

OREGON HEALTH AUTHORITY

Annual Performance Progress Report (APPR) for Fiscal Year (2010-2011)

Original Submission Date: 2010

Finalize Date: 9/1/2011

2010-2011 KPM #	2010-2011 Approved Key Performance Measures (KPMs)
	CUSTOMER SERVICE (OHA) - Percentage of customers rating their overall satisfaction with OHA above average or excellent.
	OPHP TRAINING - Percentage of attendees rating the training received as 'meets or exceeds learning experience expectations'.
1	COMPLETION OF ALCOHOL AND DRUG TREATMENT – The percentage of engaged clients who complete alcohol and other drug (AOD) abuse treatment and are not abusing AOD.
2	ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of adults employed after receiving Alcohol and Drug treatment.
2	FHIAP Administration Percentage – FHIAP administrative expenses as a percentage of total cost.
3	ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of parents who have their children returned to their custody after receiving alcohol and drug treatment.
4	ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of children whose school performance improves after receiving alcohol and drug treatment.
4	CUSTOMER SERVICE – Percent of customers rating their satisfaction with the agency’s customer service as “good” or “excellent”: overall customer service, timeliness, accuracy, helpfulness, expertise and availability of information.
5	8TH GRADER USE OF ALCOHOL - The % of 8th graders who have used alcohol within the past 30 days
6	8TH GRADER USE OF ILLICIT DRUGS - The % of 8th graders who have used illicit drugs within the past 30 days.
7	CHILD MENTAL HEALTH SERVICES - The % of children receiving mental health services who are suspended or expelled from school
8	ADULT MENTAL HEALTH SERVICES - The % of adults receiving mental health services who report positively about the outcomes of those services.
9	MENTAL HEALTH CLIENT LEVEL OF FUNCTIONING – The percentage of mental health clients who maintain or improve level of functioning following treatment.

2010-2011 KPM #	2010-2011 Approved Key Performance Measures (KPMs)
10	Problem Gambling - The % of adults who gamble much less or not at all 180 days after ending problem gambling treatment.
11	RESTRAINT RATE - Reduction in restraint hours per thousand patient hours at Oregon State Hospital.
12	LENGTH OF STAY AT OSH - Reduction in overall length of stay at Oregon State Hospital
23	PREVENTIVE SERVICES FOR OHP CHILDREN - The utilization rate of preventive services for children birth through 10 years old covered by OHP
24	PREVENTIVE SERVICES FOR OHP YOUTH AND ADULTS - The utilization rate of preventive services for youth and adults 11 years old and older covered by OHP
25	APPROPRIATE PRENATAL CARE FOR OHP CLIENTS - The % of pregnant OHP clients who received an appropriate number of prenatal care visits while on OHP
26	ACS HOSPITALIZATIONS OF OHP CLIENTS - The rate of ambulatory care sensitive condition hospitalizations of Oregon Health Plan clients
27	TEEN SUICIDE – The rate of suicides among adolescents per 100,000.
28	TEEN PREGNANCY – The number of female Oregonians ages 15 – 17, per 1,000 who are pregnant.
29	INTENDED PREGNANCY – The percentage of births where mothers report that the pregnancy was intended.
30	EARLY PRENATAL CARE - The % of low-income women who initiated prenatal care in the first 3 months of pregnancy compared to non low-income women.
31 a	TOBACCO USE – Tobacco use among adults.
31 b	TOBACCO USE – Tobacco use among youth.
31 c	TOBACCO USE – Tobacco use among pregnant women.

2010-2011 KPM #	2010-2011 Approved Key Performance Measures (KPMs)
32	CIGARETTE PACKS SOLD – Number of cigarette packs sold per capita.
33	CHILD IMMUNIZATIONS – The percentage of 24-35 month old children who are adequately immunized.
34	INFLUENZA VACCINATIONS FOR SENIORS – The percentage of adults aged 65 and over who receive an influenza vaccine.
35	SAFETY NET CLINIC USE – The percentage of uninsured Oregonians served by safety net clinics.
36	HIV/AIDS - The proportion of reported HIV/AIDS cases interviewed by a local or state public health professional and offered assistance with partner notification and referral to HIV treatment.

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2011-2013
NEW	<p>Title: HEALTHY KIDS CONNECT PARTNER PERFORMANCE AND MEMBER SATISFACTION - Percentage of Healthy Kids Connect (HKC) and Healthy Kids ESI members who rate their experience with their contracted insurance carriers as "good" or "excellent".</p> <p>Rationale: The Healthy Kids Program (HKP) relies on its partner insurance carriers to accomplish the mission of the program. The experience that members have in working with these partners is important, and this measure provides some insight into how satisfied the members are in working with HKP partners. This measure will provide OPHP with information that can be used to improve the customer satisfaction of our members.</p>
NEW	<p>Title: HEALTHY KIDS MEMBER OUT OF POCKET EXPENSE - Percentage of Healthy Kids Connect (HKC) members who spend less than 5% of their annual family income for healthcare expenses.</p> <p>Rationale: This measure informs the agency to ensure that the benefit and plan design for the Healthy Kids program is meeting the Federal standard that no Kids Connect enrollee between 200% and 300% of the FPL spend more than 5% of their annual family income for out-of-pocket expenses for healthcare. This information will be used in making decisions about plan design, subsidy rates, and other important elements of the Healthy Kids program.</p>
NEW	<p>Title: CUSTOMER SERVICE (PEBB/OEBB) - Percentage of PEBB/OEBB customers rating their overall satisfaction with DHS above average or excellent.</p> <p>Rationale: PEBB/OEBB is now part of the Oregon Health Authority. Formerly, PEBB/OEBB reported customer satisfaction as part of the DAS KPM. During this transition period, it will be reported separately.</p>
NEW	<p>Title: CUSTOMER SERVICE (OPHP) -Percent of customers rating their satisfaction with the agency customer service as "good" or "excellent": overall customer service, timeliness, accuracy, helpfulness, expertise and availability of information.</p> <p>Rationale: Required customer service measure. OPHP is now part of the Oregon Health Authority. During this transition period, OPHP will report customer service separately.</p>

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2011-2013
NEW	<p>Title: OVERWEIGHT AND OBESITY PREVALENCE - ADULT OVERWEIGHT - Percentage of people who are overweight or obese among Oregon</p> <p>Rationale: The 2007 Oregon Legislature approved and Governor Kulongoski signed Senate Bill 931, creating a task force to address the growing crisis of obesity in Oregon. As mandated by the bill, the Task Force for a Comprehensive Obesity Prevention Initiative includes four state legislators, public health representatives, and members with specific expertise in preventing obesity or promoting good nutrition and physical fitness. The policy recommendations of this Task Force can be found in this report: http://www.oregon.gov/DHS/ph/pan/docs/2010/sb931obtf09rpt.pdf.</p> <p>The prevalence of overweight and obesity constitute a public health emergency in the U.S. and in Oregon. While Oregon does not have a state program to address this epidemic, it is critical to monitor these trends so that the scope and growth of the epidemic is understood. This KPM consists of four data elements:Adult OverweightAdult ObesityYouth OverweightYouth Obesity</p>
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NEW	<p>Title: OVERWEIGHT AND OBESITY PREVALENCE - YOUTH OVERWEIGHT - Percentage of people who are overweight or obese among Oregon</p> <p>Rationale: The 2007 Oregon Legislature approved and Governor Kulongoski signed Senate Bill 931, creating a task force to address the growing crisis of obesity in Oregon. As mandated by the bill, the Task Force for a Comprehensive Obesity Prevention Initiative includes four state legislators, public health representatives, and members with specific expertise in preventing obesity or promoting good nutrition and physical fitness. The policy recommendations of this Task Force can be found in this report: http://www.oregon.gov/DHS/ph/pan/docs/2010/sb931obtf09rpt.pdf.</p> <p>The prevalence of overweight and obesity constitute a public health emergency in the U.S. and in Oregon. While Oregon does not have a state program to address this epidemic, it is critical to monitor these trends so that the scope and growth of the epidemic is understood. This measure consists of four data points:Adult OverweightAdult ObesityYouth OverweightYouth Obesity</p>

