# OHA Quality Incentive Program Study Findings

## Report on Study Required by 2023 SB966

OREGON HEALTH AUTHORITY

Portland State UNIVERSITY

Regional Research Institute

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**PSU Research Team**
It took a large team of researchers to complete this project. Without the significant contributions of all these individuals (in alphabetical order), this study would not have been possible.

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Also, this study would not have been possible without the valuable thoughtful of the OHP members who responded to the survey, health system representatives, and OHA committee members who participated in interviews. Their time, thoughts, and recommendations are the foundation of this work. Our close partnership with the OHA Health Analytics team, the OHA Health Equity Division, and many others at OHA was critical and invaluable. As thought partners and colleagues, they tirelessly supported this effort.

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# Executive Summary

The 2024 Oregon Health Authority (OHA) Quality Incentive Program (QIP) Study was an effort by OHA's Office of Heath Analytics, in partnership with the Regional Research Institute for Human Services (RRI) at Portland State University (PSU), to fulfill the request of Senate Bill (SB) 966 of the 2023 Oregon Legislative Session. SB 966 tasked OHA to examine the Coordinated Care Organization (CCO) QIP and to develop recommendations for programmatic and structural changes to address health inequities. A quantitative and qualitative study was conducted to answer the overarching research question, which focused on the potential of the QIP to further or hinder progress toward OHA's goal of eliminating health inequities by 2030.

Together, OHA and the RRI created survey instruments, a sampling plan, and a participant recruitment process. Data collection focused on four participant groups: current or recent OHP members, coordinated care organization (CCO) representatives, community-based organizations (CBOs)/providers, and related OHA committees. Data collection to gather input and feedback from OHP members involved offering a survey for completion online and on paper, in English and Spanish (with other languages available upon request). Dissemination to statewide OHP members began on June 7, 2024. The final count for completed OHP member surveys was 728. Input from representatives of CCOs, CBOs/providers, and relevant OHA committees (all of which, hereinafter, will be referred to as "health system partners") was gathered through individual and group semi-structured interviews. Ultimately, 28 interviews were completed by 60 individuals representing all system partners. Both quantitative and qualitative analyses were conducted to generate a summary of findings and recommendations. More detailed information about methodology and findings is noted in the body of this report. The following constitutes the main categories of findings: governance structure, measure and benchmark selection practices, and program operations.

## QIP Governance Structure

Overall, OHP members indicated that they trust the QIP governance structure. However, they would appreciate increased involvement of CBOs/providers and OHP members in the Metrics and Scoring Committee and in the QIP decision-making process. Hearing from and about the lived experiences of members would contribute significantly to the development and selection of metrics and would highlight the healthcare needs of members throughout the state. Additionally, members said continuing and deepening transparent communication between OHA and themselves would support them in making their own healthcare decisions.

Health system partners shared varied common themes about QIP governance structure. Some health system partners would like more OHP member involvement with OHA committees and within the broader governance structure, as well as in leadership roles, and they would like increased communication and outreach to members. Other system partners noted that committee members who are also OHP members should be paid for their service, explicitly told why, where and how their voices are needed and applied, and what OHA will do with their information and perspective, in an effort to achieve health equity.

## QIP Measure and Benchmark Selection Practices

OHP members generally approved of the Metrics and Scoring Committee making decisions about their healthcare needs/wants; however, a theme in many narrative comments indicated that more members should fill OHA

leadership roles and obtain additional seats on the Metrics and Scoring Committee, to help directly improve health equity.

Health system partners noted that the QIP has helped them focus on health equity, to identify where to focus their efforts and resources, and to understand how to use measures data to elucidate health outcomes. And while partners agree measures data has been informative, they did not always agree that measures align with health equity, nor that measures represent health access concerns or overarching health equity barriers. In addition, some health system partners shared that geographic location adds to the complexity of addressing members' healthcare wants/needs and that geographical differences are not always captured by data gleaned from current measures. Feedback related to benchmark selection, particularly toward choosing measures, suggested a need for more collaboration across all QIP entities. Clear communication about how to implement measures within varied statewide communities, clinics, and CCOs was cited as a need of health system partners. Also, metric fatigue was noted as substantial in system partners' interviews. To that end, respondents voiced interest both in adopting nationally standardized measures at OHA, and in reducing the number of new OHA metrics, as the latter can be confusing.

# QIP Program Operations

When given information about QIP operations, slightly over half of OHP members agreed that CCOs should be paid equally for achieving both benchmarks and improvement targets, CCOs should be paid fully for meeting 75% of measures, and CCOs should receive bonus money for fulfilling priority health outcome measures. When asked about QIP process engagement, many OHP members responded that the public comment system could impact the Metrics and Scoring Committee's decisions. Although 57% of participants expressed familiarity with providing public comment to influence the QIP, only about 9% reported having provided such input to state committees.

Health system partners provided feedback about QIP's operations, including measurement calculation, program payment structure, quality and challenge pool payments, as well as the use of QIP payments to help improve health equity. Health system partners issued a call for the use of national measures. Feedback related to the quality of challenge pool payments varied, including both agreement with and concern about the 75% measure achievement to earn quality pool payments. In particular, respondents discussed statewide variance and strategies to achieve health equity. Feedback specific to the challenge pool payments were also varied, with some respondents appreciating additional funds that could potentially aid equity efforts, especially approving of funds for communities experiencing the most and most complex health inequities. Yet, other respondents reported concern about fund reliance and possible lack of fund distribution past CCOs and into communities.

# Recommendations and Next Steps

The recommendations included were garnered from feedback, thoughts, ideas, and recommendations provided by all respondent groups. The recommendations are summarized across six topic areas: OHP member representation and support, clear and open communication, public comment, OHP member feedback and community feedback, OHP member and community education, and measure selection process.

Next steps for understanding the current QIP's outcomes and evaluating its current and future effectiveness for ensuring equitable health outcomes for OHP members, will include additional analyses, particularly associated with intersectionality of the data with demographics, and potentially gathering more data through focus groups and individual interviews with OHP members and CBOs/providers.

# Introduction and Background

Senate Bill 966 of the 2023 Oregon Legislative Session tasked the Oregon Health Authority (OHA) to examine the Coordinated Care Organization (CCO) Quality Incentive Program (QIP) to develop recommendations for programmatic and structural changes to address health inequities. OHA contracted with the Regional Research Institute for Human Services (RRI) at Portland State University (PSU) to partner in conducting a quantitative and qualitative study. The overarching research question focused on the ***potential of the QIP to further or hinder progress toward OHA's goal of eliminating health inequities.***

A study was implemented that gathered data from Oregon Health Plan members through a web and paper survey, and from representatives of CCOs, community-based organizations (CBOs) and providers, and relevant OHA committees (collectively referred to as health system partners) through individual and group semi-structured interviews. Data were collected over a two-month period. Both quantitative and qualitative analysis was used to support the summary of the findings described in this report and which support the recommendations provided.

# QIP Background

The basis for Oregon's QIP starts with the original authorization under the 2012 Medicaid waiver that initiated the coordinated care organization model of service provision for Oregon Health Plan (OHP) members. CCOs were designed to be locally governed and responsible for both healthcare access and quality. Each CCO receives payments to cover physical, behavioral, and oral healthcare services. In 2016, 42 CFR § 438.6 was added to allow incentive and withhold arrangements. The incentive arrangement (relevant for this discussion) allowed OHA to provide payments above the capitation rate to CCOs based on performance. The goal of the QIP is to encourage CCOs to improve the quality of care for their OHP members on a selected set of measures.

## What are the specific measures?

Historically, two public committees have made decisions about the QIP. Until passage of SB 966 in 2023, the Health Plan Quality Metric Committee set a list of measures that can be used to monitor progress made by CCOs. Then the Metrics and Scoring Committee votes on which measures to include in the QIP each year, as well as sets the performance expectations for CCOs.

The following 15 measures are in effect for 2024 (for more details on each measures see Appendix A or go to https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/PlainLanguageIncentiveMeasures_English.pdf):

- Childhood immunization status
- Immunizations for adolescents
- Child and adolescent well-care visits
- Postpartum care
- Screening for depression and follow-up plan
- Health aspects of kindergarten readiness
- Cigarette smoking prevalence
- Alcohol and drug misuse
- Preventative dental or oral health services for children
- Assessments for children in ODHS custody
- Comprehensive diabetes care
- Initiation and engagement in substance use disorder treatment
- Meaningful language access to healthcare services
- Social needs screening and referral

# How does the funding work?

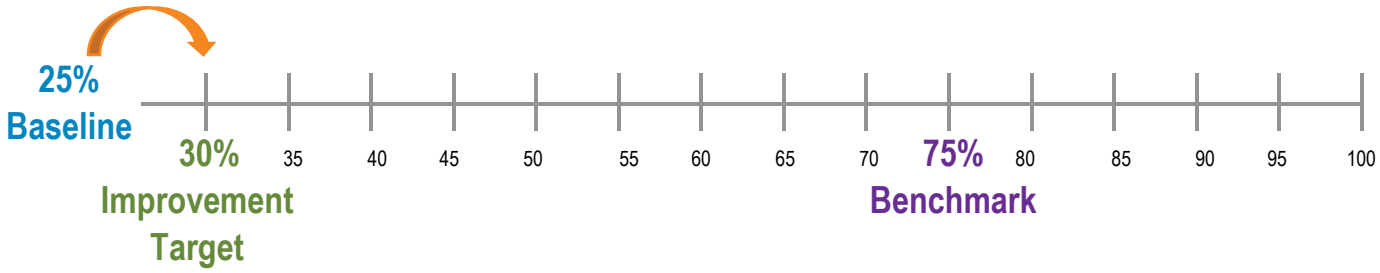
Each month, OHA pays CCOs a fixed, predetermined amount of funding for each OHP member enrolled in their plan. The payments are called capitation rates, which are developed annually by OHA and its contracted actuaries and then certified by the Centers for Medicare & Medicaid Services. CCOs can earn bonus funds that are above the capitation rate based on how well they perform on the set of healthcare quality measures that assess healthcare processes, outcomes, OHP member experiences, and more. The goal is to encourage CCOs to continually improve care that is effective, efficient, equitable, safe, patient-centered, and timely.

OHA is not permitted determine or influence how CCOs spend the bonus payments. CCOs are responsible for deciding how those funds are used, including whether and how much they share bonus payments with community-based organizations and clinics providing care.

QIP funds are paid out from two bonus pools of money. The ***Quality Pool*** includes a maximum amount of funding each CCO can annually earn based on the number of members they serve. More funding is available to CCOs with more members. Whether and how much of those Quality Pool dollars a CCO earns is dependent upon how they perform on the annually-selected list of measures. Any funds remaining in the Quality Pool are shifted to the ***Challenge Pool***. Each CCO can earn additional funds through the Challenge Pool, which is associated with a smaller set of healthcare quality measures. Historically, the Challenge Pool has had three to four selected measures. Each year, all of the incentive funds are paid out, regardless of overall CCO performance. No QIP funds are saved or carried over to the next year.

In order to earn the maximum Quality Pool funds, CCOs do not have to meet all of the healthcare quality measures. They only have to meet their performance expectations on 75% of the measures. CCOs meeting fewer than 75% of the measures receive reduced Quality Pool payments. For example, CCOs meeting 68% of the measures can earn 80% of their Quality Pool funds, CCOs meeting 62% of the measures earn 70% of the funds, and so on. CCOs can gain back unearned funds through the Challenge Pool.

To achieve a healthcare quality measure and receive the Quality Pool funds, CCOs must meet either the ***benchmark*** or their individual ***improvement target***. Benchmarks are an aspirational goal that is the same for all CCOs and usually at the 75$^{th}$ or 90$^{th}$ percentile of national performance. Improvement targets are milestones for each CCO and are set somewhere between their current performance (i.e., baseline) and the benchmark. For example, if a measure has a benchmark of 75%, some CCOs are able to achieve that benchmark. However, another CCO has a baseline performance level of 25%, so their improvement target may be set at 30%.




The purpose of the improvement targets is to encourage CCOs to gradually get closer and closer to the benchmark, as the improvement targets are raised as performance increases. Improvement targets can vary widely and are dependent upon individual CCO baseline performance levels.

## Senate Bill 966

Senate Bill (SB) 966 was established during the 2023 regular session and became effective on July 31, 2023. Included in SB966 was a requirement for OHA to conduct a CCO QIP study to develop recommendations for programmatic and structural changes. The goal of the changes would be to focus the QIP on addressing health inequities, including structural drives of those inequities. SB966 also directed OHA to ensure that individuals on OHP and from communities most harmed by health inequities are included in the study so their perspectives and voices are heard. OHA was also directed to engage metrics experts, healthcare providers, CCO representatives and other health system representatives. Finally, OHA is expected to report back to the legislature no later than September 15, 2024.

OHA has the strategic goal of eliminating health inequities by 2030. The Health Equity Committee, a subcommittee of the Oregon Health Policy Board (OHPB), was tasked with coordinating and developing policies that support that goal and promote the achievement of health equity for all Oregonians. The Health Equity Committee worked closely with OHA Equity and Inclusion Division staff to develop a definition of health equity. In October 2019, the following definition was formally adopted by OHPB and OHA, which serves as the driver behind OHA's strategic goal to eliminate health inequities by 2030. It also served as a guide for the current.

**Health Equity Definition:**
Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- the equitable distribution or redistribution of resources and power; and
- recognizing, reconciling and rectifying historical and contemporary injustices.

# OHA QIP Study

This report provides an initial summary of the methodology employed for the QIP study, a presentation of the general findings, and recommendations for the QIP based on those findings.

# Methodology

An initial OHA QIP study project kickoff meeting was held on March 18th, 2024 for OHA and RRI staff to review background materials and establish the timeline for completing the study. Following that initial meeting, RRI worked collaboratively with OHA to develop instruments, the sampling plan, and a participant recruitment process. Data collection focused on four primary participant groups:

- current or recent OHP members
- coordinated care organization (CCO) representatives
- community-based organizations (CBOs) and providers
- related OHA committees

Data were collected through an OHP member survey and virtual individual or group interviews with the other respondent groups beginning on May 2, 2024 and concluding on June 28, 2024.

## Instrument Development

Instruments were developed for each respondent group through a collaborative process between RRI and OHA staff. A survey was used to gather input from OHP members that was available both online and on paper, in English and Spanish. Other languages were available upon request, as was being able to complete the survey by phone. The survey included:

- a variety of demographic items, including the OHA's REALD (Race, Ethnicity, Language, and Disability) and SOGI (Sexual Orientation and Gender Identity) instruments
- members' OHP coverage and general healthcare experiences
- feedback on how decisions are made about high quality care for OHP members (i.e., governance structure)
- feedback about payments to CCOs for reaching healthcare quality goals (i.e., program operations)
- community engagement, particularly public comment

OHP members were not asked about the specific healthcare quality measures and the selection process of those measures because they would have needed much more background information to confidently answer questions about them. Once the survey was finalized, it was piloted with a group of OHP members who were also PSU students. Following the pilot, the survey was revised based on feedback. One critical piece of feedback was to include more explanatory information due to the complexity of the QIP. A web survey was programmed and a paper survey was formatted for dissemination to OHP members throughout Oregon.

Semi-structured interviews were developed to gather input from representatives health system partners. An initial set of items was developed for the CCO interviews, then adjusted to more appropriately address issues relevant for the other two respondent groups. Reproductions of all four instruments are included in Appendix B of this report. The interview protocols included the following general categories of questions, with the respondent groups indicated in parentheses:

- role identification (all)
- health equity and health inequities OHP members are currently experiencing (all)

- involvement/familiarity with the QIP (all)
- QIP impact on health inequities (all)
- impact of QIP on health inequities:
  - bonus funds, benchmarks, improvement targets, meeting 75% of the measures, challenge pool (CCOs, committees)
  - measures (all)
- governance structure, including the Metrics and Scoring Committee (all)

The survey and the interview protocols all included informed consent information that explained the purpose of the data collection, the estimated time it would take, the voluntary and confidential nature of the process, and how the information they provided would be used. OHP members were also told that after completing the survey, they had the opportunity to request a $50 Amazon or Safeway gift card in a digitally separate survey to thank them for their time. All respondents were given contact information for the RRI team in case they had questions about the study.

# Sampling Plan and Respondent Recruitment

## OHP Members

The goal for this study was to receive feedback from at least 300 current or recent adult OHP members. In order to invite a broad range of OHP members in a short period of time, OHA and RRI staff reached out to variety of individuals and organizations that could get the word out about the survey. Recruitment materials were created, in both English and Spanish, including a recruitment flyer and a brief fact sheet describing the OHA QIP and the study. These materials were distributed to OHA staff representing a variety of teams and programs, CBOs/providers, community advisory committees, regional health equity coalitions, OHP assister and innovator agent organizations, and the Health Equity Committee. They were also emailed to each of the Regional Health Equity Coalitions. Once the materials were shared through those avenues, they were distributed to individual OHP members, OHP member groups, or other potential recruitment agents.

Recruitment began on June 7, 2024 once the web survey was programmed and the paper version of the survey was formatted. The survey was going to remain live for three weeks through June 28, 2024; however, an extremely large influx of web survey responses occurred on June 23rd that required the survey data collection to end as of the morning of June 24, 2024. After review of the survey responses, it was determined that a number of them were spam or otherwise not appropriate for inclusion in the analysis (see explanation below). A final sample of 728 OHP member surveys were included in the analysis.

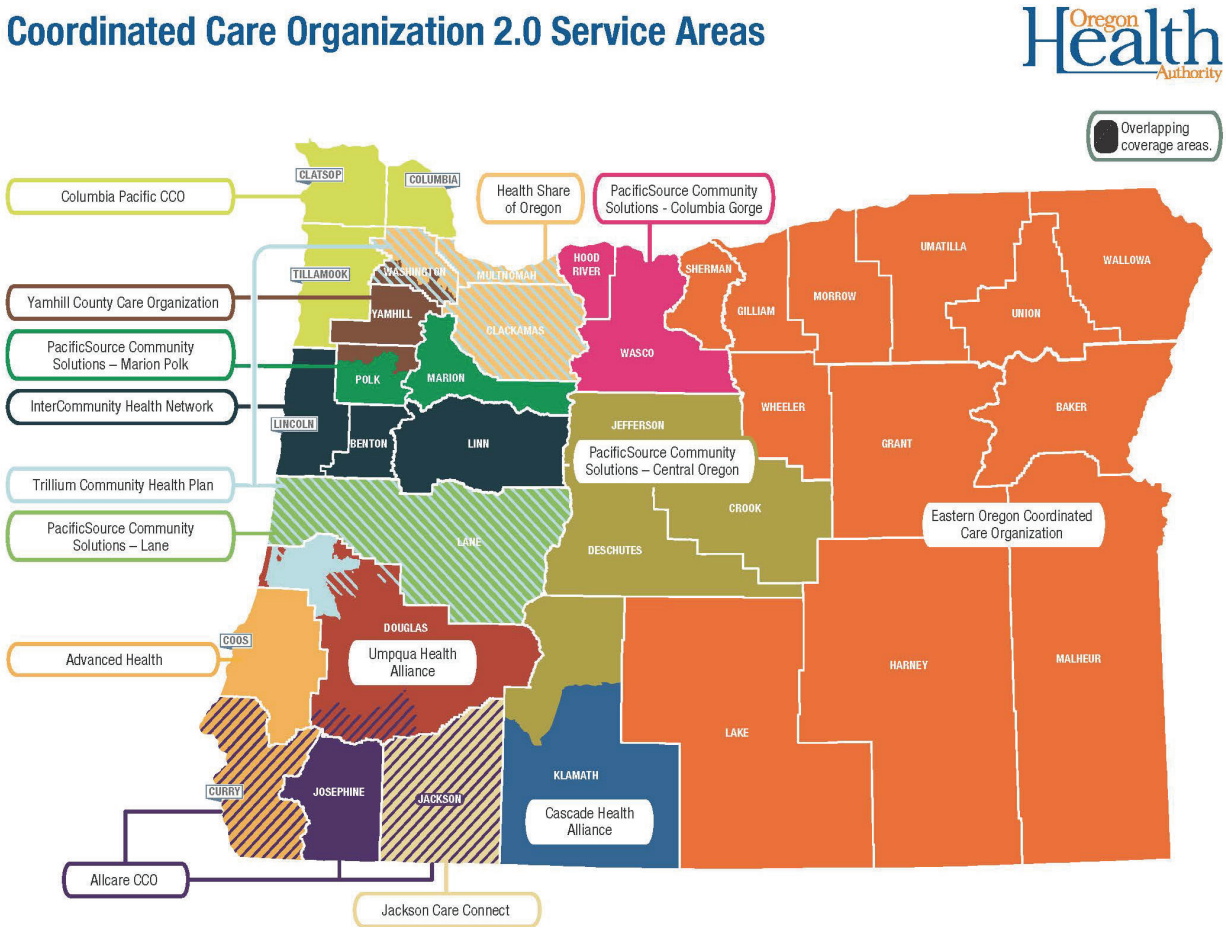
## CCO Representatives

Oregon's coordinated care model includes a network of coordinated care organizations (CCOs) that include physical health, mental health, addictions, and dental providers to serve people who receive healthcare coverage under the Oregon Health Plan (Medicaid). There are 16 CCOs operating in Oregon, including:

- Advanced Health: Coos and Curry counties
- AllCare CCO: Curry, Josephine, and Jackson counties, and part of Douglas County
- Cascade Health Alliance: part of Klamath County
- Columbia Pacific CCO: Clatsop, Columbia, and Tillamook counties

- Eastern Oregon CCO: Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler counties
- Health Share of Oregon: Clackamas, Multnomah, and Washington counties
- InterCommunity Health Network CCO: Benton, Lincoln, and Linn counties
- Jackson Care Connect: Jackson County
- PacificSource Community Solutions – Central Oregon Region: Deschutes, Crook, and Jefferson counties, and part of Klamath County
- PacificSource Community Solutions – Columbia Gorge Region: Hood River and Wasco counties
- PacificSource Community Solutions – Lane: Lane County
- PacificSource Community Solutions – Marion/Polk: Marion and Polk counties
- Trillium Community Health Plan – Southwest: Lane County and western Linn and Douglas counties
- Trillium Community Health Plan – Tri-County: Clackamas, Multnomah, and Washington counties
- Umpqua Health Alliance: part of Douglas County
- Yamhill Community Care: Yamhill County and part of Washington and Polk counties

The following map depicts the locations of all those 16 CCOs.




The goal for recruitment was to conduct at least one interview for each of the unique CCOs. Both PacificSource Community Solutions and Trillium Community Health Plan have multiple locations, but were only counted as one CCO. As a result, the goal was to complete at least 12 CCO interviews. All of the CCOs were recruited by emailing each of the 12 Chief Executive Officers, as well as a list of 80 health equity contacts. Up to three email requests were

made to each of those 92 contacts. As a result of that recruitment, 14 individual or group interviews were conducted with a total of 41 people, representing all 12 of the CCOs.

## CBOs and Providers

There are many individual CBOs/providers throughout Oregon. Due to the short timeframe for data collection, recruitment was based on existing connections with providers. Recruitment involved sending emails to CBOs in the health, mental health, addiction, and dentistry fields; through email invitations and meeting presentations to OHA committees; and following up on leads from other interview respondents. As a result of the email invitations sent, three individual interviews and one group interview with six people were conducted, for a total of nine interviewees.

## Committees

A number of committees were included in the recruitment process, including the OHA Health Equity Committee, the OHA Metrics and Scoring Committee, the OHA Medicaid Advisory Committee, and the Community Advisory Councils[1] associated with each of the Oregon CCOs. Recruitment was done either by email or during a visit to a committee meeting. Overall, there were approximately 36 individual committee members invited to participate, which resulted in completing 10 individual interviews. It is important to note that many individuals on the committees hold a variety of roles relative to this project. If, for example, an individual was part of a CCO, but also on a committee, they completed the CCO interview and their responses were included in that participant group. Although not common, if an individual held two distinct roles (e.g., committee member and OHP member) and spoke to those separately during an interview, their data was divided and included with each relevant participant group during the analysis.

Table 1 summarizes the recruitment approaches and counts, modalities used, duration of data collection, and the number of completed instruments by participant group. Recruitment materials are included in Appendix C. Due to the short data collection window and overall timeline of the study, Tribal Affairs and the nine federally recognized tribes of Oregon were not included in the sampling plan.

