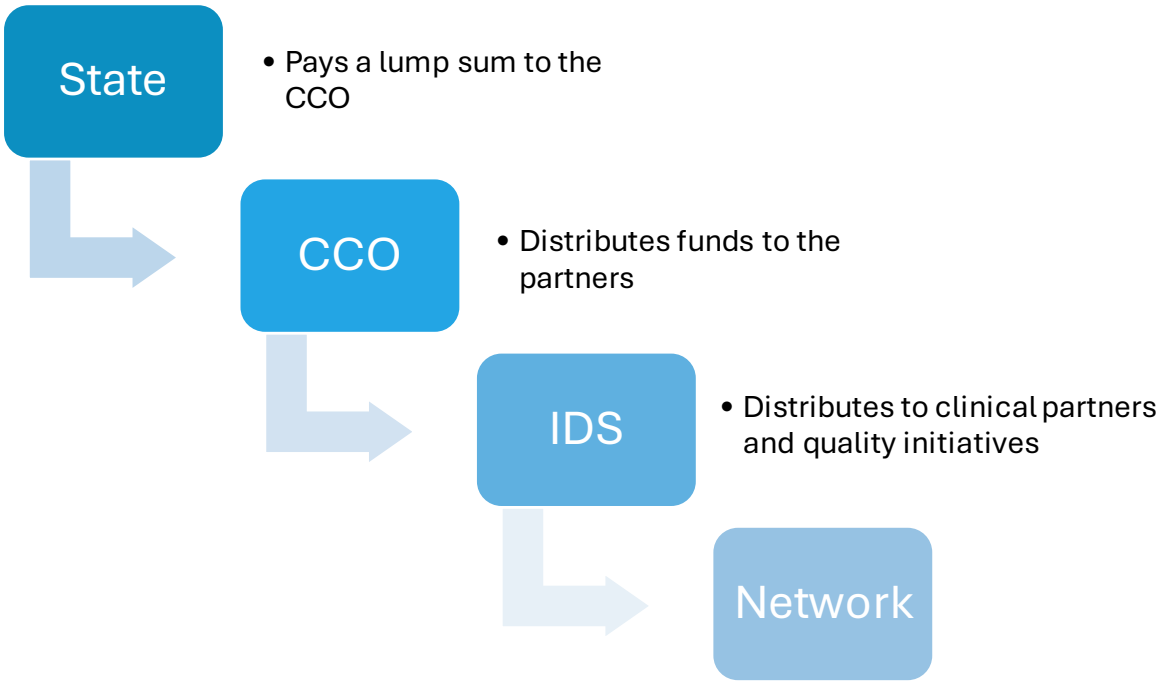
Oregon's Quality Incentive Program

The Oregon Health Authority (OHA) administers performance-based payments through the CCO Quality Incentive Program (QIP). Oregon's program is unique, as the federal government allows states to manage their programs to improve the quality of care for Medicaid members.

Each year, OHA sets aside a portion of Medicaid funds into a Quality Pool. OHSU Health IDS can earn incentive funding from this pool based on the network's performance each year on a specific set of metrics. The State of Oregon treats this as bonus funding on top of per-member-per-month capitation rates. Incentive dollars are tied to the collective outcomes of all Health Share of Oregon CCO partners, including OHSU Health IDS, CareOregon, Providence, Kaiser and Legacy. The total amount of funding available to a CCO is proportional to its Medicaid membership size. Final distribution by the CCO depends on how well each plan partner performs and the CCO's overall performance.

→ Find more information on the QIP program at OHA's CCO Quality Metrics website.

