

Call for Applications

CCO Metrics and Scoring Committee

Oregon Health Authority

The Oregon Health Authority (OHA) is currently accepting applications for membership to the CCO Metrics and Scoring Committee. Brief descriptions of the goal and work of this committee can be found below.

Overview

OHA welcomes applicants for all positions - members at large, measurement experts and CCO representatives - on the CCO Metrics and Scoring Committee. Applications will be accepted on a rolling basis to create a pool of candidates that can be used to fill any Committee vacancies that may occur throughout the year. Committee members serve initial two-year terms and may be re-appointed at the discretion of the Director of the OHA for two additional one-year terms, for a total of four years on the Committee. Committee members will be expected to commit to full participation, including effort to attend monthly meetings in-person (these meetings occur in Portland and Wilsonville). The Committee makes crucial decisions during the summer and autumn months, so attendance at these meetings is particularly critical.

The Committee consists of:

- Three members at large;
- Three individuals with expertise in health outcomes measures; and
- Three representatives of coordinated care organizations.

To apply

Applications will be accepted on a rolling basis, and should be submitted to metrics.questions@dhsoha.state.or.us. **Applicants who previously applied in the last application cycle (i.e., after November 7, 2019) need not reapply, as those applications will be automatically considered.**

Metrics and Scoring Committee Background

The Metrics and Scoring Committee was established in 2012 by Senate Bill 1580 for the purpose of recommending outcomes and quality measures for Coordinated Care Organizations (CCOs). Metrics and quality measures are used by the OHA to determine whether CCOs are effectively and adequately improving care, making quality care accessible, eliminating health disparities, and controlling costs for the populations that they serve. CCOs earn incentive dollars for their performance on the measures selected by the Metrics & Scoring Committee. Additional information on the Metrics and Scoring Committee is available online at: www.oregon.gov/oha/hpa/analytics/Pages/Metrics-Scoring-Committee.aspx

Application

Committee Recruitment

CCO Metrics and Scoring Committee

Oregon Health Authority

The purpose of this form is to assist the Oregon Health Authority and its Director in evaluating the qualifications of applicants for appointments to the CCO Metrics and Scoring Committee.

- ☐ Applications for all positions will be accepted on a rolling basis.
- ☐ Send this interest form and supplemental materials to:
metrics.questions@dhsoha.state.or.us.
- ☐ Application materials should include your resume or a brief biographical sketch, and this completed form.

PERSONAL DATA

Preferred Title: _____ (e.g., Mr, Mrs, Ms, Dr, etc.)

First Name: _____ Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Organization: _____

Occupation or Job Title: _____

Home Phone: _____ Business Phone: _____

E-mail: _____

Please indicate the position(s) in which you are interested (choose all that apply):

- ☐ CCO representative
- ☐ Member at large
- ☐ Quality Measurement Expert

Interest in appointment

Please limit your responses to one page.

Enter your responses below or on a separate sheet.

(1) Please describe why you are interested in serving on the Metrics & Scoring Committee. Include in your response your vision for health care quality metrics and the role of the Committee in that vision.

(2) Discuss how you think the CCO Quality Incentive Program and health care quality metrics can improve health equity in our state.

By submitting this form, I agree to accept appointment if selected by the Director/Governor:

Signature _____ Date _____

Send this interest form and other supplemental materials to:

metrics.questions@dhsosha.state.or.us

OHA is committed to ensuring diverse representation on all boards and committees. To help achieve this goal, we would appreciate you providing the following information. **These questions are optional and your answers are confidential.** Under state and federal law, this information may not be used to discriminate against you.

Gender Identity: _____

☐ Decline to answer

☐ LBGTQ (check if applicable)

☐ Decline to answer

Please see the next page regarding race/ethnicity demographic information.

These questions are optional and your answers are confidential. We would like you to tell us your race, ethnicity, language and disability background so that we can find and address health and service differences.

1. Do you need written materials in an alternate format (Braille, large print, audio recordings, etc.)?

☐ Yes ☐ No ☐ Don't know/Unknown ☐ Don't want to answer/Decline

If yes, which format? _____

Race and Ethnicity

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

3. Which of the following describes your **racial or ethnic identity?** Please check **ALL** that apply.

American Indian or Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

Hispanic or Latino/a

- ☐ Hispanic or Latino/a Central American
- ☐ Hispanic or Latino/a Mexican
- ☐ Hispanic or Latino/a South American
- ☐ Other Hispanic or Latino/a

Asian

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian or Pacific Islander

- ☐ Guamanian or Chamorro
- ☐ Micronesian*
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan*
- ☐ Other Pacific Islander

Black or African American

- ☐ African American
- ☐ African (Black)
- ☐ Caribbean (Black)
- ☐ Other Black

Middle Eastern/Northern African

- ☐ Northern African
- ☐ Middle Eastern

White

- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

Other Categories

- ☐ Other (please list) _____
- ☐ Don't know/Unknown
- ☐ Don't want to answer/Decline

4. If you selected more than one racial or ethnic identity above, please **CHOOSE the ONE that best represents your racial or ethnic identity:**

If you have more than one primary racial or ethnic identity please check here:

You can get this document in other languages, large print, braille, or a format you prefer. We accept all relay calls or you can dial 711. Contact Allison Proud:

Phone: 503-428-3442

Email: allison.proud@dhsosha.state.or.us

Language

5. In what **language** do you want us to:

Speak with you _____

Write to you _____

6. Do you need a **sign language** interpreter for us to communicate with you?

- ☐ Yes ☐ Don't know/Unknown
☐ No ☐ Don't want to answer/Decline

If yes, which type do you need us to communicate with you?

(ASL, PSE, tactile interpreting, etc.)

7. Do you need an **interpreter** for us to communicate with you?

- ☐ Yes ☐ Don't know/Unknown
☐ No ☐ Don't want to answer/Decline

8. How well do you speak English?

- ☐ Very Well ☐ Not at all
☐ Well ☐ Don't know/Unknown
☐ Not Well ☐ Don't want to answer/Decline

Disability Your answers will help us find health and service differences among people with and without functional difficulties. Your answers are confidential.

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

- ☐ Yes ☐ Don't know/Unknown
☐ No ☐ Don't want to answer/Decline

If yes, at what age did this condition begin? _____

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

- ☐ Yes ☐ Don't know/Unknown
☐ No ☐ Don't want to answer/Decline

If yes, at what age did this condition begin? _____

11. Does a **physical, mental, or emotional condition limit your activities** in any way?

- ☐ Yes ☐ Don't know/Unknown
☐ No ☐ Don't want to answer/Decline

If yes, at what age did this condition begin? _____

12. What is your age today? _____

Please stop now if the person is under age 5

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

- ☐ Yes ☐ Don't know/Unknown
☐ No ☐ Don't want to answer/Decline

If yes, at what age did this condition begin? _____

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

- ☐ Yes ☐ Don't know/Unknown
☐ No ☐ Don't want to answer/Decline

If yes, at what age did this condition begin? _____

15. Because of a **physical, mental, or emotional condition**, do you have serious difficulty:

a. **Concentrating, remembering or making decisions**?

- ☐ Yes ☐ Don't know/Unknown
☐ No ☐ Don't want to answer/Decline

If yes, at what age did this condition begin? _____

Please stop now if you/the person is under age 15

b. **Doing errands alone** such as visiting a doctor's office or shopping?

- ☐ Yes ☐ Don't know/Unknown
☐ No ☐ Don't want to answer/Decline

If yes, at what age did this condition begin? _____