**Table 1: Recruitment and Final Counts by Modality and Source**

| Participant Group | Recruitment Methods | Number Invited to Participate | Modality | Data Collection Duration | Number Completed |
|---|---|---|---|---|---|
| **OHP Members** | • Flyers with QR code, English and Spanish<br>• By OHA staff and committees, CBOs, and individuals<br>• Notice in CBO newsletter<br>• Survey available at healthcare event | • Actual number recruited is not known<br>• 24 contacts made to engage recruitment sources | Online and paper surveys | Pilot on 5/24/24<br>Fully live 6/7/24 | 728 completed surveys:<br>• 158 paper<br>• 570 online |
| **CCOs** | Email | 92 individual administrators and staff | Individual and group interviews | 5/2/24 to 6/13/24 | • 14 interviews<br>• 41 respondents |

[1] Community Advisory Councils (CACs) support CCOs by identifying and advocating for preventive care practices, overseeing a community health assessment, adopting a community health improvement plan, and publishing an annual report on the progress of that plan.

| Table 1: Recruitment and Final Counts by Modality and Source | | | | | |
|---|---|---|---|---|---|
| **CBOs/ Providers** | Email | 32 organizations and individuals | Individual and group interviews | 5/29/24 to 6/21/24 | • 4 interviews<br>• 9 respondents |
| **Committees** | Email to individual committee members or committee staff | 36 committee representatives | Individual and group interviews | 5/23/24 to 7/9/24 | 10 individual interviews |

## OHP Member Sample

As noted above, the OHP member web survey received a large number of responses on one weekend day, which prompted the data collection period to end early. Prior to June 23rd, a total of 515 surveys had been received. On June 23rd, 2,113 surveys were received and an additional 108 surveys were received before the web survey was closed at 11:10am on June 24th. Upon review of the web survey data, it became apparent that most of the responses received on June 23rd and 24th were spam. Extensive review of the web survey responses resulted in creating exclusion criteria to ensure that the data used for analysis was as valid as possible. Data from both the web survey and the information provided in the digitally separated gift card form survey were included in that review. Care was taken in order to ensure the confidentiality of the data and protection of participant privacy. Table 2 itemizes the exclusion criteria and the number of records excluded for each criterion. Not all of the exclusion criteria are related to spam, for example, those that were duplicates, screened out due to not meeting the eligibility criteria (i.e., OHP member, 18 years or older), or incomplete (i.e., less than 50% complete[2]).

| Table 2: Exclusion Criteria and Counts | |
|---|---|
| **Criteria** *(descending order of count)* | **Count** |
| Identical timestamp or in rapid sequence, similar responses to survey items, odd/repetitive[3] text responses, identical demographics; gift card form included no mailing address and/or phone number, identical structure of name and email address (appearing randomly generated) | 1,109 |
| Identical IP address, in rapid succession within two hours on 6/23/24, identical text responses, similar numeric responses | 626 |
| Less than five minutes to complete the 11-page survey[4] | 201 |
| Random text responses in Latin, non-Oregon zip code | 94 |
| Screened out | 49 |
| Address on gift card form outside of Oregon | 48 |
| Less than 50% complete | 28 |
| Duplicate records | 11 |
| **Total Count** | 2,166 |

After excluding those records, a total of 728 OHP member surveys were included in the analysis.

[2] A common practice in survey research is to determine a completeness cutoff for including a survey in the analysis. After reviewing the survey records and in consultation with OHA staff, a 50% cutoff was established in order for a survey to be considered complete.

[3] For example, all text responses were "no," text responses did not fit the question, repeated text responses within one survey or across a series of surveys, text responses that appeared to be generated by AI tool.

[4] Internal testing determined that the fastest time to complete the survey at least skimming the content was five minutes.

# OHP Member Respondents Characteristics

Demographic characteristics were not collected for health system partner respondents. OHP members who completed the individual online and paper surveys provided responses to a number of demographic items. These are summarized in Table 3.

**Table 3: OHP Member Respondents Demographics (*N*=728)**

| **Age** | | |
|---|---|---|
| Mean Age = 37.2 years; Standard deviation = 11.3 years; Range = 18-77 years | | |
| **Gender** *(select all that apply; descending order)* | **Count** | **Percent** |
| Girl, Woman | 417 | 57.3% |
| Boy, Man | 285 | 39.1% |
| Non-binary | 13 | 1.8% |
| I don't want to answer | 8 | 1.1% |
| Not Listed, please describe | 1-5 | ---- |
| Don't know | 1-5 | ---- |
| Agender/no gender | 1-5 | ---- |
| Genderfluid | 1-5 | ---- |
| Genderqueer | 1-5 | ---- |
| Questioning | 1-5 | ---- |
| No answer | 6 | 0.8% |
| **Transgender** *(descending order)* | **Count** | **Percent** |
| No | 669 | 91.9% |
| Yes | 25 | 3.4% |
| Don't want to answer | 1-5 | ---- |
| Questioning | 1-5 | ---- |
| Don't know | 1-5 | ---- |
| Don't know what this question is asking | 1-5 | ---- |
| No answer | 22 | 3.0% |
| **Sex** *(descending order)* | **Count** | **Percent** |
| Female | 414 | 56.9% |
| Male | 281 | 38.6% |
| Don't want to answer | 9 | 1.2% |
| Don't know | 1-5 | ---- |
| Intersex | 1-5 | ---- |
| Not listed | 1-5 | ---- |
| No answer | 16 | 2.2% |

| Table 3: OHP Member Respondents Demographics (*N*=728) | | |
|---|---|---|
| **Sexual Orientation or Sexual Identity** *(select all that apply; descending order)* | Count | Percent |
| Straight | 497 | 68.3% |
| Don't want to answer | 82 | 11.3% |
| Bisexual | 44 | 6.0% |
| Same-sex loving | 21 | 2.1% |
| Same-gender loving | 20 | 2.7% |
| Gay | 19 | 2.6% |
| Pansexual | 18 | 2.5% |
| Lesbian | 17 | 2.3% |
| I don't know what this question is asking | 14 | 1.9% |
| Don't know | 13 | 1.8% |
| Queer | 12 | 1.6% |
| Asexual | 11 | 1.5% |
| Not listed, please describe | 7 | 1.0% |
| Questioning | 1-5 | ---- |
| No answer | 27 | 3.7% |
| **Race or Ethnicity** *(select all that apply; descending order)* [5] | Count | Percent |
| White | 349 | 47.9% |
| *English* | *233* | *32.0%* |
| *Irish* | *56* | *7.7%* |
| *German* | *54* | *7.4%* |
| *Enter details (French, Swedish, Norwegian, etc.)* | *29* | *4.0%* |
| *Italian* | *23* | *3.2%* |
| *Scottish* | *18* | *2.5%* |
| *Polish* | *7* | *1.0%* |
| *Russian* | *7* | *1.0%* |
| *Romanian* | *1-5* | ---- |
| *Slavic* | *1-5* | ---- |
| *Ukrainian* | *1-5* | ---- |
| Latinx or Hispanic | 260 | 35.7% |
| *Mexican* | *154* | *21.2%* |
| *Guatemalan* | *73* | *10.0%* |
| *Central American* | *22* | *3.0%* |
| *Puerto Rican* | *6* | *0.8%* |

[5] Participants could select all of the individual races or ethnicities within each higher order category that applied to them, resulting in sums of individual subcategories that are higher than the total for that overall category.

| Table 3: OHP Member Respondents Demographics (*N*=728) | | | |
|---|---|---|---|
| *Salvadoran* | *6* | | *0.8%* |
| *Afro-Latino/a/x/e* | *1-5* | | ---- |
| *Cuban* | *1-5* | | ---- |
| *Dominican* | *1-5* | | ---- |
| *South American* | *1-5* | | ---- |
| *Enter details (Colombian, Honduran, Spaniard, etc.)* | *1-5* | | ---- |
| American Indian or Alaska Native | | 127 | 17.4% |
| *Indigenous Mexican, Central or South American* | *58* | | *8.0%* |
| *American Indian* | *52* | | *7.1%* |
| *Alaska Native* | *11* | | *1.5%* |
| *Enter details (Coquille Indian Tribe, Confederated Tribes of Coos, Aztec, Maya, etc.)* | *10* | | *1.4%* |
| *Canadian Inuit, Metis or First Nation* | *8* | | *1.1%* |
| Black or African American | | 88 | 12.1% |
| *African American* | *78* | | *10.7%* |
| *Afro-Caribbean* | *7* | | *1.0%* |
| *Ethiopian* | *1-5* | | ---- |
| *Haitian* | *1-5* | | ---- |
| *Jamaican* | *1-5* | | ---- |
| *Nigerian* | *1-5* | | ---- |
| *Somali* | *1-5* | | ---- |
| *Enter details (Trinidadian, Ghanaian, Congolese, etc.)* | *1-5* | | ---- |
| Don't know | | 26 | 3.6% |
| Asian | | 17 | 2.3% |
| *Filipino/a* | *8* | | *1.1%* |
| *Afghan* | *1-5* | | ---- |
| *Asian Indian* | *1-5* | | ---- |
| *Cambodian* | *1-5* | | ---- |
| *Chinese* | *1-5* | | ---- |
| *Communities of Myanmar* | *1-5* | | ---- |
| *Hmong* | *1-5* | | ---- |
| *Indonesian* | *1-5* | | ---- |
| *Japanese* | *1-5* | | ---- |
| *Korean* | *1-5* | | ---- |
| *Laotian* | *1-5* | | ---- |
| *Pakistani* | *1-5* | | ---- |
| *South Asian* | *1-5* | | ---- |

| Table 3: OHP Member Respondents Demographics (*N*=728) | | |
|---|---|---|
| *Taiwanese* | *1-5* | ---- |
| *Thai* | *1-5* | ---- |
| *Vietnamese* | *1-5* | ---- |
| *Enter details (Mongolian, Malaysian, Uzbeks, etc.)* | *1-5* | ---- |
| Native Hawaiian or Pacific Islander | 15 | 2.1% |
| *Marshallese* | *8* | *1.1%* |
| *CHamoru/Chamorro* | *1-5* | ---- |
| *Communities of the Micronesian Region* | *1-5* | ---- |
| *Fijian* | *1-5* | ---- |
| *Native Hawaiian* | *1-5* | ---- |
| *Samoan* | *1-5* | ---- |
| *Tongan* | *1-5* | ---- |
| *Enter details (Chuukese, Palauan, Tahitian, etc.)* | *1-5* | ---- |
| Don't want to answer | 15 | 2.1% |
| Middle Eastern/Northern African | 1-5 | ---- |
| *Egyptian* | *1-5* | ---- |
| *Iranian* | *1-5* | ---- |
| *Iraqi* | *1-5* | ---- |
| *Israeli* | *1-5* | ---- |
| *Lebanese* | *1-5* | ---- |
| *Palestinian* | *1-5* | ---- |
| *Syrian* | *1-5* | ---- |
| *Turkish* | *1-5* | ---- |
| *Enter details (Moroccan, Yemeni, Kurdish, etc.)* | *1-5* | ---- |
| Jewish | 1-5 | ---- |
| *Ashkenazi* | *1-5* | ---- |
| *Sephardi* | *1-5* | ---- |
| *Enter details (Mizrahi, etc.)* | *1-5* | ---- |
| Another category not listed. Specify: | 1-5 | ---- |
| No answer | 1-5 | ---- |
| **Use Language Other Than English at Home** *(descending order)* | Count | Percent |
| No | 454 | 62.4% |
| Yes | 249 | 34.2% |
| Don't want to answer | 1-5 | ---- |
| Don't know | 1-5 | ---- |
| No answer | 7 | 1.0% |

| Table 3: OHP Member Respondents Demographics (*N*=728) | | |
|---|---|---|
| **How well do you speak English?** | Count | Percent |
| Very well | 468 | 64.3% |
| Well | 115 | 15.8% |
| Not well | 34 | 4.7% |
| Not at all | 75 | 10.3% |
| Don't know | 11 | 1.5% |
| Don't want to answer | 7 | 1.0% |
| No answer | 18 | 2.5% |
| **Disability** *(percent Yes; descending order)* | Count | Percent |
| Serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition | 122 | 16.8% |
| Difficulty doing errands alone because of a physical, mental, or emotional condition | 73 | 10.0% |
| Serious difficulty walking or climbing stairs | 52 | 7.1% |
| Serious difficulty learning how to do things most people your age can learn | 37 | 5.1% |
| Blind or serious difficulty seeing, even when wearing glasses | 36 | 4.9% |
| Serious difficulty communicating using usual language | 29 | 4.0% |
| Deaf or serious difficulty hearing | 28 | 3.8% |
| Serious difficulty with mood, intense feelings, controlling behavior, or experiencing delusions or hallucinations | 28 | 3.8% |
| Difficulty dressing or bathing | 20 | 2.7% |
| No answer | 17 | 2.3% |
| **Highest Level of Education** | Count | Percent |
| Grade 1 through 11 | 104 | 14.3% |
| High school diploma or GED | 176 | 24.2% |
| Some college, but no degree | 116 | 15.9% |
| Associate degree (2-year degree) | 79 | 10.9% |
| Bachelor's degree (4-year degree) | 120 | 16.5% |
| Graduate or professional degree | 47 | 6.5% |
| Trade school or certification program | 23 | 3.2% |
| Something else, please specify | 23 | 3.2% |
| Don't know | 1-5 | ---- |
| I don't want to answer | 12 | 1.6% |
| No answer | 23 | 3.2% |

| Table 3: OHP Member Respondents Demographics (*N*=728) | | |
|---|---|---|
| **Housing Situation** *(descending order)* | Count | Percent |
| Rent your home | 403 | 55.4% |
| Own your home | 106 | 14.6% |
| Live with family or friends without paying rent | 93 | 12.8% |
| Have no housing or unstable housing | 41 | 5.6% |
| Other, please specify | 32 | 4.4% |
| Don't want to answer | 18 | 2.5% |
| Don't know | 1-5 | ---- |
| No answer | 32 | 4.4% |

Q31: In what month and year were you born? *[converted into age]*
Q32: What is your gender?
Q33: Are you transgender?
Q34: What is your sex?
Q36: What is your sexual orientation?
Q40: What is your race and/or ethnicity? Select all that apply and enter additional details below.
Q37: Do you use a language other than English at home?
Q38: How well do you speak English?
Q42: Are you deaf or do you have serious difficulty hearing?
Q43: Are you blind or do you have serious difficulty seeing, even when wearing glasses?
Q44. Do you have serious difficulty walking or climbing stairs?
Q45: Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
Q46: Do you have difficulty dressing or bathing?
Q47: Do you have serious difficulty learning how to do things most people your age can learn?
Q48: Using your usual (customary) language, do you have serious difficult communicating (for example, understanding or being understood by others)?
Q49: Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone, such as visiting a doctor's office or shopping?
Q50: Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?
Q53: What is the highest level of education you have completed?
Q54: Do you… [list of housing situations]?

# Analytic Approach and Findings Interpretation

The findings presented in this report come from two types of data: quantitative and qualitative. ***Quantitative data*** is numeric from the OHP Member Feedback Survey rating scales (e.g., scale with values from 1 to 5) or coded responses to closed-ended items (e.g., yes/no response options). Throughout this report, figures and tables present the distribution of responses across those survey items (i.e., frequencies). For most of the survey items, the data are summarized for the entire group of 728 respondents who participated in the survey, which is denoted by "*N*" to indicate the full sample. For other survey items, only a subset of all survey respondents was asked those questions based on an answer from a prior survey item. In those instances, the sample size will be denoted by "*n*" to indicate a subset of the full sample. Respondents who did not answer a survey item are included in the data presentations as "No Answer" in order to maintain the complete sample sizes across items. Also, below each table or figure, the exact wording of the relevant survey item(s) is reproduced for reference.

For survey items presented in figures, the percentages of respondents endorsing each option are always presented across the entire range from 0% to 100%. This is done so that all of the figures throughout the report can be compared both numerically and visually. The size of any bar or pie wedge across all graphs will be able to be compared to the size of the bar or pie wedge to any other graph to clearly interpret the proportion of respondents endorsing various survey item responses. That means that a bar/wedge that represents, for example, 30% of respondents, will be the same size no matter what figure the reader is looking at, ensuring consistency of interpretation across all survey items. Due to the small subsample sizes on demographic characteristics, conducting disaggregated analyses to compare subgroups was not included.

Survey items that included a multiple-point rating scale that provided respondents with numeric values of each rating, the presentation of results includes some additional statistics. The "mean" (denoted with *M*) is the average rating across all respondents who answered the question and the "standard deviation" (denoted with *SD*) is the degree to which the responses are dispersed in relation to the mean.

Finally, some of the survey items included a list of response options available for respondents to select, as well as a write-in option. These were used when respondents did not find what they were looking for in the response options available. In some cases, the responses were coded into existing categories within a survey item because a respondent wrote in text that actually fit into a pre-existing response option within that item.

***Qualitative data*** is text data that came from interviews with representatives of CCOs, CBOs/providers, and related OHA committees, as well as some items from the OHP Member Feedback Survey. In these instances, respondents were asked an "open-ended" question that resulted in narrative or text responses. Qualitative analysis techniques were employed that included reading all of the responses, identifying parts of the text that fell into topical areas (i.e., codes), tagging the text with those codes, and grouping similar codes into overarching themes. Those themes were then organized and summarized in the presentations found within this report to provide the reader with a synthesized understanding of the data garnered from all of the interviews or survey text responses. To support those thematic presentations, illustrative quotes from respondents are included. Those quotes were selected to represent similar comments made by other respondents, so they should not be viewed as isolated thoughts of just one person. At times, however, comments from individuals who provided a unique perspective on a topic are included to exemplify the range of responses collected.

# Limitations

As the findings in this report are reviewed, it is important to keep in mind the limitations of this study. The most influential limitation for this study was the extremely short timeline during which it was completed. Normally, implementing a study such as this would take approximately two years; however, this study was completed in only five months. With more time, data collection could have been expanded to include (a) focus groups or individual interviews with OHP members to dig deeper into some of the topics covered in the survey, (b) recruitment of more providers throughout the state and across more disciplines, and (c) targeted recruitment of OHP members geographically and demographically to allow for better representation of the population. More time would have also allowed for more extensive analysis of the data collected, including disaggregating by key demographic characteristics to identify any specific differences across subgroups.

A methodological limitation of this study was that nonprobability sampling was used for the OHP member recruitment. That means individuals were not randomly selected from the full population of current or recent OHP members. As described above, OHP members were recruited using convenience sampling, requesting partners to share the web survey link or QR code as broadly as they could. Without using a random, probability sampling approach, the findings cannot be confidently generalized to the whole population of OHP members.

Finally, the QIP governance structure, measure and benchmark selection practices, and program operations are quite complex. As much information as possible was included in the OHP member survey and the interview protocols, but more time and education of respondents would have helped them be better informed to respond to the questions being asked. Interpreting the findings must be done in the context of limited background knowledge of many respondents, especially the OHP members.

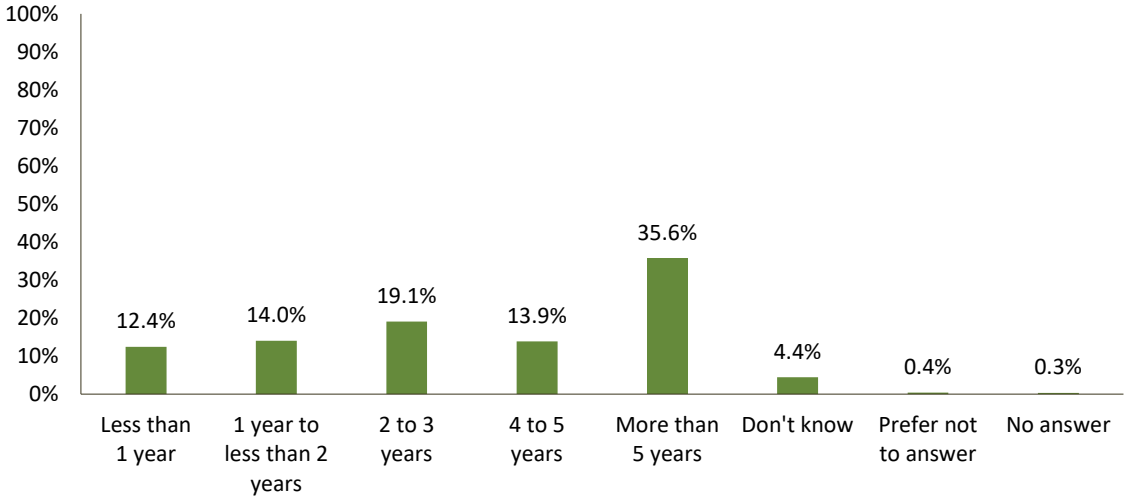
# Findings: OHP Member Feedback Survey

This findings section reports on the feedback received from OHP members. Quantitative data is presented in graphs to summarize the distribution of responses. In cases where open-ended questions served as follow-ups to numeric scale or yes/no questions, a summary of the text responses is also presented. An overall summary of OHP member text responses is then presented.

## OHP Members' Coverage and Healthcare Experiences

At the beginning of the survey, members were asked some questions about their involvement with OHP and healthcare services. As seen in Figure 1, approximately two-thirds of respondents had been served through OHP for two or more years, with the largest proportion of those respondents receiving OHP for more than five years (35.6%).

Figure 1: Length of Time as an OHP Member (*N*=728)




Q1: How long have you been on the Oregon Health Plan (OHP)? OHP is Oregon's medical assistance program. It provides healthcare coverage for people from all walks of life.

Throughout the survey, participants were provided with context about the QIP to help them answer the questions about this complex program. For example, before asking participants to identify which CCO they are a member of, there was a brief explanation of what a CCO is:

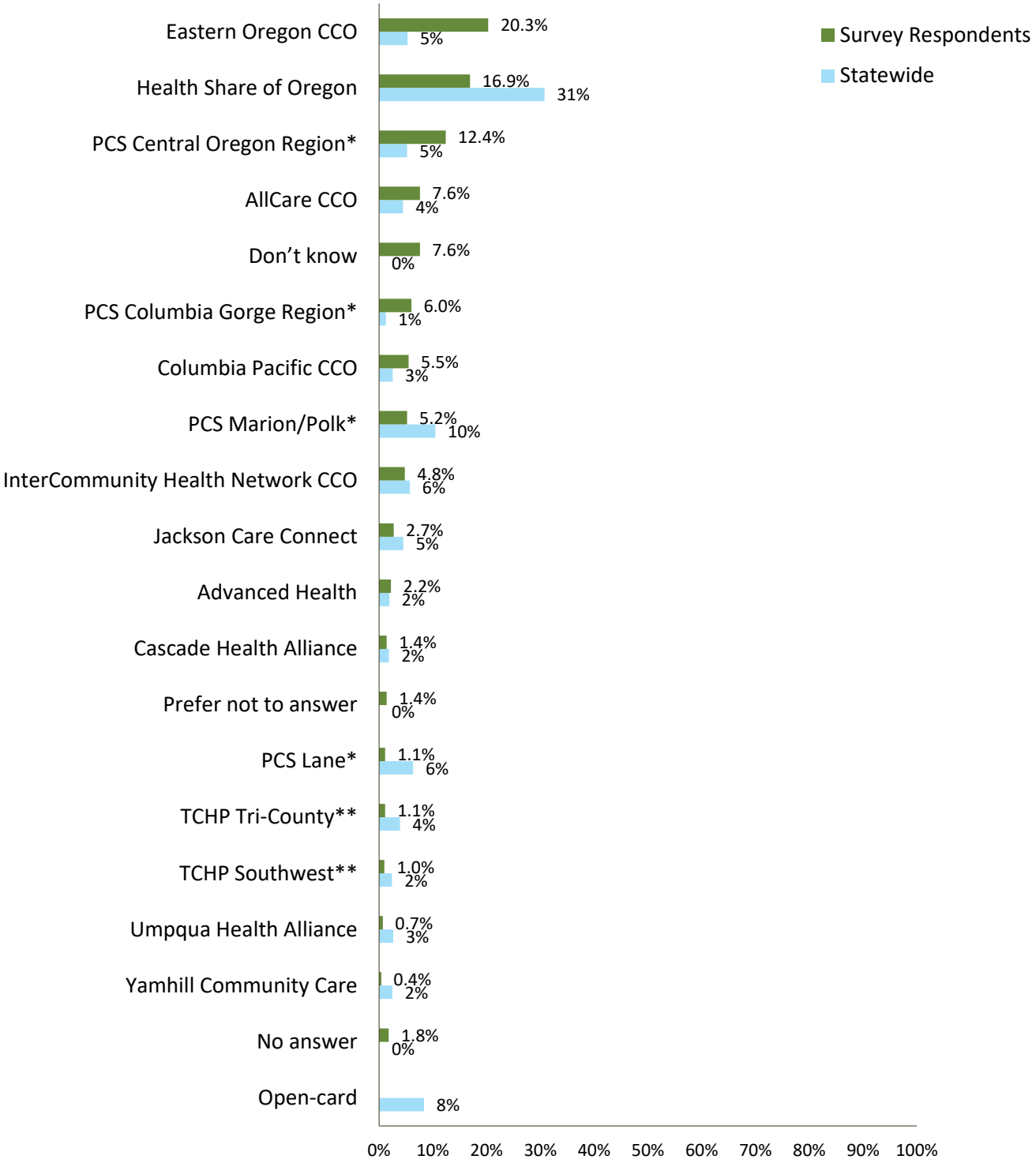
> *Oregon has 16 Coordinated Care Organizations (CCOs) that manage healthcare for OHP members. CCOs function like insurance companies. Each CCO is a network of all types of healthcare providers (medical, dental, mental health, addictions) who have agreed to work together in their local communities to serve people on OHP.*

Figure 2 presents the distribution of OHP members by CCO, as well as the distribution of membership statewide as of June 2024[6]. The highest proportion of survey respondents were members of the Eastern Oregon CCO (20.3%), followed by Health Share of Oregon (16.9%). Notably, 7.6% of participants answered that they don't know which CCO oversees their care. Although Open-card was listed in the data available for statewide membership, it was not an option in the OHP member survey, which could account for some of the respondents who did not know their CCO.

[6] Due to the nonprobability sampling approach, it is not surprising that the distribution of survey respondents does not align with the distribution of statewide membership.

It is important to note that during the data cleaning process, some participants selected a CCO that did not logically match the zip code they provided later in the survey. It is unclear why this occurred, but it could indicate that this subset of OHP members were not clear about which CCO manages their care, or they may not be certain about their zip code. Further analyses will need to be conducted to better understand this issue.

