

OREGON HEALTH AUTHORITY

Annual Performance Progress Report (APPR) for Fiscal Year (2013-2014)

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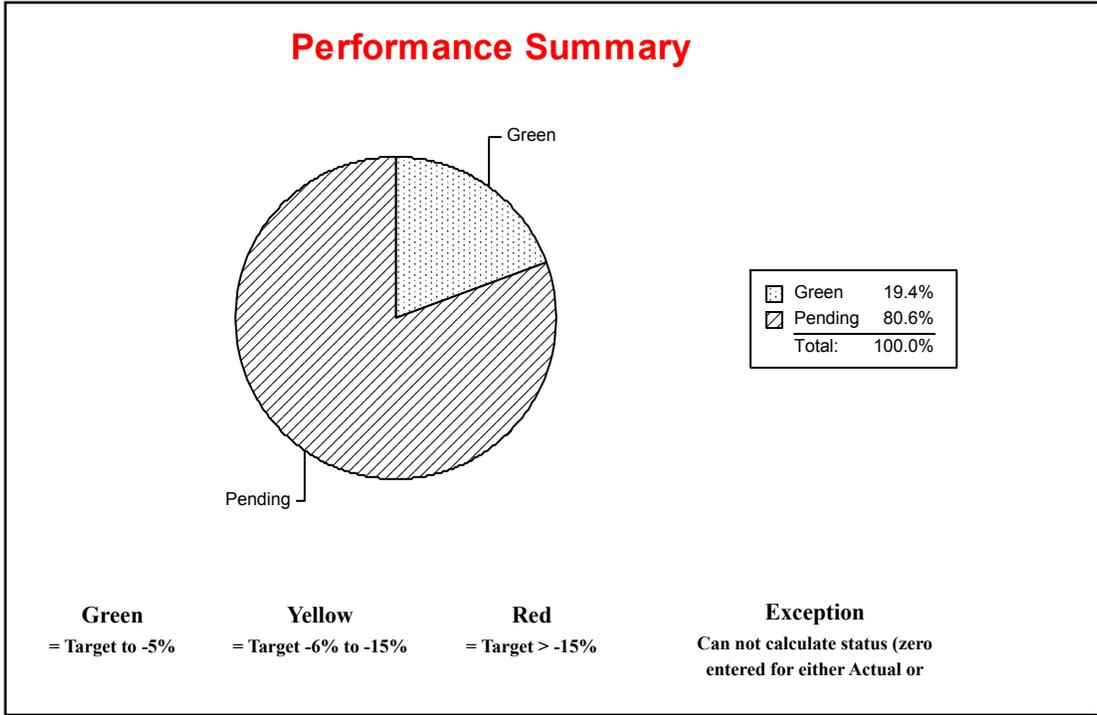
2013-2014 KPM #	2013-2014 Approved Key Performance Measures (KPMs)
1	INITIATION OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received initiation of AOD treatment within 14 days of diagnosis.
2	ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received two or more services within 30 days of initiation visit.
3	FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS - Percentage of enrollees 6 years of age and older who were hospitalized for treatment of mental health disorders and who were seen on an outpatient basis or were in intermediate treatment within seven days of discharge.
4	MENTAL AND PHYSICAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY – Percentage of children in DHS custody who receive a mental and physical health assessment within 60 days of initial custody.
5	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (INITIATION) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed: INITIATION.
6	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (CONTINUATION AND MAINTENANCE) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed: CONTINUATION AND MAINTENANCE
7	30 DAY ILLICIT DRUG USE AMONG 6TH GRADERS - Percentage of 6th graders who have used illicit drugs in the past 30 days.
8	30 DAY ALCOHOL USE AMONG 6TH GRADERS - Percentage of 6th graders who have used alcohol in the past 30 days.
9	30 DAY ILLICIT DRUG USE AMONG 8TH GRADERS - Percentage of 8th graders who have used illicit drugs in the past 30 days.
10	30 DAY ALCOHOL USE AMONG 8TH GRADERS - Percentage of 8th graders who have used alcohol in the past 30 days.
11	30 DAY ILLICIT DRUG USE AMONG 11TH GRADERS - Percentage of 11th graders who have used illicit drugs in the past 30 days.
12	30 DAY ALCOHOL USE AMONG 11TH GRADERS - Percentage of 11th graders who have used alcohol in the past 30 days.

2013-2014 KPM #	2013-2014 Approved Key Performance Measures (KPMs)
13	PRENATAL CARE (POPULATION) - Percentage of women who initiated prenatal care in the first 3 months of pregnancy.
14	PRENATAL CARE (MEDICAID) - Percentage of women who initiated prenatal care within 42 days of enrollment.
15	PRIMARY CARE SENSITIVE HOSPITAL ADMISSIONS/INPATIENT STAYS - Rate per 100,000 client years of admissions (for 12 diagnoses) that are more appropriately treated in an outpatient setting.
16	PATIENT CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT - Number of members enrolled in patient-centered primary care homes by tier.
17	ACCESS TO CARE - Percentage of members who responded "always" or "usually" too getting care quickly (composite for adult and child).
18	MEMBER EXPERIENCE OF CARE - Composite measurement: how well doctors communicate; health plan information and customer service (Medicaid population).
19	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good).
20	RATE OF TOBACCO USE (POPULATION) - Rate of tobacco use among adults.
21	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.
22	RATE OF OBESITY (POPULATION) - Percentage of adults who are obese among Oregonians.
23	RATE OF OBESITY (MEDICAID) - Percentage of Medicaid population who are obese.
24	PLAN ALL CAUSE READMISSIONS - Percentage of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years and older.
25	EFFECTIVE CONTRACEPTIVE USE (POPULATION) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
26	EFFECTIVE CONTRACEPTIVE USE (MEDICAID) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.

2013-2014 KPM #	2013-2014 Approved Key Performance Measures (KPMs)
27	FLU SHOTS (POPULATION) - Percentage of adults ages 50-64 who receive a flu vaccine.
28	FLU SHOTS (MEDICAID) - Percentage of adults ages 50-64 who receive a flu vaccine.
29	CHILD IMMUNIZATION RATES (POPULATION) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
30	CHILD IMMUNIZATION RATES (MEDICAID) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
31	CUSTOMER SERVICE (OHA) - Percentage of OHA customers rating their satisfaction with the agency's customer service as "good" or "excellent" overall, timeliness, accuracy, helpfulness, expertise, availability of information.

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2015-2017
	Title: Rationale:

OREGON HEALTH AUTHORITY		I. EXECUTIVE SUMMARY	
Agency Mission: Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.			
Contact: Cathy Iles, OHA Director's Office		Contact Phone: 503-602-1507	
Alternate:		Alternate Phone:	



1. SCOPE OF REPORT

The purpose of this annual performance report is to communicate the results of the work that is done through the Oregon Health Authority (OHA) and its partners. While the primary audience is the Oregon Legislature and other key stakeholders, it is also a communication tool for staff, other governmental agencies and the public. The 2013-15 OHA Key Performance Measures (KPMs) are intended to represent key quality and access metrics for healthcare-related services for individuals across the state. They are framed around the triple aim of better care, better health and lower cost and OHA's Quality Improvement Focus Areas as defined in Oregon's Medicaid 1115 waiver agreement with the Centers for Medicare and Medicaid Services (CMS). The goal is to align KPMs closely with Health System Transformation metrics, both statewide and Coordinated Care Organization (CCO) metrics.

2. THE OREGON CONTEXT

OHA is at the forefront of lowering and containing costs, improving quality and increasing access to health care in order to improve the lifelong health of Oregonians.

The Health Authority will transform the health care system in Oregon by:

- Improving the lifelong health of Oregonians
- Increasing the quality, reliability, and availability of care for all Oregonians
- Lowering or containing the cost of care so it's affordable to everyone

OHA knows what it needs to do to improve health care: focus on health and preventive care, provide care for everyone and reduce waste in the health care system.

OHA includes most of the state's health care programs, including Public Health, the Oregon Health Plan, Healthy Kids, employee benefits and public-private partnerships. This gives the state greater purchasing and market power to begin tackling issues with costs, quality, lack of preventive care and health care access.

The Health Authority is working to fundamentally improve how health care is delivered and paid for, but because poor health is only partially due to lack of medical care, OHA will also be working to reduce health disparities and to broaden the state's focus on prevention.

3. PERFORMANCE SUMMARY

The majority of the 2013-15 OHA KPMs are new. Baseline data are reported for either 2011 or 2012. Targets have been set for 2014 and 2015 for most of them, therefore red, yellow, green status can't be reported yet. However, there are six measures in green status, the rest are pending.

4. CHALLENGES

Oregon faces a \$3.5 billion budget crisis and health care is an ever increasing portion of our budget.

Health care spending accounts for 16 percent of the state general fund budget. The need to reform our health care system is more urgent than ever.

Oregon is a national leader in health reform thanks to the groundwork laid by the legislature.

In 2009, the legislature created Oregon Health Policy Board (OHPB) and Oregon Health Authority (OHA) to address the issues of cost, quality and access to health care. While the federal government has made new investments in insurance coverage and access, it will be up to the states to take the next steps to lower cost and improve quality.

The Oregon Health Policy Board has created an Action Plan for Health that involves actions by all stakeholders — the legislature, consumers, businesses, health care providers and others — in a staged plan. Coupled with the dollars federal reform will bring into Oregon, this plan meets the legislative mandate to "provide and fund access to affordable, quality care for all Oregonians by 2015." It also meets the spirit of innovation to seek Oregon solutions to address the problems before us.

The plan includes many items that do not require legislative action, but may require changes in how we set budget priorities. For instance, a focus on prevention and treatment of addiction saves lives and dollars as does an early focus on prevention and chronic disease. Finally, the plan emphasizes how we deliver and pay for health care to ensure health equity, promote health and contain costs, beginning with the 850,000 lives for whom the Oregon Health Authority buys health care services.

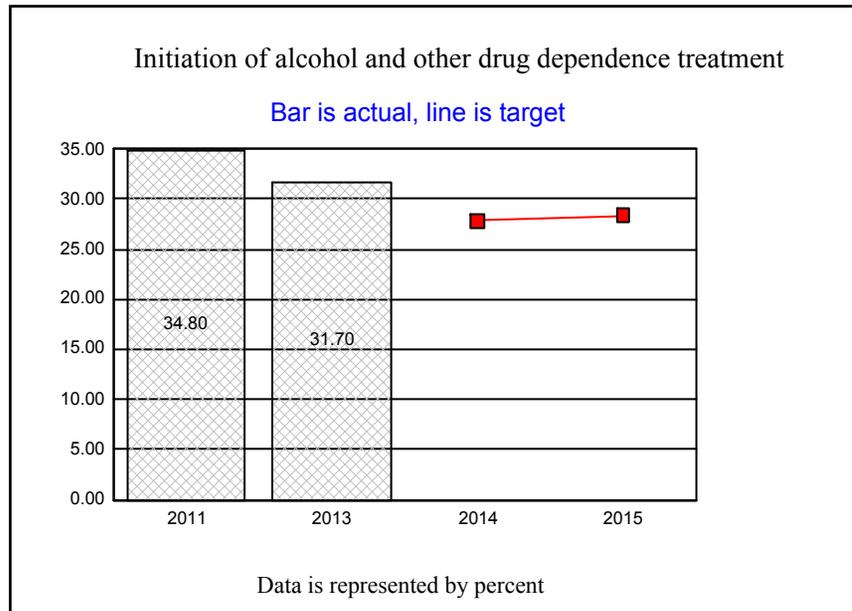
While It continues to be challenging to connect the daily work of the agency to higher level outcomes and goals, doing so will enable us to be accountable for efficient and effective processes and create a culture throughout OHA by which all managers and staff rigorously use performance measures and other metrics for decision-making, managing the daily work

and driving improvements throughout the agency. More effective communication with the public and stakeholders of the value of OHA services is desired as we attempt to educate others about our role as good stewards of public resources.

5. RESOURCES AND EFFICIENCY

2013-15 Total Fund OHA Budget = \$12,569,007,723. 4,019 positions. More detail can be found at: <http://www.oregon.gov/oha/Pages/budget-legislative.aspx>** Source: DHS/OHA Budget, Planning and Analysis

KPM #1	INITIATION OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received initiation of AOD treatment within 14 days of diagnosis.	2013
Goal	Better care/access, lower cost, better health	
Oregon Context	Better care/access, lower cost, better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: Integrating primary care and behavioral health; and improving access to effective and timely care.

2. ABOUT THE TARGETS

These improvement targets were established to result in an increase from the baseline data to the performance target which is the average of the 2011 National Medicaid 75th percentile.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2013, the initiation rate for alcohol and drug treatment was 31.7%. This represents an increase from the preliminary CY2011 data initially provided, but a decrease from the final CY2011. This measure is above the 2014 target; however, targets were set based on preliminary 2011 data.

4. HOW WE COMPARE

Oregon's initiation rate is below the 2012 national Medicaid rate of 39.4%. Additional comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

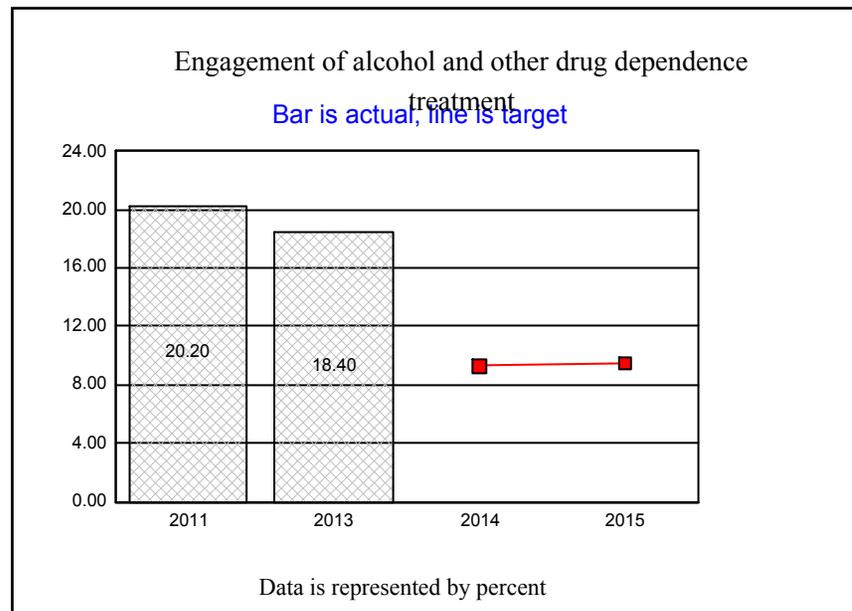
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken. It is possible that the increased statewide emphasis on alcohol and drug use screening (SBIRT) due to the CCO incentive measure will result in an increase in initiation of alcohol and drug treatment, as more individuals with risky or problematic substance use are identified and referred to treatment services.

7. ABOUT THE DATA

CY2011 baseline data have been finalized; CY2013 final data provided.

KPM #2	ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received two or more services within 30 days of initiation visit.	2013
Goal	Better care/access; lower cost; better health	
Oregon Context	Better care/access; lower cost; better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: Integrating primary care and behavioral health; and improving access to effective and timely care.

2. ABOUT THE TARGETS

These improvement targets were established to result in an increase from the baseline data to the performance target which is the average of the 2011 National Medicaid 75th percentile.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2013, the engagement rate for individuals who initiated alcohol and drug treatment was 18.4%. This represents an increase from the preliminary CY2011 data initially provided, but a slight decrease from the final CY2011 rate of 20.2%. This measure is above the 2014 target; however, targets were set based on preliminary 2011 data.

