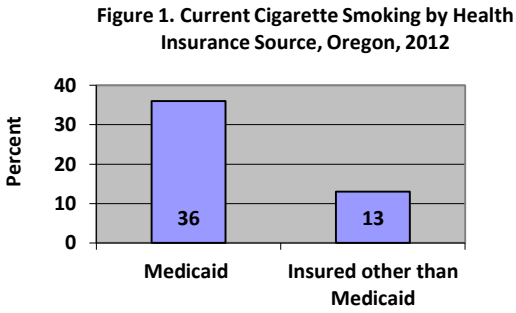
Tobacco Use Prevalence

Measurement

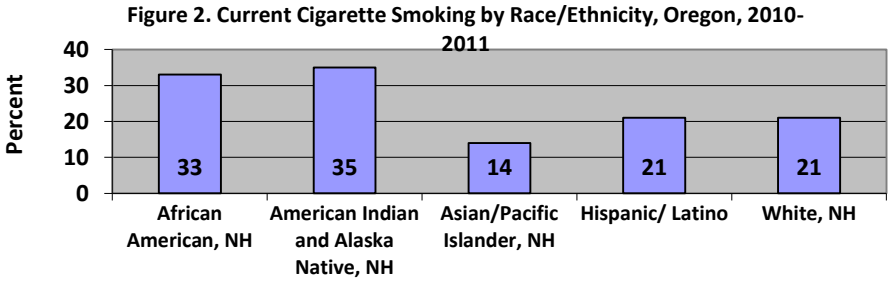
Measure type: Survey

Data source: CAHPS



Baseline: In 2012, 36% of Medicaid members were current smokers, compared to 13% among other insured Oregonians (Oregon Behavioral Risk Factor Surveillance System) (Figure 1). Data from the CAHPS survey (conducted in 2004, 2007, 2011) show that tobacco prevalence among enrollees of Medicaid Managed Care Organizations has decreased over time by 3-12 percentage points.

People who are African American or American Indian and Alaska Native are more likely to smoke cigarettes than people who are white or Hispanic/Latino (Figure 2).



According to the 2011 CAHPS survey, 50% of adult tobacco users were advised to quit by their doctor (state benchmark is 81.4%), 24% of adult tobacco users had a doctor discuss or recommend medications to quit smoking (state benchmark is 50.7%) and 22% of adult tobacco users had a doctor recommend strategies to quit smoking (state benchmark is 56.6%).

Existing benchmark(s): Oregon's 1115 Medicaid waiver aims to decrease tobacco use prevalence to 25% over the course of the demonstration period. *Oregon's Healthy Future* aims to decrease tobacco use among adults to $\leq$15%, among 11th graders to $\leq$7.5%, and among 8th graders to $\leq$5%. Healthy People 2020 aims to reduce adult cigarette smoking to 12% by 2020.

Proposed numerator: CCO enrollees ≥18 years of age who report smoking cigarettes every day, some days, or not at all

Proposed denominator: CCO enrollees ≥18 years of age

Operationalization

- Health care providers can ask members about their tobacco use at every visit, document tobacco use in the member health record, advise identified tobacco users to quit and provide referrals to cessation resources for those members who are ready to quit.
- CCOs can make available to tobacco users evidence-based treatment that includes:
    - All seven FDA-approved medications for tobacco cessation;
    - Coverage for documented multiple quit attempts and extended treatment options annually;
    - Treatment options at low or no cost out-of-pocket expenses;
    - Access to evidence-based tobacco cessation quit line telephonic counseling services, individual and group tobacco cessation counseling services
- CCOs can promote tobacco cessation services to members via handbooks, mailers, new member packets, the CCO website, etc.
- CCOs can encourage contracted hospitals and clinics to establish tobacco free campus/grounds policies to support employees and CCO members staying quit.
- CCOs can partner with local Tobacco Prevention and Education Program programs, which are implementing a variety of cessation-related activities.

Rationale

People who have Medicaid insurance are more than twice as likely to smoke cigarettes than the general population; significant disparities in tobacco use prevalence exist by age, sex and race.

Each year, smoking costs Oregonians $1.3 billion in medical expenditures and an additional $1.2 billion in premature death. About $374 million of these costs are a direct burden on state government, which pays for smoking-related health costs through Medicaid.

Tobacco use leads to disease and premature death. Among those who persist in smoking, one third will die about 13 years earlier than their nonsmoking peers. Clinicians asking all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products receives an A recommendation from the United States Preventive Services Task Force.