Figure 2: CCO Membership (*N*=728)



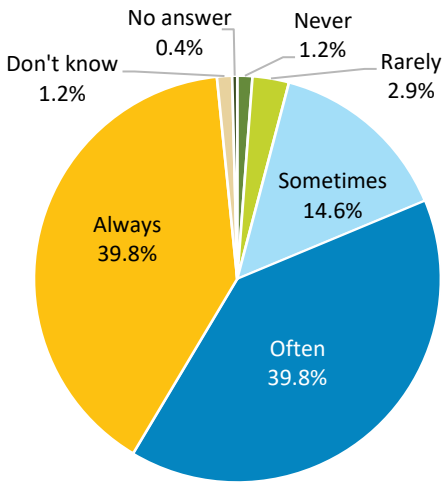

Q2: Please read through the following list and select the CCO you are currently a member of. If you are unsure, your CCO should be listed on your OHP card.

*PCS=PacificSource Community Solutions

**TCHP=Trillium Community Health Plan

The majority of participants reported that they are able to get all of their own and their family's health and wellness needs met through OHP, with 39.8% selecting each of the highest frequency ratings (i.e., **Always** and **Often),** as shown in Figure 3. This is also evident in the mean rating of 4.16 on a 5-point rating scale.

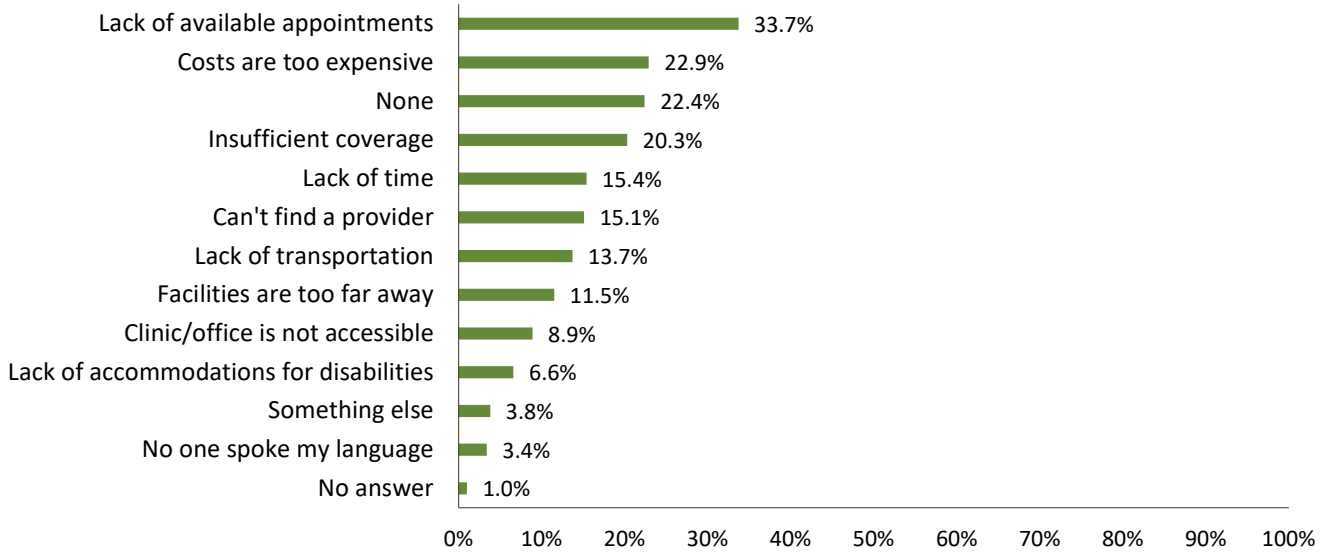
Figure 3: Frequency of Needs Being Met with OHP (*N*=728, *M*=4.16, *SD*=0.87)




Q3: Overall, how often are you able to get all of your and your family's health and wellness needs met through OHP?

In alignment with how many participants seem able to meet their needs with OHP, nearly one quarter of participants indicated that nothing has made it difficult to meet their healthcare needs in the last year. However, even though the majority of participants indicated getting needs met, there are still barriers that reduce or limit full access to care (Figure 4). The most common barrier reported was **Lack of available** appointments (33.7%), followed by **Costs are too expensive** (22.9%).

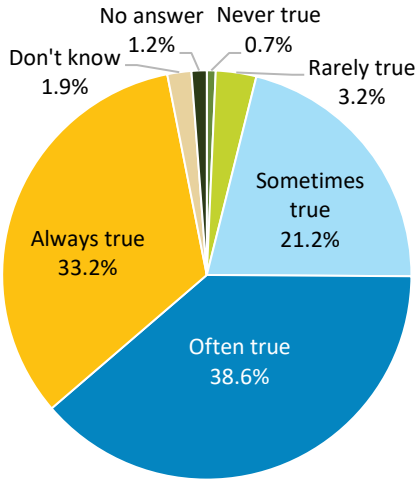
Figure 4: Barriers to Meeting Healthcare Needs with OHP (*N*=728)




Q4: In the last year, have any of these things made it difficult for you to meet your or your family's healthcare needs?

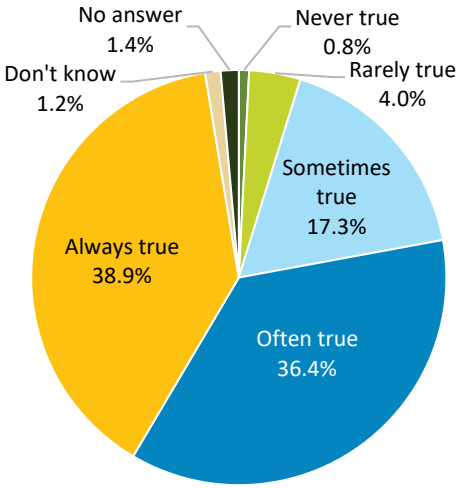
Figures 5, 6, and 7 are drawn from items that asked participants to rate how often it is true for them that they have all the information they need, their provider helped them understand their choices, and they felt listened to when making healthcare decisions. Across all three questions, the majority of participants reported that these scenarios are **Always true** (33.2%-38.9%) or **Often true** (36.4%-38.6%) for them.

Figure 5: Have Information Needed for Making Healthcare Decisions (*N*=728, *M*=4.04, *SD*=0.87)



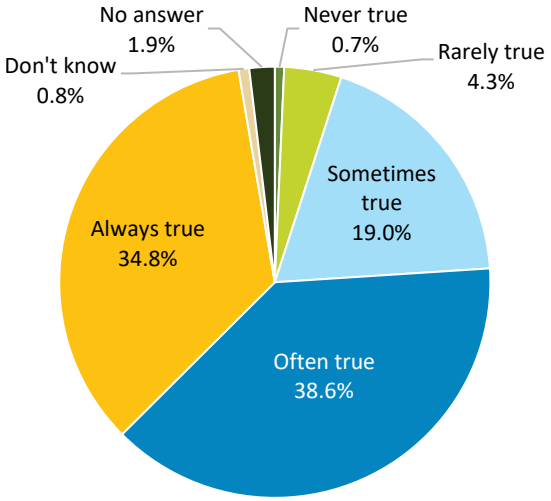

Q5: When making decisions about your healthcare, how frequently are each of the following true? I have all of the information I need.

Figure 6: Healthcare Providers Help with Healthcare Decisions (*N*=728, *M*=4.11, *SD*=0.90)




Q6: When making decisions about your healthcare, how frequently are each of the following true? My healthcare providers help me understand my choices.

Figure 7: Feel Listened to When Making Healthcare Decisions (*N*=728, *M*=4.05, *SD*=4.05)



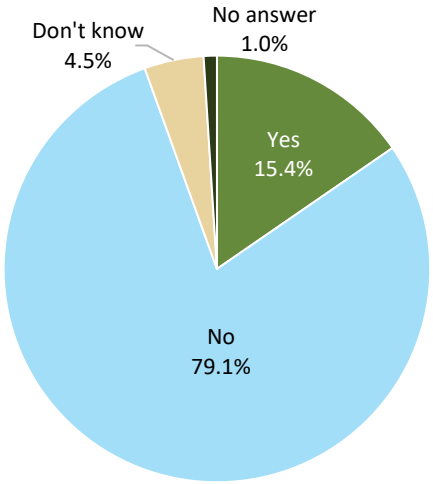

Q7: When making decisions about your healthcare, how frequently are each of the following true? I feel listened to.

Similar to Figures 5 through 7, Figures 8, 9, 10, and 11 are drawn from a set of items asking participants if they had experienced any of the following situations in the past year with a doctor, nurse, dentist, or counselor:

- acted as if they think you are not smart
- acted as if they are afraid of you
- acted as if they are better than you
- not listened to what you say

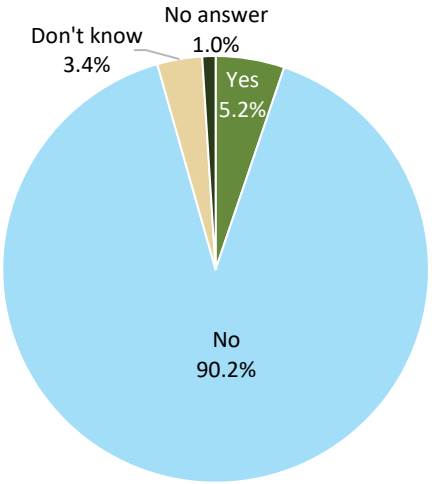
The majority of the OHP member respondents reported that they had ***not*** had any of these experiences. This ranged from 74.7% of OHP members not experiencing a healthcare professional not listening to what they had to say (Figure 11) to 90.2% of OHP members not having a healthcare professional act as if they were afraid of them (Figure 9).

Figure 8: Healthcare Professional Acted as if You're Not Smart (*N*=728)



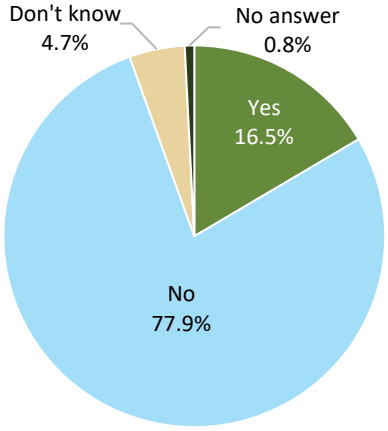

Q8: In the past 12 months, has a doctor, nurse, dentist, or counselor ever: acted as if they think you are not smart?

Figure 9: Healthcare Professional Acted Fearful of You (*N*=728)



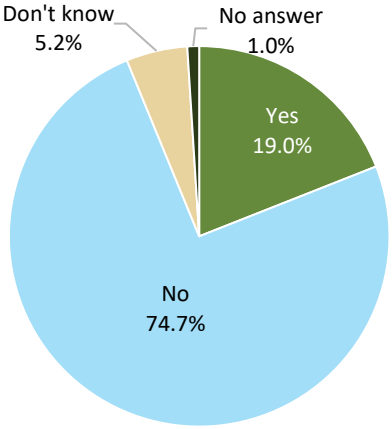

Q9: In the past 12 months, has a doctor, nurse, dentist, or counselor ever: acted as if they are afraid of you?

Figure 10: Healthcare Professional Acted Better than You (*N*=728)




Q10: In the past 12 months, has a doctor, nurse, dentist, or counselor ever: acted as if they are better than you?

Figure 11: Healthcare Professional Did Not Listen to You (*N*=728)




Q11: In the past 12 months, has a doctor, nurse, dentist, or counselor ever: not listened to what you have to say?

The 5.2% to 19.0% of respondents who did have those negative experiences with healthcare professionals were invited to share more about their experiences. Some of the things that participants mentioned were feeling overlooked or unheard, talked down to, judged, and discriminated against.

*"I feel sometimes not heard, or like my medical concerns are made light of."*

*"No matter when or why or how, if I end up needing the emergency room or have to see another provider in the office I go to. If I am in any kind of pain I am treated like a junky drug addict. That makes me not want to go into see any doctors ever"*

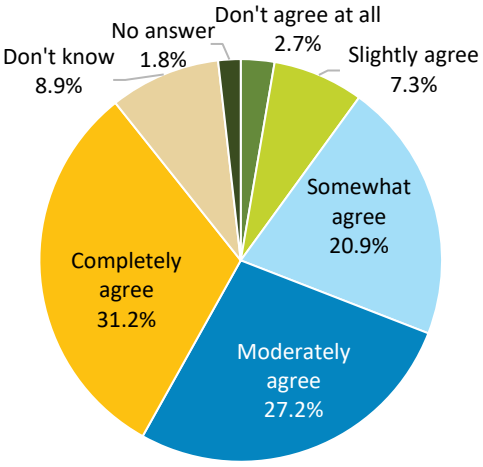
# Making Decisions about High Quality Care

The next set of survey items focused on the governance structure of the QIP and how decisions are made by the Metrics and Scoring Committee. The following background was provided to respondents:

> *The State of Oregon pays CCOs to manage healthcare for OHP members. The State also gives CCOs payments to encourage them to provide the highest quality care. This year, the state will give CCOs over $300 million in bonus payments. A group called the Metrics and Scoring Committee sets goals each year for the CCOs to meet. This Metrics and Scoring Committee identifies important health outcomes and ways to measure them. A health outcome is something that tells us how well healthcare is helping people. An example of a health outcome is that the majority of children get at least one well-child visit each year. The Metrics and Scoring Committee decides what high-quality care is and how well CCOs have to perform to earn bonus money.*
>
> *Oregon state law decides who gets to be on the Metrics and Scoring Committee and how bonus money is given out. The Committee is made up of:*
>
> - *three experts in measuring health outcomes,*
> - *three people from CCOs, and*
> - *three people who fill "at large" positions, which means they are open to anyone.*
>
> *The following questions ask for your feedback about what's important to you as an OHP member. This information will be used to identify ways to change the laws about how the Metrics and Scoring Committee works and how bonus money is given out.*

With this information in mind, participants were asked how much they agreed that the Metrics and Scoring Committee members could make decisions about what OHP members need and want for high quality healthcare. Figure 12 shows that 31.2% of respondents **Completely agree** and another 27.2% **Moderately agree**. It is important to note that nearly 11% of respondents could not or did not answer this question.

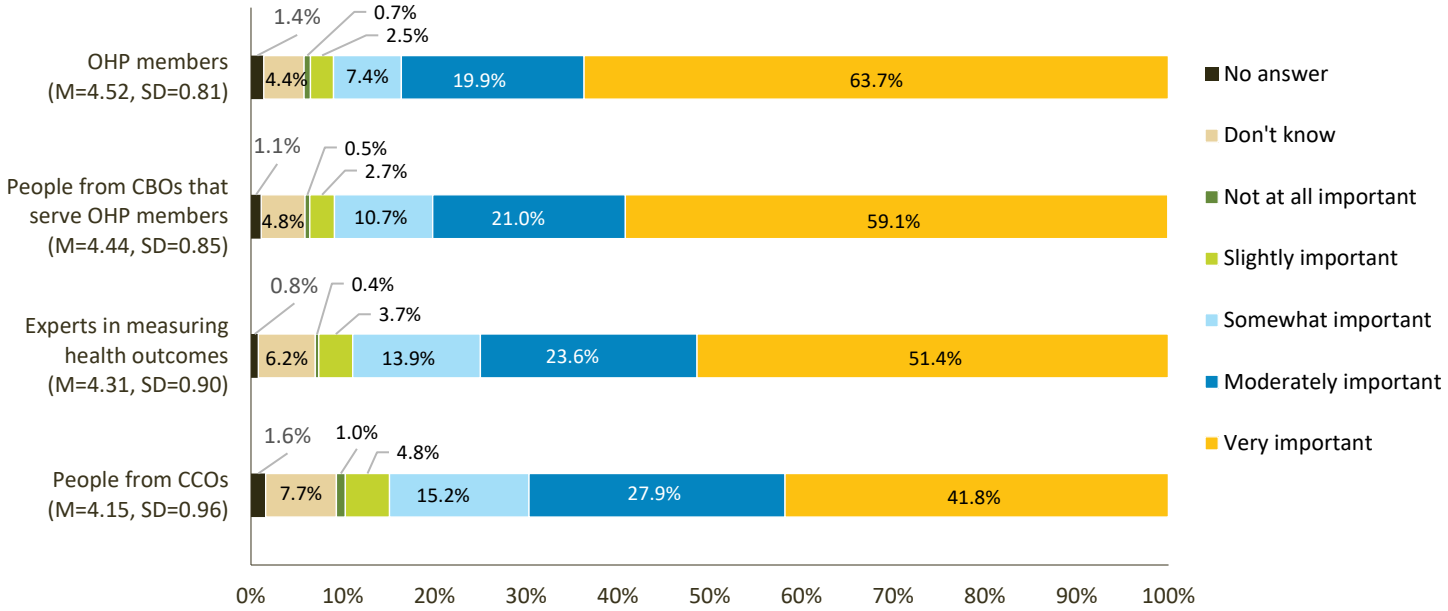
Figure 12: Metrics and Scoring Committee Making Decisions about Your Healthcare Needs (*N*=728, *M*=3.86, *SD*=1.08)




Q12: How much do you agree that the Metrics and Scoring Committee members listed above can make decisions about what you need and want for high quality healthcare?

Participants were also asked to prioritize who should be included on the committee. Figure 13 compares the answers for each of the four groups of committee members: health outcome experts, CCO representatives, community-based organization representatives, and OHP members. While many participants deemed all of these member types as **Very important**, OHP members (63.7%) and CBO representatives (59.1%) were selected most often.

Figure 13: Who Should be Included on Metrics and Scoring Committee (*N*=728, *descending order by mean score*)




In your opinion, how important is it for the Metrics and Scoring Committee to include...
Q13: experts in measuring health outcomes?
Q14: people from CCOs?
Q15: people from community-based organizations that serve OHP members?
Q16: OHP members?

As a follow up to these questions, participants were invited to share their own ideas about who else should be on the committee. While approximately half of respondents didn't have thoughts on this, there were a variety of comments with suggestions ranging from family members or patient representatives to healthcare providers and experts in social services, data, and education.

> *"3 reps from each is not enough. This is far too institutionalized to make appropriate choices for such a large population. An OHP member who represents different regions, urban to rural, may give more insight."*
>
> *"I believe people from the community, including peer mentors and the people that are actively working with OHP members intimately need to be included."*

The primary reasons cited for these recommendations were representing diverse needs and perspectives, an opportunity for community engagement, and to improve the effectiveness of the healthcare quality measures and the QIP as a whole.

Ahead of the last couple of questions relating to the Metrics and Scoring Committee, the following background was given on the ways that CCOs earn bonus money through meeting goals (i.e., benchmarks) and improvement targets.

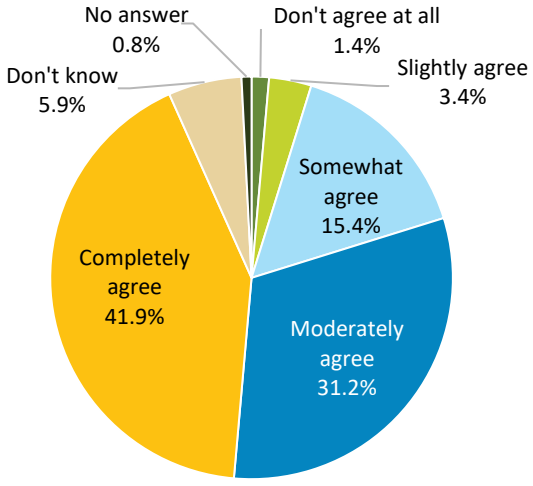
*The Metrics and Scoring Committee sets the overall goals for each of the health outcome measures that CCOs must reach to get bonus money. Those goals are set to reward high quality care. Right now, there are 15 outcome measures that CCOs must track to possibly earn the bonus money. Some examples, along with the goals, are:*

- *Percentage of children who have all their necessary immunizations by their second birthday. (Goal=68% or more OHP children served)*
- *Percentage of children ages 3 to 6 years who had one or more well-child visits in a year. (Goal=70% or more OHP children served)*
- *Percentage of people ages 18 to 75 years who had poor control of diabetes. (Goal=21% or fewer OHP members, lower percentage is better)*

*When CCOs are not able to meet an overall goal for an outcome measure, the Committee sets improvement targets for them. These targets are meant to help CCOs gradually improve each year. For example, if the goal for well-child visits is set at 70% (70 out of 100), but one CCO is only at 25%, their target might be set at 30% of OHP children served. Each CCO will have improvement targets for any outcome measure that they are not able to meet the overall goal.*

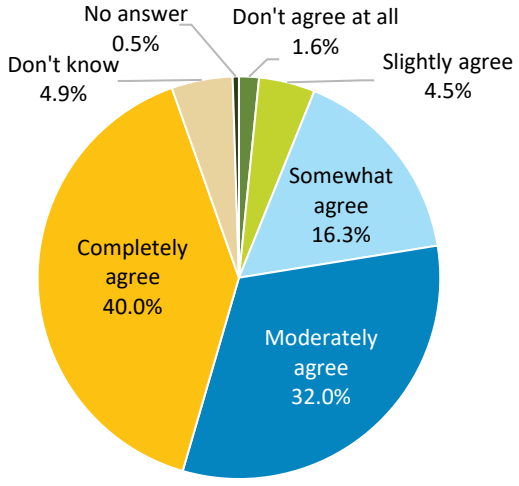
With this information in mind, most participants agreed that these processes will result in high-quality healthcare for OHP members. As seen in Figures 14 and 15, the majority of respondents **Completely agreed** or **Moderately agreed** that the approach to goal setting (73.1%) and improvement targets (72.0%) are appropriate ways of achieving the overarching goal of high-quality healthcare.

Figure 14: Goal Setting Approach Will Result in High Quality Healthcare (*N*=728, *M*=4.17, *SD*=0.93)




Q18: How much do you agree that this approach will result in high-quality healthcare for OHP members?

Figure 15: Improvement Targets will Result in High Quality Healthcare (*N*=728, *M*=4.10, *SD*=0.97)




Q19: How much do you agree that improvement targets will result in high-quality healthcare for OHP members?

# CCO Payments for Reaching Healthcare Quality Goals

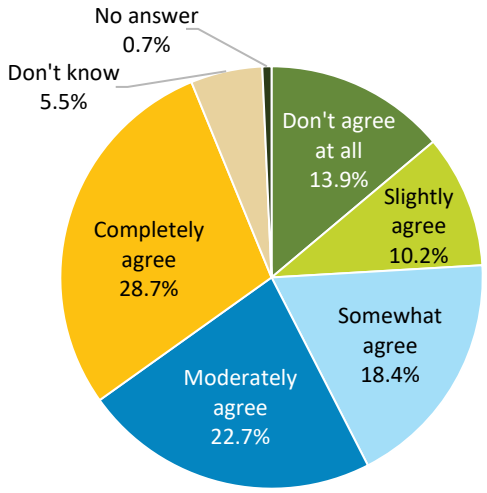
In the next section of the survey, questions focused more on the QIP payment structure and asked participants to consider whether or not they agreed with the current approach. The following context was provided to respondents:

> *CCOs currently get the same amount of bonus money for reaching overall goals or improvement targets for each of the health outcome measures. For example, imagine that $1 million is the amount of bonus money a CCO can receive for reaching a health outcome's goal. One CCO meets the overall goal of 70% of OHP children getting a well-child visit, so they get $1 million. Another CCO meets their improvement target of 30% of OHP children getting a well child visit, so they also get $1 million.*
>
> *Currently, CCOs can earn all of the bonus money, even if they don't reach all of the goals or improvement targets set by the Committee. CCOs only need to reach the goals or improvement targets for 75% or three-quarters of the health outcome measures the Metrics and Scoring Committee picked. For example, this year the Metrics and Scoring Committee picked 15 health outcome measures for CCOs to focus on. If a CCO reaches the goal or improvement target for at least 12 of these, they are paid all the bonus money.*
>
> *After OHA has given out the bonus money, any leftover money goes into something called the "Challenge Pool." The Metrics and Scoring Committee picks three or four of the health outcome measures they think are the most important. Money from the Challenge Pool is paid to CCOs who reach the goal for these health outcome measures. If a CCO did not earn all of its bonus money, the Challenge Pool may help them earn some of it back. Even if a CCO earned all of their bonus funds, they can still earn extra money from the Challenge Pool.*

Figures 16, 17, and 18 (next page) depict a set of three items that asked for participants' thoughts on CCOs opportunities to earn bonus and challenge funds. Respondents answered all three questions quite similarly, with slightly more than half either **Completely agreeing** or **Moderately agreeing** that

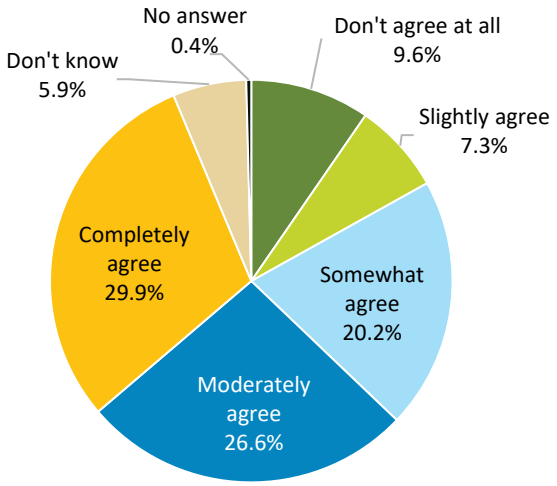
- CCOs should be paid the same amount of bonus money for reaching either the overall goal (i.e., benchmark) or their improvement target (51.4%)
- CCOs should be paid all the bonus money for meeting the goals or improvement targets for 75% (versus all) of the health outcome measures (56.5%)
- CCOs should be paid additional bonus money for meeting the goals for priority outcome measures (i.e., Challenge Pool).