4. HOW WE COMPARE

Oregon's performance is above the 2012 national Medicaid engagement rate of 10.8%. Additional comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

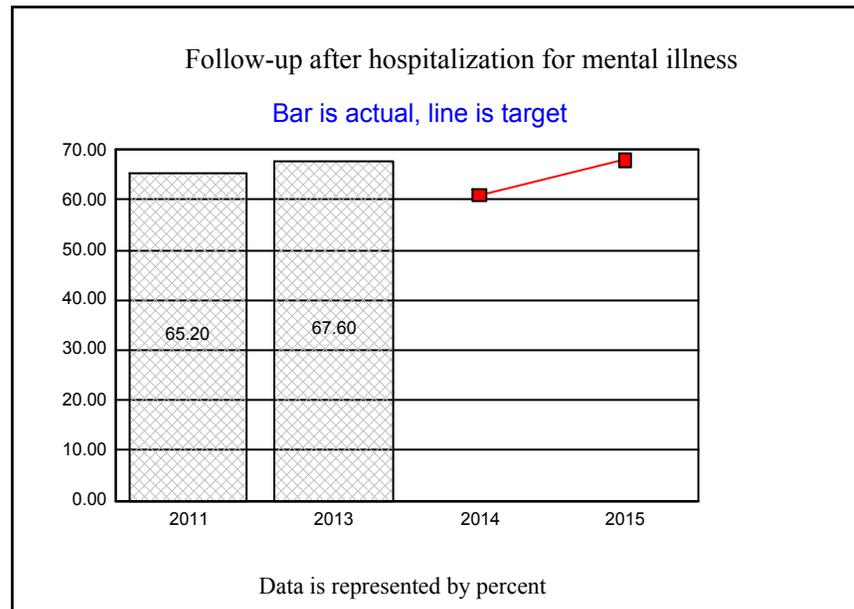
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken. It is possible that the increased statewide emphasis on alcohol and drug use screening (SBIRT) due to the CCO incentive measure will result in increased engagement of alcohol and drug treatment, as more individuals with risky or problematic substance use are identified and referred to treatment services.

7. ABOUT THE DATA

CY2011 baseline data was finalized; CY2013 data provided.

KPM #3	FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS - Percentage of enrollees 6 years of age and older who were hospitalized for treatment of mental health disorders and who were seen on an outpatient basis or were in intermediate treatment within seven days of discharge.	2013
Goal	Lower cost; better health	
Oregon Context	Lower cost; better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: reducing preventable rehospitalizations; integrating primary care and behavioral health.

2. ABOUT THE TARGETS

These improvement targets were established to result in an increase from the baseline data to the 2015 performance target which is the 2012 National Medicaid 90th percentile.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2013, 67.6% of patients ages 6 and older received a follow-up with a health care provider within 7 days of being discharged from the hospital for mental illness. This is an increase over the final CY 2011 baseline of 65.2%, but still slightly below the 2015 KPM target.

4. HOW WE COMPARE

Oregon is above the national 2012 Medicaid average of 43.7 percent and the 2012 Commercial average of 57.9%. However, Oregon is using a modified version of the measure which is including follow up care provided in community mental health settings, which results in our higher rate. Additional comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

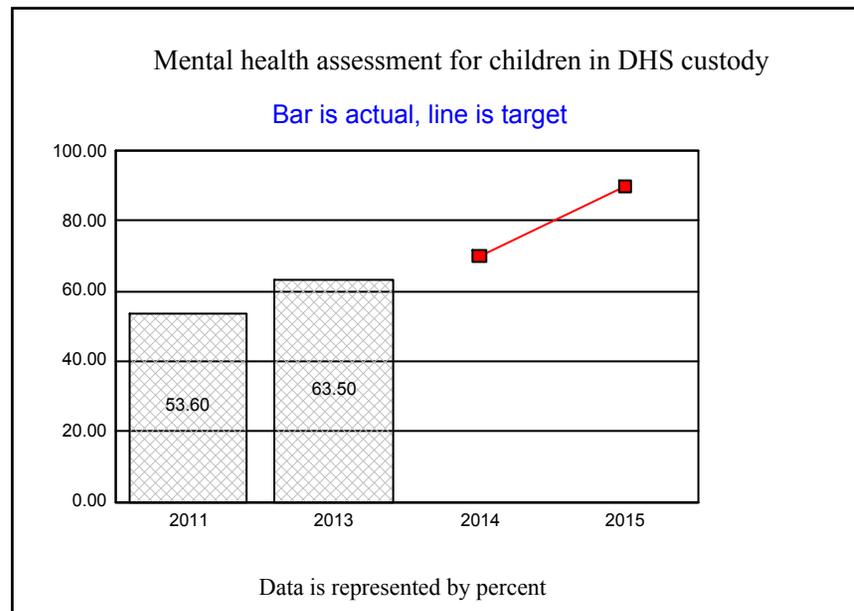
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

CY 2011 and CY 2013.

KPM #4	MENTAL AND PHYSICAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY – Percentage of children in DHS custody who receive a mental and physical health assessment within 60 days of initial custody.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Administrative data and child welfare records	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: Integrating primary care and behavioral health; improving access to effective and timely care.

2. ABOUT THE TARGETS

Targets based on calendar year 2011 baseline data and the 2013 and 2014 benchmark for the CCO incentive measures. Higher is better.

3. HOW WE ARE DOING

In 2011, 53.6% of children entering into foster care received timely mental and physical health assessments. In 2013, the rate increased slightly to 63.5%. Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results. One factor driving the improved 2013 rates was increased coordination between CCOs and local DHS branch offices.

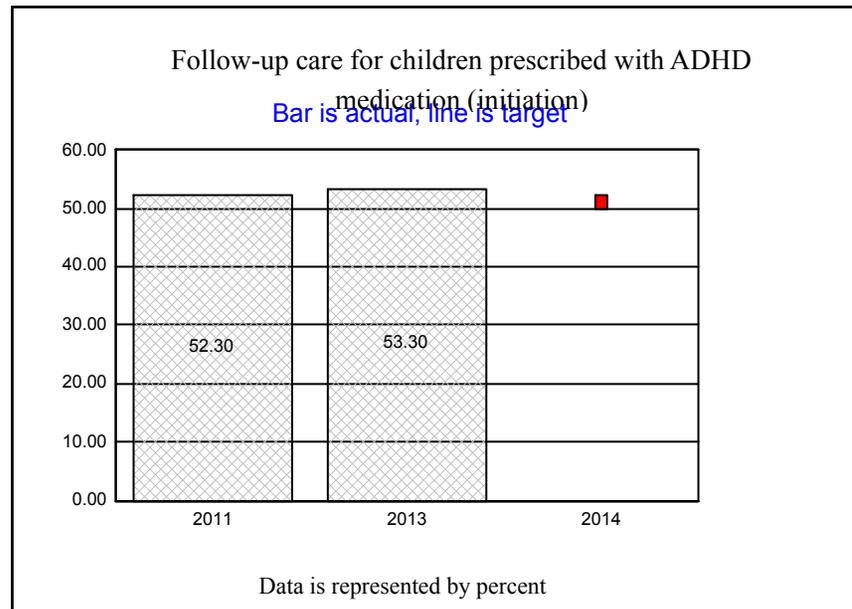
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year.

KPM #5	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (INITIATION) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed: INITIATION.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: integrating primary care and behavioral health; improving access to effective and timely care.

2. ABOUT THE TARGETS

The 2014 target is the 2012 National Medicaid 90th percentile. These targets will be revisited by the Metrics and Scoring Committee.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2011, 52.3% of children ages 6-12 had at least one follow up visit with a health care provider during the 30 days after receiving a new prescription for Attention Deficit Hyperactivity Disorder (ADHD). In 2013, the rate had increased just slightly to 53.3%, above the KPM target, and above the 90th percentile nationally. Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Oregon is above the national 90th percentile for both Medicaid and Commercial. Additional comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results. We have heard from providers that limiting the follow up visit to within the first 30 days is not well aligned with some of the current ADHD medications, which may require a 45 day initial prescription. Children with these longer initial prescriptions would fall outside of the 30 day window for this measure.

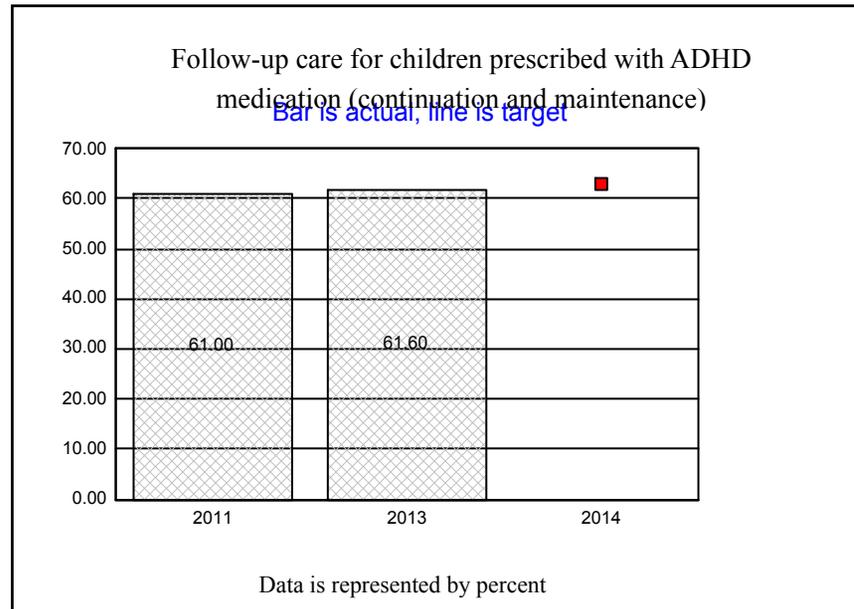
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year.

KPM #6	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (CONTINUATION AND MAINTENANCE) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed: CONTINUATION AND MAINTENANCE	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: integrating primary care and behavioral health; improving access to effective and timely care.

2. ABOUT THE TARGETS

The 2014 target is the 2012 National Medicaid 90th percentile. These targets will be revisited by the Metrics and Scoring Committee.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2011, 61.0% of children who remained on ADHD medication for 210 days after receiving a new prescription also had at least two follow up visits with a provider. In 2013, the rate had increased just slightly to 61.6%, still short of the state benchmark and KPM target of 63.0%. Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

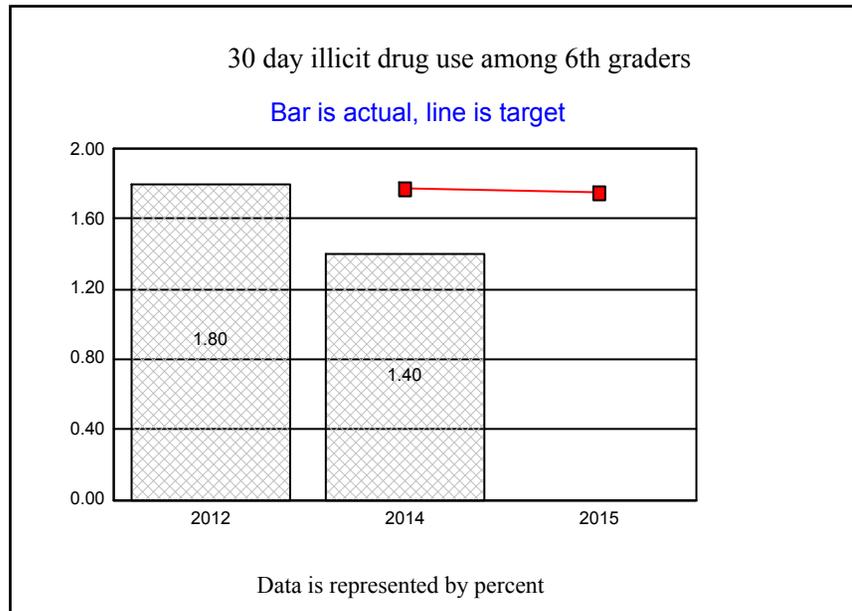
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year.

KPM #7	30 DAY ILLICIT DRUG USE AMONG 6TH GRADERS - Percentage of 6th graders who have used illicit drugs in the past 30 days.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Student wellness survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: integrating primary care and behavioral health. Addictions and Mental Health Division (AMH) uses a comprehensive approach to addressing illicit drug use issues and intervening when illicit drug use has occurred. This includes

a variety of community and county level programs funded with state and federal dollars.

In the comprehensive planning conducted at the County and Tribal levels all 36 counties and 9 tribes prioritized underage drinking as the number one concern. Closely associated with underage drinking is the use of marijuana. Marijuana is sometimes referred to as the 'turn-key drug' leading to other illicit drug use. Counties and Tribes have implemented programs to directly address underage drinking and illicit drug use. These include strategic media advocacy efforts directed at parents to set clear and specific guidelines for their children's not using alcohol and other drugs. AMH will continue to provide community grants to implement programs to reduce underage drinking and illicit drug use on the local level.

2. ABOUT THE TARGETS

Targets are based on trend data and the annual reduction necessary to meet the Healthy People 2020 goal of a 10% reduction.

3. HOW WE ARE DOING

In 2012, the rate of 6th graders who used any illicit drug in the past 30 days was 1.8%; in 2014 this decreased slightly to 1.4%.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

Favorable attitudes on the part of youth about using alcohol and other drugs can be a major predictor of their use. Parental attitudes towards drug use have a tremendous effect on youth use. Youth whose parents feel that drug use is a "rite of passage" or that "kids will be kids" have much higher rates of illicit drug use than those whose parents are clear that youth should not use drugs.

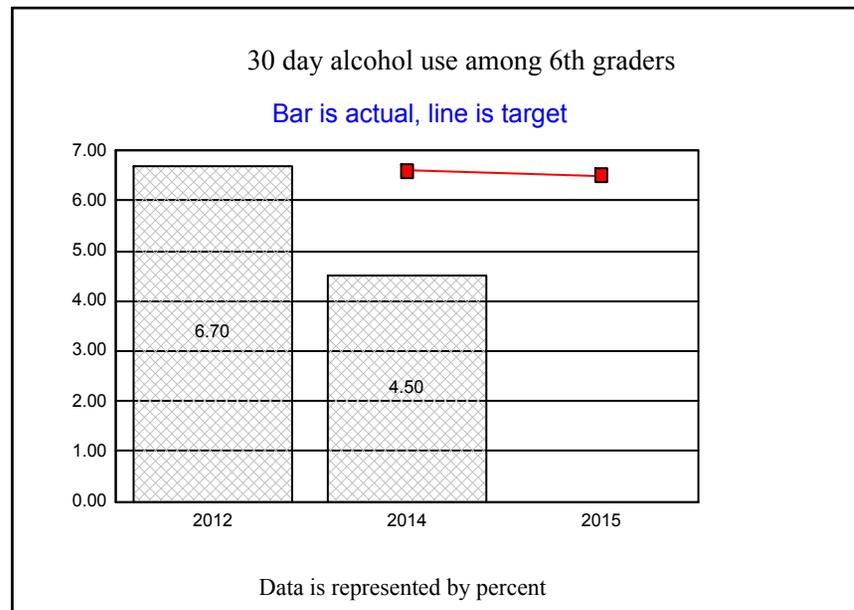
6. WHAT NEEDS TO BE DONE

Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to drug use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those opportunities. Parents who set clear and specific rules for their children continue to be a major prevention strategy to address illicit drug use.

7. ABOUT THE DATA

Data is extracted from the Oregon Student Wellness Survey. The survey is administered annually to 6th, 8th and 11th graders across the state.

KPM #8	30 DAY ALCOHOL USE AMONG 6TH GRADERS - Percentage of 6th graders who have used alcohol in the past 30 days.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Student wellness survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: integrating primary care and behavioral health. There is a comprehensive approach to addressing underage drinking issues and intervening when underage drinking has occurred. This includes a variety of community and county level programs funded with

state and federal dollars. In the comprehensive planning conducted at the County and Tribal levels, all 36 counties and 9 tribes prioritized underage drinking as the number one concern. Accordingly they have implemented programs to directly address underage drinking including minor decoy and controlled party dispersal programs, reward and reminder programs for alcohol retailers, shoulder tap (third party sales) operations, strategic media advocacy efforts directed at social policies related to underage drinking and parent programs that aid the parents in setting clear and specific guidelines concerning alcohol and other drug use.

2. ABOUT THE TARGETS

Targets are based on trend data and the annual reduction necessary to meet the Healthy People 2020 goal of a 10% reduction.

3. HOW WE ARE DOING

In 2012, 6.7% of 6th graders had at least one drink of alcohol within the past 30 days; in 2014, this decreased slightly to 4.5%, meeting the 2014 target.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

Perceptions of youth being caught – either in possession or purchasing alcohol – can be a major determinant in whether or not they use. Parental attitudes towards alcohol use have a tremendous effect on youth use. Youth whose parents feel that alcohol use is a “rite of passage” or that “kids will be kids” have much higher rates of drinking than those whose parents are clear that youth should not drink. Unfortunately, all too many Oregon parents still provide youth with a “safe” place to drink by providing the alcohol, taking away car keys so they don’t drive, or both. These mixed messages give youth the impression that it’s okay to drink, as long as they don’t drive.