Obesity Prevalence

Measurement

Measure type: Survey

Data source: CAHPS (height and weight would need to be added for 2016 fielding); EHR data when technology is developed

Baseline: In 2012, 40% of self-reported Medicaid members were obese (Figure 1; source: 2012 Oregon Behavioral Risk Factor Surveillance System Survey [BRFSS]). Significant disparities in obesity prevalence are found in the general population (Figure 2; source: 2010-11 Oregon BRFSS race oversample).

Figure 1. Percent Obese by Health Insurance Source, Oregon, 2012

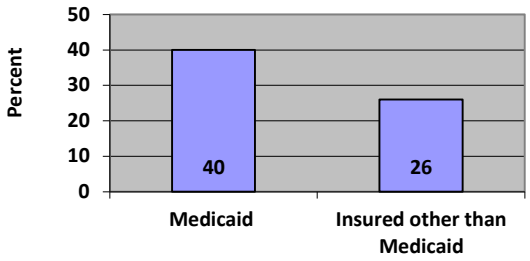
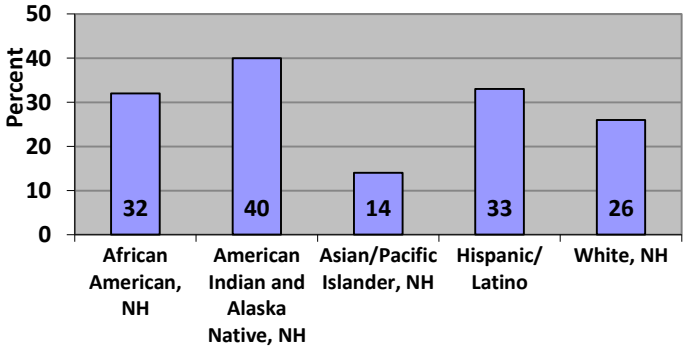


Figure 2. Percent Obese by Race/Ethnicity, Oregon, 2010-2011



Existing benchmark(s): Healthy People 2020 aims to reduce obesity among adults aged 20 years and older to 30.5%. *Oregon's Healthy Future* aims to decrease obesity to 30% or less in adults, 10% or less in 11th graders and 11% or less in 8th graders.

Proposed numerator: CCO enrollees ≥18 years of age with a BMI ≥30 based on height and weight

Proposed denominator: CCO enrollees ≥18 years of age

Operationalization

CCOs will achieve reduced obesity among their population by engaging with the communities in which their clients live, work, play and learn. At the same time, CCOs can work within their own organizations to improve health for their employees and clients, becoming an influential role model in healthy, active living for their communities.

The Centers for Disease Control and Prevention's **MPOWER** framework offers a comprehensive look at how to approach reducing the impact of obesity that can be adapted for the CCO audience.

- **Monitor** obesity and obesity-related chronic diseases and healthy eating and active living policies. CCOs can collect data on physical activity, dietary habits and obesity within their populations.
- **Promote** healthy eating and active living. CCOs can encourage hospitals within their network to work toward baby-friendly hospital certification. CCOs can establish healthy worksite committees and programs within their organizations to encourage employees and clients to eat better and move more. Policy interventions could include: offering discounted passes to employees and clients for public transportation; healthy meeting food policies; increased bike parking and decreased free car parking; and prohibiting deep fat fryers in cafeterias.
- **Protect** people from unhealthful foods and beverages and unsafe places for physical activity. CCOs can establish nutrition standards for food service offered in clinic or hospital settings.
- **Offer** evidence-based, culturally and linguistically appropriate support for people to manage their weight. CCOs can encourage team-based care include trained weight and diabetes management coaches and/or evidence-based weight management programs, ensure that referrals to evidence-based weight and diabetes management are built into electronic health record systems and require providers to receive training on weight management counseling.
- **Warn** about the dangers of sugary beverages and other unhealthful foods and the dangers of being sedentary. CCOs can develop outreach materials including advertising, social media and written materials to reach CCO members and use member networks to maximize distribution of the messages.
- **Enforce** laws that enable healthy eating and active living. CCOs can ensure that appropriate spaces and time for breastfeeding are available for employees and clients and that all hospitals and clinics are in full compliance with the law.
- **Raise** the price of unhealthful foods, and lower the price of healthful foods. CCOs can offer incentives in hospital and clinic cafeterias and vending machines to make healthier options less expensive and unhealthy options more expensive.