Figure 16: CCOs Should be Paid the Same for Goals and Improvement Targets (*N*=728, *M*=3.45, *SD*=1.40)



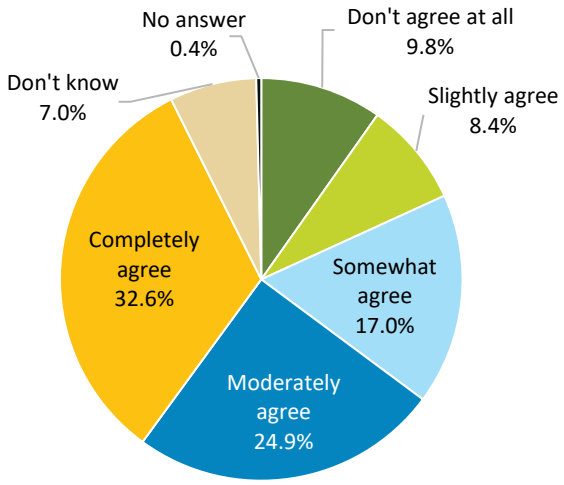

Q20: How much do you agree that CCOs should be paid the same amount of bonus money, whether they reach the overall goals or their improvement targets?

Figure 17: CCOs Should be Paid in Full for Meeting 75% of Measures (*N*=728, *M*=3.64, *SD*=1.28)




Q21: How much do you agree that CCOs should be paid all the bonus money for meeting the goals or improvement targets for 75% of the health outcome measures?

Figure 18: CCOs Should be Paid Additional Bonus Money for Priority Health Outcome Measures (*N*=728, *M*=3.67, *SD*=1.32)




Q22: How much do you agree that CCOs should be paid additional bonus money for meeting the goals for priority health outcome measures?

Also, as part of this section, participants were asked what health outcome measures they would like to see included by the Metrics and Scoring Committee. Some of the most common suggestions were behavioral health-related measures, followed by dental care, then physical health and preventive care. This prioritization underscores the comprehensive approach required to meet the diverse health needs of the OHP community, aiming to reduce health inequities and enhance accessibility to these essential services.

*"Mental health, there should be a scoring for those who are getting the quality of care they need and the feeling they are being heard and seen."*

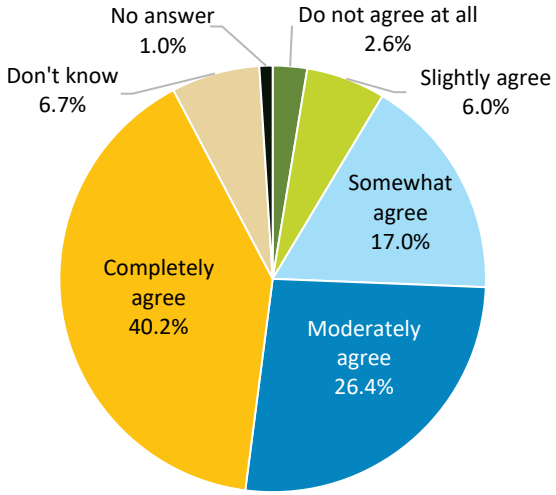
# Community Engagement

The last section of the survey prior to the demographic questions focused on experiences with and opinions about public comment. At the beginning of this section, it was explained:

> *Anyone can give input to inform the Metrics and Scoring Committee's decisions. This input is also called "public comment." Public comment can be made during video meetings or sent by email two days before the meeting.*

All participants were asked to what extent they agreed that the current system of public comments would have an impact on the Metrics and Scoring Committee's decisions. As seen in Figure 19, most participants **Completely agree** (40.2%) or **Moderately agree** (26.4%), suggesting that they believe public comment can have an impact on decisions.

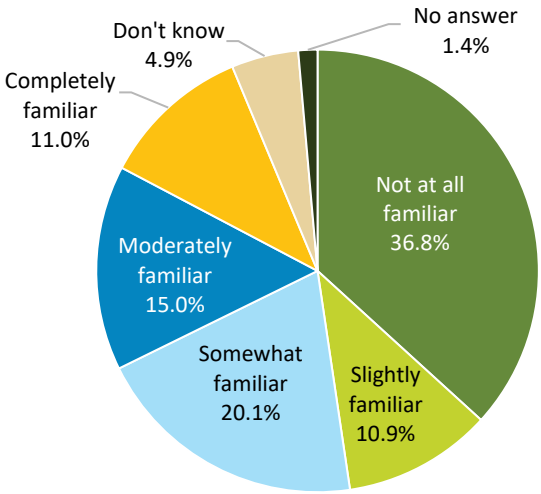
Figure 19: Public Comments Have an Impact on the Metrics and Scoring Committee's Decisions (*N*=728, *M*=4.04, *SD*=1.07)




Q25: How much do you agree that public comments would have an impact on the Metrics and Scoring Committee's decisions?

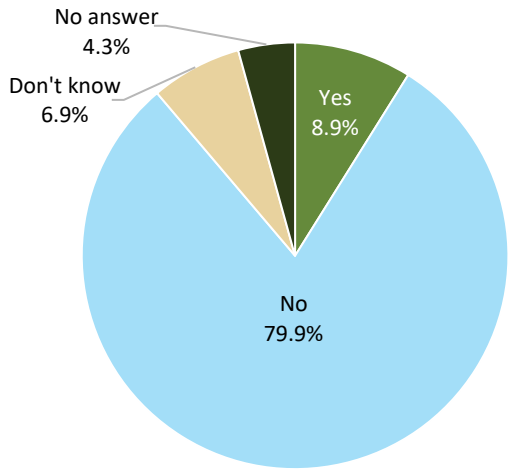
All participants were also asked their level of familiarity with giving public comment to a state committee and whether or not they had experience doing it. While 57.0% of participants expressed some level of familiarity (Figure 20, next page), just 8.9% said that they had actually given public comment before (Figure 21, next page).

Figure 20: Familiar with Giving Public Comment (*N*=728, *M*=2.49, *SD*=1.44)




Q24: How familiar are you with giving public comments to a state committee?

Figure 21: Experience Giving Public Comment to a State Committee (*N*=728)

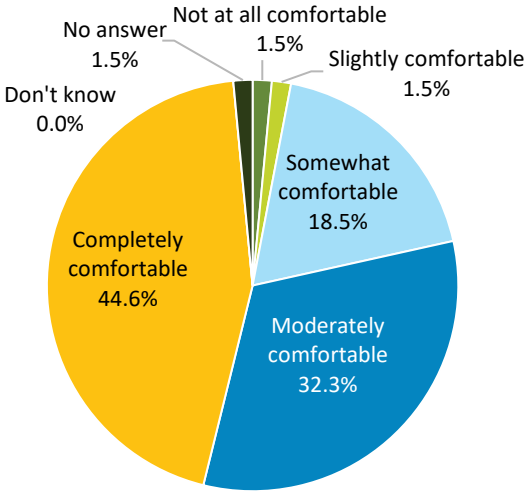



Q26: Have you previously given public comment to a state committee?

Those 8.9% (*n*=65) were asked several follow up questions about their experience, including which committees they gave public comment to. Many participants referenced a health committee of some kind, as well as various state agencies and local governmental entities.

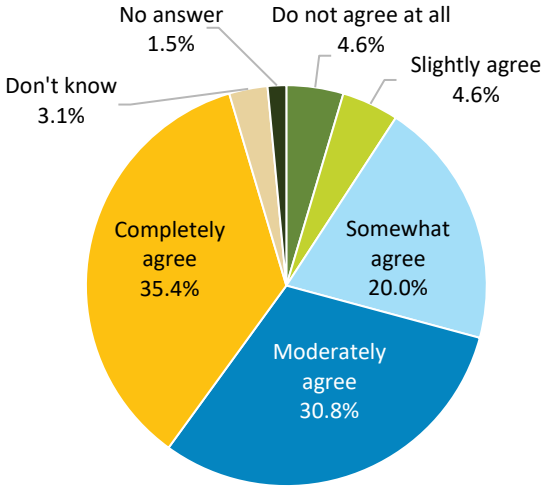
As Figure 22 shows, nearly half of those 65 participants felt **Completely comfortable** (44.6%) giving public comment. Although anyone who did not feel completely comfortable had the opportunity to share what was uncomfortable for them, very few people provided a response. This subset of participants was also asked if they felt that their public comment informed the committee's decision. There were not as many people who **Completely agreed** (35.4%) with this sentiment; however, most of the participants did agree on some level (Figure 23).

Figure 22: Comfort Giving Public Comment (*n*=65, *M*=4.19, *SD*=0.91)




Q26b: How comfortable were you giving public comment?

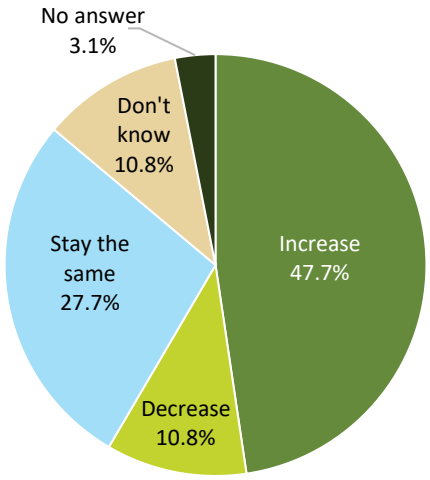
Figure 23: My Input Informed the Committee's Decision (*n*=65, *M*=3.92, *SD*=1.11)




Q26c: How much do you agree that your public comment informed the committee's decision?

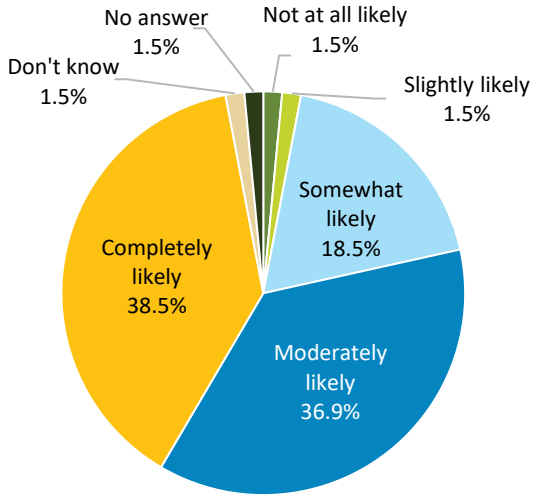
When asked if their trust in the committee changed after giving their testimony, almost half of the participants reported that their trust in the committee **Increased** (47.7%) and another 27.7% stated that their trust level **Stayed the same** (Figure 24). Similarly, the majority of participants indicated that they are either **Completely likely** (38.5%) or **Moderately likely** (36.9%) to give public comment again (Figure 25).

Figure 24: Trust in Committee After Giving Public Comment (*n*=65, *M*=2.02, *SD*=1.11)




Q26d: After giving public comment, did your trust in the committee...?

Figure 25: Likelihood of Giving Comment Again (*n*=65, *M*=4.13, *SD*=0.89)




Q26e: How likely are you to give public comment again?

For these participants, what helped them prepare to give public comment was previous experience, knowledge, researching more about the issue, and support from others. When asked if they had anything else they would like to share about their experience giving public comment, one OHP member explained, *"I'd like to share that public comment can be intimidating, but it's a powerful way to amplify marginalized voices."*

All OHP members, even those who had not previously given public comment, were asked what would make it easier for them to go in front of a committee and give public comment. Respondents frequently stated that more awareness and education ahead of time would be very helpful for them. Specifically, they would like to be notified in advance when there is an opportunity to give public testimony, as well as details about where and how to do so. Additionally, participants would like to have more background information provided to them about the issues being discussed by the committee.

> *"Providing clear guidelines on how to submit comments, what information is required and any deadlines will help. Providing easy to read summaries of key issues and proposals to help the public understand what they are commenting on."*
>
> *"Various ways to submit comments such as online forms, email, postal mail and phone calls. And holding meetings in easily accessible locations with good public transport links and convenient schedule times."*

Other suggestions included making the opportunities to give comment more accessible and varied. Participants seemed particularly interested in anonymous, confidential, and/or online routes of sharing their feedback, such as by email, text, or phone call. Due to hesitancy around speaking publicly, desires to keep their comments anonymous, and wanting time to write out their thoughts, this alternative to giving public testimony in person seemed to appeal to many participants. If they were to give comment in person, it is important to many respondents that the environment is welcoming and comfortable, as shown through the use of plain language, an openness to all voices being heard, accessible locations, and convenient times being offered. Others emphasized that in order to feel comfortable giving public comment, they would need to see evidence that previous testimony was taken seriously and made an impact on the committee's decision making.

*"If the committee was ready to listen to what I had to say…Having direct feedback on a public comment as soon as possible."*

*"Members should be warm and encouraging this will foster a culture of people speaking and giving their two cents opinion."*

When asked for suggestions of other ways OHP members could inform decisions about the QIP, the most common response was some form of *"I'm not sure."* However, there were still some ideas generated by participants, including interest in some form of a survey similar to the one they participated in for this study. They particularly wanted surveys that provided information, asked for feedback, and were widely available to all OHP members (i.e., online, over the phone, and in clinics). Some participants suggested engaging with the community through events and meetings to gather feedback and build trust. Comments also emphasized the need for OHP members to know that the QIP exists and that OHA is interested in their feedback. Respondents expressed that detailed background information must be provided anytime they are asked for their opinions. Other, less frequently mentioned ideas included using social media, flyers in clinic offices, radio advertisements, and mailers to share about the QIP more broadly with OHP members.

*"Conduct regular surveys to gather input on specific aspects of the bonus program. Ensure surveys are easy to access and complete, available both online and in paper format."*

*"OHP members could also inform decisions through surveys, focus groups, and community forums."*

# Summary of OHP Member Qualitative Responses

Participants had a lot to say about their experiences as an OHP member, their thoughts on the QIP, and the ideas they have for OHA to improve these systems. Ultimately, these open-ended survey items aimed to gather insights on how to make the QIP program more equitable, address health inequities, and enhance the overall experience for all members. This approach was designed to prioritize and highlight the voices, diverse knowledge, and expertise of current OHP members in relation to the CCO program. Although some of those thoughts have already been presented to illustrate or supplement the quantitative findings, this section provides a broader summary of those insights and feedback. As previously stated in the methodology section, keep in mind that any quotes included in this section are representative of the kinds of comments made by multiple participants around these topics.

# OHP Member Experiences

In general, participants expressed satisfaction with the services provided by healthcare providers within the CCO network. For example, some comments indicated that healthcare providers frequently assist them in understanding their options and making informed decisions regarding their healthcare plans. Overall, members reported positive experiences with healthcare providers within their CCO network.

However, other respondents reported some negative experiences with healthcare providers. Participants mentioned feeling uncomfortable, judged, overlooked, or unheard, and in some cases, discriminated against by some healthcare providers. These negative experiences were often related to their histories of addiction, mental illness, or disability.

In addition to these experiences, the need for more integrated care across healthcare providers and CCOs was emphasized. Participants suggested that this integration would reduce the need for multiple appointments, streamline treatment processes and enhance the quality of services provided to OHP members.

Some participants elaborated on the barriers they encountered in accessing health and wellness services, specifically around insufficient coverage. In some instances, these barriers included healthcare providers not accepting state insurance or specific clinics. A notable recurrent theme in the responses was the difficulty OHP members faced in accessing medications, including challenges with navigating the pharmacy system. Members expressed a need for additional support in these areas.

*"My doctors at the NARA health clinics have always gone above and beyond to help, listen, and inform me on all my options and look into different treatments, medications, or services."*

*"Bueno yo personalmente e resibido muy buen serbisio y estoy muy comforme [Good. I personally have received good services and feel comfortable]"*

*"My Dr. doesn't listen to me at all. I experienced this with a dozen Drs specialists etc. Over these years being diagnosed with mental illness. And they think I don't know anything or even about my own body. It's sad when Dr judges I have severe PTSD, trauma, schizoaffective disorder to name a few. And get treated poorly by Drs. But OHP is not responsible for the Drs behavior."*

*"I go in for something and I to get multiple appointments in order to hopefully get OHP to approve something they usually don't approve. Too much time. I wish that if the doctor refers patients somewhere OHP should automatically approve it."*

*"Prescription coverage timelines. They will only pay for a 30-day supply. But I can't get it filled until the 30 days is up which means I go without medications for 2 to 5 days every month."*

# Governance Structure

Although the quantitative data showed that participants trust that the existing Metrics and Scoring Committee members can make decisions leading to high-quality healthcare for OHP members, the qualitative data showed strong support for increased community involvement in the QIP decision-making process. Many members highlighted the importance of their firsthand experiences and understanding of diverse needs, including those of members with disabilities or from marginalized groups. Furthermore, these lived experiences would contribute significantly to the development of metrics that address OHP members' needs, thereby ensuring more comprehensive healthcare coverage in the future.

These ideas about community involvement align with the sentiment that OHP members themselves and representatives from the community-based organizations that serve OHP members are the individuals who understand the healthcare needs and concerns in each community better than anyone else. This is particularly important in light of all of the OHP members who have felt their voices and opinions were overlooked or ignored, or who faced rejection of their health insurance by some healthcare providers.

In addition to increased OHP member representation on the Metrics and Scoring Committee, participants stressed the importance of follow-up and regular reporting out by the committees, CCOs, and OHA. Through transparent communication, these systems can help members feel more assured about their healthcare choices. This approach is particularly crucial when organized to safeguard the rights of patients.

As previously discussed, participants suggested various methods to enhance their representation and participation in the QIP. Recommendations included establishing a patient representative board and providing multiple avenues for members to share their feedback. The primary reasons cited for these recommendations were representing diverse needs and perspectives, an opportunity for community engagement, and to improve the effectiveness of the healthcare quality measures and the QIP as a whole.

*"I believe people from the community, including peer mentors and the people that are actively working with OHP members intimately need to be included."*

*"People that have lived experience in trouble accessing care. That way barriers can be identified as well as bringing awareness that there even is a barrier to begin with that may not have been known of prior."*

*"Because the majority of the decisions are being taken by the researchers, professionals and others who have 0 (zero) experience of what it takes to put the food on the table and the struggles and sacrifices that people make to put the food on the table, and the burden of illness, chronic illness. I would like to ask those who are at the top negotiating tables: When was the last time that you took some time to visit the clinics, talk [to] the people, engage with non-English speakers, low-income workers, parents of children with disabilities, senior citizens about their life's experiences and their perspectives of the healthcare institutions? When was the last time, or perhaps even the first time that you used an interpreter to convey issues of life and death, or personal issues? And how did you feel?"*

*"Communicating the importance of metrics and the bonus program with clients will help them feel more supported by their insurance company. It allows the client to know that the facility they chose for their health must adhere to a certain standard of care and that the facility is working towards improving."*

# Additional Thoughts

Regarding the payment structure of the QIP, suggestions from survey respondents highlighted the importance of focusing on equity to address health disparities. According to OHP members, an equity focus means that *"more people should be covered,"* more outcome measures should be implemented, and there should be greater input from OHP members. In addition, services should be accessible and effective for all, particularly for marginalized groups by addressing barriers such as language, race, income, disability, gender identity, geography, and cultural differences.

To ensure that the QIP serves the objectives of health equity, respondents believed that approaches should be implemented to guarantee service quality and equity for OHP members. These approaches include providing avenues for members to rate the services they receive through patient outcome reports, conducting educational outreach in the community to inform about program outcomes, and obtaining regular feedback from OHP members.

*"More vulnerable persons should be under the coverage. People with mental health and addiction problems"*

*"I think there are more metrics that may be more important. Addiction and mental health issues have sky rocketed without proper direction to handle it. People are dying in our small community which has plenty of money for services but it's either not being spent (by our local hospital) or it's been spent on things that aren't truly needed for the problem."*

# Findings: Interviews with Health System Partners

The qualitative data gathered during individual and group interviews with health system partners will be primarily structured according to the research questions that served as the basis for this study. The overarching research question was: ***What is the QIP's potential to further or hinder progress towards OHA's goal of eliminating health inequities?*** The following report sections will be organized across three main QIP components: (1) the governance structure, (2) measure and benchmark selection practices, and (3) program operations. As with the OHP member discussion of qualitative findings, quotes are included that illustrate the themes identified across multiple respondents. It is also important to note that some topics were primarily voiced by only one of the subgroups of respondents. This was primarily because the other subgroups did not have anything to say about that topic.

## General Information and Perspectives

Before itemizing the findings by research question, the qualitative interviews gathered some general information from respondents, including (a) how participants defined health equity, (b) the current health inequities the participants' community faced, and (c) the participants' familiarity with the QIP.

### Defining Health Equity

Interviews began by understanding how the organization defined health equity. A subset of respondents noted they had adopted OHA's definition for consistency with the QIP or to serve as a starting point while the organization was beginning to develop health equity programs. However, a larger group of respondents included discussion of equitable access. Several respondents also mentioned that access goes *"beyond medical care"* to allocating additional resources for interpreters, transportation assistance, and health advocates for those with disabilities. This was related to both medical and behavioral healthcare.

> *"Health equity means that everyone has an opportunity to access healthcare services no matter who you are. Same access to care, options, treatment across the board and that's health equity."*
> *– CAC member*
>
> *"access to services that supports all the levels of their healthcare…in a timely manner, afford[able], caring and respectful services."*
> *– Community provider*

Other common themes included serving groups that have been economically and socially marginalized and being sensitive to their cultural environment and history with the healthcare system. *"Meeting people where they are at"* was a common theme, touching again on challenges with transportation, as well as past experiences in healthcare. Understanding the local community came up in relation to almost all of the discussions, that community knowledge is solicited and heard, that collaboration with community be an essential element of how to find out community needs.

While not related to the QIP specifically, a few respondents talked about the political climate and ways it can affect their equity work. One CCO respondent noted that despite providing care in a very white and very conservative community, there is also a great contingent of folks in the healthcare system who are committed to addressing inequities, who consider this the right thing to do. Another respondent voiced concerns about politics entering into

the QIP process, and even though this happens, they believed that the medical experts should figure out what should be done and, as noted by one CCO respondent, *"try to keep the politics out of it*."

### Objectively Defining Health Equity

Respondents noted that health equity is a value term in that it is conceptual and encompasses many elements. However, measures in the QIP need to be concrete and measurable. As one committee member put it, *"The QIP is a value-based program…Programs are what is in between the values and the goals."* Another noted that OHA was unable to answer the question *"How will you know when health equity has been achieved?"* This indicates that a more objective definition of health equity would aid in alignment. One CAC member attributed the unclear relationship between current measures and health equity to inconsistent messaging from OHA. *"If people understand what they're trying to accomplish, they will be more involved in the program."*

## Current Health Inequities

At the beginning of the interview, respondents were also asked what categories of health inequities exist for their members. Eleven total categories were identified, four of which received significant agreement across organizations. By a wide margin, geographic disparities for OHP members living in more rural areas was noted by nearly half of the respondents. Transportation/travel time for care, provider recruitment and retention, as well as the sheer size and health need variation of coverage areas were all mentioned as challenges. Of these, transportation and travel time were cited as the main drivers of geographic disparities. Several respondents noted there was a five-month period in which a crucial bus route in one part of the state was closed, significantly limiting access to care. A CAC member stated, *"inadequate roads, or roads that close in winter, and forest fires—limit access to quality healthcare."*

Racial disparities were mentioned in one-third of the interviews with a particular emphasis on American Indian populations. Social determinants of health and insufficient data were the final categories with broad consensus. Regarding data, respondents indicated challenges with understanding how their patient population differed from statewide numbers, in particular for rural areas where smaller numbers might contribute to wide year-to-year variation.

Additional areas of inequity discussed included:

- Availability of providers
- Distrust of institutions
- Disability
- Language barriers
- Food insecurity
- Support for the elderly
- Housing

Related to availability of providers, respondents described months to year-long waiting lists for dental care and a major behavioral health provider in a region that was not accepting new patients. Adding to this challenge, one CCO respondent shared that a bad experience with a behavioral health provider could stop family members from seeking services when that provider is the only local option. Many noted that the aforementioned factors were all interrelated, making it especially challenging to craft effective health equity programs. Some issues could be addressed directly but others, such as availability of providers and distrust of the medical system, felt out of their control.

## Familiarity with the Quality Incentive Program

Respondents were asked about their familiarity with the specifics of the QIP's goals and purpose. Over half stated they were familiar with the QIP and had a high level of involvement in the details of the program, a group that largely consisted of CCO representatives. The remaining respondents were broadly familiar with the program, but expressed low involvement in or understanding of metrics and incentive payments. Notably, people from advisory committees made up much of the second group and frustration was expressed at their inability to impact decisions regarding metrics and/or payment distribution.

Respondents stated the QIP's goal to be population health, improving OHP member experience, reducing costs, and, in the words of one CCO member, *"to improve care and health of Medicaid members."* Several mentioned the purpose being that of quality metrics improvement.

# Governance Structure

The first set of research questions focused on **governance structure**.

- *How can communities experiencing health inequities be centered in the program so that it advances health equity?*
- *What committee governance structure most supports a QIP primarily focused on health inequities?*
- *What changes could be made to how the program interacts with other committees of the Oregon Health Policy Board so it is primarily focused on addressing health inequities?*

## Centering Members in Governance Structure

Common themes regarding how OHP members can become more involved in the QIP were having more member representation within the committees and the governance structure more broadly, more OHP members in leadership roles, and better communication/outreach with members. However, another theme from the data suggested that OHA should continue utilizing the current system.