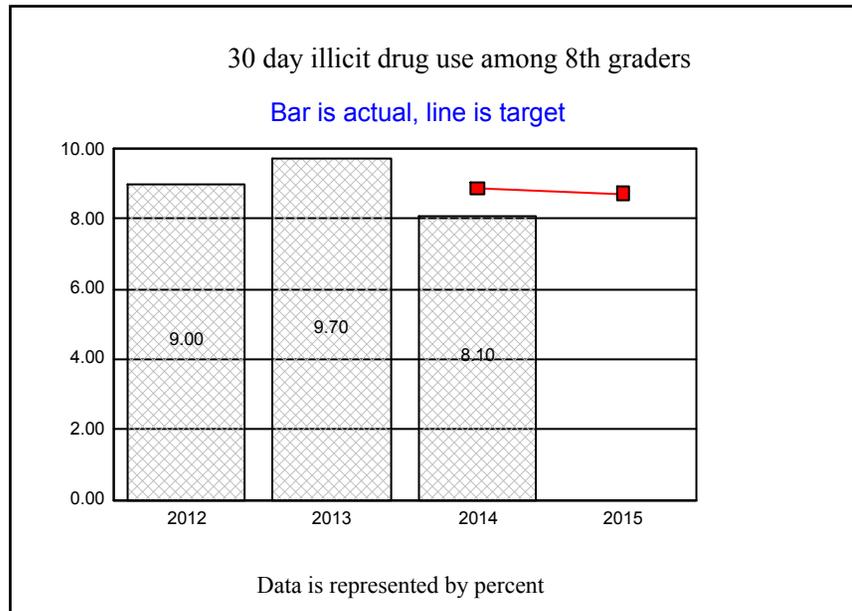
6. WHAT NEEDS TO BE DONE

Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to alcohol use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those opportunities. In addition, continued and consistent enforcement of current laws across the state would provide a constant message that Oregon does not tolerate underage drinking. Statewide media should continue to provide messages to parents that it’s against the law to provide alcohol to minors, as well as the importance of having well-defined expectations of their children regarding alcohol use.

7. ABOUT THE DATA

Data is extracted from the Oregon Healthy Teens Survey / Student Wellness Survey. The survey is administered annually to 6th, 8th and 11th graders across the state.

KPM #9	30 DAY ILLICIT DRUG USE AMONG 8TH GRADERS - Percentage of 8th graders who have used illicit drugs in the past 30 days.	2009
Goal	Better health	
Oregon Context	Better health	
Data Source	Student wellness survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: integrating primary care and behavioral health. Addictions and Mental Health Division (AMH) uses a comprehensive approach to addressing illicit drug use issues and intervening when illicit drug use has occurred. This includes

a variety of community and county level programs funded with state and federal dollars.

In the comprehensive planning conducted at the County and Tribal levels all 36 counties and 9 tribes prioritized underage drinking as the number one concern. Closely associated with underage drinking is the use of marijuana. Marijuana is sometimes referred to as the 'turn-key drug' leading to other illicit drug use. Counties and Tribes have implemented programs to directly address underage drinking and illicit drug use. These include strategic media advocacy efforts directed at parents to set clear and specific guidelines for their children's not using alcohol and other drugs. AMH will continue to provide community grants to implement programs to reduce underage drinking and illicit drug use on the local level.

2. ABOUT THE TARGETS

Targets are based on trend data and the annual reduction necessary to meet the Healthy People 2020 goal of a 10% reduction.

3. HOW WE ARE DOING

In 2012, 9% of 8th graders had used any illicit drug in the past 30 days; in 2014, this decreased slightly to 8.1%, just below the 2014 target.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

Favorable attitudes on the part of youth about using alcohol and other drugs can be a major predictor of their use. Parental attitudes towards drug use have a tremendous effect on youth use. Youth whose parents feel that drug use is a "rite of passage" or that "kids will be kids" have much higher rates of illicit drug use than those whose parents are clear that youth should not use drugs.

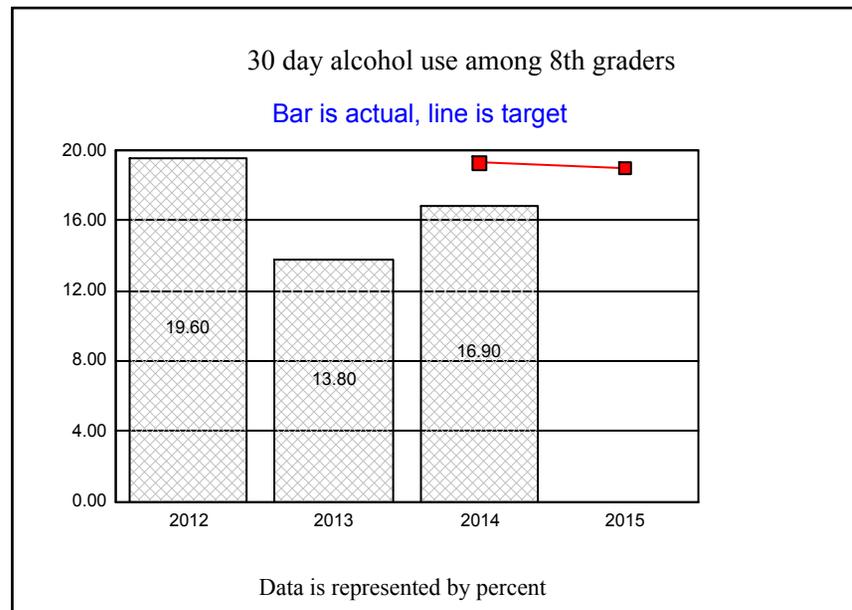
6. WHAT NEEDS TO BE DONE

Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to drug use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those opportunities. Parents who set clear and specific rules for their children continue to be a major prevention strategy to address illicit drug use.

7. ABOUT THE DATA

Data is extracted from the Oregon Student Wellness Survey / Health Teens Survey. The survey is administered annually to 6th, 8th and 11th graders across the state.

KPM #10	30 DAY ALCOHOL USE AMONG 8TH GRADERS - Percentage of 8th graders who have used alcohol in the past 30 days.	2009
Goal	Better health	
Oregon Context	Better health	
Data Source	Student wellness survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: integrating primary and behavioral health. There is a comprehensive approach to addressing underage drinking issues and intervening when underage drinking has occurred. This includes a variety of community and county level programs funded with

state and federal dollars. In the comprehensive planning conducted at the County and Tribal levels, all 36 counties and 9 tribes prioritized underage drinking as the number one concern. Accordingly they have implemented programs to directly address underage drinking including minor decoy and controlled party dispersal programs, reward and reminder programs for alcohol retailers, shoulder tap (third party sales) operations, strategic media advocacy efforts directed at social policies related to underage drinking and parent programs that aid the parents in setting clear and specific guidelines concerning alcohol and other drug use.

2. ABOUT THE TARGETS

Targets are based on trend data and the annual reduction necessary to meet the Healthy People 2020 goal of a 10% reduction.

3. HOW WE ARE DOING

In 2012, 19.6% of 8th graders had at least one drink of alcohol in the past 30 days; in 2014, the rate decreased slightly to 16.9%, meeting the 2014 target.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

Perceptions of youth being caught – either in possession or purchasing alcohol – can be a major determinant in whether or not they use. Parental attitudes towards alcohol use have a tremendous effect on youth use. Youth whose parents feel that alcohol use is a “rite of passage” or that “kids will be kids” have much higher rates of drinking than those whose parents are clear that youth should not drink. Unfortunately, all too many Oregon parents still provide youth with a “safe” place to drink by providing the alcohol, taking away car keys so they don’t drive, or both. These mixed messages give youth the impression that it’s okay to drink, as long as they don’t drive.

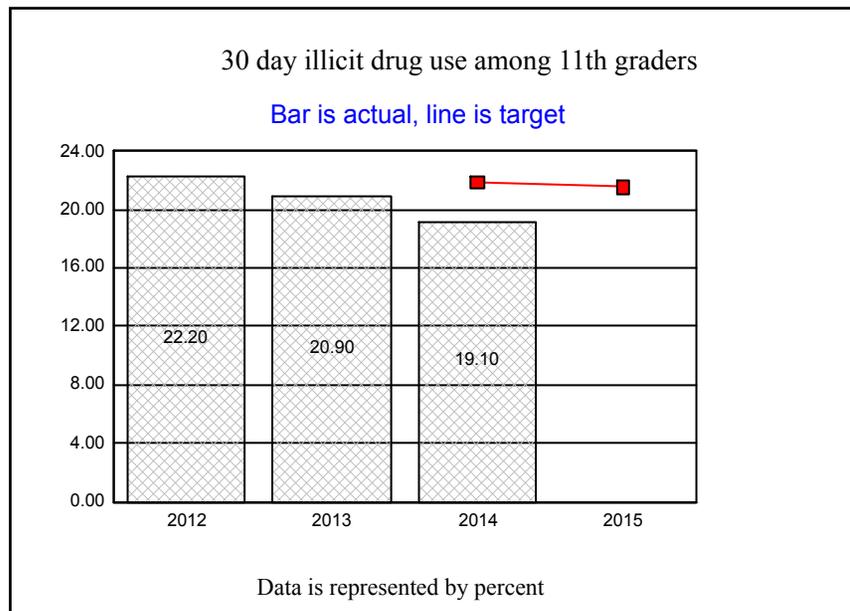
6. WHAT NEEDS TO BE DONE

Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to alcohol use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those opportunities. In addition, continued and consistent enforcement of current laws across the state would provide a constant message that Oregon does not tolerate underage drinking. Statewide media should continue to provide messages to parents that it’s against the law to provide alcohol to minors, as well as the importance of having well-defined expectations of their children regarding alcohol use.

7. ABOUT THE DATA

Data is extracted from the Oregon Healthy Teens Survey / Student Wellness Survey. The survey is administered annually to 8th and 11th graders across the state.

KPM #11	30 DAY ILLICIT DRUG USE AMONG 11TH GRADERS - Percentage of 11th graders who have used illicit drugs in the past 30 days.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Student wellness survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: integrating primary care and behavioral health.

Addictions and Mental Health Division (AMH) uses a comprehensive approach to addressing illicit drug use issues and intervening when illicit drug use has occurred. This includes

a variety of community and county level programs funded with state and federal dollars.

In the comprehensive planning conducted at the County and Tribal levels all 36 counties and 9 tribes prioritized underage drinking as the number one concern. Closely associated with underage drinking is the use of marijuana. Marijuana is sometimes referred to as the 'turn-key drug' leading to other illicit drug use. Counties and Tribes have implemented programs to directly address underage drinking and illicit drug use. These include strategic media advocacy efforts directed at parents to set clear and specific guidelines for their children's not using alcohol and other drugs. AMH will continue to provide community grants to implement programs to reduce underage drinking and illicit drug use on the local level.

2. ABOUT THE TARGETS

Targets are based on trend data and the annual reduction necessary to meet the Healthy People 2020 goal of a 10% reduction.

3. HOW WE ARE DOING

In 2012, 22.2% of 11th graders had used an illicit drug in the past 30 days; in 2014, this decreased to 19.1%, meeting the 2014 target.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

Favorable attitudes on the part of youth about using alcohol and other drugs can be a major predictor of their use. Parental attitudes towards drug use have a tremendous effect on youth use. Youth whose parents feel that drug use is a "rite of passage" or that "kids will be kids" have much higher rates of illicit drug use than those whose parents are clear that youth should not use drugs.

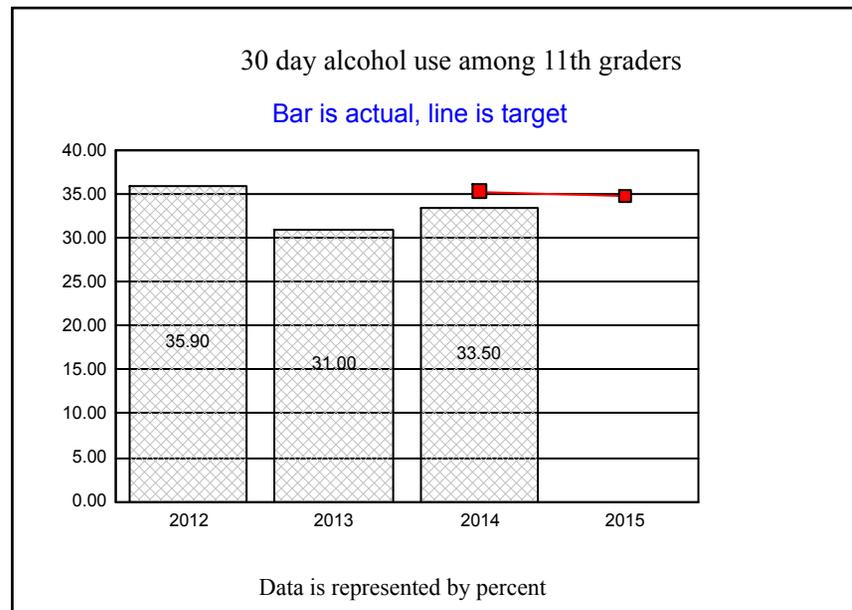
6. WHAT NEEDS TO BE DONE

Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to drug use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those opportunities. Parents who set clear and specific rules for their children continue to be a major prevention strategy to address illicit drug use.

7. ABOUT THE DATA

Data is extracted from the Oregon Healthy Teens Survey / Student Wellness Survey. The survey is administered annually to 6th, 8th and 11th graders across the state.

KPM #12	30 DAY ALCOHOL USE AMONG 11TH GRADERS - Percentage of 11th graders who have used alcohol in the past 30 days.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Student wellness survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: integrating primary care and behavioral health. There is a comprehensive approach to addressing underage drinking issues and intervening when underage drinking has occurred. This includes a variety of community and county level programs funded with

state and federal dollars. In the comprehensive planning conducted at the County and Tribal levels, all 36 counties and 9 tribes prioritized underage drinking as the number one concern. Accordingly they have implemented programs to directly address underage drinking including minor decoy and controlled party dispersal programs, reward and reminder programs for alcohol retailers, shoulder tap (third party sales) operations, strategic media advocacy efforts directed at social policies related to underage drinking and parent programs that aid the parents in setting clear and specific guidelines concerning alcohol and other drug use.

2. ABOUT THE TARGETS

Targets are based on trend data and the annual reduction necessary to meet the Healthy People 2020 goal of a 10% reduction.

3. HOW WE ARE DOING

In 2012, 35.9% of Oregon 11th graders had at least one drink of alcohol in the past 30 days; in 2014 this decreased slightly to 33.5%, meeting the 2014 target.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

Perceptions of youth being caught – either in possession or purchasing alcohol – can be a major determinant in whether or not they use. Parental attitudes towards alcohol use have a tremendous effect on youth use. Youth whose parents feel that alcohol use is a “rite of passage” or that “kids will be kids” have much higher rates of drinking than those whose parents are clear that youth should not drink. Unfortunately, all too many Oregon parents still provide youth with a “safe” place to drink by providing the alcohol, taking away car keys so they don’t drive, or both. These mixed messages give youth the impression that it’s okay to drink, as long as they don’t drive.

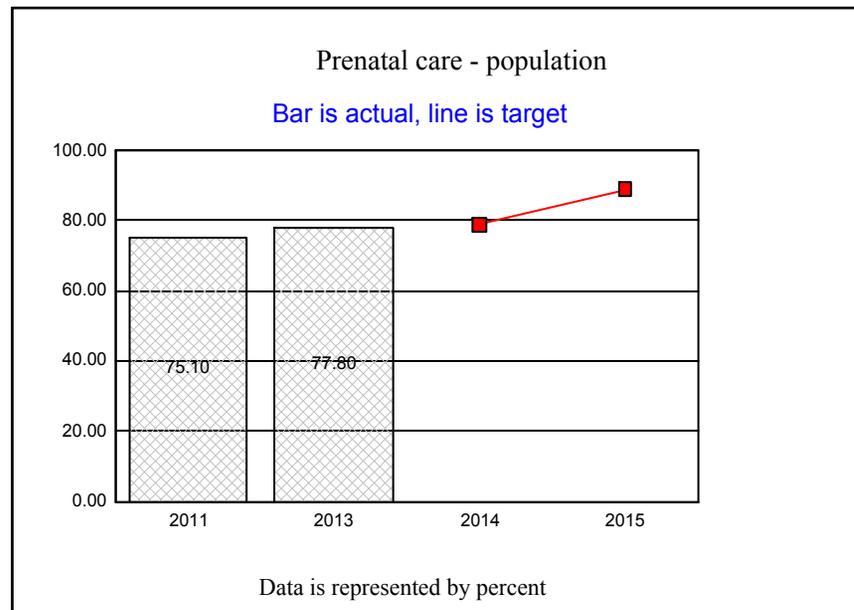
6. WHAT NEEDS TO BE DONE

Oregon needs to continue providing opportunities for youth to engage in positive, safe and healthy alternatives to alcohol use. Providing communities with adequate prevention funding to implement comprehensive evidence-based programs would give youth those opportunities. In addition, continued and consistent enforcement of current laws across the state would provide a constant message that Oregon does not tolerate underage drinking. Statewide media should continue to provide messages to parents that it’s against the law to provide alcohol to minors, as well as the importance of having well-defined expectations of their children regarding alcohol use.