2025 CCO quality funding distribution



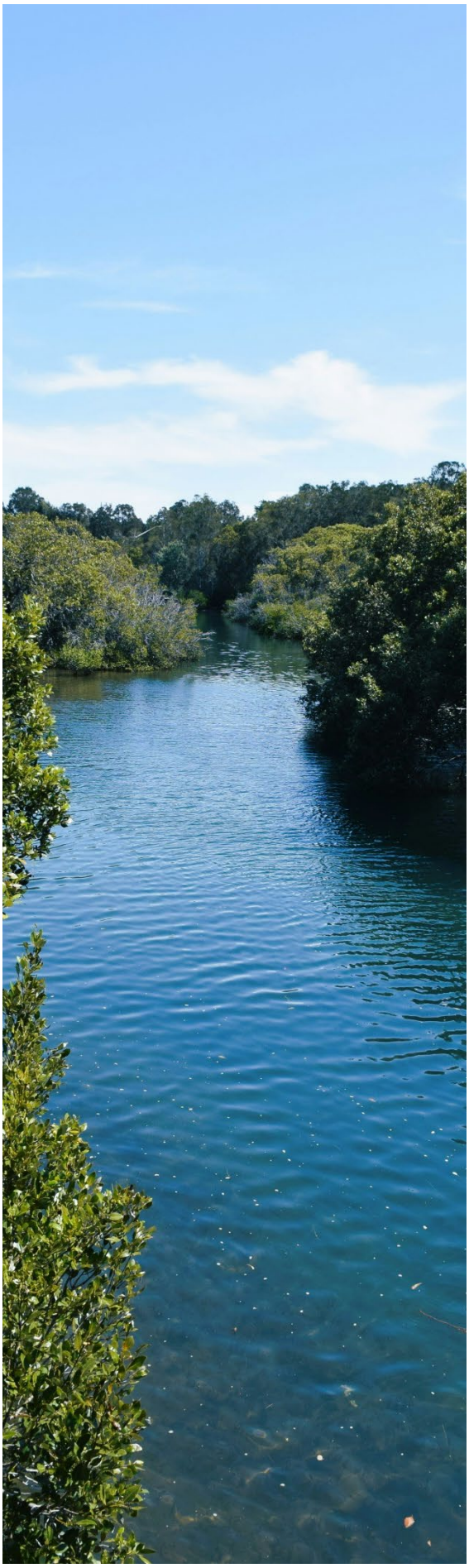
Measuring success

The 2025 QIP program measures success through a set of 13 metrics designed to assess health care processes and outcomes. The metrics track progress in providing care that is effective, timely, patient-centered and equitable.

As directed by the Oregon Legislature, the 2025 QIP program includes two types of metrics: upstream and downstream.

1. **Upstream metrics** address inequities and socio-economic factors impacting health, such as Social Drivers of Health.
2. **Downstream metrics** focus on more traditional medical care, such as immunizations and diabetes control, and must align with national requirements from the Centers for Medicare and Medicaid (CMS).

The Metrics and Scoring Committee (MSC), a public advisory body convened by OHA, selects the annual set of quality metrics and establishes performance benchmarks. These decisions are based on prior year data, expert and OHA recommendations, and input gathered through public testimony.



New in 2025

Key changes for 2025 include:

- **SDOH data reporting**: Increased emphasis on the Social Needs Screening and Referral (SDoH) metric, which now includes a data submission component requiring collaboration between clinics and IDS teams.

- **Expanded health equity metrics**: Continued focus on Meaningful Language Access (MLA) and Social Emotional Health (SEH) for young children, now with refined workflows and stronger performance monitoring.

- **Challenge pool updates**: Four metrics identified as Challenge pool opportunities with potential to earn additional funding: Timely Postpartum Care, Diabetes Control, Child Well-Care (3–6), and Preventive Dental Services. For Challenge Pool details, please see page 12.

Investing in OHSU Health IDS clinicians

Our goal is to ensure clinical practices within the OHSU Health IDS network have the tools, insights and support needed to succeed in an evolving in a complex health care landscape.

The CVT team of OHSU Health IDS delivers comprehensive support to clinical practices to achieve quality performance goals.

Our support services reduce barriers and support clinical operations by:

- Developing and sharing monthly performance dashboards highlighting care gaps, metric trends and actionable insights.
- Assisting with metric implementation and improvement strategies.
- Providing training opportunities and learning collaboratives focused on upstream metrics and cross-clinic knowledge sharing.
- Sharing information and resources for annual grants and financial incentives to strengthen quality improvement infrastructure and care delivery systems.
- Delivering hands-on support for documentation, metric audits and data submission.
- Developing partnerships with community-based organizations, network partners and content experts.