### Member Representation

By and large, respondents wanted to see more representation of OHP members, especially since the decisions being made most directly affect them. For example, one CCO respondent shared, *"There definitely should be members on these committees, they should be on the Metrics and Scoring Committee. These measures and committees have direct impact on the members of OHP and they should be at the table."* Another CCO representative stated, *"To be effective they would need to include more members on MSC. That would be the place to have more involvement. Members may have different goals, ideas, and needs, and they need to be part of the conversation where the work is really happening."* Reflective of these sentiments, a committee member respondent went a step further and shared that member voice is not enough without it being meaningful, *"The system has blocked-out member voices—and that there is opportunity within the Metrics and Scoring Committee, if member voices can be heard in a significant way."*

*"The system has blocked-out member voices—and that there is opportunity within the Metrics and Scoring Committee, if member voices can be heard in a significant way. – Committee member*

One CCO respondent offered feedback on the current methods used for incorporating member voice, as well as ways to better represent member voices in the current model. *"The public comment option that we have with the measure selection process is not very utilized. When it is, it is often driven by a measure champion who is encouraging people to speak on specific measures. Also, it's a very intimidating, not a welcoming environment to provide feedback:*

*people have two minutes, they have to prepare, verbally stand in front of a committee or provide it in writing. If it's not in writing then it's not always addressed. Committee members are there to listen, they cannot respond to people. Having a more dynamic group setting might be more effective. CACs are not enough, because they don't represent all of the populations or regions. It's a good place to start, but there needs to be more than that."*

Finally, other CCO respondents shared that it's not just member voice that is needed to create change within the current system, but voices from all involved in the healthcare system. "*I would say it's really important to have member voice. It is really important [to] not only have member voice as well. The proposal from OHA last year on how to restructure the committee gave more room for member voice but it has ended up losing some of the knowledge. One voice that is being lost is the voice of the providers on the ground. …We need the voices from CCOs, Providers, Members, CACs and equity committees and we need all of these together."* Another CCO respondent suggested, *"Having focus groups, leveraging community advisory councils to a certain extent is important. Having the voices not only of OHP members but community members who assist closely with OHP members and provide feedback is [also] important."*

> *"We need the voices from CCOs, Providers, Members, CACs and equity committees and we need all of these together."*
> *– CCO representative*

## Members in Leadership Roles

Similar to the common theme of wanting more member representation, one respondent voiced that they would like to see more members in leadership roles. For example, one CCO respondent mentioned, *"There should be more opportunities for members to be in committees. The CACs have them, but other committees (like Metrics and Scoring) don't really have chances for members at large to participate. Would also like to see more chances for members to engage at the state level."* Conversely, one CCO respondent shared that it is not fair to expect OHP members to take on leadership roles, *"When it comes to putting weight on community members for building these processes and determining outcomes, it's not a fair expectation."* With these varying perspectives from similar respondent groups, it is noteworthy that there are differing CCO perspectives about whether or not – and to what degree – OHP members should have leadership roles within the QIP processes and procedures.

## Better Communication and Outreach

Many respondents spoke to the need for better communication with members to get them more involved with the QIP and processes. They also spoke to educating members more effectively. For example, one respondent spoke to the need for education materials presented to members to not be at *"a professional level"* because this can lead to exclusion. It was noted that by communicating at a professional level, you exclude everyone not in your field; to do it at a third-grade level you allow more people at the table to participate. The effort to give out so much information "backfires" because people simply don't have access to the language that QIP representatives use, or how they break things down.

> *"OHA needs to meet people where they are at. Although it might come across as patronizing to use language that is not specialized; it does mean that people who already feel alienated by current systems can participate."*
> *– CAC member*

Another respondent mentioned that to integrate member voice within the QIP program and processes it would require education that is based on asking *"What it would take for them to understand the entire body of work, to be an active participant to influence this incentive program?"* One CCO respondent summarized in this way, *"Think about accessibility for members. CAC. What it would take for them to understand the entire body of work, to be an active respondent to influence this incentive program? Herculean step. We'll do what we can to support that, but it will take more than distributing minutes, etc. A more member-centric focus, thinking about who is in the member body. How we would measure how we're doing that? Members would decide if it's being successful."* While another respondent shared, *"There definitely should be members on these committees, they should be on the Metrics and Scoring Committee. They should also*

*be trained like the rest of us, like I had to be trained on these measures and what they actually mean."* Similarly, another respondent shared that there is a need for mentorship of members in order to support their voice within the QIP, because *"it takes time to understand these things."*

Respondents from all participant-type groups shared that there should be an investment in breaking down barriers between OHA and community partners and community members. For example, one respondent who was both a committee member and an OHP member, stated, *"When you engage community members, don't waste their time unless you have a plan on how to implement their voice."* Likewise, a CAC respondent stressed the importance of OHA needing to be open and transparent about the feedback they receive from community members and explain why something can, or cannot, be implemented; there should be a plan on how voices are implemented. It was recommended that OHA work with community organizations, specifically the small, local ones that are often underfunded, because they work most closely on the frontlines.

> *"You wanna involve members? Go to these community organizations. They have the networks."*
> *– Community provider*

Insufficient engagement with community members, and not knowing the plan for collecting community voice, were concerns. While receiving current public and written testimony from those who are familiar with OHA is helpful, additional input from the general public is also needed in order to answer such questions as:

- *What do you feel is missing?*
- *How was your experience?*
- *What do you need?*

Suggestions for soliciting community voice included town halls and holding meetings specifically so that members feel safe, heard, and have time to openly share and talk about their experiences.

## Use Current System

Although a minority CCO perspective, some respondents shared that the current model of the QIP program is effective in that it already does include member voice. For example, one CCO respondent shared there currently exists an iterative process that begins with feedback from the community, followed by administration and staff operationalization, and then providers and CCOs that seek input on that operationalization. They noted, *"So I think that the community voice leads it, but these people in charge of implementing it make sure that it's operationalized, and then we bring it back to the community, and it's iterative in that the providers and CCOs work with the community to get input and continuously improve. That process works."* While another CCO respondent shared that the representation of members have through the CACs is sufficient, *"CAC is made up of really passionate people, this is a core aspect of CCOs. CACs are a great focal point for communication. Urge OHA to use structures that already exist and are working well instead of coming up with new things that may not be a good fit for community members' time and interests.*"

## Committee Governance Structure

Respondents provided a variety of recommendations about improving Committee governance structures. As noted above, many respondents wanted more OHP members included in the process of the QIP and on OHA committees. Others noted that committee members who are also OHP members should be (a) paid for their service; (b) explicitly told how, where, and why their voices are needed; and (c) what OHA will do with the information and perspective they provide. This approach will naturally support an increased focus on health disparities and health equity.

Respondents who represented the CACs suggested creating additional mechanisms that committee members could use to increase their voice and allow OHA to hear CAC feedback. Many CAC respondents were interested in knowing more about the QIP, about measurement decisions and payment distribution decisions. For example, improving the lines of communication between OHA and community members (e.g., liaisons and innovator agents), describing details of the work so it is more transparent, building in more question-and-answer time with the Metrics and Scoring Committee, and including more discussion time that is not a formal part of providing public testimony.

> *"As you could guess, if you are sitting chair and just attending meetings, you will hear the negative things that are happening. If a provider is not behaving equitably, those are the stories you will hear. The great thing is that, over the past few years, a significant number of times in meetings, we've heard increased stories about how providers have done well by patient… there are good and bad stories, but I would be remiss if I didn't say that providers are really trying to practice with greater equity."*
> *– CAC member*

Respondents from CACs pointed out that committees that met consistently, were collaborative, and included time for information-sharing, were appreciated, seen as beneficial, and worthwhile of members' time. Overall themes related to supportive governance structures note that sharing data, discussing information about practices that were both effective and ineffective, and receiving technical assistance from OHA related to measures were seen as supporting the QIP goals, particularly addressing health inequities.

CAC, provider, and CCO respondents also appreciated when they were invited to present to OHA about what they were doing to support the QIP efforts. Interview respondents noted that providers were very motivated to share their strategies with others and they got excited to hear about what others were doing, too. Some examples from respondents included:

- *well-child days*
- *giving teenagers subway cards if they come in for their visits*
- *mobile dental clinics*

Respondents also shared critical feedback regarding the current QIP governance structure, including issues related to payouts, data, the annual switching of metrics, the numerous measurements that need to be tracked, and the relationship with OHA or the Metrics and Scoring Committee. One provider illustrated this sentiment by sharing that the QIP governance structure *"feels very top-down,"* also adding that the delay in getting payouts makes it challenging to track. Multiple CCO respondents noted that the annual switching of metrics and having numerous measures that need to be tracked can complicate the QIP functioning and processes. Finally, a lack of CCO representation on the Metrics and Scoring Committee was referenced as a health equity problem because the people and groups within the CCOs are those most affected by the decisions related to the QIP.

# Communication and Opportunities for Input

Respondents shared at length about opportunities to give feedback to OHA and about the ways information is communicated between themselves, as providers, committee members, or CCO representatives.

## Communication of Committee Decisions

### Effective Communication

Some respondents shared great appreciation for how the Metrics and Scoring Committee decisions are communicated. A provider mentioned an appreciation for the Metrics and Scoring Committee open meeting where anyone can listen and that minutes are available after the meetings. Another provider shared that, in general, there is great communication surrounding the QIP for clinics that carry the program out: *"…they make it very clear. Lots of meetings, dedicated person who communicates well. Goes through all the measures with clinics and people can ask questions."* As an example, one respondent's clinic struggled with the depression screening and follow up measure. A representative from their CCO came in to help, providing technical assistance and very clear communication. CCO respondents also noted that open communication between the CCOs was helpful, useful, and appreciated; it was reassuring to hear that creative things were being designed to specifically integrate health equity services into the CCO work. Finally, another CCO respondent noted, *"…[when] one CCO does something well, another calls them and asks how to do it as well. They learn and share from and with each other. They all want to do good work."*

> *"Similar to benchmarks and target question, there isn't a perfect way to communicate the info. There are weekly updates and public materials, which is about what is expected. This piece is communicated well."*
> *– CCO representative*

One activity associated with effective communication that CAC members appreciated is the innovator agents who provide information about the QIP and keep lines of communication open between CACs and OHA, underscored by a CAC member noting, *"I rely on our innovator agent from OHA."* They take time and provide space to hear what community members have to say about the QIP, health equity, the measurement selection process, and conducting inclusive meetings where trust can be nurtured between community members and OHA staff members. The innovator agents who met in-person and online with members of the CAC helped to provide clear information about the QIP, were seen as honest and trustworthy, and did a good job of providing links between OHA and the CACs. CAC members expressed being proud of their work, appreciative of CACs in other Oregon counties, and thankful for the chance to create connections between CACs. This could be a mechanism created more broadly to support effective communication.

### Ineffective Communication

Another group of respondents shared various concerns about how the committees are communicating what needs to be known to do the work. One CAC respondent shared that communicating via technology could pose a barrier for certain individuals. Although they reported being able to absorb all the information they need from websites, emails, and texts, they were concerned about those who are *"older or who have special issues"* that don't have the same access to these communication technologies. They were concerned that this would create a *"digital divide."* Respondents also mentioned that there are technology glitches sometimes during virtual meetings, and that committee members may have a hard time joining online, regardless of who there are, and especially in rural areas of Oregon where internet access can be limited.

Other respondents mentioned that in general, decisions regarding the QIP are not effectively communicated and that even members of the committees themselves are unaware of the measures and its decision process. A provider noted that it is unclear how to learn what the Metrics and Scoring Committee has decided and what the plan is moving forward. One CCO respondent noted, *"As far as I know there is an email that goes out. I know where to find the*

*recorded meetings, but I still struggle to find the measure set for 2024. I work on the committees and I struggle. I'm sure non-members will be struggling even more. How it gets shared with the public, I have no idea."* A CAC member shared that it feels as though decisions are being made *"behind the scenes"* and that more transparency is necessary.

Reflective of these sentiments, one CCO respondent shared that understanding macro level communication from the Metrics and Scoring Committee is very clear, but that more specific information regarding the program is not as effectively communicated. *"In terms of communication that comes from this committee, I feel pretty well-versed in the higher-level communication, but when it gets down to specifics it's less clear. There are times when we think we're passing a measure, and we're not. I don't feel those communications are as solid as they could be."* While another CCO respondent stressed the need for clarification of specific issues, as well as more open discussion and interaction opportunities. *"…I do feel listened to, but I think that's a unique situation. I think it would benefit us going forward to have more discussion. I think more interaction, open discussion, and clarifying of fine details could happen…Having a regular meeting with the [Metrics and Scoring] Committee that's structured…would be beneficial."*

*"They [decisions] aren't very well communicated, even if you're really paying attention. Sometimes [you] see blurbs in an OHA newsletter or hear about it in a meeting."*
*– CCO representative*

*"MSC chooses the universe of metrics but it's muddy how pieces are determined."*
*– Provider*

*"We don't get a copy of the reports either. Our Innovation Officer can send us like 16 pages of decisions in an email, but that doesn't help us actually understand what is happening."*
*– CAC Member*

Respondents also put forth some ideas regarding improvements that can be made to the communication style from the QIP's committees. For example, one CCO member shared that having more "office hours" where individuals can ask questions of people who have the answers would be beneficial. Additionally, one provider stated that publicizing information more in ways that are easy to find would help ensure that communication is more effective.

## Opportunities to Provide Input

Respondents gave several examples of opportunities they had to provide their input about the QIP's governing committees' decisions as well as the lack of opportunities they felt they had to provide feedback. Respondents also mentioned that the nature of the feedback mechanisms and opportunities were sometimes challenging. While many respondents did feel heard and valued, especially when voicing strategies to improve equitable health outcomes for OHP members, other respondents felt that there was a lack of opportunities to provide feedback/input. Feedback from respondents also included strategies that OHA and the QIP representatives could adopt to continue receiving both oral and written feedback from committee members.

### Information Sharing

Many respondents felt heard and listened to during their committee meeting attendance as they provided feedback about the QIP. Respondents also appreciated the information that OHA shared during meetings related to the QIP, which increased respondents' understanding of the complexities of the QIP. One CAC member said that the *"health department chain"* of command and lines of communication between OHA and their committee were working. Though health equity is not discussed at every meeting, it is talked about often, more so in recent meetings. The practice and process of the open period at the beginning of the meetings, which allows community members to voice what has been happening, are appreciated. Both the committee presentations and the speakers who specifically solicit member feedback are also appreciated; respondents feel that they really do have a voice, noting:

> *I do feel that we've had some great communications about health equity with these benchmark committees. I do feel listened to, but I think that's a unique situation. I think it would benefit us going forward to have more*

*discussion. I think more interaction, open discussion, and clarifying of fine details could happen. I know, who has time for more meetings? But when we're going forward with major changes, and developing these tools to make changes, there's room for improvement in quality and content of communication that's happening.*

Invitations from OHA staff that allow respondents additional ways to get involved are also appreciated, as a CAC member notes, *"Having listening sessions about it after it's written is totally different form the process during creation. Having those listening sessions around the state where consumers have access to talk during and not after the process is a big one."*

A couple of specific committees and their work were mentioned by respondents. For example, it was noted that the Health Equity Committee has met with Metrics and Scoring to discuss how to better collaborate, and during some of the Community Health Improvement Plan (CHIP) meetings, discussion about equity frequently happens, in addition to discussion about the QIP measures.

Other respondents said that during their committee meetings they talk about ways to get more OHP member feedback and share more information with each other about what is and is not going well. As a result of sharing information, one committee member mentioned being able to see the results of the QIP. Other committee member respondents spoke of their involvement in shaping the health equity strategy, which they believed to be an adjacent piece to the QIP. In addition, acknowledging OHA's focus on the QIP and ways OHA wants to address health inequities were seen as OHA's approach to engaging in Medicaid equity work. Feedback also included the sentiment that, based on the Centers for Medicare and Medicaid Services (CMS) rule, OHA is supposed to obtain input from the Medicaid Advisory Committee related to quality measurement and improvement.

## Challenges

Common challenges associated with opportunities for feedback were that respondents felt their input has not been utilized and that communication with OHA or the Metrics and Scoring Committee is unclear. A CCO respondent commented on the required timelines that are currently in place: two days before a meeting when submitting written, public testimony or 15 minutes when giving in-person oral testimony. These formalities can sometimes be seen as mechanisms that allow OHA to *"say that they listened,"* but when there are no opportunities to ask questions or allow for follow up conversations, the process for giving feedback can feel overly structured. Another CCO respondent said that they would like to see summaries of discussions related to testimonials be shared back out to community members.

*"We have provided input, but I don't think any of our input has ever been incorporated."*
*– CCO representative*

*"…[health equity] also means for us that individuals and communities are defined as the experts of their own health… And that health is defined [by their own] values and contexts; that they have access to resources to meet their own health goals."*
*– CCO representative*

Finally, one CCO respondent said that the timing of when QIP's decisions are communicated to the CCOs is so late compared to the work being done, that having a longer "runway" to provide input about QIP's decisions, process, and measures would offer more opportunities to engage and help craft measures. A similar sentiment was shared related to health equity: implementing equitable health strategies should look different depending on current and emergent community needs and it's important to take the time and allow the space to listen to these nuances and differences. The varied health equity considerations for CCOs operating in rural areas was further underscored by a CCO respondent stating, *"we sometimes have to take into account more than race/ethnicity. We also have to take into account distance and access in these more rural areas."* Finally, one respondent specifically noted that some of their colleagues gave feedback to Metrics and Scoring Committee leadership about the language measure, but they were not listened to.

# Measure and Benchmark Selection Practices

The second set of research questions focused on **measure and benchmark selection**.

- *What changes could be made to the measure selection process, including the measure selection criteria, so the program is primarily focused on addressing health inequities?*
- *What changes could be made to the measure retirement criteria so the program is primarily focused on addressing health inequities?*
- *What changes could be made to how bonus funds are earned (currently benchmarks and improvement targets) so the program is primarily focused on addressing health inequities?*

## Addressing Health Inequities

### Health Quality Measures

General connections between health equity and the incentive measures were explored in the interviews. Some respondents noted that the QIP has helped them focus more on health equity. A CCO respondent mentioned the benefit of having the Incentive Program in trying to put forth health equity practices, *"Because of the incentive measures they have clout to make clinics/providers/etc. to address health inequity."* Several respondents discussed how the QIP helps them identify where to focus their efforts or allocate their resources. For example, one CCO respondent shared:

> *"The Incentive Program has definitely influenced the discussion of equity within our CCO. Equity became a real priority agenda item about a year and a half ago, and we had the sense that we had to get moving on this."*
> *– CAC member*

> *"First, we have data, then analysis, then implement programs to address health inequities. We have data related to REALD and SOGI factors, even SDOH [social determinants of health] and access and location data. Having all of that data available is very important and we are trying to get more data. We are leveraging incentive payments to get more data. Our team identifies disparities in the inequity space. For example, we have lower immunization rates and have higher vaccination hesitancy rates. We have been focusing on programs that address that. The qual metric program has allowed us to be flexible in evaluating performance and evaluating disparities and then being able to focus on what's identified and implementing programs there.*

Another CCO respondent stated, *"It [the QIP] helps us understand how members are doing and what disparities might exist. … We invested early on in REALD and the quality of data that is provided to us. It helps us understand what the needs are and what we're doing today. It's helped us dive in deeper to determine where barriers might exist in the community, so that we can then go out into the community and get feedback to better understand those barriers."*

Respondents acknowledged that while the QIP has not historically focused on health equity, more of a concerted effort is now being made to understand the social determinants of health, to attend to language access, and to utilize social/emotional metrics. These changes were applauded.

## Efficacy of Current System and Measures

Respondents were asked how well they believe the current QIP measures address health inequities. Nearly half of respondents directly articulated the importance of measure selection relative to establishing priorities in the program. In the words of one CCO respondent, *"the metrics allow us to make data-driven evaluations of services, and then allocate the resources we can."* Another CCO respondent added that the measures provide a concrete way to measure what they have achieved in the program. Language access was brought up by numerous health system partners as a clear example of OHA spotlighting a need for which providers could then take clear, tangible steps to improve. A number of respondents provided positive feedback about the QIP measures, noting their meaningfulness, clarity, and support for the work they are already doing.

*"OHA has done a marvelous job of choosing a meaningful set of quality measures; [they are] relevant, well-defined, although some things need to be fixed a bit…In general, providers are able to match their work to the measures. When they need education, the CCO helps by providing guidance."*
*– CCO representative*

*"I find the work around the incentive measures to be engaging and fun. It's sort of a game, solving a puzzle. Rules set up by OHA and then [we] have to figure out what to do to make a difference for members and get you over the finish line. OHA doesn't tell us how to do it, we have a lot of latitude in the middle to get over the finish line."*
*– CCO representative*

Regarding the effectiveness of the current measure set and health equity, opinions were mixed, often within the same organization. One CAC member acknowledged the difficulty of defining such measures and stated, *"I couldn't rate it on scale, but I can tell you that inequities are a focus for our CCO."* While another CAC member believed the current system to be operating satisfactorily, *"It does have representation of a wide age group which I appreciate, they talk about young children, adolescents, pregnant people, etc. This is nice because it is not geared predominantly toward one group. I think its fine."*

CCO respondents were firmer in the belief that the current measure set does not especially align with health equity. One CCO stated, *"Metrics are not clearly connected to health disparities and it's not intentional to this end."* Other CCO interview participants provided specific examples. *"What they hear from culturally specific orgs and CACs is that the barriers community members are facing are not represented in the health equity-focused measures. So they end up investing in things that the community may not exactly need."* Another noted, *"In existing measures, there is language that often doesn't speak to health inequities. All CCOS are required to have tribal liaison, and have started conversations around SDH and they don't align with the way tribal communities work with their patients. It comes across as checking a box and going in a separate channel when compared to tribal needs and affairs."* Suggestions regarding how to effect better measure alignment with the goal of improving health equity coalesced around the topics discussed below.

## Challenges

Respondents also believed that, as one CCO respondent put it, *"Oregon just likes to do its own thing,"* and when this happens, Oregon moves away from national standards. This can result in additional inequities being created, Oregon falling behind, and not having metrics to compare ourselves to other states in the nation. To remedy this, one CCO respondent suggested using the Health Equity Index Star Ratings program developed by CMS. They noted that this would create equity-focused measures and better align with already existing health equity measures and indices.

A challenge of the QIP, as identified by one CAC member, is that not all metrics are centered in or related to health equity. *"Are we choosing metrics because we actually know that there are disparities there and that is something we want to address? … Is health equity being considered as an afterthought or is it part of the original design?"*

Respondents also asked that as OHA and Oregon legislators consider making changes, they include rural voice and rural needs, change only what needs to be changed, keep what is working, and focus on improving what already exists. Interview respondents expressed their interest in working with OHA to improve equitable health outcomes for OHP members, and respondents also acknowledged that, in the words of one CCO respondent, sometimes *"we are just starting this journey and we may not have the knowledge about where to go to then have a meaningful impact on health equity."* The inclusion of diverse community voices was further discussed by another CCO respondent, stating:

> *There needs to be a plan and project in place in order to engage the community. How we do school boards now [as an analogy] should be a similar setup for members to hear and share their experiences. We do public and written testimony now but those are the people who are really in the know, not general public members. What do you feel is missing, how was your experience, what do you need? Town halls for members to really be included.*

Related to measures and data gathering, some respondents spoke to the need of collecting more equitable demographic data for members as well as staff. For example, one provider suggested that everyone, including CCOs, frontline staff, and healthcare staff, need to become more comfortable asking demographic data, especially questions about identity information. This respondent felt that it is important to acknowledge that asking OHP members about their identities may be uncomfortable for healthcare staff, which is why training is so important to assist in normalizing the process of asking all demographic questions for all OHP members.

Another key theme around aligning the measure set to health equity was the idea of acknowledging differences in communities across the state. Multiple respondents indicated that a statewide approach to health equity was unrealistic and unhelpful. For example, one CCO respondent shared, *"…the specific measures are not always geared to what the community would like to see focus on."* Another CCO respondent warned that focusing on the measures may have a negative result for OHP member. Other respondents noted concerns related to the potential to rely on the QIP measures solely or heavily, introducing a risk that healthcare is provided to satisfy the measurement criteria (doctor-centered care), thus potentially reducing the care that OHP members (patient-centered care) actually need.

One CCO respondent suggested, *"The theoretical solution would be the creation of an equity analytics portion that would review each CCO individually, create a series of measures to present to Metrics and Scoring to use for that CCO region based on that CCO region's needs, as opposed to trying to create something to govern the state."* Another CCO respondent shared that in the goal of attaining health equity they need more support regarding data infrastructure, *"…we just need the infrastructure in place, more work on REALD."*

*"We end up doing very targeted outreach and potentially forcing people to get services that they don't want to get for reasons that are up to them. That is something that really needs to be thought about and evaluated thoughtfully when making decisions on increasing equity."*
*– CCO representative*

*"The flow of money doesn't directly compel CCOs to focus on inequities. Rather than focusing on the perfect measure, focus on doing the work to address programming to fill gaps."*
*– CCO representative*

# Measure Selection Process

## Need for Collaboration

Respondents indicated a desire to be more involved in the measure selection process. One CCO respondent stated that *"[we need] a more robust back-and-forth about what health inequities are being seen, and how these incorporate into community health improvement plans. There needs to be more opportunities to have this conversation."* It was noted that the collaboration could and should extend beyond the CCOs implementing the measures. As one CAC member put it, *"Finding out what Oregonians think would involve talking to Oregonians. Having people on the committee, going out to*

*listening sessions with the community, having ways to work with partners in Community Partner Outreach Program or partners in the agency to find out more about what the people who rely on these services consider quality healthcare. And make that the basis of the quality improvement program."*

When respondents were asked what changes to the measure selection process would support health equity, the overwhelming response was more collaboration. Only a couple respondents indicated any involvement in measure selection through the Metrics and Scoring Committee. The vast majority expressed challenges with communication around measures and measure selection. Many felt there was limited opportunity for involvement in the process. Multiple respondents urged for more communication between all parties – OHA and QIP entities – as well as opportunities for QIP entities to learn from each other.