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NEW	<p>Title: SAFETY NET CLINIC USE - MEDICAID - Oregonians on Medicaid served by safety net clinics as a percentage of total Oregonians on Medicaid</p> <p>Rationale: _____ _____ _____ _____</p>
NEW	<p>Title: SAFETY NET CLINIC USE - MEDICARE - Oregonians on Medicare served by safety net clinics as a percentage of total Oregonians on Medicare</p> <p>Rationale: This additional safety net clinic measure is proposed in order to get a better understanding of who is served in Federally Qualified Health Clinics (FQHCs) and if there is a substitution between categories of patients served in FQHCs (categories are: uninsured, Medicaid, Medicare, Other). In order to better understand the changing patient mix of Safety Net Clinics and to better understand their role in providing primary care to individuals that are 65 or more years old and/or have a permanent disability.</p>
NEW	<p>Title: SAFETY NET CLINIC USE - UNINSURED -Uninsured Oregonians served by safety net clinics as a percentage of total uninsured Oregonians</p> <p>Rationale: This KPM will now report three distinct populations being served by safety net clinics:UninsuredMedicaidMedicareThis will allow a better understanding of who is being served in Federally Qualified Health Centers (FQHCs) and if there is a substitution between categories of patients served. It will also allow better understanding of the impact of Federal and State health care reforms on the safety net.</p>
NEW	<p>Title: CHILD MENTAL HEALTH SERVICES - The % of children receiving mental health services whose attendance at school improves</p> <p>Rationale: Attendance at school demonstrates a successful outcome for a child receiving mental health services.</p>

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2011-2013
NEW	<p>Title: ALCOHOL & DRUG TREATMENT EFFECTIVENESS - The percentage of clients whose income increases by completing alcohol and drug treatment services</p> <p>Rationale: Improvements in income for people receiving alcohol and drug services is a demonstrable outcome of treatment services. Baseline data will be gathered for 2009 allowing targets to be set.</p>
NEW	<p>Title: ACCESS TO MENTAL HEALTH SYSTEM - Percentage of people with severe emotional disorders or severe mental illness served within the public mental health system</p> <p>Rationale: There is a large percentage of people who need mental health services who do not receive them. This measure tracks the percentage who receive services through public dollars made available through DHS.</p>
NEW	<p>Title: YOUTH MENTAL HEALTH SERVICES - ARRESTS - Percentage of children demonstrating a decrease in the number of arrests in the 12 months following the initiation of mental health services</p> <p>Rationale: A key goal for mental health services offered to children and their families to facilitate recovery and resiliency. Decreasing contact with the criminal justice system through a demonstrated decrease in arrests is one way to show this is happening.</p>
NEW	<p>Title: ALCOHOL AND DRUG TREATMENT SERVICES - CRIME-FREE - Percentage of clients who remain crime free during alcohol and drug treatment services</p> <p>Rationale: People in alcohol and drug treatment services are often referred by criminal justice authority. Decreased arrest rates while in treatment demonstrate the benefit of being in treatment.</p>
NEW	<p>Title: DOLLARS SPENT ON MENTAL HEALTH SERVICES - FACILITY VS COMMUNITY - Percentage of dollars spent on facility-based mental health services compared to community-based mental health services</p> <p>Rationale: A general goal for people participating in mental health services is recovery. People in recovery should be living in the most independent setting possible while receiving the services they need. One of AMH's goals is to direct more resources towards community services compared to institutional/facility services to allow more opportunity for recovery.</p>
NEW	<p>Title: ALCOHOL & DRUG TREATMENT EFFECTIVENESS - Percentage of children reunited with parents participating in Intensive Treatment Recovery Services.</p> <p>Rationale: The changes make this measure specific to parents participating in the ITRS program designed to help reunite children and parents.</p>
NEW	<p>Title: SECLUSION RATES - Occurrences of seclusion per 1,000 patient hours in facility-based mental health care</p> <p>Rationale: Seclusion techniques never provide beneficial patient treatment, although they can be used at times for patient safety. The goal within all AMH facility-based care is to minimize the use of seclusion.</p>

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2011-2013
NEW	<p>Title: EARLY PRENATAL CARE - The % of low-income women who initiated prenatal care in the first 3 months of pregnancy compared to non low-income women: a) WIC enrolled (low-income women)</p> <p>Rationale: We propose reporting two data points for this measure:a) WIC enrolled (proxy for low-income women)b) Non WIC enrolled (proxy for non low-income women)</p>
NEW	<p>Title: EARLY PRENATAL CARE - The percentage of low income women who initiated prenatal care in the first 3 months of pregnancy compared to non-low income women: b) Non WIC enrolled (proxy for non low-income women)</p> <p>Rationale: We propose reporting two data points for this measure:a) WIC enrolled (proxy for low-income women)b) Non WIC enrolled (proxy for non low-income women)</p>
NEW	<p>Title: PREVENTIVE QUALITY INDICATOR (PQI) - HOSPITALIZATIONS FOR AMBULATORY CARE SENSITIVE CONDITIONS OF OHP CLIENTS - The rate of ambulatory care sensitive condition hospitalizations of Oregon Health Plan clients by condition</p> <p>Rationale: The following changes have occurred since this measure was last run: The entire database has changed since the previous rates were calculated The AHRQ software used to calculate PQI measures has been upgraded from version 3.1 to 4.1 In order to better compare with State of Oregon and national rates, claims are proportioned to 100,000 member years instead of 10,000 member months. The Oregon Health Plan prioritizes preventive health care services. Evidence suggests that good preventive care can reduce the risk of hospitalization for some chronic and acute conditions. These conditions are called ambulatory care sensitive conditions & Ambulatory care means medical office or clinic based health services and sensitive means the condition can be treated in this setting. The Prevention Quality Indicator measure represents hospital admission rates for clients 18 years old and older for the following 12 ambulatory care sensitive conditions: Diabetes, short-term complications (PQI #1) Diabetes, long-term complications (PQI #3) Chronic obstructive pulmonary disease (PQI #5) Hypertension (PQI #7) Congestive heart failure (PQI #8) Dehydration (PQI #10) Bacterial pneumonia (PQI #11) Urinary infections (PQI #12) Angina without procedure (PQI #13) Uncontrolled diabetes (PQI #14) Adult asthma (PQI #15) Lower extremity amputations among patients with diabetes (PQI #16) With high-quality, community-based primary care, hospitalization for these illnesses sometimes can be avoided. In addition to quality of care, a higher PQI rate can be an indication of a primary care access concern.</p> <p>Although not shown here as a Key Performance Measure, for quality improvement and management purposes, the measure is designed for additional analysis by subcategories of race and ethnicity and by delivery systems of specific managed care plan, primary care management, and fee for service.</p>