7. ABOUT THE DATA

Data is extracted from the Oregon Healthy Teens Survey / Student Wellness Survey. The survey is administered annually to 8th and 11th graders across the state.

KPM #13	PRENATAL CARE (POPULATION) - Percentage of women who initiated prenatal care in the first 3 months of pregnancy.	2013
Goal	Better care/access; lower cost; better health	
Oregon Context	Better care/access; lower cost; better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

Outreach and link women to early and adequate prenatal care

Oregon Mothers Care (OMC), a statewide initiative to improve access to early prenatal care, provides services throughout Oregon at 29 sites serving 26

counties. The program links women to health insurance enrollment and health care providers, and is funded by Title V, along with local funds. The OMC program has developed partnerships among public and private agencies to streamline, coordinate, and promote access to prenatal services. Project components include a referral and support system for prenatal services, including dental services, and an ongoing public awareness, outreach, and education campaign.

An MCH warm-line assists pregnant women to access prenatal care services and other services in their community. The warm-line is now a part of the statewide 211 info line. This allows 24 hours a day, 7 days a week as well as on-line access to comprehensive community based information and referral.

Statewide home visiting system

Prenatal Home Visiting programs work to increase access and effective utilization of prenatal care and other services for high risk pregnant women. Oregon was awarded both formula and competitive Maternal and Infant Early Childhood Home Visiting (MIECHV) grants. The grants are enhancing access to both clinical and home visiting services through expansion of Healthy Families America/Healthy Start, Early Head Start, and Nurse Family Partnership home visiting services. Public Health Nurse Maternity Case Management (MCM) and home visiting services are offered through local health departments.

Collaboration with state public health partners

Ongoing collaboration with state public health partners (reproductive health, family planning and WIC) ensures that education about the importance of prenatal care is discussed and women who screen positive for pregnancy are referred to early care.

Surveillance and data collection

Administration and analysis of the PRAMS survey of post-partum women to collect information related to prenatal care access for surveillance and program planning. Oregon PRAMS data has been continuously collected since 1998 and provides information about utilization, access, and quality of prenatal care.

Policy advocacy for early prenatal care system and quality improvements

Supporting CCOs in achieving early prenatal care for members by developing resources and offering technical assistance for CCOs and local public health authorities. **Medicaid provides prenatal health coverage for undocumented women** As of October 2013, Medicaid coverage for prenatal services is available to pregnant women who would otherwise be eligible for OHP except for their immigration status. Initially a pilot project in two counties, the program is now statewide.

2. ABOUT THE TARGETS

Early initiation of prenatal care maximizes opportunities for women to prepare for labor/delivery, motherhood and the longterm health of both child and mother. The desired direction of change is to increase the percent of women who initiate prenatal care in the first 3 months of their pregnancy.

3. HOW WE ARE DOING

The rate of first trimester prenatal care has risen from 70.2% in 2008 to 77.8 in 2013. Starting in 2008, there was a change in how prenatal care was calculated from the birth certificate making trend analysis prior to that time difficult.

4. HOW WE COMPARE

The overall rate in Oregon nears the HP 2020 objective of 77.9%, however rates vary by race/ethnicity and maternal age. According to the March of Dimes Peristats, in 2012, Washington's rate was 73.5% and California's 82.8%, compared to 76.3% in Oregon.

5. FACTORS AFFECTING RESULTS

Women give a variety of reasons for not accessing early prenatal care. Women may not feel that early care is important, may not know they are pregnant, or may be experiencing barriers such as lack of insurance coverage, inability to get an appointment or unreliable transportation.

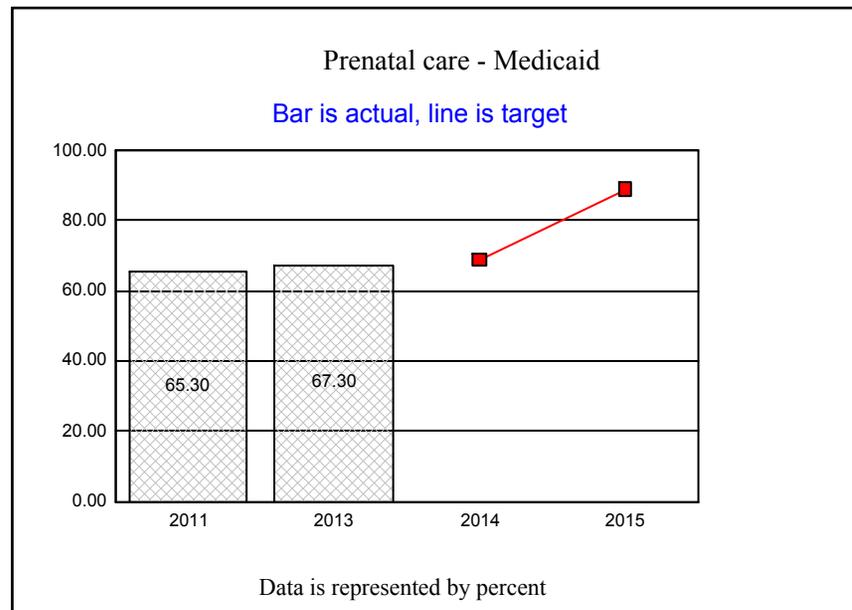
6. WHAT NEEDS TO BE DONE

Opportunities to increase rates of early prenatal care have arisen as the Affordable Care Act (ACA) is implemented and health care transformation efforts in Oregon move forward. Medicaid expansion and the creation of Oregon's Health Insurance Marketplace (Cover Oregon) mean that more women are eligible for insurance regardless of pregnancy status. More insured women will hopefully mean that more women will have established care providers who can either provide or refer for prenatal care. In addition, the Affordable Care Act includes a mandate for health insurance to cover preventative services including preconception health visits. Preconception health visits are an opportunity to teach women about the importance of early prenatal care.

7. ABOUT THE DATA

Prenatal care initiation is calculated from birth certificates and reported out by calendar year of the child's birth. It is calculated from several variables: (1) date of first prenatal care visit; (2) first day of pregnancy and (3) definition of first trimester. (1) Date of first prenatal care visit depends on mother's prenatal care chart being available or mother's recall. (2) First day of pregnancy depends on mother's recall of the date on which her last menstrual period began. This date is sometimes imputed by taking Clinical Estimate of Gestation and calculating first day of pregnancy. (3) First trimester is often but not universally defined as the first 91 days since the date on which the mother's last menstrual period began.

KPM #14	PRENATAL CARE (MEDICAID) - Percentage of women who initiated prenatal care within 42 days of enrollment.	2013
Goal	Better care/access; lower cost; better health	
Oregon Context	Better care/access; lower cost; better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

Outreach and link women to early and adequate prenatal care

Oregon Mothers Care (OMC), a statewide initiative to improve access to early prenatal care, provides services throughout Oregon at 29 sites serving 26

counties. The program links women to health insurance enrollment and health care providers, and is funded by Title V, along with local funds. The OMC program has developed partnerships among public and private agencies to streamline, coordinate, and promote access to prenatal services. Project components include a referral and support system for prenatal services, including dental services, and an ongoing public awareness, outreach, and education campaign.

An MCH warm-line assists pregnant women to access prenatal care services and other services in their community. The warm-line is now a part of the statewide 211 info line. This allows 24 hours a day, 7 days a week as well as on-line access to comprehensive community based information and referral.

Statewide home visiting system

Prenatal Home Visiting programs work to increase access and effective utilization of prenatal care and other services for high risk pregnant women. Oregon was awarded both formula and competitive Maternal and Infant Early Childhood Home Visiting (MIECHV) grants. The grants are enhancing access to both clinical and home visiting services through expansion of Healthy Families America/Healthy Start, Early Head Start, and Nurse Family Partnership home visiting services. Public Health Nurse Maternity Case Management (MCM) and home visiting services are offered through local health departments.

Collaboration with state public health partners

Ongoing collaboration with state public health partners (reproductive health, family planning and WIC) ensures that education about the importance of prenatal care is discussed and women who screen positive for pregnancy are referred to early care.

Surveillance and data collection

Administration and analysis of the PRAMS survey of post-partum women to collect information related to prenatal care access for surveillance and program planning. Oregon PRAMS data has been continuously collected since 1998 and provides information about utilization, access, and quality of prenatal care.

Policy advocacy for early prenatal care system and quality improvements

Supporting CCOs in achieving early prenatal care for members by developing resources and offering technical assistance for CCOs and local public health authorities. **Medicaid provides prenatal health coverage for undocumented women** As of October 2013, Medicaid coverage for prenatal services is available to pregnant women who would otherwise be eligible for OHP except for their immigration status. Initially a pilot project in two counties, the program is now statewide.

2. ABOUT THE TARGETS

Early initiation of prenatal care maximizes opportunities for women to prepare for labor/delivery, motherhood and the longterm health of both child and mother. The desired direction of change is to increase the percent of women who initiate prenatal care in the 3 months of their pregnancy. The 2014 KPM target is the 2012 national Medicaid 75th percentile (for administrative data only). This is also the 2013 benchmark for the CCOs, which will be revisited by the Metrics & Scoring Committee annually.

3. HOW WE ARE DOING

The rate of first trimester prenatal care for Medicaid has increased slightly from 65.3% in 2011 to 67.3% in 2013, still shy of the 69% target.

4. HOW WE COMPARE

Oregon's 2013 performance is close to the national 2012 75th percentile for Medicaid (administrative data only); however, Oregon's Medicaid rate is still below the first trimester prenatal care rate for the general population.

5. FACTORS AFFECTING RESULTS

Women give a variety of reasons for not accessing early prenatal care. Women may not feel that early care is important, may not know they are pregnant, or may be experiencing barriers such as lack of insurance coverage, inability to get an appointment or unreliable transportation.

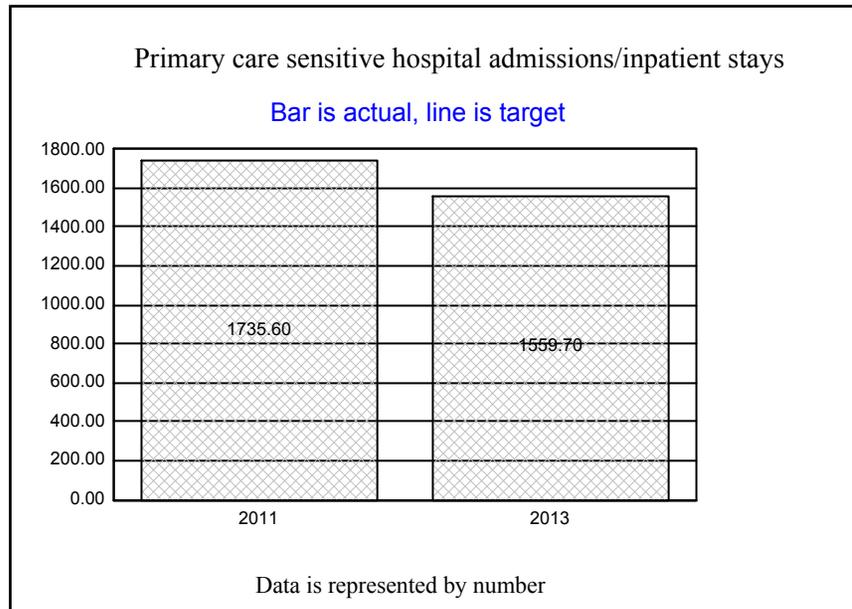
6. WHAT NEEDS TO BE DONE

Opportunities to increase rates of early prenatal care have arisen as the Affordable Care Act (ACA) is implemented and health care transformation efforts in Oregon move forward. Medicaid expansion and the creation of Oregon's Health Insurance Marketplace (Cover Oregon) mean that more women are eligible for insurance regardless of pregnancy status. More insured women will hopefully mean that more women will have established care providers who can either provide or refer for prenatal care. In addition, the Affordable Care Act includes a mandate for health insurance to cover preventative services including preconception health visits. Preconception health visits are an opportunity to teach women about the importance of early prenatal care.

7. ABOUT THE DATA

Calendar year. This measure is calculated using administrative data only; in 2014, the measure will include medical record review, which will give a more accurate report of the timeliness of prenatal care for Medicaid.

KPM #15	PRIMARY CARE SENSITIVE HOSPITAL ADMISSIONS/INPATIENT STAYS - Rate per 100,000 client years of admissions (for 12 diagnoses) that are more appropriately treated in an outpatient setting.	2013
Goal	Lower cost; better health	
Oregon Context	Lower cost; better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: Reducing preventable rehospitalizations.

2. ABOUT THE TARGETS

Targets have not yet been established. The statewide performance measure targets under the CMS waiver call for a 10% reduction in these admission rates.

3. HOW WE ARE DOING

In 2011, the composite rate for all prevention quality indicators was 1,735.6/100,000 member years; in 2013, the composite rate had decreased to 1,559.7/100,000 member years, a trend in the right direction.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As more data are collected, we will have a better understanding of the factors affecting results.

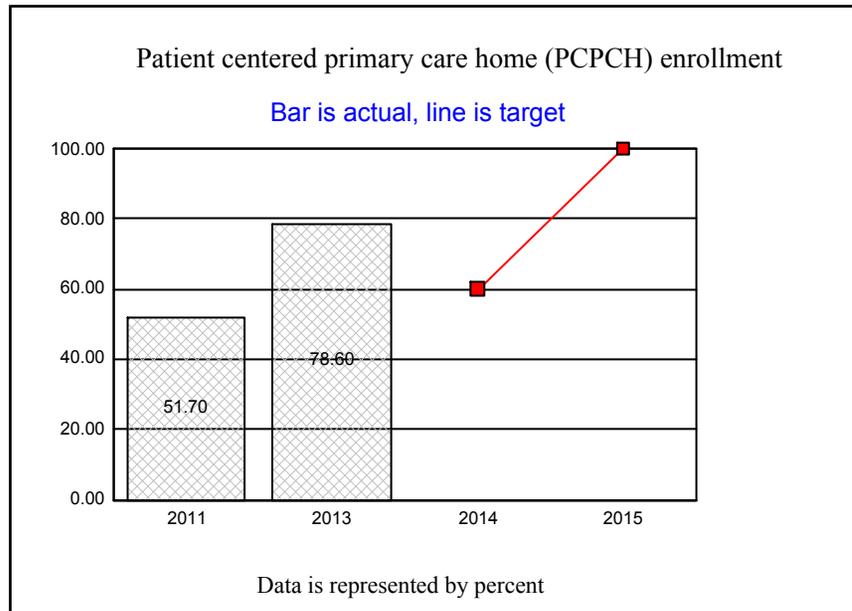
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year, administrative data; data are reported per 100,000 member years.

KPM #16	PATIENT CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT - Number of members enrolled in patient-centered primary care homes by tier.	2013
Goal	Better care/access	
Oregon Context	Better care/access	
Data Source	Patient-Centered Primary Care Home enrollment data are reported quarterly by CCOs.	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: Improving access to effective and timely care; Improving primary care for all populations.

2. ABOUT THE TARGETS

These targets have been established to achieve the goal of having 100% of Medicaid members enrolled in a recognized patient-centered primary care home. This aligns with the CCO incentive measure target.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2011, 51.8 percent of Medicaid members were enrolled in a certified patient centered primary care home. This increased to 78.6 percent by the end of 2013, well above the 2014 target of 60 percent. All but one CCO saw increased PCPCH enrollment between 2011 and 2013. Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

Coordinated care organizations are driving improvement on this measure through two main efforts: (1) working with contracted providers to go through the PCPCH recognition process, and (2) preferentially assigning members to certified PCPCHs. As we collect more data, we will have a better understanding of the factors affecting the results.