## Population Considerations

For organizations serving rural areas outside of Portland and Salem, simply having enough individuals for data was a frequently cited problem. One CCO respondent noted that *"One of the problems the QIP can run into in the more rural counties is that we have overwhelmingly white communities and for metrics split on race/ethnic lines we end up in the trap of working with very small numbers."* Respondents noted at times they had to search out patients in certain demographics to reach minimum threshold numbers, feeling as if they had come all the way around to a different type of inequity. One CCO representative mentioned that targeting certain racial populations according to metric qualifications/standards "felt gross" due to them having such small subpopulations and having to track people down based on identity. Regarding the rural experience, a CAC member shared that there should be specific goals for rural counties, "They [the CAC] feel like too much time, resources, energy goes into the BIG programs and these big programs don't get out to [our] county – there should be specific goals for rural counties and specific locations/areas within the county. People in this community "turn off" when they hear about Portland/Salem – but when hear about a local issue they know about it, they are more amenable to work on that issue."

Suggestions were made regarding tailoring measures to the specific area to avoid small number issues and random fluctuations, as well as integrating local health issues. One CCO respondent stated that *"Each population and county is unique and figuring out how to factor those differences into the program would be nice."* It was noted that communities create their own community health plan every five years, which could be used to identify local health priorities that may be uniquely applicable to certain regions.

## Standardization and Metric Fatigue

Multiple respondents expressed frustration at the sheer volume of work related to tracking and measuring additional metrics. For example, one CCO respondent shared, *"…providers are impacted and struggling to make it happen"* adding that *"providers are stretched thin."*

> *"There is a high administrative burden on providers to report for metrics. When metrics are very similar in nature but don't overlap, then reporting has to be adjusted for multiple metrics bodies."*
> *– CCO representative*

Many health system partners voiced that the QIP measures, as an addition to metrics required for dozens of other programs, are challenging. There was broad consensus for OHA to adopt more nationally standardized measures. Respondents shared that having multiple and varying measures adds a great deal of burden to providers who must carry them out. Aligning metrics to current measures for targeting inequity will decrease burden on providers and better equip them to eliminate health disparities. One provider shared that current measures are not focused enough on patient care and that results in reduced value for them, as well as their patients.

Another CCO respondent explained, *"The administrative burden of each custom measure is massive, and we're not even providers. Even when OHA does take a nationally standardized measure and tweaks it a little bit…Those tweaks make validation different for different metrics, and it jeopardizes progress when data doesn't align, it impacts metrics, and then payments to providers are impacted…Even just the three equity metrics there are currently, it takes more than one FTE to manage these."* The CCO representative went on to suggest, *"A menu of metrics makes for a better approach that can align better with current CCO metrics priorities. Trying to add to existing measures, or move away from clinical measures entirely, makes me worried that we'll see a slide in progress. I want to see health equity incorporated in clinical metrics in a nationally standardized way."*

> *"Measures rolled out without understanding, 80% of what they're doing has nothing to do with patient care. It's all admin tracking and reporting so they can get paid for it, complicating processes and negatively impacting patient care. … Pitting measure[s] against best patient care, have to choose between meeting metrics or helping people."*
> *–Provider*

Some, but not all respondents, shared concerns about the potential of the QIP to be very *"data-heavy."* Acknowledging healthcare equity work that has only explicitly been measured by the QIP may run the risk of narrowly defining health equity if QIP's measurable criteria are the only things measuring equity. This narrower and limiting focus on health equity may foster the belief that Oregon's healthcare system is equitable because the data suggest it to be; however, healthcare equity may not actually exist in a broader sense. This possibility was noted by a CCO respondent, stating:

> *Be cautious about having a data heavy dialogue. Because the measures are so data specific, the team that manages the measures is a very data-forward team. By focusing on measures that can be measured, health equity becomes defined by only measurable criteria. This can potentially be limiting, and may propagate a false [sense] that Oregon's health-care system is equitable because the data says so, when in actuality it is not. … There is not a disagreement with the measures—they are necessary—but they are 'doctor heavy', and not whole person, individual-oriented care.*

## Custom and Upstream Metrics

By far, the most critical feedback regarding QIP measures was directed at OHA's custom-created measures (i.e., upstream measures), with numerous respondents noting that those measures presented a burden on top of their many other quality reporting obligations, especially as they were often not well understood or easily tracked. While some appreciated having the opportunity to set up workflows and monitor their progress, others noted that the custom measures tended to be quite prescriptive, taking time and effort to modify an existing workflow. It was also noted that the custom measures almost always require manual tracking as they rarely conform to data held within electronic health records. One CCO respondent shared, *"The homegrown quality measures carry with them some skepticism because they are not as well tested, and it can feel rushed; so what is the validity?"*

The upstream measures were also critiqued for their focus on process over outcomes and the sense that providers were being asked to operate outside their scope of influence. One provider stated, *"They're being asked to be social workers, they can't fill that gap. They need measures that fall within their sphere of influence to focus on."* Another CCO respondent explained, *"It seems like sometimes we're looking so far upstream that we're losing track of the downstream, clinical measures."* Yet another CAC respondent claimed that process measures were limited in their usefulness, as CCOs often achieved them in a year or two, leaving little room for improvement thereafter. However, one CCO respondent shared appreciation for the upstream measures:

> *From our perspective, the upstream measures are more robust and have more of an ability to impact health equity. Being able to focus on some of those structural changes and more process-related work has been a lot more meaningful for impact on health inequity other than just honing in on populations that we identify through an analysis of REALD and SOGI and then targeting that population, which can lead to unintended outcomes.*

## Quality Reporting and Measure Specifications

Regarding the current measure set and experience thus far, many respondents commented that the measures were too prescriptive. Several organizations noted the huge amount of quality reporting required for the federal government and private payers in addition to those for OHA. A strong desire was expressed by many to seek alignment with other quality reporting programs, and in particular to align the requirements of how the data is captured. The most notable example was language access and the measure specification requiring interpreters to be OHA certified. Organizations saw the intent to be good, but felt that including a specific certification type created unnecessary barriers. As one CCO respondent explained, *"There's a saying in colon cancer screening: among what's approved, which one is best? It's whichever one people will do! Apply that to interpreters. If you raise the bar so high, you lose an opportunity."* Another CCO respondent commented that when OHA does provide flexibility it creates a more collaborative, problem-solving environment. This respondent also shared that at times OHA measure specifications leave providers feeling like they are in a lose-lose situation.

> *If we exclude a provider because they are not on an EHR and therefore not keeping up with HIT, then we are no longer going to have a sufficient PCP base for our area to meet our access to care standard requirements… OHA has created this position where we have to include a provider that is technologically illiterate, but at the same time we cannot do anything about it because if we get rid of them, then we are not meeting our access to care. There's no way around it, no flexibility on the spectrum of their different policies.*

*"When it comes to the divide from intent into implementation there ends up being a loss…in order to see effective outcomes they need to be less prescriptive."*
*– CCO representative*

*"[The] language access measure is frustrating. Goes beyond national standards for interpreters' competence. Makes it difficult to achieve since they require OHA certification for interpreters."*
*– CCO representative*

*"For example, the SDOH metric is a bit more freeform, which is helpful for when we recognize a barrier, we can work with it. For the most part, it's been helpful to have flexibility."*
*– CCO representative*

## Additional Thoughts about Health Quality Measures

Regarding the current measure set, respondents had many ideas, but cautioned OHA to not make big changes too quickly. One committee member suggested that OHA develop *"a subset of health equity specific or priority measures"* to use alongside existing measures so as to provide continuity for providers.

To summarize, general respondent feedback included:

- Define how the agency will know, in an objective manner, when health equity has been achieved.
- Consider ways to account for differences in communities across the state.
- Greater utilization of nationally-recognized standards.
- Limit use of homegrown measures to those for which there is no existing, comparable standard.
- Focus on more outcome-based, clinical measures.
- Create space for flexibility in the measure set.
- Include more measures directed toward the primary cohort; i.e., adult OHA members.
- Create standardized data systems and processes.

Although recommendations regarding changes to the specific measures was not a component of this study, respondents across all groups (i.e., CCOs, CACs, committees) shared the following ideas for modifying the existing measures or adding measures:

- Wellness visits and/or annual exams (add additional measures)
- Preventive care (add additional measure)
- Pre-partum care (add additional measures)
- More behavioral health measures
- Modify smoking prevalence to a focus on reduction
- Social needs screening should be altered to match the national standard
- Remove OHA certification requirement on language access
- Split depression screening and follow-up
- Vaccine measure should be whether a vaccine was offered and counseled instead of received

## Measure Retirement

Regarding retirement of measures, respondents agreed that once a benchmark was more or less met it should be retired to allow for new measures. Many commented that continuing with a measure to pursue incrementally higher benchmarks in effect punishes those who performed well or had a very small margin for improvement while doing little for patients. Many were of the opinion that process measures should be retired more quickly, since once a process was in place there was almost no year-to-year opportunity for improvement. It was also suggested that some measures be retired on the basis of repeatedly small sample sizes, since such data is especially susceptible to random variation.

As noted above, however, the changing of measures can be overwhelming. Some respondents shared concern regarding how the measures shift from year to year, and that in doing so workflow is disrupted for providers and leads to metric fatigue. One committee member stated that *"The practicing clinician said that there is a shift from volume of care to quality of care. Instead of paying providers for meeting a quota, they are incentivized to meet certain standards, or measures. Yet, each year the measures change and can provide some significant challenges for the providers — workflow, etc. CCO metrics exist in an environment where the providers have metric fatigue…"*

*"We can't improve a certain thing forever up until 100%, there is no way. There will always be member choice and we are all humans. A more realistic goal is to create a genuinely achievable metric, not arbitrarily repeatedly raising the bar. We also need to be able to talk about retirement more frequently."*
*– CCO representative*

*"Yet, each year the measures change and can provide some significant challenges for the providers — workflow, etc. CCO metrics exist in an environment where the providers have metric fatigue…"*
*– Committee member*

## Earning Incentive Payments

Within both the Quality Pool and Challenge Pool, success is measured on the basis of CCO performance on individual measures. There are two means by which CCOs are deemed "successful," either by achieving a uniform benchmark set by OHA or by meeting an improvement target specific to each CCO's past performance. Organizations were asked about their experiences with both types of performance targets and how the use of these targets could be altered to focus on health inequities.

## Benchmarks

Respondents had mixed feelings regarding benchmarks. They acknowledged that benchmarks are essential to directing progress, but indicated some uncertainty with respect to how current benchmarks are set.

Whether accurate or not, the impression of some CCOs is that the level of change required to meet a benchmark is hard to achieve. For example, one CCO respondent noted that the amount of change requested in a year is extremely challenging. Instead of the current benchmark timeline, some health system partners shared a desire for benchmarks that do not change annually.

Other organizations also expressed that benchmarks were not always adjusted to what felt like an appropriate level. One CCO respondent explained, *"The selection of benchmarks is hotly contested. The way the committee determines measures – sometimes a routine conversation, sometime a contested conversation."* However, several respondents stated that although setting benchmarks was challenging, in general the current process worked. One CCO respondent explained, *"[the] benchmarks are necessary and informed by data."* Another CCO respondent added, *"In general, they are effective, it's how they have to measure it and it's the kernel that they can report back about."*

One committee member suggested combining measures, such that two or three measures could be grouped together and entities would need to succeed on all measures in the group to be considered successful. By coupling things such as basic preventive care for physical, mental, and dental health, providers will need to commit to more integrated care and communication.

Despite mixed feedback on the benchmark setting, common ground was found with respect to the actual performance data and how that could be used. One provider stated, *"The benchmarks themselves are not enough to address health equity."* A CCO respondent explained through the use of an example:

> *Yes, the benchmarks are important, but if you break it down by population, how are we actually doing with well-child visits? If we're only reaching the white kids but not the Latinx kids, are we actually improving equity? Let's not get rid of well-child checks, they're important, but let's figure out which populations these well-child visits are making a difference for. To me, that's a step towards eliminating health disparities. So yes, let's work with the benchmark, but not lose sight of the disparities we're trying to target.*

Others similarly echoed the desire to see and understand stratified clinical data rather than expecting health equity to come from overall benchmarks. For example, one committee member shared that *"From a health equity lens, OHA is not using data properly to show/analyze if they are transforming healthcare equitably amongst populations."*

*"When benchmarks come out that are very high, they struggle meeting them while doing everything else. Just too high, not that the measure is wrong."*
*– CCO representative*

*" …sometimes they're too easy, sometimes they're too high."*
*– CCO representative*

*"The benchmarks address the need of the OHP population as a whole. This is a diverse group – REALD has a lot of variety. It is hard to determine if they are all receiving equitable treatment. Setting the benchmarks is a step in the right direction, but still incomplete."*
*– Provider*

### Improvement Targets

The majority of respondents reported support for the inclusion of improvement targets, as well as OHA's use of the Minnesota method. Positive comments included:

- *"Improvement targets seem reasonable about what can change in a year." (CCO)*
- *"All of this is done very well. Like how the improvement targets are set, [it's] justifiable." (CCO)*
- *"In general, the improvement targets are good." (CCO)*

However, one CCO respondent explained how the improvement targets can have a negative side. *"These targets create unintended consequences because they don't necessarily encourage everyone to strive for the best every year because if you overperform, then you will have a very challenging year next year. It is very frustrating. We are expected to continue to improve a high outcome, and it can be very challenging. It happens to all CCOs with various metrics."*

Another CCO respondent expressed similar frustration with the improvement target calculation in that CCOs struggling the most with measures are also being asked to demonstrate much higher percentage improvement than those who already have processes in place. *"Somebody that's already struggling is required to make a drastic increases and improvement."* The respondent suggested that needing to achieve a significant increase to reach the performance threshold might turn a CCO off from putting in the effort. A possible solution to this could be the implementation of an improvement ceiling to allow for more incremental progress on measures.

# Program Operations

The final set of research questions focused on **program operations**.

- *What changes could be made to the measure calculations (including what baseline is used) so the program is primarily focused on addressing health inequities?*
- *What changes could be made to the program payment structure so the program is primarily focused on addressing health inequities (e.g., proportion of measures met to earn all funds, inclusion of a Challenge Pool worth extra funds, etc.)?*
- *What changes could be made to the program timeline so that it advances health equity?*

## Measure Calculation

Throughout the interviews, comments were provided on the measure calculation or the ways in which a measure is achieved. A predominant theme (also discussed above) was a desire for greater alignment between the specifications of OHA's measures and national measures. Many noted that national measures go through an extensive vetting process and are only approved after a substantial dataset is available from which to develop meaningful benchmarks. Respondents spoke positively on the QIP's use of both benchmark and improvement targets as a means to earn incentive payments and urged OHA to continue with both calculation approaches.

> *"Targets vs. benchmarks are great because not all parts of the state start at the same starting line, so it allows them as a CCO to continue improving."*
> *– CCO representative*

One CAC member suggested that OHA should be more active in data collection to ensure the integrity of calculations. Some respondents did not have thorough understanding of the measure calculations beyond speaking to benchmarks and improvement targets.

# Program Payment Structure

As noted above, CCOs can earn QIP incentive payments through two different pools: the Quality Pool and the Challenge Pool. To earn all of their Quality Pool funds, CCOs need to meet performance expectations on at least 75% of the measures. Any unearned Quality Pool funds are rolled into the Challenge Pool. The Challenge Pool provides funds for meeting performance expectations on a subset of prioritized measures.

## Quality Pool Payments

Respondents were asked about the 75% measure achievement threshold to earn Quality Pool payments. Some respondents were in support of the current measure achievement threshold, while others shared that it was a challenging to meet. For example, one CCO respondent shared that it is *"both reasonable and challenging."* Many commented that a 100% threshold was unrealistic, but having a goal greater than 50% was necessary. *"There's got to be an amount, they have to pick a number,"* was the general sentiment as summarized by a CCO respondent. Responses indicated that in general it felt like a number that was achievable, but not without effort.

A handful of respondents expressed concern that, as one CCO respondent stated, 75% *"might feel hard for CCOs to meet, especially if they are particularly hard measures."* One recommendation to remedy this challenge, put forth by a CCO respondent, was that the achievement level *"should be nuanced and specific to each county… [we have] only so much bandwidth to create quality improvement approaches. Some of the new measures have been larger scope – really big, collaborative, many part projects. It's reasonable to see a lot of improvement but not to improve on so many measures."*

> *"Disparities and access to care really vary among regions and CCOs, so finding a way to adjust for that and the meeting 75% of improvement targets to get 100% quality pool funds methodology is a way to minimally account for that some way, but trying to think about that in a more robust way is worth re-evaluating."*
> *– CCO representative*

## Challenge Pool Payments

Respondents had varying opinions on the structure of payments as related to the Challenge Pool. CCO respondents generally supportive commented that it was *"an elegant way to ensure that we use all the funds and reward well-functioning CCOs,", "It's a wildcard and fun," "[a] guide to which measures they need to prioritize,"* and *"good for pushing the needle."* However, some of those same organizations noted an uncomfortable tension where *"it creates a dynamic that others' failure leads to your success"* and that it was *"a little strange that it takes money from CCOs and gives it to other CCOs."*

Many organizations in support did, however, express that the selection committee members *"don't seem to have clear criteria on how the three to four measures for the challenge pool are selected"* (Committee Member). It was noted that the Challenge Pool measures in some years functioned better. While a year focused on adolescent care was good, some found it an odd choice because children are not the largest Medicaid cohort. Those in support of maintaining the Challenge Pool structure as is, with additional payments going to success on prioritized measures, appreciated the additional funds and focused set, but wanted more insight regarding the prioritization process.

Other respondents were in favor of alternative ways to distribute the Challenge Pool. These alternate approaches coalesced around additional support for underfunded CCOs and CCOs facing the greatest challenges. As one CCO respondent put it, OHA could *"potentially use the Challenge Pool as a more transformational bucket of funds."* One committee member suggested, *"To receive money should be conditional on the improvement of healthcare for those populations that are experiencing disparities. Communities/populations that are experiencing health disparities are the ones that should be incentivized."* This respondent took the Challenge Pool a step further and noted, *"All this money is*

*going to CCOs, but there are so many community organizations that work directly with OHP members, and help close these gaps. I would like to see a chunk of the money to not only go to CCOs, but also to these organizations."*

## Use of QIP Payments in Driving Health Equity

Respondents provided generally positive feedback about the value of incentive payments and the opportunities it provides. Many CCOs attested to returning incentive dollars to the providers responsible for care. For some CCOs this *"meant that we could fund behavioral health providers,"* or they could focus on *"hiring a role called a panel manager, [that] does population health,"* or they could set up *"peer support specialists, peer led peer run programs."* Others found success in *"leverage[ing] the QIP in value-based payment agreements that we have with providers. [It] creates buy-in, but also provides resources to providers to be able to do this work and change the infrastructure."*

One respondent felt that their CCO was choosing to focus their QIP funds on health equity, and that there is some trust that this funding was actually being dedicated to equitable healthcare. The chance for CCOs to manage their own QIP funds was seen as positive, especially when CCOs cover several different counties, which can have both concentrated and dispersed populations, and can be similar and different in many ways. One CAC member mentioned that, *"For example, from a Portland perspective we're viewed as a rural community, but the reality locally is more complex."*

The other frequent use of funds was community reinvestment. One CCO respondent stated they *"invest dollars in not just the metrics-specific work, but general community reinvestment to support healthcare system transformation and addressing health inequities."*

> *"These funds can be used to support providers in driving quality and equity improvement changes."*
> *– CCO representative*
>
> *"The funds have been extremely helpful and necessary as it has funded community work, which is in-line with social determinants of health."*
> *– CCO representative*

## Incentive Payment Operations

Among CCO respondents, a couple noted dissatisfaction not with the payments themselves, but how the payments are handled. *"It's so complicated and takes a long time to be received, so they can't even include it in their budget,"* was the critique of one provider. Another CCO respondent stated, *"they [OHA] have become increasingly prescriptive for how CCOs handle problems and how the QIP dollars can be spent. What we would like is for OHA to set out the intentions for the QIP dollars and what they are trying to accomplish."*

One CAC member expressed skepticism about the use of incentive payments, noting that they are not confident that the funds are invested in direct care. Other respondents noted that reserve funds are worrisome because they may divert healthcare funds into profit-taking activities and that they are, as one CAC member put it, *"attractive bait for takeover organizations from out of state, such as private equity/venture capital groups that look for big pension funds."* Because these reserve funds are big pots of money, respondents expressed concern that venture capitalists may take over a CCO or get a merger approved, resulting in the risk that reserve funds would not be used for what they were meant to be used for.

> *"One issue that OHA needs to confront is the dollar amount that these CCOs are putting into reserves instead of spending it on healthcare. …That's my biggest discomfort with CCOs – they're allowed to operate like private companies and allowed to use as profit."*
> *– CAC member*

While the vast majority of interviewees felt payments were helpful, a handful noted that in some cases it created an expectation or dangerous reliance on funds in budgeting recurring costs. As one CAC member stated, *"Sometimes clinics become really reliant on funds that come from incentive funds and think of it as their right. We can't raise the*

*standards because if they don't get the money from QIP then they can't provide quality care. They stop thinking about it as a quality payment and think about it instead of the bottom line of what they're providing."* Another CCO respondent mentioned, *"providers rely on what the QIP labels as 'bonus' dollars that are essential for these more rural counties."*

### Inability of Payments to Address the Problem

For a subset of respondents, the incentive payments were appreciated, but the opinion was that key health equity issues were tied to social factors without any apparent solution. As one CAC member explained, *"Lack of providers is tied to the housing issue; there are no houses to rent/ buy, and no land, and there are no contractors to build on the land even if you can purchase land. The issue is layered beyond lack of providers or that contributes to a lack of providers/healthcare access."*

## Changes to the Program Timeline to Advance Health Equity

Though this study did not directly ask respondents about the program's timeline, they provided input on this topic. However, commentary regarding the program's timeline did not always directly connect to advancing health equity. Rather, it was more focused on the impact the timeline has on how they manage and respond to the requirements of the QIP. For example, one provider noted that there are too many measures to track and that switching metrics each year complicates the QIP program functioning and processes.

Another CCO respondent commented, *"Sometimes updated measure specs haven't historically come out with enough lead time. [They] sometimes come out after the first of the year. CCO and providers need to adjust, to be able to get ready."* Additional reflections that CCOs and providers need more time to:

- receive training on the measures,
- learn ways to use the measures effectively, and
- receive additional support and guidance from OHA to properly screen and use the required measures.

Time related to other QIP-specific and programmatic processes were also discussed by interview respondents. For example, some respondents said that payouts to CCOs were slow to come; and that if the payout process was expedited, it would improve the overall QIP goals and outcomes. Timelines related to patient care were also discussed, including the need for providers to be credentialed with payers, which can take up to four months post hire, before they are allowed to see patients. These delays contribute to access barriers and they negatively impact care. Respondents requested that this process needs to be faster, because not doing so delays care and unnecessarily harms patients.

# Recommendations and Next Steps

## Recommendations Based on OHP Member and Health System Partner Feedback

The recommendations put forth by the research team for this study were garnered from feedback, thoughts, ideas, and recommendations provided by respondents themselves, that is, OHP members, CBOs/providers, committee members, and CCOs. Recommendations are placed in lists that correspond to a given topic area. The recommendation topic areas, in no particular order, are as follows:

- OHP member representation and support
- clear and open communication
- public comment
- OHP member feedback and community feedback
- OHP member and community education
- measure selection process.

Throughout the recommendation lists, OHP member as well as health system partner recommendations were represented, with the exception of the Measure Selection Process list. This is due to the fact that questions regarding the measure selection process were not asked of OHP members (as outlined in the methodology section of this report). Notably, one recommendation found in the OHP Member Representation and Support list requires a legislative change (highlighted in ***bold italics***). All other recommendations found throughout this section of the report do not require a legislative change, but will need to be implemented by OHA or the Metrics and Scoring Committee.

### OHP Member Representation and Support

- ***Greater representation of OHP members and CBO representatives on the Metrics and Scoring Committee who also represent diverse needs and perspectives (e.g., from different regions, urban to rural).***
  - Hearing from and about the lived experiences of members would contribute significantly to the development and selection of metrics and would highlight the healthcare needs of members throughout the state.
  - Elevating their voice and input would have weight and influence on health equity improvement decisions.
- Provide mentorship of members to support their voice within the QIP. For example, have peer mentors who would actively work with OHP members and support them in having Metrics and Scoring Committee seats.
- Establish an OHP member board to support more representation and participation with the QIP.

## Clear and Open Communication

- Continue and deepen the transparent communication between OHA and members, and those members who may serve on committees or provide input (e.g., liaisons and innovator agents). This would support member voice and choice when making their own healthcare decisions.
- Follow-up and regular reporting out by the committees, CCOs, and OHA.
- Increased mechanisms of communication and outreach with OHP members and CACs.
- More OHP member involvement with and representation on OHA committees and within the governance structure more broadly.
- Committee members who are also OHP members should be (a) paid for their service, while ensuring compensation does not affect their benefits eligibility; (b) explicitly told how, where, and why their voices are needed; and (c) informed about what OHA will do with the information and perspective they provide, supporting an increased focus on health disparities and health equity.
- More consistent, clear, and ongoing communication between members, the Metrics and Scoring Committee, and OHA. Better communication with members to get them more involved with the QIP and its processes.
- More open and transparent communication from OHA about the feedback they receive from community members and explanations for why something can, or cannot, be implemented.
- More clear communication from the Metrics and Scoring Committee on the decision-making process for measures. This includes clarifying fine details of specific issues and more open discussion and interaction opportunities.
- Publicize information more in ways that are easy to find to help ensure that communication is more effective.
- Create OHA and Metric and Scoring Committee "office hours" where individuals can ask questions of people who have the answers.