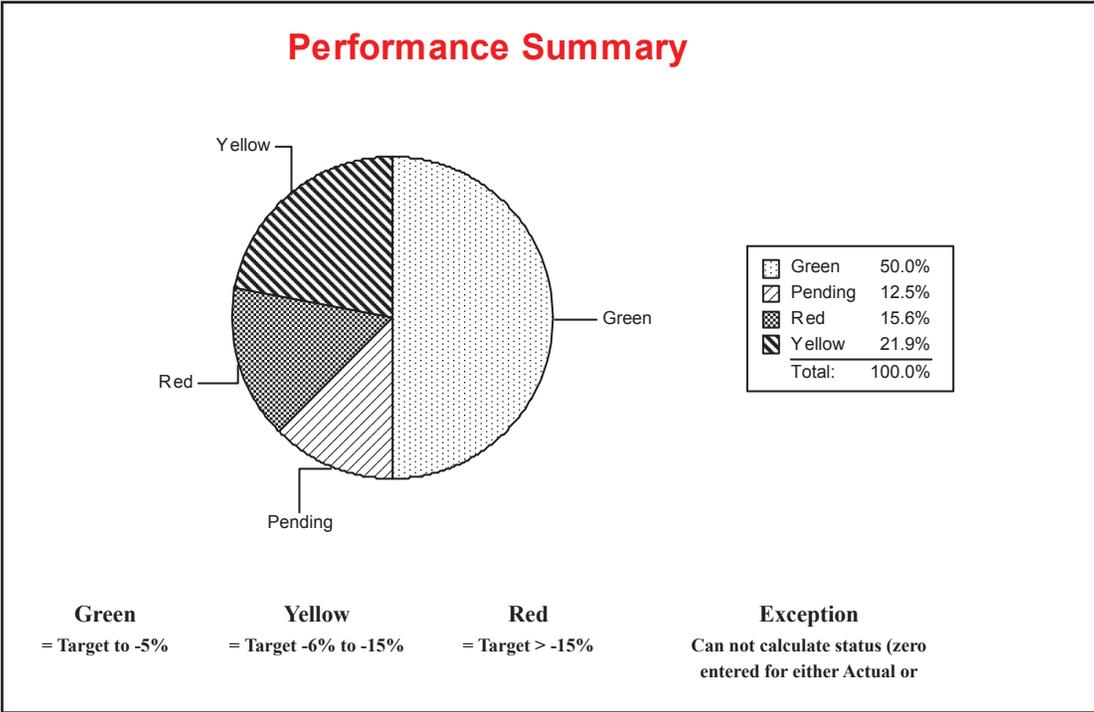
New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2011-2013
DELETE	<p>Title: COMPLETION OF ALCOHOL AND DRUG TREATMENT – The percentage of engaged clients who complete alcohol and other drug (AOD) abuse treatment and are not abusing AOD.</p> <p>Rationale: This measure is being dropped in favor of more specific outcomes related to completion of alcohol and drug treatment.</p>
DELETE	<p>Title: ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of adults employed after receiving Alcohol and Drug treatment.</p> <p>Rationale: We are proposing to drop this KPM and replace it with one focusing on increased income.</p>
DELETE	<p>Title: ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of parents who have their children returned to their custody after receiving alcohol and drug treatment.</p> <p>Rationale: This measure actually looked at whether or not the parent(s) completed the alcohol and drug treatment, which is usually only one of many requirements to regain custody of their children. A new measure has been proposed that actually tracks reunification.</p>
DELETE	<p>Title: SAFETY NET CLINIC USE – The percentage of uninsured Oregonians served by safety net clinics.</p> <p>Rationale: This KPM will now report three distinct populations being served by safety net clinics: Uninsured Medicare Medicaid</p>
DELETE	<p>Title: MENTAL HEALTH CLIENT LEVEL OF FUNCTIONING – The percentage of mental health clients who maintain or improve level of functioning following treatment.</p> <p>Rationale: We are proposing to drop this measure as it doesn't demonstrate enough sensitivity to show changes in outcomes.</p>

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2011-2013
DELETE	<p>Title: ACS HOSPITALIZATIONS OF OHP CLIENTS - The rate of ambulatory care sensitive condition hospitalizations of Oregon Health Plan clients</p> <p>Rationale: DMAP requests to drop this measure and replace it with the 12 conditions that comprise the measure. In addition, please note the following changes: The entire (MMIS) database has changed since the previous rates were calculated The AHRQ software used to calculate PQI measures has been upgraded from version 3.1 to 4.1 In order to better compare with the State of Oregon and national rates, claims are proportioned to 100,000 member years instead of 10,000 member months The Oregon Health Plan prioritizes preventive health care services. Evidence suggests that good preventive care can reduce the risk of hospitalization for some chronic and acute conditions. These conditions are called ambulatory care sensitive conditions. Ambulatory care means medical office or clinic based health services and sensitive means the condition can be treated in this setting. The Prevention Quality Indicator measure represents hospital admission rates for the following 12 ambulatory care sensitive conditions: Diabetes, short-term complications (PQI #1) Diabetes, long-term complications (PQI #3) COPD - Chronic obstructive pulmonary disease (PQI #5) Hypertension (PQI #7) Congestive heart failure (PQI #8) Dehydration (PQI #10) Bacterial pneumonia (PQI #11) Urinary infections (PQI #12) Angina without procedure (PQI #13) Uncontrolled diabetes (PQI #14) Adult asthma (PQI #15) Lower extremity amputations among patients with diabetes (PQI #16)</p>
DELETE	<p>Title: CHILD MENTAL HEALTH SERVICES - The % of children receiving mental health services who are suspended or expelled from school</p> <p>Rationale: We are proposing to drop this KPM for one that reports improved attendance of the same population.</p>
DELETE	<p>Title: ADULT MENTAL HEALTH SERVICES - The % of adults receiving mental health services who report positively about the outcomes of those services.</p> <p>Rationale: We are proposing to drop this measure in favor of more specific measures relating to the outcomes of mental health services.</p>
DELETE	<p>Title: EARLY PRENATAL CARE - The % of low-income women who initiated prenatal care in the first 3 months of pregnancy compared to non low-income women.</p> <p>Rationale: We want to report two data points for this measure: a) WIC enrolled (proxy for low-income women) and b) Non WIC enrolled (proxy for non low-income women)</p>