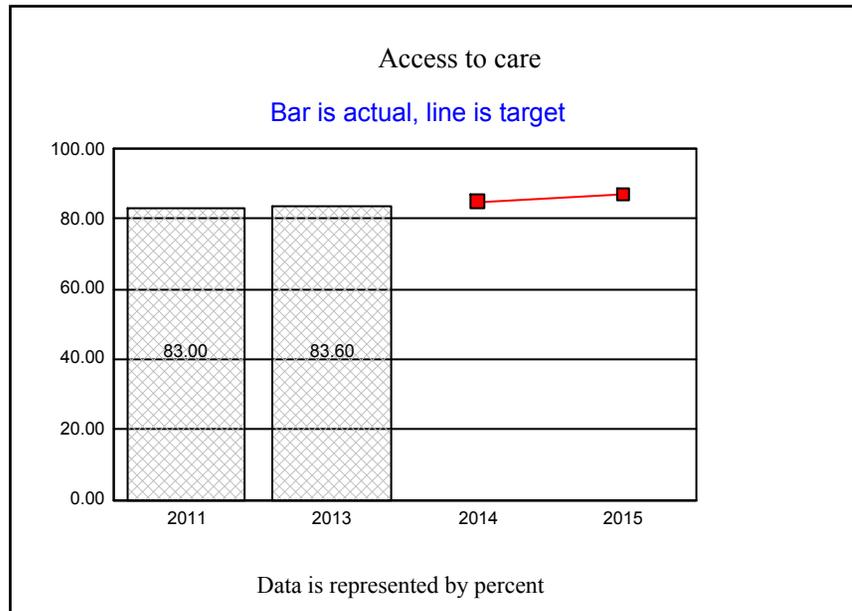
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year. Data are self-reported by CCOs as part of their contractually required provider network capacity / network adequacy reporting.

KPM #17	ACCESS TO CARE - Percentage of members who responded "always" or "usually" too getting care quickly (composite for adult and child).	2013
Goal	Better care/access; better health	
Oregon Context	Better care/access; better health	
Data Source	CAHPS Health Plan survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: Improving access to effective and timely care.

2. ABOUT THE TARGETS

Targets are based on the 2012 National Medicaid 75th percentile.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2011, 83 percent of adults and children received appointments and care when they needed them. In 2013, this increased slightly to 83.6 percent, still below the benchmark of 87.0 percent. This increase was seen in 10 of the 15 Coordinated Care Organizations (CCOs).

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

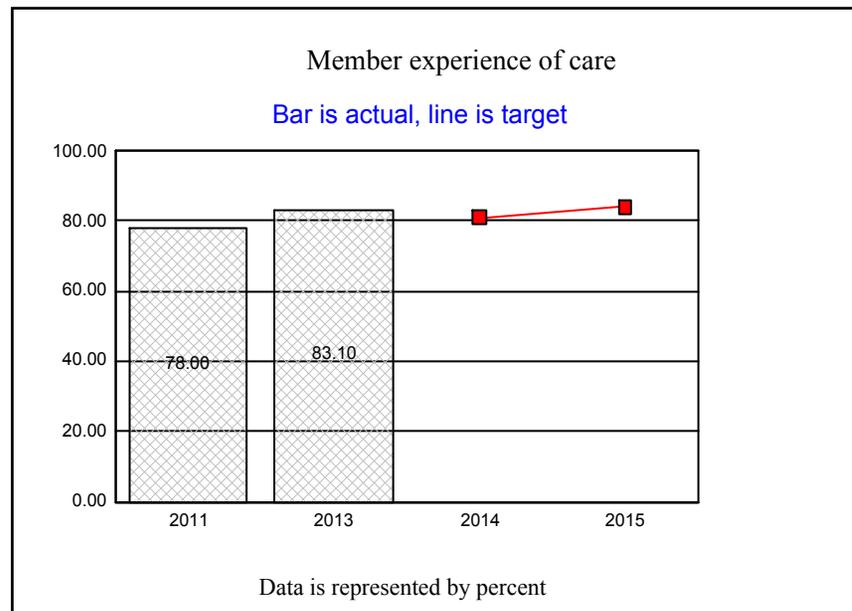
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year. This KPM reports the percentage of members who responded "always" or "usually" to getting care quickly. Results are a composite of adult and child survey questions.

KPM #18	MEMBER EXPERIENCE OF CARE - Composite measurement: how well doctors communicate; health plan information and customer service (Medicaid population).	2013
Goal	Better care/access	
Oregon Context	Better care/access	
Data Source	CAHPS Health Plan survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: Improving access to effective and timely care.

2. ABOUT THE TARGETS

Targets are based on the 2012 National Medicaid 75th percentile.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2011, 78 percent of adults and children reported they received needed information or help and thought they were treated with courtesy and respect by customer service staff. In 2013, the rate increased to 83.1 percent, just shy of the benchmark of 84.0 percent, but still notable considering this increase occurred as CCOs were newly established. This increase from 2011 to 2013 was seen across 13 of the 15 CCOs. Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

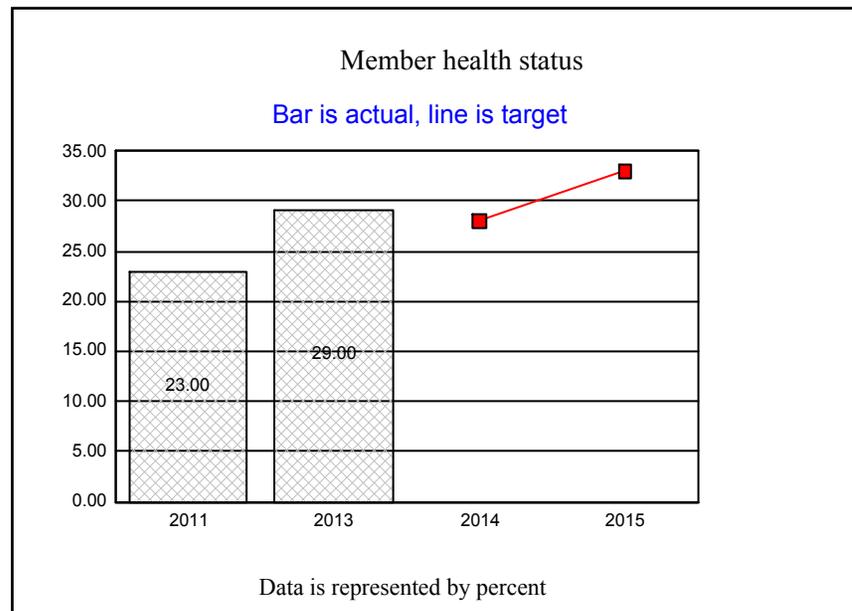
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year. This KPM reports on the following elements: getting care needed; getting care quickly; how well doctors communicate; health plan information. Results are a composite of adult and child survey questions.

KPM #19	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good).	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	CAHPS survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Areas: Addressing discrete health issues; improving primary care for all populations.

2. ABOUT THE TARGETS

The targets are based on the National Medicaid 75th percentile.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2011, 23% of CCO enrollees responding to the CAHPS survey had a positive self-reported rating of overall health (excellent or very good). In 2013, this had increased to 29%, meeting the 2014 target.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

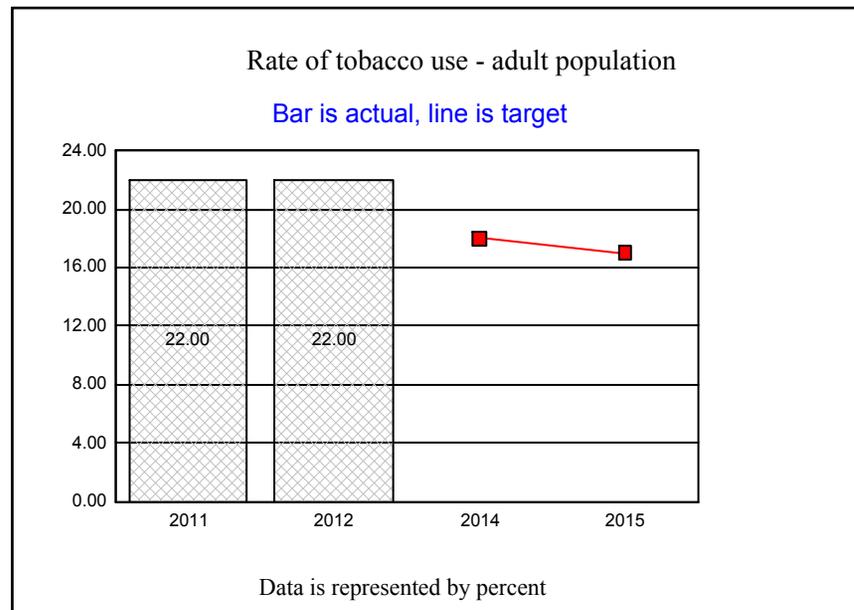
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year. The results report the percentage of CAHPS survey respondents with a positive self-reported rating of overall health.

KPM #20	RATE OF TOBACCO USE (POPULATION) - Rate of tobacco use among adults.	2002
Goal	Better health	
Oregon Context	Better health	
Data Source	BRFSS	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

The goal of the Oregon Tobacco Prevention and Education Program (TPEP) is to reduce tobacco use among all Oregonians. This is accomplished by focusing on the components of the World Health Organization’s MPOWER framework: **Monitor** tobacco use and prevention policies, **Protect** people from tobacco smoke, **Offer** help to quit tobacco use, **Warn** about the dangers of tobacco, **Enforce** bans on tobacco advertising, promotion and sponsorship, and **Raise** the price of tobacco. This work is undertaken by the county, tribal and

state tobacco programs working synergistically to ensure that every Oregonians experiences the benefits of tobacco prevention work in the places where they live, work, play, and learn. No single component of Oregon's TPEP is solely responsible for reducing tobacco use—a comprehensive approach must be employed to effectively decrease tobacco use.

2. ABOUT THE TARGETS

Tobacco use is the leading preventable cause of death in Oregon and the nation. Cigarette smoking is the most common form of tobacco use. Quitting tobacco at any age has significant health benefits. Successful efforts to decrease the prevalence of tobacco use among all Oregon adults and Oregon adults who are covered by Medicaid will lead to reduced morbidity and mortality. This in turn will contribute substantially toward the OHA|DHS vision of “a healthy Oregon” in the short-term and long-term.

3. HOW WE ARE DOING

In 2012, the proportion of adult tobacco users in the Medicaid population was 43 percent higher than among the general adult population (34% versus 22%).

4. HOW WE COMPARE

Other groups report cigarette smoking prevalence alone, rather than tobacco use prevalence, so no external data are readily available to compare against.

5. FACTORS AFFECTING RESULTS

The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidence-based funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, to eliminate exposure to secondhand smoke, and to identify and eliminate tobacco-related disparities. For Oregon, the recommended funding is \$ 11.60 per capita, which equates to \$43 million annually. This recommendation represents just a fraction of the cost of tobacco use, with more than \$2.5 billion lost to medical care and lost productivity annually in Oregon.

During the 2013-2015 biennium Oregon is slated to receive about \$2.87 per capita for tobacco prevention from all funding sources, which is 28% of CDC's recommended funding for tobacco prevention. This is comparable with what was allotted to Oregon tobacco prevention a dozen years ago, however, funding levels have been much lower in the years in between. TPEP also received approximately \$2.87 per capita during the 2001-2003 biennium, but was temporarily shuttered when the Legislature directed the allocated revenues elsewhere. After this interruption, smoking among pregnant women and adolescents stopped decreasing, and per capita consumption of cigarettes increased for the first time since the program was first implemented.

6. WHAT NEEDS TO BE DONE

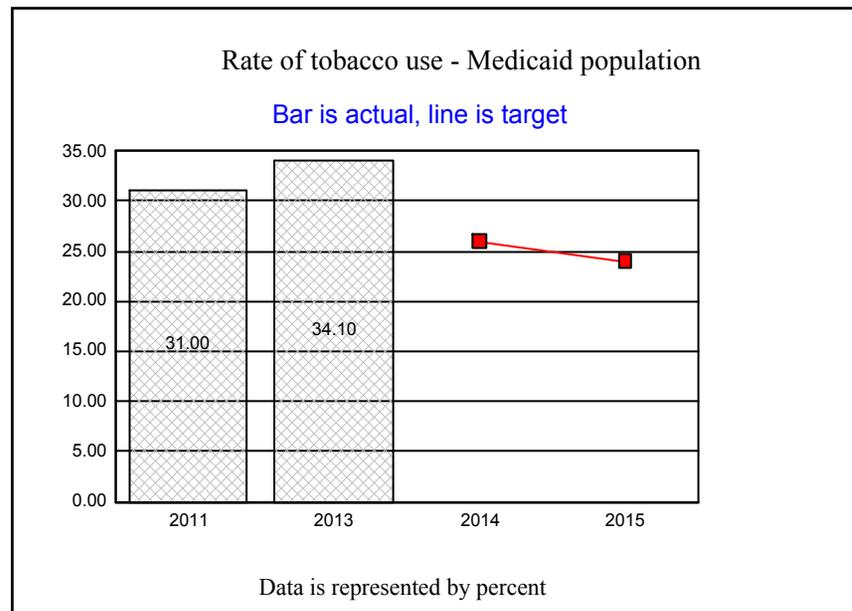
Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use, and conversely, increases in funding for tobacco prevention lead to increased success in reducing tobacco use. To keep youth and young adults from starting to smoke, protect Oregonians from

secondhand smoke, identify and eliminate tobacco-related disparities and help smokers quit, funding for comprehensive tobacco control needs to be increased. Prior successes in Oregon and a substantial evidence-base from elsewhere tell us that a comprehensive program is the most effective means to counter the devastating effects of tobacco.

7. ABOUT THE DATA

Tobacco use prevalence among adult Oregonians is available annually and reported once per calendar year. The estimate is derived from the Oregon Behavioral Risk Factor Surveillance System (BRFSS), a telephone-administered survey of adults that examines health related behaviors. Advantages associated with this data source include its widespread use across the nation, permitting national and cross-state comparison (although, as mentioned previously, other groups report cigarette smoking rather than tobacco use). The Oregon BRFSS began including cellular telephones in its sample in 2010, which improved the representativeness of the estimate. Data collected in 2010 and later, however, cannot be compared with earlier years. "Tobacco use" is defined as having smoked at least 100 cigarettes in a lifetime and currently smoking every day or some days, and/or currently using chewing tobacco, snuff, or snus every day or some days.

KPM #21	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	CAHPS survey	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

The goal of the Oregon Tobacco Prevention and Education Program (TPEP) is to reduce tobacco use among all Oregonians. This is accomplished by focusing on the components of the World Health Organization’s MPOWER framework: **Monitor** tobacco use and prevention policies, **Protect** people from tobacco smoke, **Offer** help to quit tobacco use, **Warn**

about the dangers of tobacco, **Enforce** bans on tobacco advertising, promotion and sponsorship, and **Raise** the price of tobacco. This work is undertaken by the county, tribal and state tobacco programs working synergistically to ensure that every Oregonians experiences the benefits of tobacco prevention work in the places where they live, work, play, and learn. No single component of Oregon's TPEP is solely responsible for reducing tobacco use—a comprehensive approach must be employed to effectively decrease tobacco use.

2. ABOUT THE TARGETS

Tobacco use is the leading preventable cause of death in Oregon and the nation. Cigarette smoking is the most common form of tobacco use. Quitting tobacco at any age has significant health benefits. Successful efforts to decrease the prevalence of tobacco use among all Oregon adults and Oregon adults who are covered by Medicaid will lead to reduced morbidity and mortality. This in turn will contribute substantially toward the OHA|DHS vision of “a healthy Oregon” in the short-term and long-term.

3. HOW WE ARE DOING

In 2012, the proportion of adult tobacco users in the Medicaid population was 43% higher than among the general adult population (34% vs 22%). The tobacco use prevalence increased in the Medicaid population from 31% in 2011 to 34% in 2013.

4. HOW WE COMPARE

Among data included in the national CAHPS survey database, in 2013, 69% of Medicaid members nationally reported they currently smoke or use tobacco every day, some days or not at all, compared to the Oregon rate of 34%.