## Public Comment

- Provide additional support for members with providing public comment, including:
  - more information ahead of time, particularly about the issues being discussed by the Metrics and Scoring Committee.
  - notification in advance of when there is an opportunity to give public testimony, as well as details about where and how to do so.
- Ensure that the opportunities to give public comment are more accessible and varied, including:
  - opportunities for anonymous or confidential of sharing feedback, such as by email, text, online form, or phone call.
  - an environment welcoming and comfortable
  - use of plain language, an openness to all voices being heard, accessible locations, and convenient times.
- Follow up on public testimony efforts in order to feel comfortable giving public comment, members need to see evidence that previous testimony was taken seriously and made an impact on the committee's decision making.
- Provide summaries of discussions related to testimonials, that are then shared with community members.
- Include more discussion time that is not a formal part of providing public testimony.

## OHP Member and Community Feedback

- More surveys as a mechanism for providing feedback on QIP. Members want surveys that provide information, ask for feedback, and are widely available to all OHP members (i.e., online, over the phone, and in clinics)
- Engage with the community through town halls, events, and meetings so that members feel safe, build trust, are heard, and have time to openly share feedback and talk about their experiences. (L)
- Provide avenues for members to rate the services they receive through patient outcome reports and to provide regular feedback.
- Creation of a plan outlining how member voices are being utilized, how community voice will be collected, and how OHA will engage with the community.

## OHP Member and Community Education

- More education in general (not just for public comment) and outreach for members. This study revealed that OHP members did not know that the QIP exists and that OHA is interested in their feedback.
- Conduct educational outreach in the community to inform about program outcomes.
- Education materials for OHP members need to not be at *"a professional level"* because this can lead to exclusion.

## Measure Selection Process

- More collaboration is needed across all QIP entities when selecting measures and clear communication about how to implement them within various types of communities, clinics, and CCOs across the state should be included.
- Extend timeline for changing metrics to no less than two years. The annual switching of metrics and having numerous measures that need to be tracked can complicate the QIP functioning and processes.
- Hold more open Metrics and Scoring Committee meetings that provide opportunities to ask questions or allow for follow up conversations.
- Allow more time for providing feedback on measure selections. The timing of when QIP's decisions are communicated to the CCOs is so late compared to the work being done, that having a longer "runway" to provide input about QIP decisions, process, and measures would offer more opportunities to engage and help craft measures.

# Next Steps

Next steps for understanding the current QIP's outcomes and evaluating its current and future effectiveness for ensuring equitable health outcomes for OHP members, might include several things. Due to the very tight timeline for undertaking the work of this current study, the study team did not have time to analyze and present OHP member data beyond basic frequencies. That said, it would be interesting to compare member responses based on, for example, geographical living location of members, and based on their race/ethnicity, gender identity and sexual orientation, and age. Also, as noted in the OHP Member Feedback section of this report, the data revealed an apparent mismatch between OHP member identification of their CCO and their zip code. For example, a respondent may have selected the Eastern Oregon CCO, but listed a zip code in northwest Oregon. Further analyses will be conducted to determine how common this mismatch was, identify any potential patterns, and consider other data,

such as how long participants had been on OHP, to identify factors that contributed to the mismatch.

Beyond collecting information from OHP members with a survey, given the complexity of the QIP, it would also be helpful to have more time with members to provide more information about the QIP before asking them questions about the program. This could be done through individual interviews or focus groups, either in-person or online.

Hearing from more providers, those who practice in various sectors of health, including behavioral health, who are connected to varying CCOs and/ or community-based clinics and organizations throughout the state, would lend additional feedback about the QIP governance structure, the metrics used to assess care, and the programmatic operations of the QIP as it affects providers. The current study of the QIP had insufficient time to obtain feedback from various types of providers throughout the state.

In addition, as these preliminary results are shared with relevant OHA committees, offices, and groups, additional areas of focus and study will be addressed, as feasible.

# Appendix A: 2024 QIP Incentive Measures

1. ***Childhood Immunization Status (Combo 3):*** Percentage of children that turned 2 years old during the measurement year and had the Dtap, IPV, MMR, HiB, HepB, VZV, and PCV vaccines by their second birthday.

2. ***Immunizations for Adolescents (Combo 2):*** Percentage of adolescents that turned 13 years old during the measurement year and had the meningococcal, Tdap, and HPV vaccines by their 13th birthday.

3. ***Child and Adolescent Well-Care Visits (incentivized for children ages 3-6, kindergarten readiness):*** Percentage of children ages 3 to 6 that had one or more well-child visits with a PCP during the measurement year.

4. ***Prenatal & Postpartum Care - Postpartum Care:*** Percentage of deliveries of live births between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.

5. ***Screening for Depression and Follow-Up Plan:*** 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 the eligible encounter.

6. ***Health Aspects of Kindergarten Readiness:*** CCO System-Level Social-Emotional Health: The aim of this measure is that children from birth to age 5, and their families, have equitable access to services that support their social-emotional health and are the best match for their needs. The measure has four components: 1) Social-Emotional Health Reach Metric Data Review and Assessment 2) Asset Map of Existing Social-Emotional Health Services and Resources 3) CCO-Led Cross-Sector Community Engagement 4) Action Plan to Improve Social-Emotional Health Service Capacity and Access.

7. ***Cigarette Smoking Prevalence:*** Percentage of Medicaid members (ages 13 and older) who currently smoke cigarettes

8. ***Alcohol and Drug Misuse:*** Screening, Brief Intervention and Referral for Treatment (SBIRT): Percentage of patients ages 12 years and older who received an age-appropriate screening and, of those with a positive full screen, percentage who received a brief intervention or referral to treatment.

9. ***Members Receiving Preventive Dental or Oral Health Services, ages 1-5 (kindergarten readiness) and 6-14:*** Percentage of enrolled children ages 1-5 (kindergarten readiness) and 6-14 who received a preventive dental or oral health service during the measurement year

10. ***Oral Evaluation for Adults with Diabetes:*** Percentage of adults with diabetes who received at least one oral evaluation within the reporting year.

11. ***Assessments for Children in ODHS Custody:*** Percentage of children ages 0-17 who received a physical health assessment, children ages 1-17 who received a dental health assessment, and children ages 3-17 who received a mental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care).

12. ***Comprehensive Diabetes Care:*** Hemoglobin A1c (HbA1c) Poor Control (>9.0%): Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.

13. ***Initiation and Engagement of Substance Use Disorder Treatment:*** Initiation and Engagement of Substance Use Disorder Treatment.

14. ***Health Equity Measure:*** Meaningful Language Access to Healthcare Services for persons with limited English proficiency: The proportion of visits with spoken and sign language interpreter needs that were provided with OHA qualified or certified interpreter services.

15. ***Social Determinants of Health: Social Needs Screening & Referral:*** To build system capacity, this measure requires CCOs to (1) prepare for equitable, trauma-informed, and culturally responsive screening and referrals, (2) work with community-based organizations to build capacity for referrals and meeting social needs, and (3) support data sharing between CCOs, providers, and community-based organizations. Later, CCOs start reporting social needs screening and referral data.

# Appendix B: Data Collection Instruments

Included in this appendix are:

- OHP Member Feedback Survey (paper version, identical web survey content)
- CCO Representative Interview Guide
- Provider Interview Guide
- Committee Interview Guide

## OHP Member Feedback Survey

Welcome to the OHP Member Feedback Survey! The goal of this survey is to better understand what OHP members think is important to fully support their health and wellness. For this survey, **health** can involve physical health, mental health, dental health, and addiction for you or members of your family.

We are a team of researchers at Portland State University. We are working with the Oregon Health Authority (OHA). OHA is an agency that oversees healthcare throughout Oregon. Together, we hope to gather information that will help make changes to rules and state laws to better serve OHP members throughout Oregon.

One of OHA's goals is to make sure that the health system creates health equity. Health equity means the highest level of health for all people. It means that everyone has a fair and just opportunity to reach their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, income, geography, preferred language, or anything else that affects access to care and health outcomes.

The survey will take you about 20-30 minutes to complete. We provide quite a bit of background information for you to read. The healthcare system is complex, so we hope this information is helpful.

The survey is voluntary. You can decide what you tell us. You can stop at any time, and you can skip any question you don't want to answer.

We will keep the information you tell us confidential. We will not share your individuals answers with anyone outside of the research team.

After we gather all of the surveys, we will review all the data and prepare a report that summarizes the findings from everyone who contributed. Your name or identity will NEVER be tied to your responses in any way.

After doing the survey, you can give us your contact information in a separate form, so we can send you a $50 Amazon or Safeway gift card to thank you for your time!

If you have any questions about this survey, please contact Keisha Muia (muia @pdx.edu) or Mary Oschwald (oschwald@pdx.edu).

## Your Healthcare Coverage and Experiences as an OHP Member

**0. Are you currently on the Oregon Health Plan (OHP) or have you been on OHP in the last six months?**

- ○ Yes
- ○ No → ***Thank you for your interest, but we are only surveying people currently or recently on OHP.***

**0.0 Are you 18 years old or older?**

- ○ Yes
- ○ No → ***Thank you for your interest, but we are only surveying people who are at least 18 years of age.***

**1. How long have you been on the Oregon Health Plan (OHP)? OHP is Oregon's medical assistance program. It provides healthcare coverage for people from all walks of life.**

- ○ Less than 1 year
- ○ 1 year to less than 2 years
- ○ 2 to 3 years
- ○ 4 to 5 years
- ○ More than 5 years
- ○ Don't know
- ○ Prefer not to answer

Oregon has 16 Coordinated Care Organizations (CCOs) that manage healthcare for OHP members. CCOs function like insurance companies. Each CCO is a network of all types of healthcare providers (medical, dental, mental health, addictions) who have agreed to work together in their local communities to serve people on OHP.

**2. Please read through the following list and select the CCO you are currently a member of. If you are unsure, your CCO should be listed on your OHP card.** *[select ONLY one]*

- ○ Advanced Health
- ○ AllCare CCO
- ○ Cascade Health Alliance
- ○ Columbia Pacific CCO
- ○ Eastern Oregon CCO
- ○ Health Share of Oregon
- ○ InterCommunity Health Network CCO
- ○ Jackson Care Connect
- ○ PacificSource Community Solutions – Central Oregon Region
- ○ PacificSource Community Solutions – Columbia Gorge Region
- ○ PacificSource Community Solutions – Lane
- ○ PacificSource Community Solutions – Marion/Polk
- ○ Trillium Community Health Plan – Southwest
- ○ Trillium Community Health Plan – Tri-County
- ○ Umpqua Health Alliance
- ○ Yamhill Community Care
- ○ Don't know
- ○ Prefer not to answer

**3. Overall, how often are you able to get all of your and your family's health and wellness needs met through OHP?**

| 1 | 2 | 3 | 4 | 5 | ○ |
|---|---|---|---|---|---|
| Never | Rarely | Sometimes | Often | Always | Don't know |

**4. In the last year, have any of these things made it difficult for you to meet your or your family's healthcare needs?** *[select ALL that apply]*

- ☐ Can't find a provider
- ☐ Clinic/office is not accessible
- ☐ Costs are too expensive (co-pays, prescriptions, etc.)
- ☐ Facilities are too far away
- ☐ Insufficient coverage
- ☐ Lack of accommodations for disability(ies)
- ☐ Lack of available appointments
- ☐ Lack of transportation
- ☐ Lack of time
- ☐ No one spoke my language
- ☐ Something else *[please specify]*:_____
  _____
- ☐ None

| When making decisions about your healthcare, how frequently are each of the following true? *[circle ONLY one rating each]* | Never True | Rarely True | Sometimes True | Often True | Always True | Don't know |
|---|---|---|---|---|---|---|
| **5. I have all of the information I need.** | 1 | 2 | 3 | 4 | 5 | ○ |
| **6. My healthcare providers help me understand my choices.** | 1 | 2 | 3 | 4 | 5 | ○ |
| **7. I feel listened to.** | 1 | 2 | 3 | 4 | 5 | ○ |

| In the past 12 months, has a doctor, nurse, dentist, or counselor ever: *[select ONLY one rating each]* | Yes | No | Don't know |
|---|---|---|---|
| **8. acted as if they think you are not smart?** | ○ | ○ | ○ |
| **9. acted as if they are afraid of you?** | ○ | ○ | ○ |
| **10. acted as if they are better than you?** | ○ | ○ | ○ |
| **11. not listened to what you say?** | ○ | ○ | ○ |

If you answered Yes to any of these questions, please tell us more about your experiences. _____

_____

_____

## Making Decisions about High Quality Care for OHP Members

The State of Oregon pays CCOs to manage healthcare for OHP members. The State also gives CCOs payments to encourage them to provide the highest quality care. This year, the state will give CCOs over $300 million in bonus payments. A group called the **Metrics and Scoring Committee** sets goals each year for the CCOs to meet. This Metrics and Scoring Committee identifies important health outcomes and ways to measure them. A health outcome is something that tells us how well healthcare is helping people. An example of a health outcome is that the majority of children get at least one well-child visit each year. The Metrics and Scoring Committee decides what high-quality care is and how well CCOs have to perform to earn bonus money.

Oregon state law decides who gets to be on the Metrics and Scoring Committee and how bonus money is given out. The Committee is made up of:

- three experts in measuring health outcomes,
- three people from CCOs, and
- three people who fill "at large" positions, which means they are open to anyone.

The following questions ask for your feedback about what's important to you as an OHP member. This information will be used to identify ways to change the laws about how the Metrics and Scoring Committee works and how bonus money is given out.

**12. How much do you agree that the Metrics and Scoring Committee members listed above can make decisions about what you need and want for high quality healthcare?**

| 1 | 2 | 3 | 4 | 5 | ○ |
|---|---|---|---|---|---|
| Do not agree at all | Slightly agree | Somewhat agree | Moderately agree | Completely agree | Don't know |

| In your opinion, how important is it for the Metrics and Scoring Committee to include… *[circle ONLY one rating each]* | Not at all important | Slightly important | Somewhat important | Moderately important | Very important | Don't know |
|---|---|---|---|---|---|---|
| **13. experts in measuring health outcomes?** | 1 | 2 | 3 | 4 | 5 | ○ |
| **14. people from CCOs?** | 1 | 2 | 3 | 4 | 5 | ○ |
| **15. people from community-based organizations that serve OHP members?** | 1 | 2 | 3 | 4 | 5 | ○ |
| **16. OHP members?** | 1 | 2 | 3 | 4 | 5 | ○ |

**17. In your opinion, should anyone else be on the Metrics and Scoring Committee?** _____

_____

**17a. Please tell us why you think those additional people should be on the Metrics and Scoring Committee.**

_____

_____

The Metrics and Scoring Committee sets the ***overall goals*** for each of the health outcome measures that CCOs must reach to get bonus money. Those goals are set to reward high quality care. Right now, there are 15 outcome measures that CCOs must track to possibly earn the bonus money. Some examples, along with the goals, are:

- Percentage of children who have all their necessary immunizations by their second birthday. (Goal=68% or more OHP children served)
- Percentage of children ages 3 to 6 years who had one or more well-child visits in a year. (Goal=70% or more OHP children served)
- Percentage of people ages 18 to 75 years who had poor control of diabetes. (Goal=21% or fewer OHP members, lower percentage is better)

**18. How much do you agree that this approach will result in high-quality healthcare for OHP members?**

| 1 | 2 | 3 | 4 | 5 | ○ |
|---|---|---|---|---|---|
| Do not agree at all | Slightly agree | Somewhat agree | Moderately agree | Completely agree | Don't know |

When CCOs are not able to meet an overall goal for an outcome measure, the Committee sets ***improvement targets*** for them. These targets are meant to help CCOs gradually improve each year. For example, if the goal for well-child visits is set at 70% (70 out of 100), but one CCO is only at 25%, their target might be set at 30% of OHP children served. Each CCO will have improvement targets for any outcome measure that they are not able to meet the overall goal.

**19. How much do you agree that improvement targets will result in high-quality healthcare for OHP members?**

| 1 | 2 | 3 | 4 | 5 | ○ |
|---|---|---|---|---|---|
| Do not agree at all | Slightly agree | Somewhat agree | Moderately agree | Completely agree | Don't know |

## Payments to CCOs for Reaching Healthcare Quality Goals

CCOs currently get the same amount of bonus money for reaching overall goals or improvement targets for each of the health outcome measures. For example, imagine that $1 million is the amount of bonus money a CCO can receive for reaching a health outcome's goal. One CCO meets the overall goal of 70% of OHP children getting a well-child visit, so they get $1 million. Another CCO meets their improvement target of 30% of OHP children getting a well child visit, so they also get $1 million.

**20. How much do you agree that CCOs should be paid the same amount of bonus money, whether they reach the overall goals or their improvement targets?**

| 1 | 2 | 3 | 4 | 5 | ○ |
|---|---|---|---|---|---|
| Do not agree at all | Slightly agree | Somewhat agree | Moderately agree | Completely agree | Don't know |

Currently, CCOs can earn all of the bonus money, even if they don't reach all of the goals or improvement targets set by the Committee. CCOs only need to reach the goals or improvement targets for 75% or three-quarters of the health outcome measures the Metrics and Scoring Committee picked. For example, this year the Metrics and Scoring Committee picked 15 health outcome measures for CCOs to focus on. If a CCO reaches the goal or improvement target for at least 12 of these, they are paid all the bonus money.

**21. How much do you agree that CCOs should be paid all the bonus money for meeting the goals or improvement targets for 75% of the health outcome measures?**

| 1 | 2 | 3 | 4 | 5 | ○ |
|---|---|---|---|---|---|
| Do not agree at all | Slightly agree | Somewhat agree | Moderately agree | Completely agree | Don't know |

After OHA has given out the bonus money, any leftover money goes into something called the ***"Challenge Pool."*** The Metrics and Scoring Committee picks three or four of the health outcome measures they think are the most important. Money from the Challenge Pool is paid to CCOs who reach the goal for these health outcome measures. If a CCO did not earn all of its bonus money, the Challenge Pool may help them earn some of it back. Even if a CCO earned all of their bonus funds, they can still earn extra money from the Challenge Pool.

**22. How much do you agree that CCOs should be paid additional bonus money for meeting the goals for priority health outcome measures?**

| 1 | 2 | 3 | 4 | 5 | ○ |
|---|---|---|---|---|---|
| Do not agree at all | Slightly agree | Somewhat agree | Moderately agree | Completely agree | Don't know |

**23. If you were on the Metrics and Scoring Committee, what health outcome measures would you want to include? This can be anything that relates to physical health, mental health, dental health, addiction, and social wellness.** _____

_____

_____

## Community Engagement

Anyone can give input to inform the Metrics and Scoring Committee's decisions. This input is also called ***"public comment."*** Public comment can be made during video meetings or sent by email two days before the meeting.

**24. How familiar are you with giving public comments to a state committee?**

| 1 | 2 | 3 | 4 | 5 | ○ |
|---|---|---|---|---|---|
| Not at all familiar | Slightly familiar | Somewhat familiar | Moderately familiar | Completely familiar | Don't know |

**25. How much do you agree that public comments would have an impact on the Metrics and Scoring Committee's decisions?**

| 1 | 2 | 3 | 4 | 5 | ○ |
|---|---|---|---|---|---|
| Do not agree at all | Slightly agree | Somewhat agree | Moderately agree | Completely agree | Don't know |

**26. Have you previously given public comment to a state committee?**

- ○ Yes *[answer #26a-#26g]*
- ○ No *[skip to #27]*
- ○ Don't know *[skip to #27]*

**26a. What state committee(s) did you give public comment to?** _____

_____

**26b. How comfortable were you giving public comment?**

| 1 | 2 | 3 | 4 | 5 | ○ |
|---|---|---|---|---|---|
| Not at all comfortable | Slightly comfortable | Somewhat comfortable | Moderately comfortable | Completely comfortable | Don't know |

**If you were not completely comfortable, what was uncomfortable about giving public comment?**

_____

_____

**26c. How much do you agree that your public comment informed the committee's decision?**

| 1 | 2 | 3 | 4 | 5 | ○ |
|---|---|---|---|---|---|
| Do not agree at all | Slightly agree | Somewhat agree | Moderately agree | Completely agree | Don't know |

**26d. After giving public comment, did your trust in the committee:**

- ○ Increase
- ○ Decrease
- ○ Stay the same
- ○ Don't know

**26e. How likely are you to give public comment again?**

| 1 | 2 | 3 | 4 | 5 | ○ |
|---|---|---|---|---|---|
| Not at all likely | Slightly likely | Somewhat likely | Moderately likely | Completely likely | Don't know |

**26f. What helped prepare you to give public comment?** _____

_____

_____

**26g. What else would you like to share about your experience giving public comment?** _____

_____

_____

**27. What would make it easier for you to give public comment to a committee?** _____

_____

_____

**28. Besides public comment, are there other ways you think OHP members could inform decisions about the bonus program?** _____

_____

_____

**29. What other comments or suggestions do you have about how decisions should be made for the bonus program?** _____

_____

## Final Set of Questions

In order to understand the needs, experiences, and beliefs of different communities throughout Oregon, we ask you to provide some information about yourself. You can skip any questions that you don't feel comfortable answering. Remember, we will protect your information and privacy.

**30. What is your 5-digit ZIP code?** _____

**31. In what month and year were you born?** _____/_____
month / year

**32. What is your gender?** *[select ALL that apply]*

- ☐ Girl or woman
- ☐ Boy or man
- ☐ Non-binary
- ☐ Agender/No gender
- ☐ Genderfluid
- ☐ Genderqueer
- ☐ Questioning
- ☐ Not listed, my gender is: _____
- ☐ I have a gender identity not listed here that is specific to my ethnicity: _____
- ☐ Don't know
- ☐ Don't know what this question is asking
- ☐ Don't want to answer

**33. Are you transgender?** *[select only ONE]*

- ○ Yes
- ○ No
- ○ Questioning
- ○ Don't know
- ○ Don't know what this question is asking
- ○ Don't want to answer

**34. What is your sex?** *[select only ONE]*

- ○ Female
- ○ Male
- ○ Intersex
- ○ Don't know
- ○ Don't want to answer
- ○ Not listed, my sex is:

_____

**35. Describe your sexual orientation or sexual identity in any way you prefer:**

_____

**36. What is your sexual orientation?** *[select ALL that apply]*

- ☐ Same-gender loving
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Pansexual
- ☐ Straight (attracted mainly to or only to other gender(s) or sex(es))
- ☐ Asexual
- ☐ Queer
- ☐ Questioning
- ☐ Not listed, my sexual orientation is:

_____

- ☐ Don't know
- ☐ Don't know what this question is asking
- ☐ Don't want to answer

**37. Do you use a language other than English at home?** Select **one.**

- ○ No *[skip to question 38]*
- ○ Yes
- ○ Don't know *[skip to question 38]*
- ○ Don't want to answer *[skip to question 38]*

**37a. What language(s) do you use at home?**

_____

**38. How well do you speak English?**

| ○ | ○ | ○ | ○ | ○ | ○ |
|---|---|---|---|---|---|
| Very well | Well | Not well | Not at all | Don't know | Don't want to answer |

**39. How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?**

_____

**40. What is your race and/or ethnicity? Select all that apply and enter additional details below.**

**American Indian and Alaska Native**

☐ American Indian
☐ Alaska Native
☐ Canadian Inuit, Metis or First Nation
☐ Indigenous Mexican, Central or South American
☐ Enter details (Coquille Indian Tribe, Confederated Tribes of Coos, Aztec, Maya, etc.)_____
_____

**Asian**

☐ Afghan
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Communities of Myanmar
☐ Filipino/a
☐ Hmong
☐ Indonesian
☐ Japanese
☐ Korean
☐ Laotian
☐ Pakistani
☐ South Asian
☐ Taiwanese
☐ Thai
☐ Vietnamese
☐ Enter details (Mongolian, Malaysian, Uzbeks, etc.)
_____

**Black and African American**

☐ African American
☐ Afro-Caribbean
☐ Ethiopian
☐ Haitian
☐ Jamaican
☐ Nigerian
☐ Somali
☐ Enter details (Trinidadian, Ghanaian, Congolese, etc.) _____

**Hispanic and Latino/a/x/e**

☐ Afro-Latino/a/x/e
☐ Central American
☐ Cuban
☐ Dominican
☐ Guatemalan
☐ Mexican
☐ Puerto Rican
☐ Salvadoran
☐ South American
☐ Enter details (Colombian, Honduran, Spaniard, etc.)
_____

**Jewish**

☐ Ashkenazi
☐ Sephardi
☐ Enter details (Mizrahi, etc.) _____
_____

**Middle Eastern/Northern African**

☐ Egyptian
☐ Iraqi
☐ Iranian
☐ Israeli
☐ Lebanese
☐ Palestinian
☐ Syrian
☐ Turkish
☐ Enter details (Moroccan, Yemeni, Kurdish, etc.)
_____

**Native Hawaiian or Pacific Islander**

☐ CHamoru/Chamorro
☐ Communities of the Micronesian Region
☐ Fijian
☐ Marshallese
☐ Native Hawaiian
☐ Samoan
☐ Tongan
☐ Enter details (Chuukese, Palauan, Tahitian, etc.)
_____

**White**

☐ English
☐ Irish
☐ Italian
☐ German
☐ Polish
☐ Romanian
☐ Russian
☐ Scottish
☐ Slavic
☐ Ukrainian
☐ Enter details (French, Swedish, Norwegian, etc.)
_____

**Other Categories**

☐ Another category not listed. Specify: _____
_____
☐ Don't know *[skip to question 42]*
☐ Don't want to answer *[skip to question 42]*

**41. If you checked more than one category, is there one you think of as your primary racial or ethnic identity?** *[select only ONE]*

○ Yes. Please circle your primary racial or ethnic identity above.
○ I don't have just one primary racial or ethnic identity.
○ No. I identify as Biracial or Multiracial.
○ N/A. I only checked one category above.
○ Don't know
○ Don't want to answer

**42. Are you deaf or do you have serious difficulty hearing?**

- ○ Yes → **This condition began at age: _____**
- ○ No
- ○ Don't know
- ○ Don't want to answer

**43. Are you blind or do you have serious difficulty seeing, even when wearing glasses?**

- ○ Yes → **This condition began at age: _____**
- ○ No
- ○ Don't know
- ○ Don't want to answer

**44. Do you have serious difficulty walking or climbing stairs?**

- ○ Yes → **This condition began at age: _____**
- ○ No
- ○ Don't know
- ○ Don't want to answer

**45. Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?**

- ○ Yes → **This condition began at age: _____**
- ○ No
- ○ Don't know
- ○ Don't want to answer

**46. Do you have difficulty dressing or bathing?**

- ○ Yes → **This condition began at age: _____**
- ○ No
- ○ Don't know
- ○ Don't want to answer

**47. Do you have serious difficulty learning how to do things most people your age can learn?**

- ○ Yes → **This condition began at age: _____**
- ○ No
- ○ Don't know
- ○ Don't want to answer

**48. Using your usual (customary) language, do you have serious difficulty communicating (for example understanding or being understood by others)?**

- ○ Yes → **This condition began at age: _____**
- ○ No
- ○ Don't know
- ○ Don't want to answer
- ○ Don't know what this question is asking

**49. Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?**

- ○ Yes → **This condition began at age: _____**
- ○ No
- ○ Don't know
- ○ Don't want to answer

**50. Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?**

- ○ Yes → **This condition began at age: _____**
- ○ No
- ○ Don't know
- ○ Don't want to answer

**51. If you identify as someone with a disability, or as having a physical, mental, emotional, cognitive, or intellectual condition, what would you like us to know? _____**
**_____**

**51a. At what age did you first identify as having a disability? _____**

*[If Yes was <u>not</u> selected for <u>all</u> questions 42-50 and question 51 does not apply to you, skip to question 53.]*

**52. Do you need or want disability-related accommodations?**

- ○ Yes
- ○ No

**52a. If Yes, please specify the type of accommodations desired: _____**

**53. What is the highest level of education you have completed?** *[select only ONE]*

- ○ Grade 1 through 11 *[specify grade:]*_____
- ○ High school diploma or GED
- ○ Some college, but no degree
- ○ Associates degree (2-year degree)
- ○ Bachelor's degree (4-year degree)
- ○ Graduate or professional degree
- ○ Trade school / certification program
- ○ Something else *[please specify:]* _____
- ○ Don't know
- ○ I don't want to answer

**54. Do you…**

- ○ Own your home
- ○ Rent your home
- ○ Live with family or friends without paying rent
- ○ Have no housing or unstable housing
- ○ Other *[please specify:]* _____
- ○ Don't know
- ○ Don't want to answer

**Thank you for your time and your feedback. If you would like us to send you a $50 Amazon or Safeway gift card, please complete the Gift Card Form.**

# CCO Representative Interview Guide

**Introduction:**
Thank you for being willing to participate in this valuable study that we are conducting in partnership with the Oregon Health Authority's (OHA) Office of Health Analytics. The purpose of the study is to better understand how the Quality Incentive Program for CCOs might be better aligned with OHA's goal of eliminating health inequities by 2030.