Rationale

People who have Medicaid are more than one and a half times more likely to be obese than those who have a health insurance other than Medicaid (see page 1). People who are non-Hispanic African American, non-Hispanic American Indian and Alaska Native, or Hispanic/Latino are more likely to be obese than people who are non-Hispanic white. Conversely, people who are non-Hispanic Asian/Pacific Islander are less likely to be obese than all other racial/ethnic groups (see page 1).

In Oregon, medical costs related to obesity among adults were estimated to have reached $1.6 billion in 2006, with $339 million of that paid by Medicare and $333 million paid by Medicaid. In addition, obese persons are estimated to have annual medical costs that are $1,429 higher than non-obese persons.

Obesity prevention directly addresses the triple aim. In Oregon, obesity contributes to the deaths of about 1,400 Oregonians each year. Overweight and obesity are major risk factors for chronic diseases such as diabetes, cancer, high blood pressure, high cholesterol, arthritis, heart disease and stroke. Nearly 73 percent of adult Oregonians with a history of heart attacks were overweight or obese in 2009. In 2013, the American Medical Association officially recognized obesity as a disease in its own right. Obesity causes disease and makes disease management more complicated. Weight loss alone can, in some cases, be enough to avoid or forestall taking medications to control chronic conditions such as high blood pressure or diabetes. Weight loss is often more effective, and less expensive, than pharmaceutical interventions for chronic conditions. Treating obesity-related illnesses costs Oregon at least $1.6 billion in medical expenditures annually.

Oregon Public Health Division
April 2014

Pregnancy among Females Aged 15-17 Years

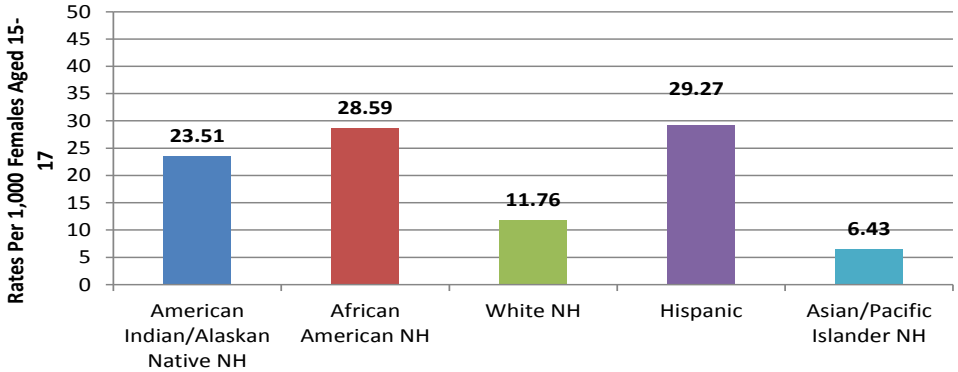
Measurement

Data source: MMIS

Measurement period: January 1-December 31, 2015

Baseline: The 2012 pregnancy rate among females aged 15-17 years was 15.78 per 1,000. American Indian/Alaska Native, black and Hispanic females aged 15-17 years have a higher pregnancy rate than white non-Hispanic females (Figure 1 below).

Figure 1. Pregnancy Rates Per 1,000 among 15-17 Year Old Females in Oregon, 2012



Note: NH=Non-Hispanic
Source: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority (2013).

Existing benchmark(s): The Healthy People 2020 target for pregnancy among females aged 15-17 years is 36.2 per 1,000 nationally. The rate of birth (per 1,000) for teenagers aged 15 through 17 years is also Title V Maternal and Child Health National Outcome Measure**.**

Proposed numerator: Number of enrolled females aged 15-17 years with a pregnancy diagnosis

Proposed denominator: Number of enrolled females aged 15-17 years

Operationalization

- CCOs can partner with their region's local public health authorities on existing teen pregnancy prevention initiatives.
- CCOs can work with providers to ensure reproductive health needs are being addressed at adolescent well visits, by providing tools such as "One Key Question" as a method for assessing pregnancy intent.

- CCOs can promote access to reproductive health services through systems of care (e.g. School-Based Health Centers).
- CCOs can support implementation of evidence-based teen pregnancy prevention programs in the community and in the clinic setting using Traditional Health Workers or health educators.

Rationale

Teen pregnancy is closely linked to a number of other critical issues, including poverty, income disparity, high school completion and overall child and family well-being. Reducing teen pregnancy would reduce the risk of negative social, education and health outcomes and lead to cost savings for the state. The rationale behind using the 15-17 year old age group is that this group is more vulnerable to the negative outcomes of pregnancy and less likely to have intended pregnancies than older teens (18-19 years).