New Delete	Proposed Key Performance Measures (KPM's) for Biennium 2011-2013
DELETE	<p>Title: FHIAP Administration Percentage – FHIAP administrative expenses as a percentage of total cost.</p> <p>Rationale: CHANGE TITLE TO "OPHP ADMINISTRATIVE PERCENTAGE - OPHP administrative expenses as a percent of total cost". This measure previously evaluated only the Family Health Insurance Assistance Program (FHIAP) administrative expenditure percentage. However, OPHP operations now includes FHIAP, Healthy Kids Connect (HKP) and the Oregon Medical Insurance Pool (OMIP). There are several staff members that perform duties that serve more than one of these programs and one shared facility that serves them all. The proposal is to change the existing FHIAP administration measure to an OPHP administration measure that will more accurately reflect the overall administrative efficiency and performance of the agency. In addition, the historical data will be adjusted to reflect the combined FHIAP and OMIP administration percentage.</p>
DELETE	<p>Title: CUSTOMER SERVICE – Percent of customers rating their satisfaction with the agency’s customer service as “good” or “excellent”: overall customer service, timeliness, accuracy, helpfulness, expertise and availability of information.</p> <p>Rationale: CHANGE TITLE TO: "CUSTOMER SERVICE (OPHP) - Percent of customers rating their satisfaction with the agency's customer service as "good" or "excellent": overall customer service, timeliness, accuracy, helpfulness, expertise and availability of information. OPHP is now part of the Oregon Health Authority. OPHP customer service will be reported separately during this transition period.</p>

Proposed Key Performance Measures Targets for Biennium 2009-2011	2012	2013
Title: TEEN PREGNANCY – The number of female Oregonians ages 15 – 17, per 1,000 who are pregnant.	21.50	21.00
Title: ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of children whose school performance improves after receiving alcohol and drug treatment.	70.00	70.50
Title: TOBACCO USE – Tobacco use among adults.	18.30	18.30
Title: CIGARETTE PACKS SOLD – Number of cigarette packs sold per capita.	44.50	43.00
Title: CHILD IMMUNIZATIONS – The percentage of 24-35 month old children who are adequately immunized.	76.50	77.00
Title: INFLUENZA VACCINATIONS FOR SENIORS – The percentage of adults aged 65 and over who receive an influenza vaccine.	77.00	77.00
Title: PREVENTIVE SERVICES FOR OHP YOUTH AND ADULTS - The utilization rate of preventive services for youth and adults 11 years old and older covered by OHP	0.98	1.00
Title: PREVENTIVE SERVICES FOR OHP CHILDREN - The utilization rate of preventive services for children birth through 10 years old covered by OHP	4.95	5.00
Title: APPROPRIATE PRENATAL CARE FOR OHP CLIENTS - The % of pregnant OHP clients who received an appropriate number of prenatal care visits while on OHP	65.50	67.10
Title: 8TH GRADER USE OF ALCOHOL - The % of 8th graders who have used alcohol within the past 30 days	27.00	26.50
Title: 8TH GRADER USE OF ILLICIT DRUGS - The % of 8th graders who have used illicit drugs within the past 30 days.	13.50	13.00
Title: Problem Gambling - The % of adults who gamble much less or not at all 180 days after ending problem gambling treatment.	76.50	77.00
Title: LENGTH OF STAY AT OSH - Reduction in overall length of stay at Oregon State Hospital	230.00	225.00

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		Contact Phone: 503-945-5855	
Alternate: John Britton		Alternate Phone: 503-945-6597	



1. SCOPE OF REPORT

This report covers a broad array of programs throughout the Oregon Health Authority (OHA), such as addiction services, health/medical services, mental health services, health policy and research, insurance assistance and public health. that support the mission and goals of the agency. Of course these measures don't capture all the work that's done within OHA. The purpose of this annual performance report is to communicate the results of the work that is done. 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.

2. THE OREGON CONTEXT

OHA helps achieve Oregon's goals around safe, caring and engaged communities, and healthy, sustainable surroundings. The OHA Key Performance Measures support many Oregon Benchmarks such as: #39 Teen pregnancy; #40 Prenatal care; #41 Infant mortality, #42 Immunizations; #43 HIV diagnosis; #44 Adult non-smokers; #45 Preventable death; #50 8th grade substance abuse; #53 Alcohol/Tobacco abstinence during pregnancy. More information about Oregon Benchmarks can be accessed at http://www.oregon.gov/DAS/OPB/KPM_links.shtml

3. PERFORMANCE SUMMARY

OHA has achieved green status on 15 (50%) KPMs. Seven (22%) KPMs achieved yellow status. Five (16%) achieved red status. Four (13%) KPMs received "pending" status until comparisons to targets can be made.
Green status = Target to -5% Yellow status = Target -6% to -15% Red status = Target > -15%

4. CHALLENGES

Poor economic conditions and unemployment appear to have an influence on many measures. Cuts in funding and limited resources (such as staff and providers) have an impact on whether or not we can achieve our desired results. Other challenges include the fact that the work of OHA is complex and requires coordinated efforts to see an impact in the results. It's not uncommon for clients to have multiple barriers to face. They may have drug or alcohol abuse issues, involvement with law enforcement, have mental health challenges, or be unemployed. Many of our outcomes are about human behavior changes, such as teen pregnancy and alcohol and drug abuse, which makes it challenging to achieve the desired results.

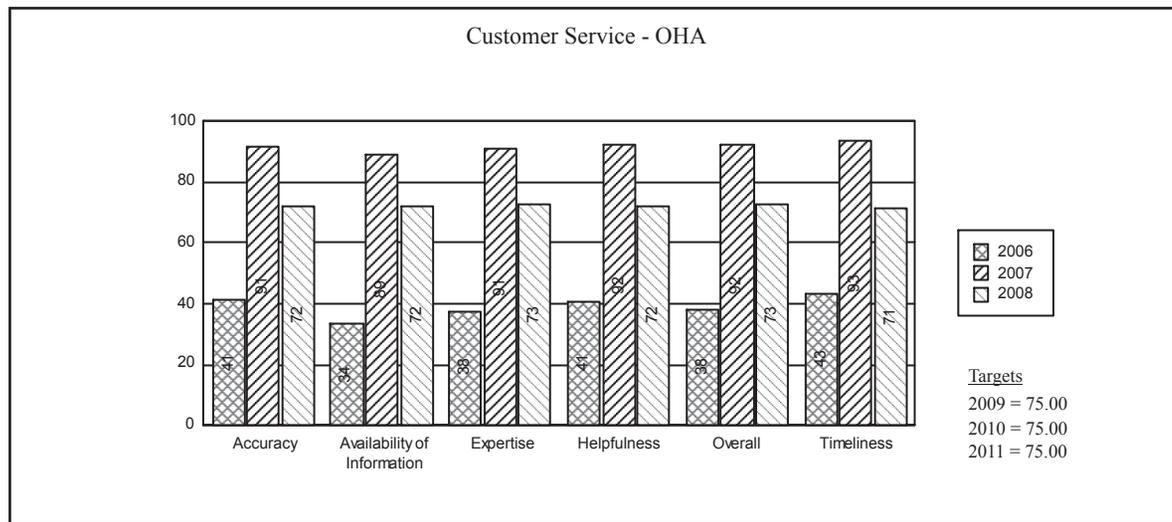
It continues to be a challenge to connect the daily work of the agency to intermediate and high level outcomes. However, doing so will enable us to prioritize and clarify the results of what we do (effectiveness) and the importance of efficient processes, thereby creating a culture throughout OHA by 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