For this study, we are collecting data from a variety of people including CCO administrators, committee members (e.g., representatives from the Community Advisory Council), OHP providers, and OHP members. In today's interview, we will be asking you about your experiences with the Quality Incentive Program and your perspective on how effectively the program is addressing health inequities. The findings and recommendations from this study will be presented to the state legislature later this year.

This discussion may take up to an hour, depending on how much you have to share. Again, we appreciate your willingness to help us out with our study.

**Informed Consent:**
Prior to beginning the discussion, it is important for me to review what's involved so you can fully consent to participation. Based on this information, if you do not want to participate, that is completely fine, and we appreciate your willingness to consider it.

- Participating in this interview is voluntary. You can be selective in what you tell us. You can stop at any time, and you can skip any question you don't want to answer. Your choice to do the interview or not will not affect your relationship with OHA, Portland State University, or any other organizations you are involved with.
- If you change your mind later and do not want us to include your feedback, you can let us know. We will remove your answers.
- We will keep the information you tell us confidential. We will not share your individual answers with anyone outside the evaluation team.
- We expect that there is minimal to no risk for you participating in this interview. One possibility is that you may feel uncomfortable sharing your thoughts and feedback about the Quality Incentive Program or OHA in general.
- After we complete all of the interviews, we will review all the data and prepare a report for OHA that summarizes the findings from everyone who contributed. Your name or identity will NEVER be tied to your responses in any way.

Do you have any questions before we begin? *[Address any questions they have the best you can. Otherwise, note other questions and we will follow-up later.]*

To simplify things, throughout this interview we will refer to the Quality Incentive Program for CCOs as "the Incentive Program."

1. I'd like to start by asking: what is your role at this CCO? *[If more than one person is being interviewed, ask each person.]*

2. Before we focus on the Incentive Program,
   a. What does health equity mean for your organization?
   b. Based on the data you have, what health inequities currently exist for your members?

3. How involved are you in the Incentive Program?

a. *[If not at all or minimally involved:]* How familiar are you with that program?
b. *[If applicable:]* What is your understanding of the goal or purpose of the Incentive program/payments?

4. How has the Incentive Program affected your organization's ability to address health inequities for OHP members?
   a. *[If not specifically mentioned:]* How do you think the Incentive Program could be more aligned with OHA's goal of eliminating health inequities among OHP members?
   b. *[If not specifically mentioned:]* What are some ways your providers have addressed health inequity among the OHP members they serve?

5. Now I'd like to talk about some of the features of the Incentive Program. How well have the bonus funds affected your organization's ability to improve the quality of care and health equity for OHP members?
   a. *[If they don't mention benchmarks:]* What is your experience with the benchmarks?
   b. *[If they don't mention improvement targets:]* What is your experience with the improvement targets?
   c. *[If they don't mention meeting a certain proportion of measures:]* What do you think about having to meet 75% of the measures to earn all bonus funds?
   d. *[If they don't mention the Challenge Pool:]* What do you think about the Challenge Pool?

6. What impact have the incentive dollars made for your provider network and your members? *[If needed: What types of investments have you made with the incentive funds?]*

The final set of questions are about the incentive measures and governance structure.

7. How well do you think the current incentive measures address health inequities? As a reminder, the list of 2024 CCO incentive measures was sent to you when we scheduled this interview.
   a. Are there measures you would change or add?

8. What is your experience with the Incentive Program governance structure, including the Metrics & Scoring Committee?
   a. How effective is the current structure at addressing health inequity? *[If necessary: What would you suggest changing in the overall structure and governance?]*
   b. What do you think about how committee decisions are communicated?
   c. How do you feel about your opportunities to provide input on the Incentive Program governing committees' decisions?
   d. How might OHP members be more involved?
   e. Is there anything about the measure selection process you would change to better focus on advancing health equity?

9. Is there anything else you'd like to share about what is working well with the Incentive Program, particularly in terms of addressing health inequities?
   a. What is not working well?

***Thank you for your time.*** *If you have any follow-up questions or think of anything else you would like to contribute to this evaluation, please reach out to us. Our contact information is in the introductory email we sent you.*

# OHP Provider Interview Guide

**Introduction:**

Thank you for being willing to participate in this valuable study that we are conducting in partnership with the Oregon Health Authority's (OHA) Office of Health Analytics. The purpose of the study is to better understand how the Quality Incentive Program might be better aligned with OHA's goal of eliminating health inequities by 2030.

For this study, we are collecting data from a variety of people including CCO administrators, committee members (e.g., representatives from the Community Advisory Council), OHP providers, and OHP members. In today's interview, we will be asking you about your experiences with the Quality Incentive Program and your perspective on how effectively the program is addressing health inequities. The findings and recommendations from this study will be presented to the state legislature later this year.

This discussion may take up to an hour, depending on how much you have to share. Again, we appreciate your willingness to help us out with our study.

**Informed Consent:**
Prior to beginning the discussion, it is important for me to review what's involved so you can fully consent to participation. Based on this information, if you do not want to participate, that is completely fine, and we appreciate your willingness to consider it.

- Participating in this interview is voluntary. You can be selective in what you tell us. You can stop at any time, and you can skip any question you don't want to answer. Your choice to do the interview or not will not affect your relationship with OHA, Portland State University, or any other organizations you are involved with.
- If you change your mind later and do not want us to include your feedback, you can let us know. We will remove your answers.
- We will keep the information you tell us confidential. We will not share your individual answers with anyone outside the evaluation team.
- We expect that there is minimal to no risk for you participating in this interview. One possibility is that you may feel uncomfortable sharing your thoughts and feedback about the Quality Incentive Program or OHA in general.
- After we complete all of the interviews, we will review all the data and prepare a report for OHA that summarizes the findings from everyone who contributed. Your name or identity will NEVER be tied to your responses in any way.

Do you have any questions before we begin? *[Address any questions they have the best you can. Otherwise, note other questions and we will follow-up later.]*

To simplify things, throughout this interview we will refer to the Quality Incentive Program as "the Incentive Program."

**First, a couple questions about your practice and health equity.**

1. What kind of health practice do you have?

2. What is your role?

3. Which CCO(s) are you currently part of?

**Before we focus on the Incentive Program…**

4. What does health equity mean to you as a provider?

5. What health inequities currently exist for the OHP members you serve?

**This final set of questions asks about the Quality Incentive Program through OHA and its impact on healthcare experience of the OHP members you serve.**

6. How familiar are you with OHA's Quality Incentive Program? *[If familiar, after securing answer, go to #7.]*
   a. *[If not at all familiar, ask:]* What examples can you share of what you have done in the past two years to increase health equity for the OHP members you serve? *[After securing answer, conclude the interview and thank them for their time.]*

7. How has the incentive program affected health equity for your OHP members?
   a. How do you think the Incentive Program could be more aligned with OHA's goal of eliminating health inequities among OHP members?

8. How effective do you think the incentive program's measures are at addressing health inequity? *[If needed, possibly just mention a few:]* The current 15 incentive measures are (list with descriptions is here: I:\Staff\GSSW\RRI\OHA CCO Study\Survey Instruments\ CCO Administrators):
   - *Childhood immunizations*
   - *Immunizations for adolescents*
   - *Child & adolescent well-care visits*
   - *Prenatal & postpartum care*
   - *Screening for depression and follow-up plan*
   - *Health aspects of kindergarten readiness*
   - *Cigarette smoking prevalence*
   - *Alcohol & drug misuse*
   - *Preventive dental or oral health services for ages 1-5 years and 6-14 years*
   - *Oral evaluation for adults with diabetes*
   - *Assessments for children in DHS custody*
   - *Comprehensive diabetes care*
   - *Initiation & engagement of substance use disorder treatment*
   - *Meaningful language access to healthcare services for people with limited English proficiency*
   - *Social determinants of health: Social needs screening & referral*

   a. Are there any measures that you would add, change, or remove?

9. What is your experience with the Incentive Program governance structure, including the Metrics & Scoring Committee?
   a. How effective is the current structure at addressing health inequity?
   b. What would you suggest changing in the overall structure and governance?
   c. Are decisions made about the Incentive Program clearly communicated to providers?
   d. What do you think about your opportunities to provide input on Incentive Program decisions?
   e. How might OHP members be more involved with the Incentive Program?

10. Is there anything else you would like to share about the Quality Incentive Program from your perspective as a provider?

We also have a survey for OHP members. Would you be able to distribute a flyer with a web address and QR code for an online version of the survey or hand out paper copies of the survey to OHP members?

***Thank you for your time.*** *If you have any follow-up questions or think of anything else you would like to contribute to this evaluation, please reach out to us. Our contact information is:* Mary Oschwald (oschwald@pdx.edu) or Keisha Muia (muia@pdx.edu).

# OHA Committee Members – Interview Guide

**Introduction:**

Thank you for being willing to participate in this valuable study that we are conducting in partnership with the Oregon Health Authority's (OHA) Office of Health Analytics. The purpose of the study is to better understand how the Quality Incentive Program for Coordinated Care Organizations (CCOs) may be furthering or hindering progress toward OHA's goal of eliminating health inequity by 2030.

For this study, we are collecting data from a variety of people including committee members, CCO administrators, OHP providers, and OHP members. In today's interview, we will be asking you about your experiences with the CCO Quality Incentive Program and your perspective on how effectively the program is addressing health inequities. The findings and recommendations from this study will be presented to the state legislature later this year.

This discussion will take up to an hour, depending on how much you have to share. Again, we appreciate your willingness to help us out with our study.

**Informed Consent:**

Prior to beginning the discussion, it is important for me to review what's involved so you can fully consent to participation. Based on this information, if you do not want to participate, that is completely fine, and we appreciate your willingness to consider it.

- Participating in this interview is voluntary. You can be selective in what you tell us. You can stop at any time, and you can skip any question you don't want to answer. Your choice to do the interview or not will not affect your relationship with OHA, Portland State University, or any other organizations you are involved with.
- If you change your mind later and do not want us to include your feedback, you can let us know. We will remove your answers.
- We will keep the information you tell us confidential. We will not share your individual answers with anyone outside the evaluation team.
- We expect that there is minimal to no risk for you participating in this interview. One possibility is that you may feel uncomfortable sharing your thoughts and feedback about the CCO Quality Incentive Program or OHA in general.
- After we complete all of the interviews, we will review all the data and prepare a report for OHA that summarizes the findings from everyone who contributed. Your name or identity will NEVER be tied to your responses in any way.

Do you have any questions before we begin? Just to simplify things, we will refer to the CCO Quality Incentive Program throughout this interview by saying "the Incentive Program."

Would you mind if we audio record this interview? The only reason to do it is to ensure that we accurately and completely document what you have to say. Once we have our notes finalized, we will delete the recording.

1. I'd like to start by asking: what is your role on the *[name]* committee? *[If more than one person is being interviewed, ask each person.]*

2. Before we focus on the Incentive program,
   a. What does health equity mean to your committee?
   b. What health inequities are OHP members currently experiencing?

3. How involved is your committee with the Quality Incentive Program?
   a. *[If not at all or minimally involved:]* How familiar are you with that program?
   b. *[If involved]:* How much do you think your committee has the ability to influence aspects of the Incentive Program? (e.g., the incentive payment structure, the benchmarks chosen to assess CCO outcomes, the instruments/ measures that are used to assess outcomes)

4. How do you think the Incentive Program could be more aligned with OHA's goal of eliminating health inequities among OHP members?
   a. What are some ways providers in your community have addressed health inequity among the OHP members they serve?

5. Now I'd like to talk about some of the features of the Incentive Program. How well have the bonus funds improved the quality of care and health equity for OHP members in your community? *[Depending on their familiarity with the Incentive Program, ask any/all of the following questions:]*
   a. What is your experience with the benchmarks for CCOs? *[If familiar, ask:]* What do you think of them?
   b. What is your experience with the improvement targets for CCOs? *[If familiar, ask:]* What do you think of them?
   c. What do you think about having to meet 75% of the measures to earn all bonus funds? *[If familiar, ask:]* What do you think of them?
      d. What do you think about the Challenge Pool? *[If familiar, ask:]* What do you think of them?

The final set of questions are about the incentive measures and governance structure.

6. How well do you think the current incentive measures address health inequities? *[If they need the list, it can be emailed to them.]*
   a. Are there measures you would change or add?

7. What is your committee's experience with the Incentive Program governance structure, including the Metrics & Scoring Committee?
   a. How effective do you think the current governance structure is at addressing health inequity? *[If necessary: What would you suggest changing in the overall structure and governance?]*
   b. What do you think about how committee decisions are communicated?
   c. How do you feel about your opportunities to provide input on the Incentive Program governing committees' decisions?
   d. How might OHP members be more involved?
   e. Is there anything about the measure selection process you would change to better focus on advancing health equity?

8. Is there anything else you'd like to share about what is working well with the Incentive Program, particularly in terms of addressing health inequities?
    a. What is not working well?

9. On a final note, what interested you about participating in this committee?

***[If time, ask:]*** We also have a survey for OHP members to complete. Would you be able to share that with OHP members in your community? *[If yes, send them an email with a link to the web survey.]*

***Thank you for your time.*** *If you have any follow-up questions or think of anything else you would like to contribute to this evaluation, please reach out to us. Our contact information is in the introductory email we sent you.*

# Appendix C: Recruitment Materials

Included in this appendix are:

- OHP Member recruitment flyer
- OHP QIP Description
- Email invitation for individual or group interview

# SHARE YOUR FEEDBACK ABOUT OREGON HEALTH PLAN (OHP)

**Why?**

As an OHP member, we want your feedback about what's important to fully support your health and wellness. We also want to hear your ideas about how to make sure OHP members are getting high-quality care.

**What?**

We are inviting you to complete a survey that may take 20-30 minutes. It includes questions about accessing health services, how quality health care decisions are made, and how to spend money to improve services.

**When?**

Please complete the survey by June 28, 2024.

**How?**

OHP members who are 18 years or older can complete the survey online at ohpfeedback.org or by scanning the QR code below. You can also complete it by phone or request a paper copy by calling 503-725-9533. If you complete the survey online, please finish it before leaving the website. If you leave before completing the survey, your answers will not be saved. If you complete the survey by mail, please return it to: ***Portland State University, Regional Research Institute (RRI), PO Box 751, Portland, OR 97207***.

**Who?**

We are a team from Portland State University. We are working with the Oregon Health Authority, an agency that oversees health care throughout Oregon.

**Choice & Privacy?**

***Completing the survey is totally voluntary.*** It's your choice to do it or not. You can skip any question that you do not want to answer.

***The survey is completely anonymous.*** Your identity will not be tied to your answers in any way. Your answers will be combined with answers from other OHP members who complete the survey.

**Thank You!**

To thank you for taking your time and feedback, we will send you a $50 Amazon or Safeway gift card. After completing the web survey, you will be directed to a secure, online gift card form completely separate from your survey answers. If you complete the survey on paper, please fill out the gift card form and return it with your survey. Once received, the gift card form will be kept separate from your survey.

If you are interested in learning more, please contact Keisha Muia at muia@pdx.edu or Mary Oschwald at oschwald@pdx.edu. Thank you!

Portland State UNIVERSITY

# Comparta sus comentarios sobre OREGON HEALTH PLAN (OHP)

**¿Porque?**

Como miembro de OHP, queremos recibir sus comentarios sobre lo que es importante para apoyar su salud y bienestar. También queremos escuchar sus ideas sobre cómo asegurarnos que los miembros de OHP están recibiendo atención de alta calidad.

**¿Que?**

Los invitamos a completar una encuesta que tomará 20 a 30 minutos a completar. La encuesta incluye preguntas sobre el acceso a los servicios de salud, como se toman las decisiones de calidad en la atención médica, y cómo utilizar fondos para mejorar los servicios.

**¿Cuando**

Por favor complete la encuesta antes del 28 de Junio

**¿Como?**

Miembros del plan de Salud de Oregon (OHP) que tienen 18 años o más pueden completar la encuesta escaneando el código QR encontrado abajo. También se pueden completar por teléfono al (503) 725-9533. También puede solicitar una copia física usando el número de teléfono. Si accede a la encuesta por línea, por favor termine la encuesta antes de cerrar la página web. Si usted cierra la página web, será posible que sus respuestas no se guarden. Al completar la encuesta por copia física por favor entregue su copia a la dirección: **Portland State University, Regional Research Institute (RRI) PO Box 751, Portland, OR, 97207**

**¿Quien?**

Somos un equipo de la Universidad Estatal de Oregon. Estamos trabajando con la Autoridad de Salud de Oregon, una agencia que supervisa la atención médica en todo Oregon.

**¿Elección y privacidad?**

***Completar la encuesta es completamente voluntaria.*** Es su decisión a cumplir o no cumplir la encuesta. Puede omitir cualquier pregunta que no se siente cómodo contestar. Sus respuestas se combinaran con las respuestas de otros miembros de OHP que completen la encuesta.

***La encuesta es completamente anónima.*** Su identidad no será conectada a sus respuestas de ninguna manera.

**¡Gracias!**

Para agradecerle por su participación para proporcionar comentarios le enviaremos una tarjeta de regalo de Amazon o de Safeway de $50. Si completa la encuesta por línea, usted va ser dirigido a una página web en donde puede ingresar su información postal. Si completa la encuesta por copia física, por favor ingresar su información en el formulario de tarjeta de regalo. Al recibir ambos formularios, el formulario de la tarjeta de regalo se mantendrá separado de su encuesta.

Si usted está interesado en aprender más, comuníquese con Keisha Muia al muia@pdx.edu o Mary Oschwald al oschwald@pdx.edu.

Portland State UNIVERSITY

**Oregon Health Authority (OHA)**
**Quality Incentive Program Evaluation Summary**

## *What is the OHA Quality Incentive Program?*

This program encourages Coordinated Care Organizations (CCOs) to improve the quality of healthcare that Oregon Health Plan (OHP) members receive. By participating in the Quality Incentive Program, CCOs can earn bonus money based on how well they perform on a set of healthcare quality measures. The state will give these organizations over $350 million in bonus payments this year. Currently, the Metrics and Scoring committee decides what high-quality care is and what CCOs need to do to earn bonus funds.

## *What is Senate Bill 966?*

The bill states: "*The Oregon Health Authority shall study the coordinated care organization quality incentive program administered by the authority and the structure of the metrics and scoring subcommittee, created in ORS 414.638, to develop recommendations for programmatic changes and changes to the subcommittee structure so that the design of the coordinated care organization quality incentive program is primarily focused on addressing health inequities, including the structural drivers of health inequities.*

- ***In conducting the study, the authority shall work with individuals whose health is most affected by the medical assistance program and individuals from communities most harmed by health inequities. The authority shall also engage with metrics experts, healthcare providers, coordinated care organizations and other health system representatives.***
- *Not later than September 15, 2024, the authority shall report to the interim committees of the Legislative Assembly related to health, in the manner provided in ORS 192.245, the findings and recommendations from the study and may include recommendations for legislation."*

## *What are we interested in knowing?*

Oregon state law decides who gets to be on the committee and how CCO bonus funds are awarded. The legislature wants feedback about what is important to OHP members, metrics experts, healthcare providers, CCOs, and other health system representatives. They also want to know how to pay CCOs for high quality healthcare. This information will be used to decide how to change the laws.

### *Who will be interviewing you /providing the survey to you?*

The Regional Research Institute (RRI) at Portland State University is a research team working in partnership with OHA to collect information from OHP members and others throughout the state to assist in improving access to health services. The RRI research team is interviewing representatives from CCOs, community-based organizations/providers, and relevant committee members. They have also created an OHP member survey that is available online and in paper format, in both English and Spanish. If OHP members would like to complete the survey by phone, they can call 503-725-9533. OHP members will receive a $50 gift card for completing the survey.

### *What will be done with the information collected?*

Once all of the interviews have been completed and OHP members have had an opportunity to complete the survey, all of the information will be analyzed and summarized in a report for OHA. They will use that report to create a summary for the Oregon legislature. Findings from the study will also be shared more broadly with OHP members and other interested parties later in 2024. All of the information collected is confidential, so any report will protect the identity of everyone who completed an interview or survey.

### *Who do I contact for more information?*

For more information about the Metrics and Scoring committee and the Quality Incentive Program, please visit our website (https://www.oregon.gov/oha/hpa/analytics/pages/metrics-scoring-committee.aspx) or connect with Gladys Rivera, Quality Incentive Program Senior Analyst (Gladys.Rivera@oha.oregon.gov, 971-388-6568). For more information about the study, please contact Keisha Muia (muia@pdx.edu) or Debi Elliott (elliottd@pdx.edu, 503-725-5198).

## Email Invitation for Individual or Group Interview

Subject: Feedback Opportunity – OHA CCO Quality Incentive Program

Hello *[name]*,

We are with the Regional Research Institute for Human Services at Portland State University. We have partnered with the Oregon Health Authority to evaluate the Coordinated Care Organization (CCO) Quality Incentive Program (QIP). The primary goal of the evaluation is to develop programmatic and governance structure recommendations so the program addresses health inequities, including the structural drivers of health inequities. According to OHA's definition, health equity will be achieved when:

- all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.
- the equitable distribution or redistribution of resources and power.
- recognizing, reconciling, and rectifying historical and contemporary injustices occurs.

Ultimately, a final report of the findings will be prepared and submitted to the Office of Health Analytics and the Oregon legislature.

***As a/the [role], you have valuable insight into what's working and what could be improved for the CCO Quality Incentive Program.*** We invite you to participate in an approximately 45 – 60-minute individual or group interview that will allow us to gather feedback about the CCO Quality Incentive Program and how it may affect OHA's goal of eliminating health inequity.

Participation in the interview is completely voluntary and confidential. We will conduct interviews virtually by videoconference or phone, whichever you prefer. The discussion will involve questions about the CCO Quality Incentive Program committee structure, incentive model, impact on providers, and impact on OHP members. Attached is the consent information and interview questions.

We have an extremely short timeline to collect data for this evaluation; we need to collect all data by June, 15th, 2024.

Please email us back if you would like to talk about the Quality Incentive Program; we hope to hear from you! Thanks in advance.

And, please let us know if you feel that others in your *[affiliation/organization]* should be included. Thank you for your time and we look forward to learning from you, Keisha Muia and Mary Oschwald.

For more information about this evaluation, you can reply to this email or contact Keisha Muia at muia@pdx.edu or Mary Oschwald at 503-725-9602, oschwald@pdx.edu.

*[Evaluation Team Member]*