As indicated in Figure 1, there is a disparity with regard to race and teen pregnancy rates among 15-17 year old females in Oregon. The statewide rate was 15.78 per 1,000 in 2012, with the white non-Hispanic females' rate being below the state average (11.76 per 1,000). Hispanic females had the highest rate at 29.27 per 1,000, followed closely by black non-Hispanic females at 28.59 per 1,000. This disparity in pregnancy rates places minority females at higher risk for experiencing the negative outcomes of teen pregnancy, such as poverty and lower educational attainment.

Preventing teen pregnancy may reduce negative health outcomes of pre-term birth and low birth weight as infants born to teen mothers are more likely to be pre-term and be born low-birth weight than infants born to older mothers. Females who delay childbearing until their 20s are more likely to finish high school than females who give birth during their teens. Finishing high school has been identified as one of the best indicators of future health outcomes, with people who graduate from high school having better health outcomes than their cohorts who did not finish.

Reducing teen pregnancy rates will result in lower healthcare costs. The National Campaign to Prevent Teen and Unplanned Pregnancy (2011) estimates that Oregon taxpayers saved $77 million in 2008 **alone** due to the decline in teen pregnancy rates.

Annual Influenza Vaccination

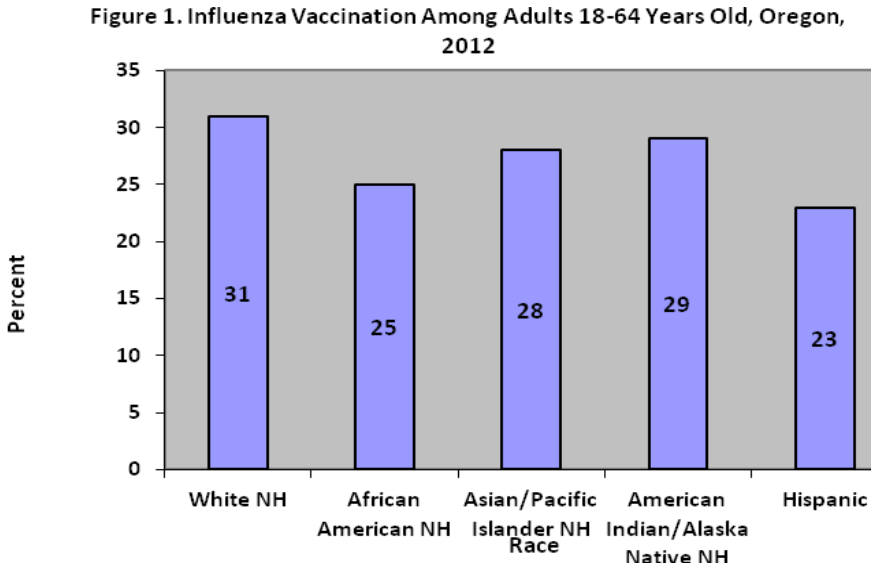
Measurement

Measure type: HEDIS

Data source: MMIS; ALERT database

Measurement period: January 1-December 31, 2015

Baseline: According to the 2011 CAHPS survey, 58.5% of adults aged 50-64 reported receiving an influenza vaccine. In 2012, 29.7% of adults aged 18-64 years reported receiving the influenza vaccine, as reported by the Oregon Behavioral Risk Factor Surveillance System Survey (BRFSS) (Figure 1 below).



Existing benchmark(s): The national Healthy People 2020 target for population immunization coverage is 80% for non-high risk persons and 90% for high-risk persons (defined by the Advisory Committee on Immunization Practices) and healthcare workers.

Proposed numerator: Number of enrolled patients ≥6 months-64 years of age that received an influenza vaccination within the past 12 months

Proposed denominator: Number of enrolled patients ≥6 months-64 years of age

Operationalization

- Both primary care and subspecialty clinics can offer flu vaccination to all patients over six months of age at any patient encounter after influenza vaccine is available. Strategies for improving vaccination rates include use of standing orders, computerized record reminders, performance feedback for providers, home visits, mailed or telephoned reminders to patients and expanding access in clinical settings (such as holding drop-in clinics or express lane vaccination services).

- Other venues where patients can obtain influenza vaccination include retail pharmacies, school-based health centers, and vaccination clinics held by local health departments and community groups.

- The Oregon Immunization Program, in partnership with the CDC, provides influenza vaccine at no cost to providers with patients who are less than 19 years of age, uninsured, underinsured, enrolled in Medicaid or Native American/Alaska Native.

