

The CareOregon Quality Metrics Toolkit was created to support our network partners caring for our members. Our goal is to: share knowledge about Oregon Health Authority's Coordinated Care Organization Incentive Metrics and the CMS Medicare Stars Measures; help create a better understanding of the quality health metrics and why they are important; assist with the implementation of workflows and best practices; and assist with tracking and monitoring of quality performance.

CareOregon Quality Metrics Toolkit Measure Sheet Definitions

Performance Measure Set:

CCO Incentive Metric: The Coordinated Care Organization (CCO) Incentive Metrics are determined by the Oregon Metrics & Scoring Committee, which was established in 2012 by Senate Bill 1580 to create outcomes and quality measures for CCOs. The measures are negotiated with the Centers for Medicaid and Medicare Services (CMS) as part of Oregon's 1115 waiver agreement. The CCO has then individualized improvement targets that are designed to decrease the distance between current performance and the OHA established benchmark each year.

Medicare Star Measure: The Medicare Stars Measures are determined by CMS. The Star Rating System measures the performance of Medicare Advantage and Part D plans, by comparing them against the rest of the country. There are over 40 measures which constitute the Star Rating System, with plans scored on a 5 Star scale for each. The individual measures are scored and weighted to determine a plan's overall Stars score. 5 Star plans have a special enrollment period and earn increased reimbursement from CMS.

Quality Measurement Type:

Structural Measures: Gives consumers a sense of a health care provider's access capacity, systems, and processes to provide high-quality care, e.g. whether the health care organization uses electronic medical records or medication order entry systems.

Process Measures: Indicates what a provider does to maintain or improve health of patients. They are typically generally accepted recommendations for clinical practice. They are the parts/steps in the system which measures if it was performed as planned, e.g. for diabetes: % of patients whose hemoglobin A1c level was measured twice in the past year.

Outcome Measures: Reflect the impact of the health care service or intervention on the health status of patients. How does the system impact the clinical values of patients, e.g. for diabetes: average hemoglobin A1c level for the population of patients with diabetes?

Patient Experience: Captures a person's perception of their experience with healthcare service using surveys, e.g. access to and ability to navigate services, or time spent waiting.



Data Source/Type: These data types refer to how measurement information is collected for performance monitoring.

Claims: An invoice a provider sends to a health plan for services of care provided to a plan member. CPT and diagnosis codes contained in the invoice serve to capture care outlined in quality improvement CCO Incentive Metrics and Medicare Star Measures.

Chart Documentation: How clinical care providers and staff record a patient's health status and care services received during a visit. This information is critical when conducting a comprehensive medical record review. When looking for evidence of care (not reflected through claims or diagnosis), if care is given but it is not reflected in a patient chart, it didn't happen.

eQMs: Clinical Quality Measures (CQM) are a mechanism for assessing observations, treatment, processes, experience, and/or outcomes of patient care. Electronic CQMs are reported using electronic specifications from an electronic health record (EHR) in the form of a report.

Survey: survey instruments capture self-reported information from patients about their health care experience and outcome. Surveys are typically administered to a sample of patients by mail, by telephone, or via the intranet.

Other: Data source not addressed via claim, chart documentation, eCQM, or survey.