2009-11 Total Fund Budget by Division This section provides overall budget information for OHA and the major program areas. Division | Total Funds (in millions) | %
Funds Additions and Mental Health Services Division (AMH) | \$939.6 | 9.0%
Division of Medical Assistance Programs (DMAP)* | \$6,097.6 | 58.1%
Oregon Educator's Benefit Board (OEBB) | \$1,344.8 | 12.8%
Office of Medical Insurance Pools (OMIP) | \$409.0 | 3.9%
Office of Private Health Partnerships (OPHP) | \$144.3 | 1.4%
Public Employees' Benefit Board (PEBB) | \$1,035.9 | 9.9%
Public Health Division (PHD) | \$523.8 | 5.0% TOTAL FUNDS = \$10,495.0

* For purposes of this report, DMAP includes OHA Admin, OPDP, OHPR, OHK** Source: DHS/OHA Budget, Planning and Analysis

KPM #	CUSTOMER SERVICE (OHA) - Percentage of customers rating their overall satisfaction with OHA above average or excellent.	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	Consumer Assessment of Health Plans Survey (CAHPS)	
Owner	OHA, Cathy Iles, Performance Management Coordinator, Office of Continuous Improvement, 503-602-1507	



1. OUR STRATEGY

OHA strives to be a world-class human and health services organizations. We are fundamentally changing the way we do business to provide more effective and efficient client services and improve accountability. The goal is to build a foundation for continuous improvement so we are always doing our best work by constantly measuring our performance and quickly resolving problems. Our transformation efforts are resulting in reduced red tape, reduced wait time for clients and improved customer service.

2. ABOUT THE TARGETS

2010 and 2011 targets were set based on 2008 results. Our methodology has varied greatly from year to year making it difficult to develop meaningful targets.

3. HOW WE ARE DOING

This is our third year reporting on customer service. Each year we've used a different methodology, therefore it's impossible, at this time, to determine whether or not we're seeing an improvement in the service we provide to clients.

4. HOW WE COMPARE

At this time, we are unable to compare our results to other agencies, organizations or jurisdictions. We can't compare our results from year to year because of the changes in survey methodology.

5. FACTORS AFFECTING RESULTS

In 2008, we exceeded our target for overall customer service. This was the first year using results from the CAHPS survey, so we don't have data to compare to yet.

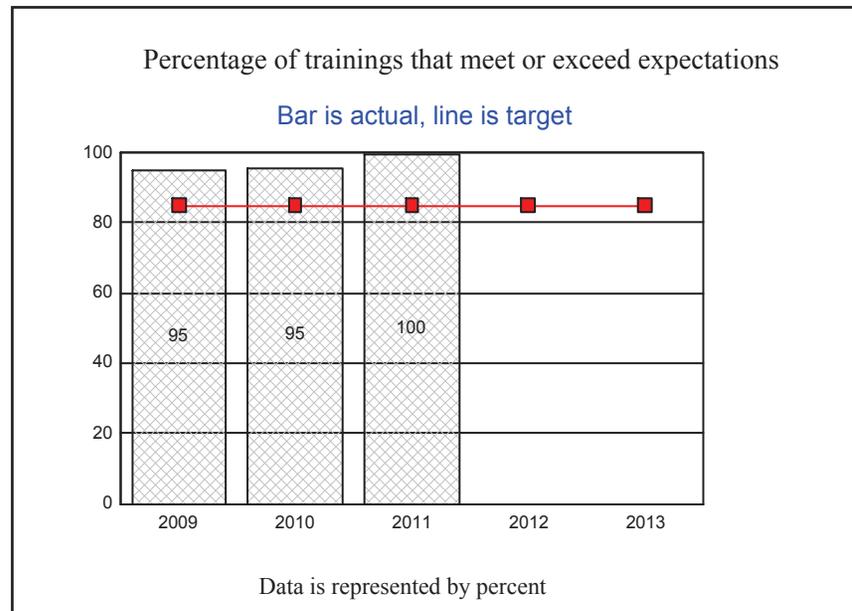
6. WHAT NEEDS TO BE DONE

As we've transitioned to DHS and OHA, we will revisit how we gather customer feedback. The CAHPS survey has been used for reporting DHS customer service, including Divisions that are now part of the Oregon Health Authority (AMH, DMAP, PHD). There are other organizations that have become part of OHA who have been reporting customer service using their own methodology (PEBB, OEBC, OPHP, OMIP). We will develop a plan for a comprehensive measurement of customer service that adequately represents DHS clients.

7. ABOUT THE DATA

Reporting cycle - fiscal year. The 2008 results are from the Consumer Assessment of Health Plans Survey (CAHPS). It was administered through the Division of Medical Assistance Programs (DMAP) over a 10-week period (October-December 2007) using a mixed-mode (mail and telephone) five-wave protocol. This protocol consisted of a pre-notification letter, an initial survey mailing and reminder postcard to all respondents, followed by a second survey mailing and reminder postcard to non-respondents. Phone follow-up was conducted for members who had not responded to the mailings. Respondents were surveyed in English and Spanish. The sampling plan for the adult and child surveys called for a random sample of 900 eligible members per plan in each age group. To be eligible, members had to have been enrolled in Oregon Health Plan for at least six months as of December 31, 2006. The final selected sample consisted of 13,962 adult OHP enrollees and 13,747 child OHP enrollees. For the customer service questions, we received approximately 10,600 responses. We will continue to use the CAHPS survey, which is a biennial survey, to report on customer service. **New data will be available in fall 2011.** This KPM was audited in summer 2010. It was certified as "verified" - procedures were documented and variances between the KPM results originally reported and subsequently recreated were all within allowable limits.

KPM #	OPHP TRAINING - Percentage of attendees rating the training received as 'meets or exceeds learning experience expectations'.	2009
Goal	To provide Oregon insurance producers, consumers and the advocate community with timely, accurate, and well-designed and presented information on health insurance and state health insurance programs in Oregon. This KPM measures the satisfaction with the training given by those attending OPHP-sponsored sessions.	
Oregon Context	In ORS 735.702, the agency is directed to provide "a central source for information about resources for health care and health insurance." The training provided by the agency fulfills this mission. In addition, by providing training and information to Oregon insurance producers, consumers and the advocate community, the agency can help lower the number of people without health insurance (Oregon Benchmark 55).	
Data Source	A database will be created that collects information from a survey done at the conclusion of each training. The survey will ask attendees if the training given: 1) did not meet their learning experience expectation; 2) somewhat meets the expectation; 3) meets the expectation; or 4) exceeds the expectation. Surveys will also provide the opportunity to provide specific feedback on the training program.	
Owner	OHA – OPHP, Information Education & Outreach, Mark Jungvirt, 503-378-5461	



1. OUR STRATEGY

The purpose of Information, Education and Outreach (IEO) is to educate the public about OPHP programs and the health insurance system to make them better consumers. The best way to do this is through intensive and informative trainings for insurance carriers, producers, employers, medical providers and other community partners who work with our target audience. These partners, in turn, are better able to link uninsured Oregonians with programs that can help them, thus lowering the uninsured rate. In addition to carriers, producers, employers and advocacy groups, a key training target for IEO trainings is the Department of Human Services (DHS) and Oregon Health Authority (OHA) staff. The Family Health Insurance Assistance Program (FHIAP) is an alternative for many Oregonians who qualify for Oregon Health Plan (administered by OHA) but either choose private insurance or can't get into OHP because of budget limits. FHIAP and HKC also serve people/families that are making the transition from public- to private sector programs. There is a need for ongoing training about how all Oregon programs work together. During stakeholder trainings, IEO also reaches out to county health departments, safety net clinics, medical providers, state employment offices, employer human resource personnel, medical providers and advocacy groups that help people with applications.