5. FACTORS AFFECTING RESULTS

The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidence-based funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, to eliminate exposure to secondhand smoke, and to identify and eliminate tobacco-related disparities. For Oregon, the recommended funding is \$10.09 per capita, which equates to \$39.3 million annually. This recommendation represents just a fraction of the cost of tobacco use, with more than \$2.5 billion lost to medical care and lost productivity annually in Oregon.

During the 2013 - 2015 biennium Oregon is slated to receive about \$2.87 per capita for tobacco prevention from all funding sources, which is 28% of CDC's recommended funding for tobacco prevention. This is comparable with what was allotted to Oregon tobacco prevention a dozen years ago, however, funding levels have been much lower in the years in between. TPEP also received about \$2.87 per capita during the 2001-2003 biennium, but was temporarily shuttered when the Legislature directed the allocated revenues elsewhere. After this interruption, smoking among pregnant women and adolescents stopped decreasing and per capita consumption of cigarettes increased for the first time since the program was first implemented.

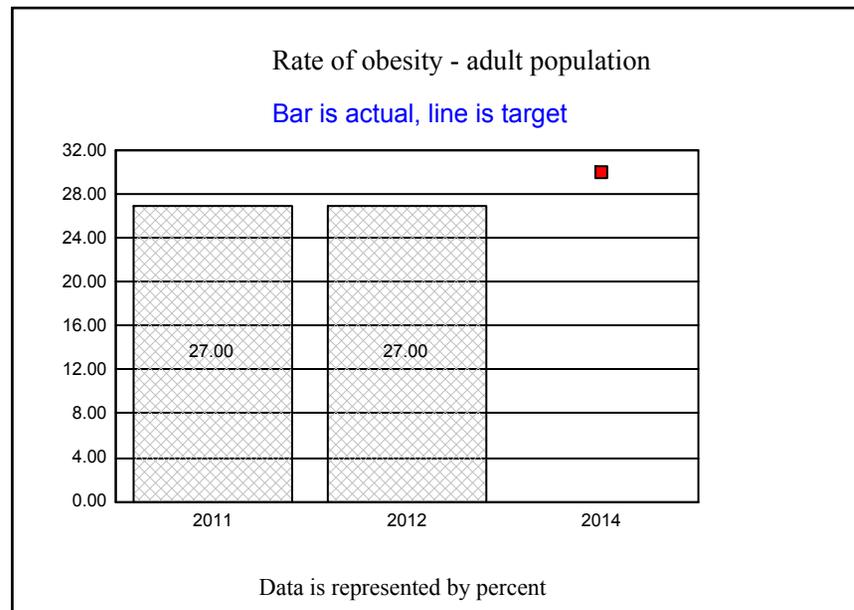
6. WHAT NEEDS TO BE DONE

Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use, and conversely, increases in funding for tobacco prevention lead to increased success in reducing tobacco use. To keep youth and young adults from starting to smoke, protect Oregonians from secondhand smoke, identify and eliminate tobacco-related disparities and help smokers quit, funding for comprehensive tobacco control needs to be increased. Prior successes in Oregon and a substantial evidence-base from elsewhere tell us that a comprehensive program is the most effective means to counter the devastating effects of tobacco.

7. ABOUT THE DATA

Tobacco use prevalence among adult Oregonians on Medicaid is on an annual reporting cycle, computed once per calendar year. The estimate is derived from the Oregon Consumer Assessment of Healthcare Providers and Systems (CAHPS), a survey that examines experiences with health plans and their services among Medicaid enrollees.

KPM #22	RATE OF OBESITY (POPULATION) - Percentage of adults who are obese among Oregonians.	2010
Goal	Better health	
Oregon Context	Better health	
Data Source	Behavioral Risk Factor Surveillance System (BRFSS)	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

In 2013, the Oregon Public Health Division was awarded funding from the Centers for Disease Control and Prevention (CDC) to reduce obesity as part of an integrated cooperative agreement to prevent and control diabetes, heart disease, obesity and associated risk factors, and promote school health. Ultimately a comprehensive, coordinated, statewide obesity prevention program/initiative will be required to slow the increase in obesity. These resources are not sufficient to build a comprehensive program, although they will allow

some efforts to start.

2. ABOUT THE TARGETS

Over the past two decades, obesity has become a national and state health crisis. In Oregon, obesity contributes to the deaths of about 1,500 Oregonians each year, making it second only to tobacco as the state's leading cause of preventable death. Obesity is also a major risk factor for chronic diseases such as diabetes, cancer, high blood pressure, high cholesterol, arthritis, heart disease and stroke. Since 1990, Oregon's adult obesity rate has increased 121 percent. If Oregon remains on this trajectory, children born today will not live as long as their parents or grandparents do.

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, people affected by obesity are estimated to have annual medical costs \$1,429 higher than non-obese people. Obesity prevalence grew steadily in Oregon and the U.S between 1990 and 2010, and has remained flat since. In 2010, CDC launched a new methodology for calculating BRFSS estimates, which appears to increase many estimates, but is designed to produce more representative, accurate estimates. Considering these factors, the trajectory for obesity is estimated to reach around 30% in the general population by 2017 so the target was set to be 30% or less. Since Oregon has limited funding for obesity prevention and control, targets were modest.

3. HOW WE ARE DOING

In 2012, the proportion of adults who are obese in the Medicaid population was 52% higher than the proportion of adults who are obese in the general population (41% vs 27%).

4. HOW WE COMPARE

Recently released data from the CDC's national Behavioral Risk Factor Surveillance System (BRFSS) indicate that Oregon's obesity prevalence is tied for 23rd/24th place in the nation among all states and the District of Columbia (Oregon, 27.3%; range: Colorado, 20.5% –Louisiana, 34.7%.) Estimates of obesity prevalence among the Medicaid population by state are not available.

5. FACTORS AFFECTING RESULTS

Poor nutrition and lack of physical activity are the main factors driving obesity in Oregon. Obesity results from calorie consumption that exceeds the number of calories expended. Since calorie consumption is difficult and costly to assess accurately, eating ≥ 5 servings of fruits and vegetables a day is used as marker of a healthy diet. Regular physical activity is also a critical component of weight control.

During 2011, fewer than one in four Oregon adults consumed ≥ 5 servings of fruits and vegetables per day, which has been relatively unchanged since 1996. Among youth the situation is similar: about one in four Oregon eighth-graders consumed five or more servings a day of fruits and vegetables in 2013. Young people also drink a lot of sugary beverages: about 12 percent of eighth-graders report drinking an average of one or more soft drinks a day. This means that about one in ten eighth-graders consume enough soda to add more

than 1,000 extra calories to their diets each week.

In 2011, 24% of adult Oregonians met aerobic and muscle strengthening recommendations for physical activity. In 2013, 60% of Oregon eight-graders met physical activity recommendations of getting one or more hours of activity on most days of the week.

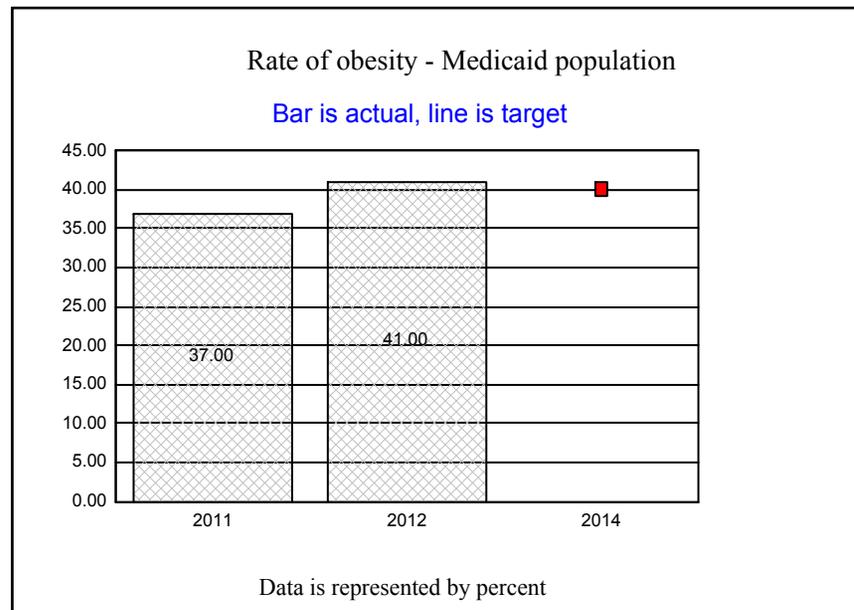
6. WHAT NEEDS TO BE DONE

Comprehensive, collaborative statewide and community-based obesity prevention programs that include standards for physical activity and nutrition can make it easy for children and adults to access healthy foods and physical activities where they live, work, play and learn. Unless appropriate steps are taken to curb the obesity crisis in Oregon, the costs in Oregon lives and dollars will be too great for the state to sustain. Obesity is a preventable disease. It occurs in predisposed children and adults living in environments that promote eating too many calories and too little physical activity. Like other chronic diseases, prevention is the optimal approach and is our strategy to address this public health crisis.

7. ABOUT THE DATA

Obesity prevalence among adult Oregonians is available annually and computed once per calendar year. It is derived from calculations of body mass index (BMI) from the Oregon Behavioral Risk Factor Surveillance System (BRFSS), a telephone-administered survey that examines health-related factors including height and weight. Advantages associated with this data source include its widespread use across the nation, permitting national and cross-state comparisons. The Oregon BRFSS began including cellular telephones in its sample in 2010, which improved the representativeness of the estimate. Data collected in 2010 and later, however, cannot be compared with earlier years. One disadvantage of these data is that respondents tend to give responses that skew their BMI slightly lower (either by over-reporting height or under-reporting weight), although over time this bias is assumed to be relatively constant.

KPM #23	RATE OF OBESITY (MEDICAID) - Percentage of Medicaid population who are obese.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

In 2013, the Oregon Public Health Division was awarded funding from the Centers for Disease Control and Prevention (CDC) to reduce obesity as part of an integrated cooperative agreement to prevent and control diabetes, heart disease, obesity and associated risk factors, and promote school health. Ultimately a comprehensive, coordinated, statewide obesity prevention program/initiative will be required to slow the increase in obesity. These resources are not sufficient to build a comprehensive program, although they will allow

some efforts to start.

2. ABOUT THE TARGETS

Over the past two decades, obesity has become a national and state health crisis. In Oregon, obesity contributes to the deaths of about 1,500 Oregonians each year, making it second only to tobacco as the state's leading cause of preventable death. Obesity is also a major risk factor for chronic diseases such as diabetes, cancer, high blood pressure, high cholesterol, arthritis, heart disease and stroke. Since 1990, Oregon's adult obesity rate has increased 121 percent. If Oregon remains on this trajectory, children born today will not live as long as their parents or grandparents do. 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, people affected by obesity are estimated to have annual medical costs \$1,429 higher than non-obese people. Obesity prevalence grew steadily in Oregon between 1990 and 2010, and has remained flat since. In 2010, CDC launched a new methodology for calculating BRFSS estimates, which appears to increase many estimates, but is designed to produce more representative, accurate estimates. Considering these factors, the trajectory for obesity is expected to reach around 30% in the general population by 2017 so the target was set to be 30% or less. Since Oregon has limited funding for obesity prevention and control, targets were modest.

3. HOW WE ARE DOING

In 2012, the proportion of obese adults in the Medicaid population was 52% higher than the proportion of obese adults in the general population (41% vs. 27%). The 2012 data show an increase in the proportion of obese adults in the Medicaid population, from 37% to 41%.

4. HOW WE COMPARE

Recently released data from the CDC's national Behavioral Risk Factor Surveillance System (BRFSS) indicate that Oregon's obesity prevalence is tied for 23rd/24th place in the nation among all states and the District of Columbia (Oregon, 27.3%; range: Colorado, 20.5% –Louisiana, 34.7%.) Population-based estimates of obesity prevalence among the Medicaid population by state are not available.

5. FACTORS AFFECTING RESULTS

Poor nutrition and lack of physical activity are the main factors driving obesity in Oregon. Obesity results from calorie consumption that exceeds the number of calories expended. Since calorie consumption is difficult and costly to assess accurately, eating ≥ 5 servings of fruits and vegetables a day is used as marker of a healthy diet. Regular physical activity is also a critical component of weight control.

During 2011, fewer than one in four Oregon adults consumed ≥ 5 servings of fruits and vegetables per day, which has been relatively unchanged since 1996. Among youth the

situation is similar: about one in four Oregon eighth-graders consumed five or more servings a day of fruits and vegetables in 2013. Young people also drink a lot of sugary beverages: about 12 percent of eighth-graders report drinking an average of one or more soft drinks a day. This means that about one in ten eighth-graders consume enough soda to add more than 1,000 extra calories to their diets each week.

In 2011, 24% of adult Oregonians met aerobic and muscle strengthening recommendations for physical activity. In 2013, 60% of Oregon eight-graders met physical activity recommendations of getting one or more hours of activity on most days of the week.

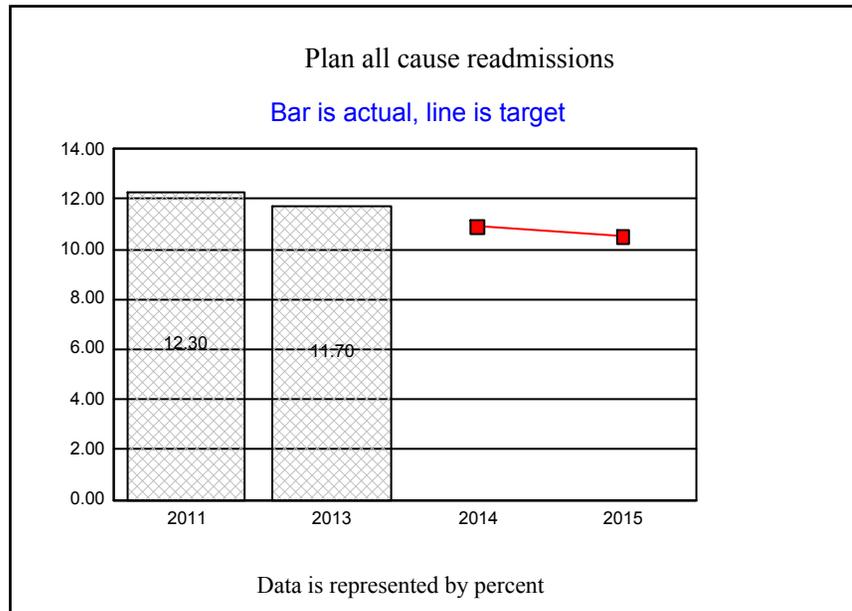
6. WHAT NEEDS TO BE DONE

Comprehensive, collaborative statewide and community-based obesity prevention programs that include standards for physical activity and nutrition can make it easy for children and adults to access healthy foods and physical activities where they live, work, play and learn. Unless appropriate steps are taken to curb the obesity crisis in Oregon, the costs in Oregon lives and dollars will be too great for the state to sustain. Obesity is a preventable disease. It occurs in predisposed children and adults living in environments that promote eating too many calories and too little physical activity. Like other chronic diseases, prevention is the optimal approach and is our strategy to address this public health crisis.

7. ABOUT THE DATA

Obesity prevalence among Oregon adult Medicaid recipients is available annually and computed once per calendar year. It is derived from calculations of body mass index (BMI) from the Oregon Behavioral Risk Factor Surveillance System (BRFSS), a telephone-administered survey that examines health related factors including height and weight. Advantages associated with this data source include its widespread use across the nation, permitting national and cross-state comparisons. The Oregon BRFSS began including cellular telephones in its sample in 2010, which improved the representativeness of the estimate. Data collected in 2010 and later, however, cannot be compared with earlier years. One disadvantage of these data is that respondents tend to give responses that skew their BMI slightly lower (either by over-reporting height or under-reporting weight), although over time this bias is assumed to be relatively constant. OHA Health Analytics is investigating other means by which to collect these data in the future, including Oregon Consumer Assessment of Healthcare Providers and Systems (CAHPS), online health assessments, or the Medicaid BRFSS, which is a special administration of a BRFSS-like survey to Medicaid enrollees.

KPM #24	PLAN ALL CAUSE READMISSIONS - Percentage of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years and older.	2013
Goal	Lower cost	
Oregon Context	Lower cost	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: Reducing preventable rehospitalizations.