Why quality performance matters

Strong quality performance does more than unlock incentive funding; it directly improves the lives of our Medicaid members.

Through better preventive care, chronic disease management and attention to social drivers, we can reduce unnecessary hospitalizations, improve health equity and ensure our members receive the right care at the right time.

Focusing on quality improvement allows IDS clinicians to:

- Provide effective and appropriate care for our most vulnerable patients.
- Drive change in the most positive way for our system.
- Empower patients through shared decision-making related to their care.

Every clinic's contribution helps shape the future of Medicaid care in Oregon.

Our collective success lifts the entire OHSU Health IDS.

The IDS reinvests incentive dollars into:

- Clinic infrastructure
- Annual grants, available for quality projects
- Integrated behavioral health models, including funding to help clinics establish the Collaborative Care Model
- Training and development, such as a partnership with OHSU Harold Schnitzer Diabetes Health Center to train primary care nurses and pharmacists to better support members with diabetes
- Incentives for training and workflow development for upstream metrics, including the SDOH and SEH metrics

System participation expectations

Clinics operating under the OHSU Health IDS umbrella must participate in the IDS Quality Program. Each organization (identified by TIN) must:

- ✓ Participate in quality improvement efforts, including attending quarterly and monthly meetings hosted by OHSU Health IDS.
- ✓ Report data to OHSU Health IDS as required by specific metric.
- ✓ Implement workflows and data capture processes for both upstream and downstream metrics.
- ✓ Submit attestation or supplemental data for metrics that require clinic reporting.

Health equity commitment

OHSU Health IDS is dedicated to reducing health disparities and advancing health equity across our network. We believe that quality improvement must explicitly address the root causes of inequity. Equity is not a side effort; it is a foundational pillar of our quality strategy.

Our commitment to equity includes:

- Prioritizing equity-related metrics, such as Meaningful Language Access (MLA) and Social Needs Screening.
- Collaborating with clinics to improve data collection on Race, Ethnicity, Language and Disability (REAL-D).
- Investing in culturally responsive care models and interpreter services.
- Providing incentives for upstream workflows that serve historically marginalized communities.

OHSU Health IDS quality initiatives

Upstream Quality Metrics

Importance

Upstream metrics address inequities and socio-economic factors impacting health, such as Social Drivers of Health. The intention of these metrics is to be transformative, tackling historical and contemporary injustices that impact health outcomes. The State of Oregon develops upstream metrics, and these metrics require more collaboration across the CCO.

Metrics to monitor

- Assessments for children in ODHS Custody (DHS Assessments)
- Young Children Receiving Social-Emotional Issue-Focused Intervention and Treatment (SEH)
- Social Determinants of Health: Social Needs Screening and Referrals (SDoH)
- Health Equity Measure: Meaningful Access to Health Care Services for Persons Who Prefer a Language other than English (LOE) and Persons Who are Deaf or Hard of Hearing (MLA)

Action plan

- Attend network quality improvement meetings.
- Educate clinical staff on the importance of addressing health inequities.
- Participate in Upstream Metrics training offered by the CCO or IDS.
- Submit all required reports to the IDS.
- Participate in quality activities and workflow development as required in upstream metric glide paths.

Downstream Quality Metrics

Importance

These metrics reflect the traditional medical model, such as preventive screenings, chronic disease management and childhood immunizations. Downstream metrics focus on outcomes and often include a trackable medical result.

Downstream metrics have two categories: Clinic reported (eCQM) and claims based.

Clinic reported downstream

- Diabetes: HbA1c Poor Control (>9)
- Screening for Depression and Follow-Up

Report only, not part of QIP:

- Cigarette Smoking Prevalence
- SBIRT (Screening, Brief Intervention & Referral to Treatment)

Claims reported downstream:

- Immunizations for Adolescents
- Childhood Immunizations
- Initiation and Engagement of SUD Treatment (bundled measure and must meet both initiation and engagement benchmarks)
- Child and Adolescent Well-Care Visits (incentivized for ages 3-6)
- Prenatal and Postpartum Care: Postpartum Care Rate

Report only, not part of QIP:

- Controlling High Blood Pressure

Action plan:

- Participate in network and system quality improvement meetings.
- Participating in all training offered by the CCO or IDS.
- Submit all required reporting to the IDS.