Rationale

Influenza is a significant cause of morbidity and mortality. On average, influenza infects 10%–20% of the population; hospitalizes an estimated 55,000–431,000 and kills 3,000–49,000 individuals per year.[1] Influenza-related complications are most common in those >65 years and <2 years of age, as well as among those with certain high-risk conditions, such as chronic cardiovascular and lung disease, metabolic conditions and pregnancy. The highest attack rates of influenza occur in school-aged children, who appear to be major propagators of infection; immunization of this age group has been shown to result in decreased spread of influenza in the community. Annual influenza vaccination is the primary means of preventing influenza and its complications. Influenza vaccine is 73% effective in healthy adults <65 years of age when vaccine strains are well matched to those circulating.[2] For these reasons, annual vaccination of everyone ≥6 months of age against influenza is recommended by the CDC and its Advisory Committee on Immunization Practices and the Oregon Immunization Program.[3]

[1] MMWR 2010; 59:1057–62.
[2] Cochrane Database Syst Rev 2010:CD001269, cited in MMWR 2013; 62(RR-07), available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6207a1.htm?s_cid=rr6207a1_w
[3] MMWR 2013; 62(RR-07).

HPV Vaccination

Measurement

Measure type: HEDIS; CHIPRA

Data source: MMIS; ALERT database

Measurement period: January 1-December 31, 2015

Baseline: In 2013, 33% of Oregon females aged 13-17 years received three doses of HPV vaccine (source: ALERT IIS).

Existing benchmark(s): The Healthy People 2020 target for HPV vaccination is that 80% of female adolescents aged 13-15 years will have received 3 doses of HPV vaccine.

Proposed numerator: Number of females aged 13 years who have had three doses of HPV vaccine by their 13th birthday

Proposed denominator: Number of female adolescents aged 13 years

The proposed measurement aligns with the National Quality Foundation (NQF 1959) measure.

Operationalization

- Health care and social service providers can educate parents/caregivers about the need for HPV vaccine and vaccine safety. Educational brochures can be obtained from Oregon Immunization Program and CDC at no or low cost.
- Providers can check HPV vaccination status during each adolescent visit. Providers can schedule the visit for next dose before the patient leaves the office.
- HPV vaccination reminders can be sent to parents. Providers can identify and generate reminder notices to adolescents in need of a vaccine via ALERT.
- HPV vaccination can be provided through low or no-cost vaccine via the Vaccines for Children program.
- Providers can request a vaccination coverage evaluation by the Oregon Immunization program.

Rationale

HPV is the most common sexually transmitted infection in the United States; 6.2 million people are newly infected each year. HPV is the cause of genital warts and several types of cancers; if not diagnosed and treated early a portion of HPV-related cancers lead to death[1]. Therefore, the Advisory Committee on Immunization Practices recommends routine HPV vaccination for females aged 9-26 years. Yet, only 61% of Oregon girls aged 13–17 years have received ≥1 dose of HPV vaccine. Many fewer girls (33%) in this age group have received all three recommended doses of HPV vaccine. The Oregon HPV Impact program estimates that over 3500 cases of high-grade cervical dysplasia occur annually among women aged 21–29 years. Many of these are preventable by HPV vaccination. High grade cervical dysplasia is detected by Pap smear. Routine cervical cancer screening by Pap smear and related tests and follow-up and treatment of high-grade cervical dysplasia costs an estimated $66 million each year in Oregon. Though regular screening for cervical cancer should continue; routine vaccination beginning at age 9–11 years can be expected to reduce some of these expenses related to follow-up of abnormal Pap smears.

Oregon Public Health Division
April 2014

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[1] Markowitz L, Dunne E, Saraiya M, Lawson H, Chesson H, Unger E. (2007). Quadrivalent Human Papillomavirus vaccine: Recommendations for the Advisory Committee on Immunization Practices. *Morbidity and Mortality Weekly Report,* 56(RR02): 1-24. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5602a1.htm.