2. ABOUT THE TARGETS

Targets were created using an average of the 2012 Commercial and Medicare 75th percentiles. For this KPM, lower is better.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. In 2011, 12.3 percent of adult patients who had a hospital stay were readmitted for any reason within 30 days of discharge. By 2013, the readmission rate had improved slightly to 11.7 percent. Nine CCOs also saw improvements in their readmission rates and two CCOs saw no change in their rates. Readmissions were reduced across African Americans, American Indian/Alaskan Natives, Asian Americans, and Whites, but increased for Hispanics and Hawaiian/Pacific Islanders. Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

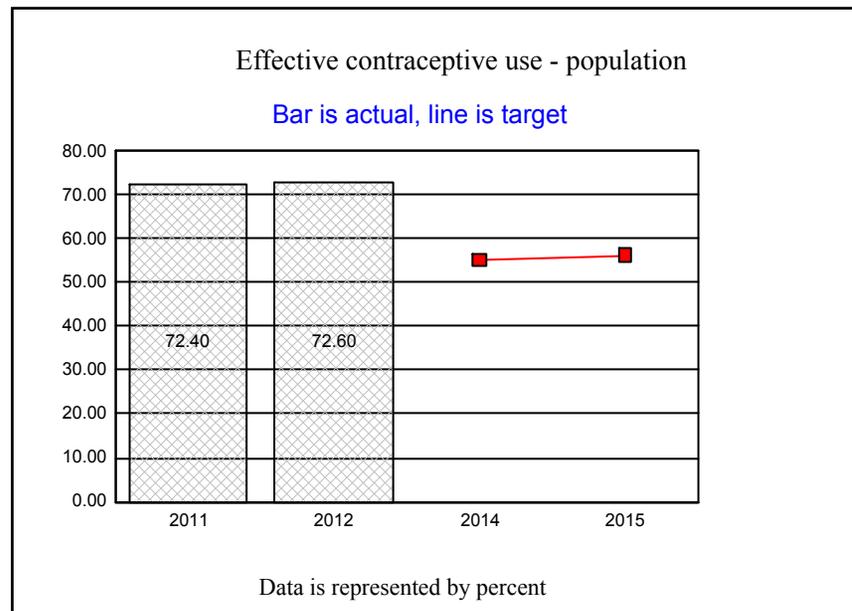
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year.

KPM #25	EFFECTIVE CONTRACEPTIVE USE (POPULATION) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Behavioral Risk Factor Surveillance System (BRFSS)	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: Improving primary care for all populations.

2. ABOUT THE TARGETS

Targets are based on preliminary calendar year 2011 baseline data. Higher is better. Targets may need to be revised to reflect updated performance data.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. The effective contraceptive rate for the general population is just below the Medicaid rate in the baseline year; the general population rate increased slightly in 2012, compared to a larger increase in the Medicaid population. Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

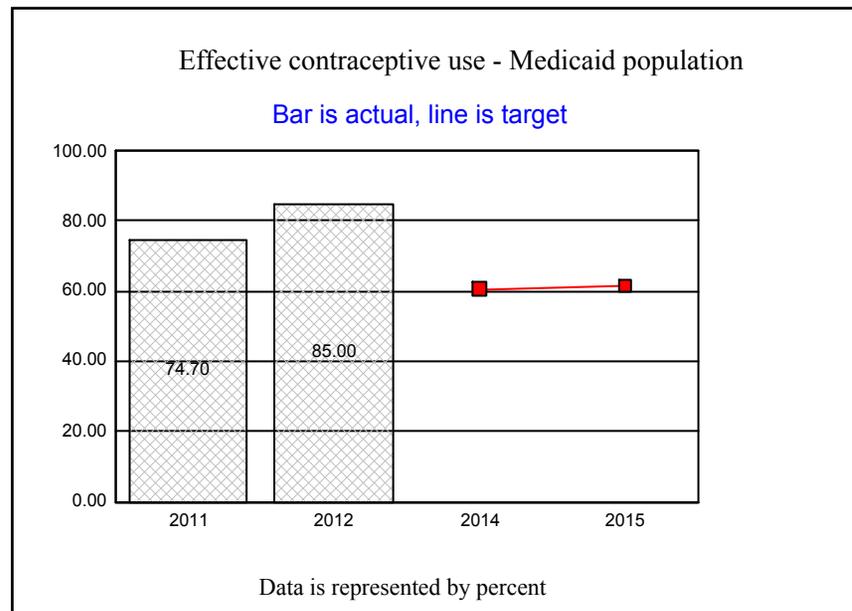
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year 2011 and 2012. Revised estimates for 2011 and updated data for 2012 have been calculated; missing and incomplete information that was previously included in the preliminary 2011 data have been removed from the analysis, resulting in an increase to the rates.

KPM #26	EFFECTIVE CONTRACEPTIVE USE (MEDICAID) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Behavioral Risk Factor Surveillance System (BRFSS)	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

This KPM supports the Quality Improvement Focus Area: Improving primary care for all populations.

2. ABOUT THE TARGETS

Targets are based on preliminary calendar year 2011 baseline data. Higher is better. Targets may need to be revised to reflect updated performance data.

3. HOW WE ARE DOING

Calendar year 2011 is the baseline for this measure. The Medicaid rate of effective contraceptive use holds just above the rate for the general population. The Medicaid rate has increased from 2011 to 2012, although some of the increase may be due to fluctuations in measurement due to small numbers. Additional comparisons will be made in future reports.

4. HOW WE COMPARE

Comparisons will be made in future reports as appropriate.

5. FACTORS AFFECTING RESULTS

As we collect more data, we will have a better understanding of the factors affecting the results.

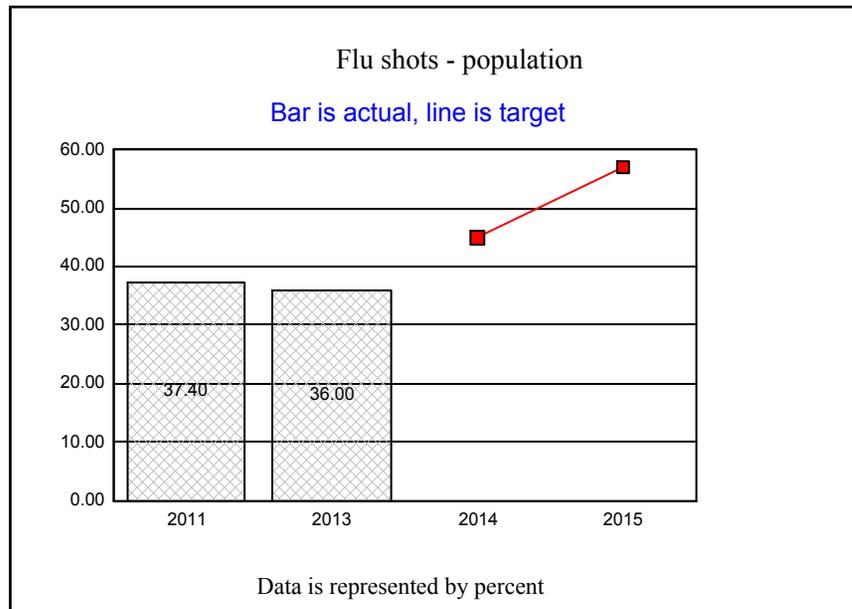
6. WHAT NEEDS TO BE DONE

As we collect more data, we will have a better understanding of specific actions to be taken.

7. ABOUT THE DATA

Calendar year 2011 and 2012. Revised estimates for 2011 and updated data for 2012 have been calculated; missing and incomplete information that was previously included in the preliminary 2011 data have been removed from the analysis, resulting in an increase to the rates.

KPM #27	FLU SHOTS (POPULATION) - Percentage of adults ages 50-64 who receive a flu vaccine.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Behavioral Risk Factor Surveillance System (BRFSS)	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

The Oregon Immunization Program supports the efforts of its various public and private partners (e.g., pharmacies, healthcare institutions, long-term care facilities) to immunize adults against influenza. These activities include: the work of Oregon’s lifespan immunization coalition, Immunize Oregon; projects such as the 2013-2014 Adult Immunization Special Project, which sought to strengthen the adult immunization infrastructure; protocols and legislation supporting pharmacy vaccination practices; and the provision of

technical support to public and private providers. We also promote the use of the ALERT Immunization Information System (IIS). Pharmacists and providers that receive state-supplied vaccine are required to report vaccinations into this system.

2. ABOUT THE TARGETS

The goal is to increase influenza immunization rates to meet the Healthy People 2020 objective of 80% for individuals 18-64 years of age.

3. HOW WE ARE DOING

In 2012, 37% of 50-64 year olds in Oregon had received an influenza vaccination in the past 12 months. This measure has shown little improvement over the years.

4. HOW WE COMPARE

In 2012, 37% of 50-64 year olds in Oregon had received an influenza vaccination in the past 12 months. In comparison, 42.7% of people in this age range, nationwide, received an influenza vaccination. State-specific vaccination rate estimates range from 32.6% to 51.1%.

5. FACTORS AFFECTING RESULTS

Immunization rates are influenced by public perception of the need for and efficacy of vaccinations. Factors that negatively influence rates include: the absence of policies that motivate health systems to routinely vaccinate all clients and employees (although improvement has been seen on this point in recent years), limited funding for adult immunizations, and challenges around increasing provider use of the ALERT IIS – the statewide immunization registry – that could provide immunization information for providers about their adult populations. During the 2007 legislative session, HB 2188 passed expanding ALERT IIS to a lifespan registry, and during the 2011 legislative session, HB 2371 passed stating that VFC and 317 providers need to report all administered doses to ALERT IIS. Pharmacies are now also required to report all administered vaccines to the ALERT IIS. Over the next few years as the IIS collects and processes data, the IIS will contain more comprehensive immunization histories across the lifespan, which will help healthcare providers identify candidates for vaccine and potentially send out reminders to clients to seek out an influenza immunization every year.

6. WHAT NEEDS TO BE DONE

Depending on available resources and with the support of Immunize Oregon, we plan on the following:

- Continue to educate the public and healthcare providers about the benefits of influenza vaccinations
- Continue to support efforts to increase vaccination of health care workers
- Increase the number of adult providers who report vaccination information to the ALERT IIS
- Assess adult population capture in the IIS to produce near real-time estimates of coverage, by county, throughout the flu season
- Continue to promote the administration of influenza vaccine whenever immunization providers give any other immunization, such as pneumococcal vaccine or

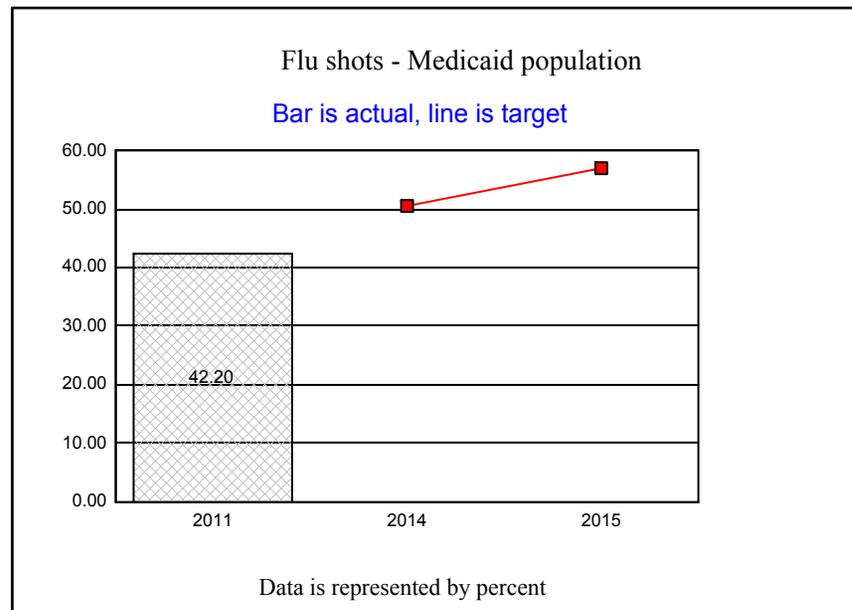
tetanus/diphtheria/pertussis vaccine

- Continue to partner with pharmacies, as these are commonly the vaccination venues for older adults

7. ABOUT THE DATA

Reporting period - calendar year. This measure presents the percent of adults, 50-64 years of age, who reported receiving an influenza vaccination in the previous 12 months as reported on the Behavioral Risk Factor Surveillance survey (BRFSS). [Survey question: During the past 12 months, have you had a flu shot?]. Please note that although responses can be for either intra-muscular or nasal vaccine, the nasal vaccine is only given up through age 49. Data for 2013 were not yet available at the time of this writing. Beginning in 2011, a different weighting system was used such that estimates before 2011 are not directly comparable to those for 2011 and subsequent years.

KPM #28	FLU SHOTS (MEDICAID) - Percentage of adults ages 50-64 who receive a flu vaccine.	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Behavioral Risk Factor Surveillance System (BRFSS)	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

The Oregon Immunization Program supports the efforts of its various public and private partners (e.g., pharmacies, healthcare institutions, long-term care facilities) to immunize adults against influenza. These activities include: the work of Oregon’s lifespan immunization coalition, Immunize Oregon; projects such as the 2013-2014 Adult Immunization Special Project, which sought to strengthen the adult immunization infrastructure; protocols and legislation supporting pharmacy vaccination practices; and the provision of

technical support to public and private providers. We also promote the use of the ALERT Immunization Information System (IIS). Pharmacists and providers that receive state-supplied vaccine are required to report vaccinations into this system.

2. ABOUT THE TARGETS

The goal is to increase influenza immunization rates to meet the Healthy People 2020 objective of 80% for individuals 18-64 years of age.

3. HOW WE ARE DOING

In 2012, 37% of all 50-64 year olds in Oregon (not just Medicaid recipients) had received an influenza vaccination in the past 12 months. This measure has shown little improvement over the years.

4. HOW WE COMPARE

In 2012, nationwide, 42.7% of all people in this age range received an influenza vaccination. State-specific vaccination rate estimates range from 32.6% to 51.1% with Oregon's rate at 37%.

5. FACTORS AFFECTING RESULTS

Immunization rates are influenced by public perception of the need for and efficacy of vaccinations. Factors that negatively influence rates include: the absence of policies that motivate health systems to routinely vaccinate all clients and employees (although improvement has been seen on this point in recent years), limited funding for adult immunizations, and challenges around increasing provider use of the ALERT IIS – the statewide immunization registry – that could provide immunization information for providers about their adult populations. During the 2007 legislative session, HB 2188 passed expanding ALERT IIS to a lifespan registry, and during the 2011 legislative session, HB 2371 passed stating that VFC and 317 providers need to report all administered doses to ALERT IIS. Pharmacies are now also required to report all administered vaccines to the ALERT IIS. Over the next few years as the IIS collects and processes data, the IIS will contain more comprehensive immunization histories across the lifespan, which will help healthcare providers identify candidates for vaccine and potentially send out reminders to clients to seek out an influenza immunization every year.

6. WHAT NEEDS TO BE DONE

Depending on available resources and with the support of Immunize Oregon, we plan on the following:

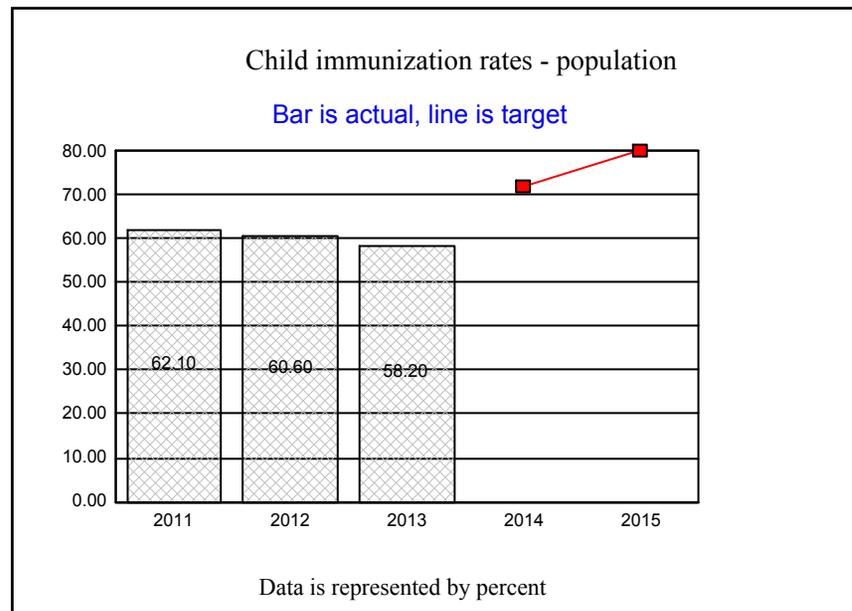
- Continue to educate the public and healthcare providers about the benefits of influenza vaccinations
- Continue to support efforts to increase vaccination of health care workers
- Increase the number of adult providers who report vaccination information to the ALERT IIS
- Assess adult population capture in the IIS to produce near real-time estimates of coverage, by county, throughout the flu season

- Continue to promote the administration of influenza vaccine whenever immunization providers give any other immunization, such as pneumococcal vaccine or tetanus/diphtheria/pertussis vaccine
- Continue to partner with pharmacies, as these are commonly the vaccination venues for older adults

7. ABOUT THE DATA

Reporting period – calendar year. This measure presents the influenza immunization rate among Medicaid recipients, 50-64 years of age. The source of the immunization data is the ALERT IIS, which is a statewide system that records reported immunization data from 100% of public providers and 93% of private providers. Rates are obtained by matching Medicaid enrollees from the MMIS/DSSURS system against information in the ALERT IIS.