Challenge Pool Metrics

Importance

OHSU Health IDS earns additional incentive funding by meeting a subset of Challenge Pool metrics. After distributing funding to all CCOs based on the percentage of metrics met, OHA makes residual dollars available for meeting criteria for the Challenge Pool. The Metrics and Scoring Committee selected four Challenge Pool metrics for 2025.

2025 Challenge Pool Metrics:

- Timely Postpartum Care
- Diabetes Poor Control: A1c >9
- Child Well-Care Visits (Ages 3-6)
- Preventive Dental or Oral Health Services

OHSU Health IDS may reference dental metrics as part of aggregated CCO reporting. However, our internal quality prioritizes performance measures tied to physical health care. Contracted dental care organizations are accountable for dental performance metrics, including funding and reporting.

2025 Metric benchmarks and descriptions

Measure	Benchmark
Well-Care Visits, Age 3-6*	72%
Childhood Immunizations	69%
Immunizations for Adolescents	40.9%
Diabetes: HbA1c Poor Control*	20% (lower is better)
Postpartum Care*	87%
Social Emotional Health for Young Children	11%
Screening for Depression and Follow-Up Plan	73.8%
Initiation and Engagement of Substance Use Disorder Treatment	49%; 18.8%
Meaningful Language (Health Equity)	50%
SDOH: Social Needs Screening & Referral	Report only
Assessment for Children in ODHS Custody	93.2%
Preventive Dental or Oral Health Services, Ages 1-5 and 6-14*	60.6%; 67.3%

*=Challenge Pool metrics

Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Measure Reporting Type

Clinic reported

Description

Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

Patient Population

All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter (with a primary care clinician) during the measurement period.

Numerator

Patients screened for depression on the date of the encounter or up to 14 days before the date of the encounter using an age-appropriate standardized tool. AND, if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

Exclusions

History of bipolar disorder

Exceptions

- Patient refuses to participate in or complete the depression screening.
- Documentation of medical reasons for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status).

Measurement Period

1/1/2025 – 12/31/2025

2025 Full Measure Specifications

Diabetes: HbA1c Poor Control

Measure Reporting Type

Clinic reported

Description

Percentage of patients 18-75 years old with diabetes who had a hemoglobin A1c (HbA1) > 9.0%, or no A1c recorded during the measurement period (Lower score indicates better quality).

Patient Population

Patients 18-75 years old with diabetes by the end of the measurement period and with a visit during the measurement period.

Numerator

Patients whose most recent hemoglobin A1c (HbA1c) performed during the measurement period is >9.0% or is missing or was not performed during the measurement period.

Exclusions

- Hospice or palliative care
- 66+ in long-term care
- 66+ meeting advanced illness and frailty criteria

Exceptions

None

Measurement Period

1/1/2025 – 12/31/2025

2025 Full Measure Specifications

Childhood Immunizations (Combo 3)

Measure Reporting Type

- Claims and Alert IIS
- Incentivized

Description

Patients turning age 2 in reporting period with completed Combo 3 vaccine series as outlined in the metric specifications. Required vaccines for 2025 include:

- DTAP: Four diphtheria, tetanus and acellular pertussis
- IPV: Three polio
- MMR: One measles, mumps and rubella
- HiB: Three Haemophilus influenzae type B
- HepB: Three hepatitis B
- VZV: One chicken pox
- PCV: Four pneumococcal conjugates

Patient Population

All children turning age 2 in measurement period

Numerator

Those with completed vaccine series on or before their 2nd birthday

Exclusions

- Hospice or palliative care
- Death
- Contraindication to a childhood vaccine on or before their 2nd birthday

Exceptions

None

Measurement Period

1/1/2025 – 12/31/2025

2025 Full Measure Specifications

Immunizations for Adolescents (Combo 2)