2. ABOUT THE TARGETS

The goal is to have 85% of those who attend our trainings report that the training “meets or exceeds” their learning experience expectations, which means that we are providing our audience with the information that they need. Constant turnover in public and private organizations and changes in laws affecting state programs and the health insurance industry require OPHP to provide ongoing training to key partners. The extent and frequency of training is dictated in part by program openings, and the OPHP budget, but the need for relevant and up to date information remains the same.

3. HOW WE ARE DOING

OPHP has been above the target for the past three years.

4. HOW WE COMPARE

There is no direct comparator to the work that OPHP does to train stakeholders.

5. FACTORS AFFECTING RESULTS

All factors are within the control of OPHP.

6. WHAT NEEDS TO BE DONE

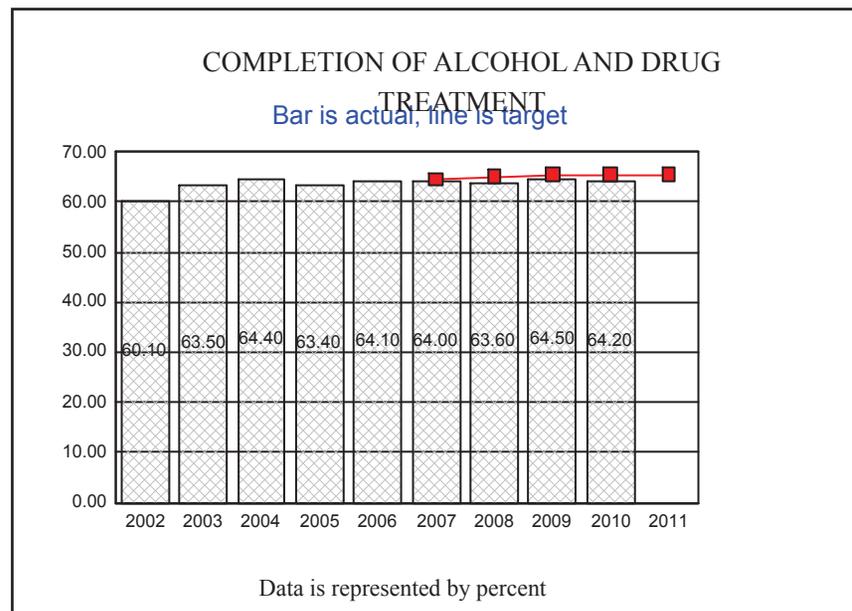
OPHP will continue to provide free or low-cost education to newly licensed producers and producers who need continuing education, as well as key community partners. OPHP

will do so in a manner that meets or exceeds their expectation. The agency is exploring other ways to deliver training, such as webinars and online classes.

7. ABOUT THE DATA

OPHP has a mechanism by which all data for this measure is electronically collected at the end of each training session. The data is then combined with data from other trainings and reported each year.

KPM #1	COMPLETION OF ALCOHOL AND DRUG TREATMENT – The percentage of engaged clients who complete alcohol and other drug (AOD) abuse treatment and are not abusing AOD.	2002
Goal	People are healthy	
Oregon Context	Oregon Benchmark #50a - 8th Grade Substance Abuse (alcohol), #50b - 8th Grade Substance Abuse (illicit drugs), #53a - Alcohol Abstinence During Pregnancy, #53b - Tobacco Abstinence During Pregnancy, Alcohol/Drug Abuse	
Data Source	Addictions and Mental Health Division, Client Process Monitoring System database	
Owner	OHA - Addictions and Mental Health Division, Program Analysis & Evaluation Unit Contact: Jon Collins 503 945 6429	



1. OUR STRATEGY

Completion of treatment services leads to better outcomes for the client.

2. ABOUT THE TARGETS

The higher the completion rate the better.

3. HOW WE ARE DOING

The completion rate for clients has been steadily increasing for the past seven years. The Division is working with providers to continue this trend through a quality improvement process and by incorporating this measure into performance-based contracting.

4. HOW WE COMPARE

Nationally the completion rate was 51% in 2003, according to reports available from the Substance Abuse and Mental Health Services Administration Office of Applied Studies. 2003 is the most recent reliable data available.

5. FACTORS AFFECTING RESULTS

There are a number of factors affecting this measure including referral source (legal referrals are more likely to complete), type of service being delivered (residential compared to outpatient completion), and the quality of services (varies by provider and by type of service delivered). Methadone clients and clients receiving detoxification services are not included in this measure, as it is inappropriate for this type of measure.

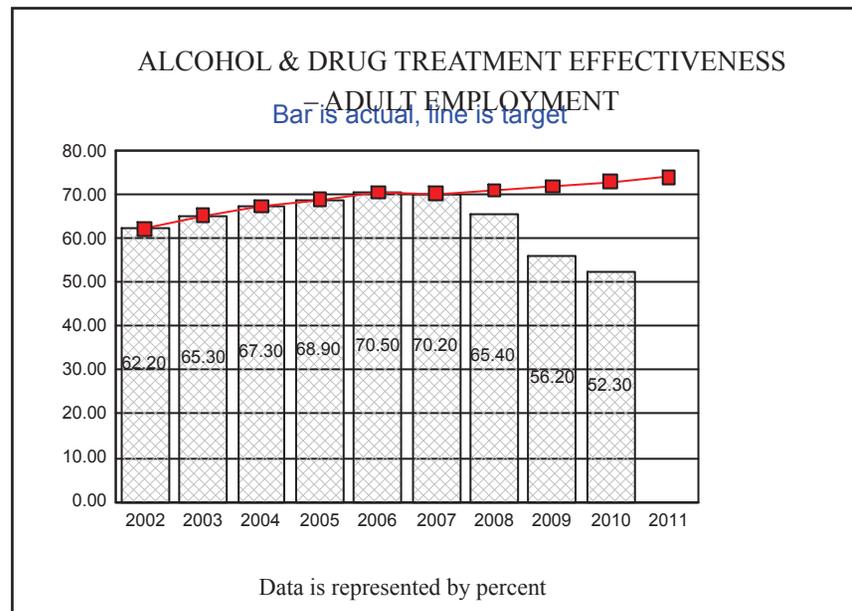
6. WHAT NEEDS TO BE DONE

The Division will continue quality improvement and process improvement efforts to improve completion rates.