KPM #29	CHILD IMMUNIZATION RATES (POPULATION) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

The Vaccines for Children program supplies vaccine and technical assistance to private and public providers who serve eligible children. The ALERT Immunization Information System (IIS) maintains a database of all reported vaccine for provider reference and identifies all shots due. Pharmacists and providers that receive state-supplied vaccine are

required to report vaccinations into this system. Vaccines, funds, and technical assistance are provided annually to local health departments to improve immunization coverage rates for children. Education and training opportunities are offered for public and private providers throughout the year to provide up-to-date information about vaccine efficacy, safety, and reporting, as well as storage and handling.

2. ABOUT THE TARGETS

The goal is to increase immunization rates to meet the Healthy People 2020 objective of 80% coverage for the 4:3:1:3:3:1:4 series. The rate is calculated for the percent of children immunized with four or more doses of diphtheria, tetanus and pertussis (DTaP); three or more doses of polio; one or more doses of measles, mumps, rubella (MMR); three or more doses of *Haemophilus Influenzae* type b; three or more doses of hepatitis B; one or more doses of varicella, and four or more doses of pneumococcal conjugate vaccine (4:3:1:3:3:1:4).

3. HOW WE ARE DOING

The 4:3:1:3:3:1:4 rate for children 24-35 months of age in 2013 is 58.2%. This is a decline from 60.6% in 2012 and 62.1% in 2011.

4. HOW WE COMPARE

This KPM reflects children 24-35 months olds with vaccines reported to the statewide immunization information system (IIS). A national comparison is difficult because national data is based on the National Immunization Survey (NIS), which is a telephone survey that samples a limited number of Oregon residents 19-35 months of age. However, the national NIS rate for the 4:3:1:3:3:1:4 series in 2012 was 68.4% (+/- 1.4%), with 68.7% (+/- 6.7%) for Oregon, 65.2% (+/- 7.2%) for Washington, and 63.0% (+/- 8.2%) for Idaho.

5. FACTORS AFFECTING RESULTS

Completion of the four-dose PCV series has declined from 77.8% in 2010, 75.6 in 2011, and 73.7% in 2013. Other vaccines in the 4:3:1:3:3:1:4 series have stayed generally stable during that time. The Immunization Program oversees the Vaccines for Children (VFC) program, a federally funded entitlement that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. The success of VFC is based upon partnership between the Oregon Immunization Program and public and private providers. Ninety-five percent of Oregon's childhood immunizations are captured in the ALERT IIS, which is used to estimate immunization rates, while also providing a clinical record for providers to accurately assess the vaccine needs of individual children. Other influences include parent and provider knowledge, attitudes, and practices.

6. WHAT NEEDS TO BE DONE

To continue our success, OHA needs to:

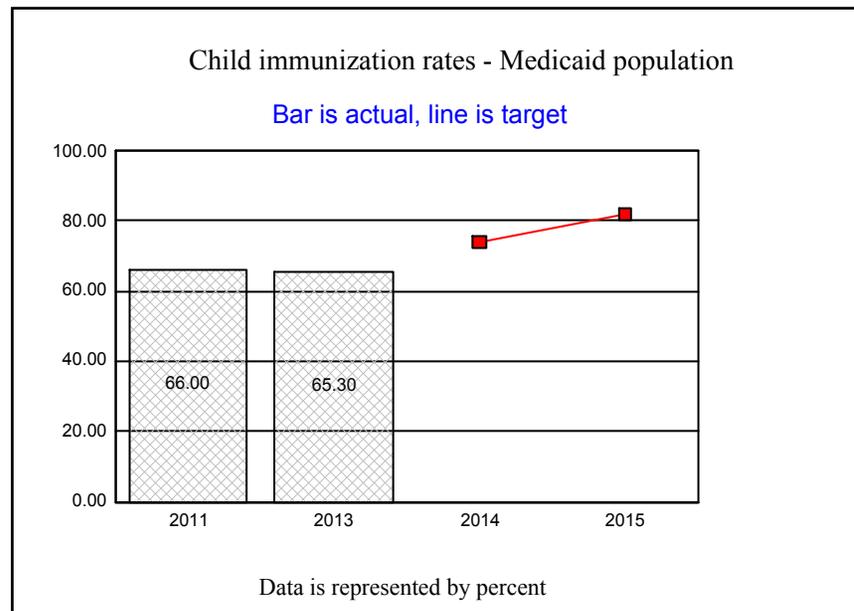
- Continue to provide funding, vaccines, and consultation to all local health departments
- Continue to work with other OHA programs to identify referral and assessment opportunities

- Continue to work with internal and external partners to effectively communicate with consumers regarding vaccine safety and the importance of receiving vaccines according to the ACIP-recommended vaccine schedule
- Continue to work with the Centers for Disease Control and Prevention (CDC), vaccine manufacturers, and providers to assure that appropriate strategies are in place for storage and handling of vaccines, as well as strategies specifically designed to respond to a vaccine shortage
- Support the implementation of SB 132, which requires parents, who are seeking non-medical exemptions from vaccinations, to submit either a provider signature or a certificate verifying that they have received education about the risks associated with not immunizing their child

7. ABOUT THE DATA

Reporting cycle – calendar year. This measure presents the statewide immunization rate for children 24 to 35 months of age. The data source is the ALERT IIS, which is a statewide system that records reported immunization data from 100% of public providers and 93% of private providers. The immunizations assessed include 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 Varicella and 4 PCV (4:3:1:3:3:1:4).

KPM #30	CHILD IMMUNIZATION RATES (MEDICAID) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).	2013
Goal	Better health	
Oregon Context	Better health	
Data Source	Administrative data	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

The Vaccines for Children program supplies vaccine and technical assistance to private and public providers who serve eligible children. The ALERT Immunization Information System (IIS) maintains a database of all reported vaccine for provider reference and identifies all shots due. Pharmacists and providers that receive state-supplied vaccine are

required to report vaccinations into this system. Vaccines, funds, and technical assistance are provided annually to local health departments to improve immunization coverage rates for children. Education and training opportunities are offered for public and private providers throughout the year to provide up-to-date information about vaccine efficacy, safety, and reporting, as well as storage and handling.

2. ABOUT THE TARGETS

The goal is to increase immunization rates to meet the Healthy People 2020 objective of 80% coverage for the 4:3:1:3:3:1:4 series. The rate is calculated for the percent of children immunized with four or more doses of diphtheria, tetanus and pertussis (DTaP); three or more doses of polio; one or more doses of measles, mumps, rubella (MMR); three or more doses of *Haemophilus Influenzae* type b; three or more doses of hepatitis B; one or more doses of varicella, and four or more doses of pneumococcal conjugate vaccine (4:3:1:3:3:1:4).

3. HOW WE ARE DOING

In 2011, the Medicaid baseline rate used for CCO incentive measure calculation was 66.0%; this decreased slightly in 2013 to 65.3%.

4. HOW WE COMPARE

The National Immunization Survey (NIS) involves a telephone survey that samples Oregon residents 19-35 months of age. The national rate for the 4:3:1:3:3:1:4 series in 2011-12 was 68.4% (+/- 1.4%), with 68.4% (+/- 6.8%) for Oregon, 61.7% (+/- 8.4%) for Washington, and 61.4% (+/- 8.0%) for Idaho.

5. FACTORS AFFECTING RESULTS

The Immunization Program oversees the Vaccines for Children (VFC) program, a federally funded entitlement that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. The success of VFC is based upon partnership between the Oregon Immunization Program and public and private providers. Ninety-five percent of Oregon's childhood immunizations are captured in the ALERT IIS, which is used to estimate immunization rates, while also providing a clinical record for providers to accurately assess the vaccine needs of individual children. Other influences include parent and provider knowledge, attitudes, and practices.

6. WHAT NEEDS TO BE DONE

To continue our success, OHA needs to:

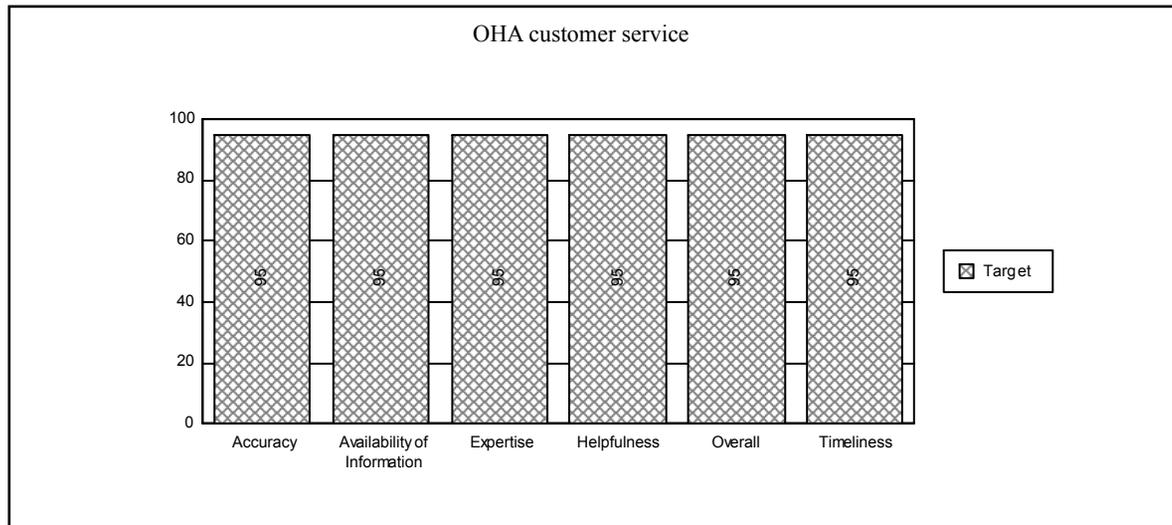
- Continue to provide funding, vaccines, and consultation to all local health departments
- Continue to work with other OHA programs to identify referral and assessment opportunities
- Continue to work with internal and external partners to effectively communicate with consumers regarding vaccine safety and the importance of receiving vaccines according to the ACIP-recommended vaccine schedule

- Continue to work with the Centers for Disease Control and Prevention (CDC), vaccine manufacturers, and providers to assure that appropriate strategies are in place for storage and handling of vaccines, as well as strategies specifically designed to respond to a vaccine shortage
- Support the implementation of SB 132, which requires parents, who are seeking non-medical exemptions from vaccinations, to submit either a provider signature or a certificate verifying that they have received education about the risks associated with not immunizing their child.

7. ABOUT THE DATA

Reporting period – calendar year. This measure presents the two-year old child immunization rate among Medicaid recipients. The immunizations assessed include 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 Varicella and 4 PCV (4:3:1:3:3:1:4). The source of the immunization data is Medicaid administrative claims data, combined with ALERT IIS, which is a statewide system that records reported immunization data from 100% of public providers and 93% of private providers. Rates are obtained by matching Medicaid enrollees from the MMIS/DSSURS system against information in the ALERT IIS.

KPM #31	CUSTOMER SERVICE (OHA) - Percentage of OHA customers rating their satisfaction with the agency's customer service as "good" or "excellent" overall, timeliness, accuracy, helpfulness, expertise, availability of information.	2006
Goal	OHA Mission: Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.	
Oregon Context	OHA Mission: Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.	
Data Source	Surveys - TBD	
Owner	OHA Performance Management Coordinator, 503-602-1507	



1. OUR STRATEGY

OHA is fundamentally changing the way we do business to provide more effective and efficient services and improve our own accountability. The goal is to build a foundation for continuous improvement so we are always doing our best work by routinely measuring our performance and resolving issues. Our transformation efforts will result in reduced red tape, reduced wait time for clients and improved customer service.

2. ABOUT THE TARGETS

Targets were established from previous customer service results.

3. HOW WE ARE DOING

There is no data available for OHA overall at this time. The Oregon Educator's Benefit Board conducted a survey of members. The results for the time period of October 2-12 - September 2013 are as follows: Timeliness of services provided = 84.5% Ability to provide services correctly the first time = 83.6% Helpfulness of staff = 84.1% Knowledge and expertise of staff = 83.1% Availability of information = 78.7% Overall service = 83.0%

4. HOW WE COMPARE

At this time, we are unable to compare our results to other agencies and organizations.

5. FACTORS AFFECTING RESULTS

As we collect new data, we will have a better understanding of the factors affecting the results.

6. WHAT NEEDS TO BE DONE

As we continue transforming the health systems in Oregon, we need to establish a more thorough and sustainable way to collect feedback from those we serve. We will be putting those pieces in place over the next year.

7. ABOUT THE DATA

Calendar year.

Agency Mission: Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.

Contact: Cathy Iles, OHA Director's Office

Contact Phone: 503-602-1507

Alternate:

Alternate Phone:

The following questions indicate how performance measures and data are used for management and accountability purposes.

1. INCLUSIVITY

*** Staff:** Staff are involved in the identification and refinement of Key Performance Measures. Feedback is sought to validate the measures. Over the next biennium, staff will become more involved in identifying, tracking and using performance metrics to make improvements to the work we do. These metrics should ultimately link to our KPMs or other high-level measures and inform us of our progress.

*** Elected Officials:** Elected officials provide input to the agency KPMs, targets and strategies.

*** Stakeholders:** Customer feedback is gathered to help guide strategies for effective service delivery. We continue to work closely with Legislative Fiscal Office and DAS Budget and Management to ensure we are making continuous improvements to our KPMs so they provide useful and relevant information for decision-making and management.

*** Citizens:** Community forums related to budget development and priority-setting are a way to identify and validate priorities, expectations and performance areas.

2 MANAGING FOR RESULTS

OHA continues to develop an internal performance management system that will provide a foundation for measuring the effectiveness of the routine work, actively managing breakthrough initiatives, conducting regular check-ins to review results and engage in continuous improvement. As we start to connect the performance management system throughout the organization it creates a line of sight for employees to understand the impact of their work on the mission, vision and goals of the agency.

3 STAFF TRAINING

Management and staff continue to receive training related to continuous improvement and Lean tools. Training in both online and classroom formats is available. The courses are introducing staff to the principles and concepts for thinking about work in terms of systems, processes and continuous improvement. A component of these trainings focus on metrics and how to effectively measure the results of our work. People are becoming more familiar with using data and

	<p>information to inform our strategies and decision-making.</p> <p>Required courses for managers teach about creating a culture of continuous improvement to achieve results to become a high-performing organization. Workshops help prepare managers to assist their work groups to establish and sustain Lean Daily Management elements and practices, and improve their ability to guide work teams to constructively and practically select and use metrics to improve their work.</p>
<p>4 COMMUNICATING RESULTS</p>	<p>* Staff : · The annual performance report is posted online and used for information sharing. Regular communication to staff reinforces the importance of gathering and using data to inform decision-making and understanding the effectiveness of our programs.</p> <p>* Elected Officials: · The annual performance report is posted online and included in the agency request document for purposes of sharing performance results, showing accountability, and informing the budget development process. KPMs are presented during the Ways & Means presentations to describe program results.</p> <p>* Stakeholders: · The annual performance report is posted online and used for information sharing.</p> <p>* Citizens: The annual performance report is posted online and used for information sharing.</p>