Measure Reporting Type

- Claims and Alert IIS
- Incentivized

Description

Patients turning age 13 in reporting period with completed Combo 2 vaccine series as outlined in the metric specifications. Required vaccines for 2025 include:

- Meningococcal: One meningococcal serogroups A,C,W,Y on or between the 11th and 13th birthdays
- Tdap: One tetanus, diphtheria toxoids and acellular pertussis on or between the 10th and 13th birthdays
- HPV: Two human papillomavirus vaccines between the 9th and 13th birthdays

Patient Population

All children turning age 13 in measurement period

Numerator

Those with completed vaccine series on or before their 13th birthday

Exclusions

- Hospice or palliative care
- Death

Exceptions

None

Measurement Period

1/1/2025 – 12/31/2025

2025 Full Measure Specifications

→ **Get metric descriptions and tips on our OHSU Health IDS Quality Metric Navigator page**

Assessments for Children in ODHS Custody

Measure Reporting Type

- Claims
- Incentivized

Description

The percentage of patients entering ODHS custody and remaining in custody for at least 60 days who had an assessment for physical health, mental health and dental health within that first 60 days.

Patient Population

Patients aged 0-17 entering ODHS custody and remaining for 60 days.

Numerator

Patients aged 0-17 who received a physical, mental, and dental health assessment within 60 days of placement notification

Exclusions

- CCO did not receive notification of placement by OHA.
- Child entered Run-Away status or transferred to Oregon Youth Authority within 60 days.
- Entered ODHS custody more than 30 before OHA notification.
- Not enrolled in the CCO or did not meet continuous enrollment criteria.

Exceptions

- Delayed start of enrollment in CCO
- Children in Trial Reunification when CCO notified of placement; or status changed to Trial Reunification within 60 days after placement

Measurement Period

11/1/2024 – 10/31/2025

2025 Full Measure Specifications

Child and Adolescent Well Care Visits (age 3-6)

Measure Reporting Type

- Claims
- Incentivized

Description

The percentage of patients turning 3-6 years old during the measurement year with a well visit. All well visits for children aged 3-17 are tracked at the state level; ages 3-6 are incentivized.

Patient Population

All patients turning ages 3-6 during the measurement period

Numerator

Patients aged 3-6 with a well child visit in measurement period

Exclusions

- Hospice or palliative care
- Death

Exceptions

None

Measurement Period

1/1/2025 – 12/31/2025

2025 Full Measure Specifications

Meaningful Language Access (Health Equity)

Measure Reporting Type

- Clinic reported
- Incentivized

Description

The percentage of patients with self-identified interpreter need and a qualifying visit in the measurement year, when an OHA-certified or qualified interpreter was used.

Patient Population

Patients with a self-identified interpreter need and a qualifying visit in the measurement year

Numerator

Patients who had an OHA-certified or qualified interpreter for the qualifying visit

Exclusions

- Patient refused interpreter due to visit provided in primary language.
- Patient confirms that interpreter need is inaccurate.

Exceptions

None

Measurement Period

1/1/2025 – 12/31/2025

2025 Full Measure Specifications

SEH: Young Children Receiving Social-Emotional Issue-Focused Intervention/Treatment Services

Measure Reporting Type

- Claims
- Incentivized

Description

The percentage of patients turning 1-5 years old during measurement period receiving specific social emotional health intervention or therapies.

Patient Population

All patients turning age 1-5 during the measurement year

Numerator

Patients with specific CPT codes dropped in claims. Specific codes listed in metric specifications.

Exclusions

Death

Exceptions

None

Measurement Period

1/1/2025 – 12/31/2025

2025 Full Measure Specifications

SDoH: Social Needs Screening and Referral

Measure Reporting Type

Component 1: Attestation only.

Component 2: Report only on sample of patients selected by OHA. IDS collaborates with CCO on data sharing and sample completion.

Description

Component 1: Self-attestation for meeting all must pass elements.

Component 2: Annual screening of all members for three domains: housing instability, food insecurity and transportation needs with an OHA-approved screening tool. If positive, provide a referral within 15 days.