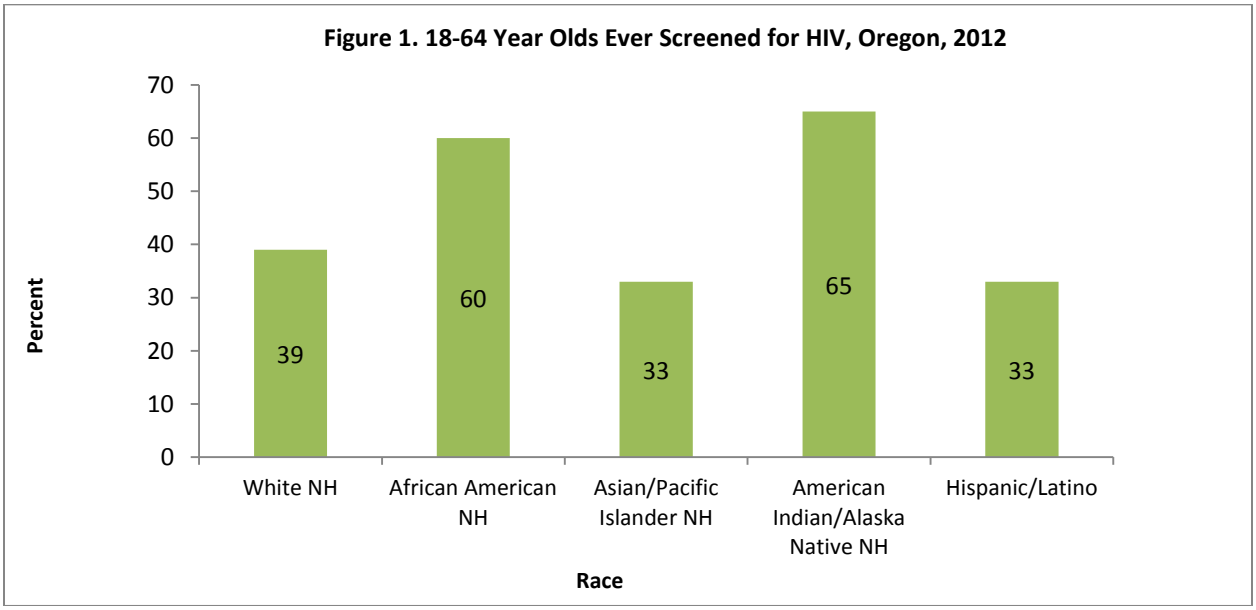
HIV Screening

Measurement

Data source: Administrative claims or CCO member survey data with sufficient sample size to provide adequately precise estimates for each CCO.

Measurement period: January 1-December 31, 2015

Baseline: In 2010 37.5% of Oregon adults aged 18-64 years reported ever having received an HIV test, according to the Oregon Behavioral Risk Factor Surveillance System Survey (Figure 1 below).



Existing benchmark(s): The Healthy People 2020 target for *annual* HIV screening is 18.9% for adolescents and adults ages 15-44.

Proposed numerator: Number of persons aged 15–65 years with documentation of at least one HIV screening test

Proposed denominator: Number of persons enrolled aged 15-65 years

Operationalization

- Primary care providers can send a periodic letter to all enrollees advising them of all age-appropriate preventive health recommendations and advising them how they can get these done conveniently; including HIV screening.
- Use the EHR reminder systems to prompt providers to offer HIV screening annually and document date(s), location and results of previous HIV screenings.
- Routinize HIV screening by including signage and other messaging indicating why everyone should be tested and advising clients of any opt-out policies for HIV testing.

Rationale

An estimated 5,568 people are known to have HIV infection in Oregon and 250 people are newly diagnosed each year. In addition to those already known to be infected, Oregon Health Authority's Public Health Division estimates that another 500–1000 people are HIV infected but are not aware of this fact. Public health experts estimate that these 10% to 18% yet-undiagnosed people of the total number of HIV-infected Oregonians are the source of 50% to 70% of all new infections. Efforts at high-risk screening over 30 years have not led to timely diagnosis of all HIV infections. Consequently, 30% to 40% of people newly diagnosed with HIV in Oregon have advanced illness at the time HIV infection is diagnosed, indicating that they've had the infection for years, and representing missed opportunities to contribute to expanded lifespan for those individuals and reduced transmission of new infections. For these reasons Centers for Disease Prevention and the US Preventive Services Task Force both recommend universal screening for HIV among persons aged 15 – 65 years of age in the US. Rates of new infections among African Americans are 2 to 5-fold higher and rates among Hispanics almost 2-fold higher than among non-Hispanic whites. Lifetime medical costs for treatment of HIV infection exceed $250,000. Universal screening for HIV will likely lead to more timely diagnosis for the majority of people infected with HIV, leading in turn to decreased mortality and morbidity of HIV infection, lower lifetime cost of care, and fewer new HIV infections.

Oregon Public Health Division
April 2014