7. ABOUT THE DATA

Data are extracted from the Division's Client Process Monitoring System (CPMS), which tracks all publicly funded substance abuse treatment services. The Division produces reports on this data regularly and travels to different areas of the state to insure through training that appropriate /accurate data are submitted to the CPMS. Data were corrected since the FY 2006 annual performance progress report. Targets were adjusted based on the corrected data. This KPM was audited in 2009 and was certified as "verified" meaning that performance reported is consistently accurate within plus or minus five percent and adequate controls are in place to ensure consistency and accuracy in collection of all supporting data and subsequent reports.

KPM #2	ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of adults employed after receiving Alcohol and Drug treatment.	2007
Goal	People are living as independently as possible	
Oregon Context	Achieving employment by end of treatment	
Data Source	Client Process Monitoring System (CPMS)	
Owner	OHA - Addictions and Mental Health Division, Karen Wheeler, 503-945-6191	



1. OUR STRATEGY

AMH requires addiction treatment providers to assess vocational / employment status and to partner locally with workforce initiatives to create effective linkages for the clients they serve. Oregon’s AMH strategy relates to the Oregon Business Plan initiative to increase access to treatment and intervention services for Oregon workers who have alcohol

and drug problems but no insurance.

2. ABOUT THE TARGETS

For a majority of individuals with substance use conditions, incorporating daily structure, positive peer associations, and meaningful, legal means toward becoming self-sufficient promotes stability and long-term recovery. The higher the rate the better.

3. HOW WE ARE DOING

Oregon has been doing well regarding employment at discharge but due to the economy and employment conditions in Oregon, beginning in 2008, it is expected the employment percentage at discharge to decrease compared to previous 2-3 years.

4. HOW WE COMPARE

Oregon along with all states reports to the federal government employment at admission and discharge from treatment for outpatient, intensive outpatient, and residential services. According to SAMHSA (<http://nationaloutcomemeasures.samhsa.gov>) in 2008, 42.8% of clients were working part or full time at discharge. For 2008 and part time or full time work only, 58.2% of Oregonians are employed. The KPM includes individuals who work at some level no matter how limited.

5. FACTORS AFFECTING RESULTS

State unemployment rates significantly affect reported employment rates for clients served.

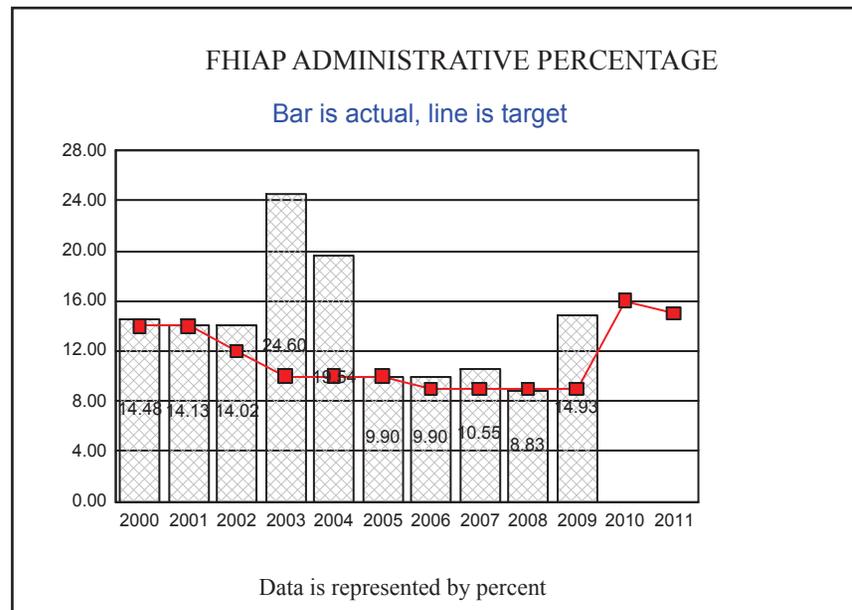
6. WHAT NEEDS TO BE DONE

More emphasis needs to be placed on co-occurring disorder treatment, additional case management services, supported employment strategies, and recovery management services.

7. ABOUT THE DATA

Data are extracted from the Division's Client Process Monitoring System (CPMS), which tracks all publicly funded substance abuse treatment services. The Division produces reports on this data regularly and travels to different areas of the state to insure through training that appropriate/accurate data are submitted to the CPMS. Data were corrected since the FY 2006 annual performance progress report. Targets were adjusted based on the corrected data. The included 2008 year used any youth receiving outpatient, intensive outpatient or residential treatment services and discharged from treatment during the calendar year. If a client reported partial employment (less than 17 hours/week), part time or full time employment they were counted as employed.

KPM #2	FHIAP Administration Percentage – FHIAP administrative expenses as a percentage of total cost.	2000
Goal	HEALTH CARE SUBSIDIES - Provide subsidies to low-income Oregonians to assist with cost of health insurance premiums.	
Oregon Context	Oregon Benchmark #55 - Health Insurance	
Data Source	Compares total administrative expenditures from SFMA to total program costs in SFMA (accounting system).	
Owner	OHA – OPHP, Karla Messer-Holt, Business Services Manager, 503-378-3930	



1. OUR STRATEGY

The strategy of the agency is to maximize our current fixed cost administrative resources. If we maximize our fixed administrative costs while our program expenditures grow, then as a percentage, administrative expenditures will drop. Also, the agency is utilizing variable cost resources as much as possible during

times of peak demand, enabling the agency to respond to the significant swings in funding levels for the program from biennium to biennium with minimal impact to the agency's administrative cost percentage and to its fixed infrastructure. In addition, the agency is committed to reviews of staffing levels, office space, and common practices and processes.

2. ABOUT THE TARGETS

The target for this measure is difficult to set when funding for the program is shifting. The current targets were set during a period of growth for the agency. However, during the 2007-09 biennium, the agency had to cut program expenditures due to changes in federal funding. The targets for future time periods will again be reviewed through this legislative budget process.

3. HOW WE ARE DOING

The agency has made progress in reducing the administrative costs of the FHIAP subsidy program in part by succeeding in getting enrollment in the program to a level that maximizes the efficiency of its fixed costs and staffing resources. In 2003 and 2004, during the early stages of implementing the agency's expansion, administrative costs were high as a percentage of the total budget because there were economies of scale that had not been realized. From 2005 through 2008, the agency met economies of scale and was able to bring down administrative costs to targeted levels. In 2009, due to a reduction in federal funding, enrollment and the program expenditures associated with that enrollment dropped significantly. As a result, the administrative expenditures increased as a percentage of the total cost. It is anticipated that the administrative expenditures will come in under target for 2010 and 2011.

4. HOW WE COMPARE

While there are a handful of other premium assistance programs in the country, each program is operated under a unique federal waiver (including direct tie-ins to state Medicaid programs) and under different private market conditions, making direct relevant comparisons difficult. However, policy representatives from several states periodically contact staff to discuss how their state may design/implement a similar program to FHIAP because we continue to be successful in reaching our budgeted enrollment goals while also experiencing success in reducing administrative overhead costs.