Patient Population

All IDS members, regardless of whether a member had a visit with a primary care clinician

Numerator

Rate 1: Percentage of members who screened positive in each of three domains of housing, food insecurity and transportation needs

Rate 2: Of the population screened, the percentage of members with a positive screen

Rate 3: Of the sample population with an identified need, those who received at least one referral for each identified need within 15 calendar days

Note: 2025 is the first year of reporting data for this metric. Performance will be based on data completion of a sample of 1,067 members.

Exclusions

None

Exceptions

Rate 1: Member declines to be screened in in **all** three domains with an OHA-approved tool

Rate 2: None

Rate 3: Member declines **all** referrals

Measurement Period

Component 1: 01/01/2025 – 12/31/2025

Component 2: 12/15/2024 – 12/14/2025

2025 Full Measure Specifications

Initiation and Engagement of SUD Treatment

Measure Reporting Type

Claims

Description

Percentage of patients aged 18 and older with a new substance use disorder (SUD) receiving intervention services within 14 days of diagnosis, such as an in-office or telehealth visit with a SUD diagnosis or a prescription for opioid use disorder or alcohol use disorder medication. After initiation of treatment, continued engagement in treatment within 34 days of initiation. Patients ages 13 and older are tracked at the state level for all cohorts (alcohol, opioid and other drug).

Patient Population

All patients 18 and older with a new substance abuse diagnosis in the measurement period

Numerator

Initiation: Patients 18 and older receiving intervention within 14 days of a new substance use disorder diagnosis

Engagement: Patients 18 and older must have two separate visits or medication events within 34 days of initiation

Exclusions

Hospice or palliative care

Exceptions

None

Measurement Period

11/15/2024 – 11/14/2025

2025 Full Measure Specifications

Timely Postpartum Care

Measure Reporting Type

- Hybrid Sample – claims and chart review
- Incentivized

Description

The percentage of patients with a live delivery in the measurement period who receive a postpartum care visit within a window of 7-84 days.

Patient Population

Patients with a live delivery in the measurement window

Numerator

Patients with a postpartum care visit containing specific elements outlined in the specifications between 7-84 days from delivery

Exclusions

- Hospice or palliative care
- Death

Exceptions

None

Measurement Period

10/08/2024 – 10/07/2025

2025 Full Measure Specifications

SBIRT (Screening, Brief Intervention & Referral to Treatment)

Measure Reporting Type

- Clinic reported
- Non-incentivized

Description

Reporting only

Percentage of patients with a qualifying visit with a primary care clinician who are screened for substance use disorder and, if positive, brief intervention or referral to treatment documented within two days after the qualifying encounter. Screening can occur up to 14 days before the visit date.

Patient Population

Patients aged 12 and older with a primary care visit in the measurement period

Numerator

Rate 1: All patients aged 12 and older with an age-appropriate screening documented

Rate 2: If full screen positive, brief intervention or referral to treatment documented

Exclusions

- Active diagnosis of substance use disorder, dementia or mental degeneration
- Patient engaged in treatment for one year before the qualifying visit
- Hospice or palliative care

Exceptions

- Urgent/emergent situation or place of care
- Patient refused brief screen
- Patient refused full screen

Measurement Period

1/1/2025 – 12/31/2025

2025 Full Measure Specifications

→ **Get metric descriptions and tips on our OHSU Health IDS Quality Metric Navigator page**

Cigarette Smoking Prevalence

Measure Reporting Type

- Clinic reported
- Non-incentivized

Description

Rate 2 only: Percentage of patients 13 years or older who had a qualifying visit with a primary care clinician during the measurement period and who had their smoking and/or tobacco use recorded and who are cigarette smokers.

Patient Population

Patients 13 years or older who had a qualifying visit with a primary care clinician during the measurement period and who had their smoking and/or tobacco use recorded.

Numerator

Patients who are identified as cigarette smokers.

Exclusions

Hospice or palliative care

Exceptions

None

Measurement Period

1/1/2025 – 12/31/2025

2025 Full Measure Specifications

Controlling High Blood Pressure

Measure Reporting Type

Clinic reported

Description

Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90 mmHg) during the measurement period.

Patient Population

Patients 18-85 years of age by the end of the measurement period who had a visit during the measurement period and a diagnosis of essential hypertension starting before and continuing into or starting during the first six months of the measurement period.

Numerator

Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.

Exclusions

- Hospice or palliative care
- End stage renal disease (ESRD), dialysis or renal transplant
- Pregnancy
- 66-80 meeting advanced illness and frailty criteria
- 81+ meeting frailty criteria
- 66+ in long-term care

Exceptions

None

Measurement Period

1/1/2025 – 12/31/2025

2025 Full Measure Specifications

→ **Get metric descriptions and tips on our** OHSU Health IDS Quality Metric Navigator page

OHSU Health Plan Services quality improvement meeting

Meeting Schedule 2025

August – virtual

September – virtual

October – in-person

November – virtual

December – no meeting

Who should attend:

- Clinic leadership
- Quality improvement staff
- Population health teams
- Care coordinators

OHSU Health Plan Services IDS quality improvement (QI) meetings connect clinical quality staff to enhance quality performance across the IDS network.

Meetings focus on quality performance for Medicaid (CCO Quality Incentive Program), the Medicare Shared Savings Program (MSSP), and Medicare Advantage (MA) plans.

Topics include:

- Data trends
- Gap closure strategies
- Best practices and tips
- Changes in quality requirements
- Actionable steps to improve outcomes
- Reporting expectations

Participants also hear from guest speakers and experts on issues like health equity, behavioral health integration and documentation improvement. Participation promotes shared accountability, drives performance and supports the mission of improving care for OHSU Health IDS members.

OHSU Health IDS network clinics

- Adventist Health Clinics:
  - Clackamas
  - Damascus
  - Gresham Station
  - Parkrose
  - Portland
  - Sandy
  - Troutdale
- Hillsboro Medical Center
  - Orenco Station
  - Hillsboro Internal Medicine
  - South Hillsboro
  - Forest Grove
- OHSU
  - DCH Campus
  - DCH Bethany
  - Beaverton
  - Gabriel Park
  - South Waterfront
  - Richmond

OHA QIP resources

OHA offers resources to help CCOs and clinics navigate QIP program requirements and improve metric performance. There is a detailed specification sheet for each metric. Technical assistance is available through webinars, guidance documents and training.

→ Find resources and specifications for all incentive metrics online.

Public QIP committees

IDS and CCO representatives may attend regular public meetings of the MSC and other advisory groups for information on metric selection, benchmarks and specifications.

Technical Advisory Group (TAG)

The Technical Advisory Group is responsible for developing recommendations for implementing and operationalizing incentive metrics, including specifications for Oregon-based upstream metrics. The voting members of this committee are CCO representatives and at-large community members. OHA staff serve in an advisory role. All meetings are public, with recordings available after each meeting. The committee reviews all public comments before making final recommendations on metric specifications.

→ Learn more at TAG

Metrics and Scoring Committee (MSC):

The MSC selects all quality metrics and benchmarks for the QIP program. This committee's voting members are CCO representatives, metric experts and at large positions. OHA staff serve in an advisory role. MSC meets monthly with an annual timeline to choose all metrics for the following year's program. These meetings are public, with public comment welcomed via written testimony before the meeting or during the public comment portion of each meeting. After the metric set is selected, MSC allows for a one-month public comment period before finalizing metrics and benchmarks in October.

→ Learn more at Metrics and scoring

Quality Health Outcomes Committee (QHOC)

Quality Health Outcomes Committee is an OHA committee comprised of clinical leaders from the CCO community. They meet once a month to develop improvement strategies and share best practices to achieve better health outcomes and lower costs. coordinate the goals of the CCOs across the state to achieve better health outcomes and lower costs.

→ Learn more at QHOC

Contact information

OHSU Health Services, Clinical Value and Transformation Team

healthservicesquality@ohsu.edu

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For quality information, visit OHSU Health IDS Quality Metric Navigator


OHSU
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