5. FACTORS AFFECTING RESULTS

The biggest factor affecting results is economy of scale, which is driven by program funding. There is a threshold of service required regardless of the number of lives served in the program. There is a fixed cost associated with providing this threshold of service. As the total budget of the program is reduced, the percentage of administrative expenditures is increased and vice versa, without any change in the dollars spent on administration.

6. WHAT NEEDS TO BE DONE

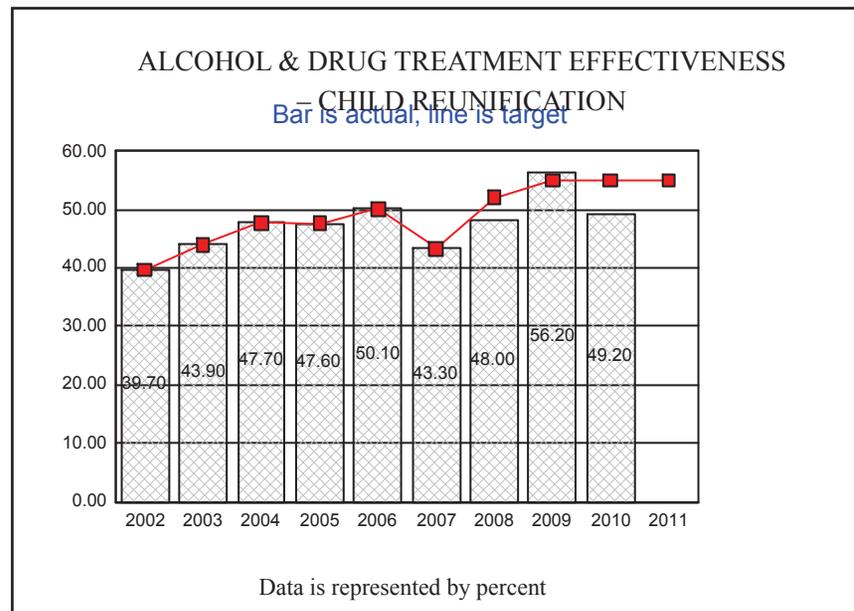
The agency continues to streamline as many processes as possible to provide the highest level of service possible within allowed budgets.

7. ABOUT THE DATA

The percentage of administration is a calculation of total FHIAP administrative costs compared to the total FHIAP budget. It does not include administration of the Information, Education and Outreach program. This KPM is measured by State Fiscal Year (July - June).

This KPM was audited by the DHS Internal Audits group in summer 2010. It was certified as "verified" - procedures were documented and variances between the KPM results originally reported and subsequently recreated were all within allowable limits.

KPM #3	ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of parents who have their children returned to their custody after receiving alcohol and drug treatment.	2007
Goal	People are healthy.	
Oregon Context	Prevent out-of-home placements	
Data Source	Client Process Monitoring System (CPMS)	
Owner	OHA - Addictions and Mental Health, Karen Wheeler, 503-945-6191	



1. OUR STRATEGY

To deliver services promoting family reunification.

2. ABOUT THE TARGETS

The higher the rate the better.

3. HOW WE ARE DOING

Despite new investments in addiction treatment and recovery support services made during the 2007-2009 biennium there was a slight decline for 2010.

4. HOW WE COMPARE

We do not have any national data to compare to.

5. FACTORS AFFECTING RESULTS

When investments are made in addiction treatment, as evidenced by targeted investments for this population, positive outcomes can be predicted. This system outcome was one of the specific aims for the Addictions and Mental Health Division (AMH), in collaboration with the Children, Adults and Families Division (CAF), during the 2007 – 2009 biennium as a result of the new investments. In addition, AMH held contractors accountable and led efforts to improve case coordination between addiction treatment providers and child welfare services during the 2007 – 2009 biennium.

6. WHAT NEEDS TO BE DONE

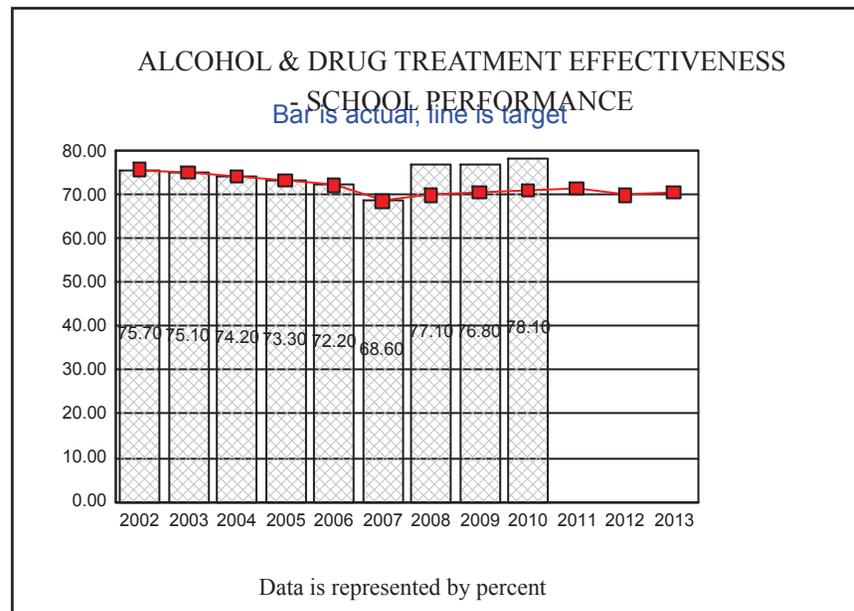
Maintain capacity for clinical treatment and recovery services provided to parents at risk or involved in the child welfare system to retain positive trend in this measure. AMH will continue to be an assertive purchaser of these services by holding contractors accountable for outcomes and performance. Through an AMH Transformation Initiative, emphasize will be placed on process improvement strategies for addiction service providers serving parents and families involved in the child welfare system during the 2009 – 2011 and 2011 0 2013 biennia. Performance-based contract management tools were implemented during 2009 – 2011 which will continue to be used and refined during 2011 – 2013.

7. ABOUT THE DATA

Data are extracted from the Division's Client Process Monitoring System (CPMS), which tracks all publicly funded addiction treatment services. The Division produces reports on this data regularly and travels to different areas of the state to insure through training that appropriate/accurate data are submitted to the CPMS. Data were corrected since the FY 2006 annual performance progress report. Targets were adjusted based on the corrected data. The included 2009 year used individuals receiving outpatient, intensive outpatient or residential treatment services and discharged from treatment during the calendar year. For the purposes of this measure, parents referred to treatment by the child welfare system were assigned a value of "yes" or "no" based on the data collection procedure for capturing whether or not the individual sufficiently met the Child Welfare Service Agreement requirements to progress towards regaining custody of their children. It should be noted that beginning 2007, AMH, working with CAF, developed a process that goes beyond

this measure to capture system-level outcomes associated with parent-child reunification by matching administrative data.

KPM #4	ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of children whose school performance improves after receiving alcohol and drug treatment.	2007
Goal	People are healthy	
Oregon Context	Alcohol and drug treatment effectiveness	
Data Source	Client Process Monitoring System database	
Owner	OHA - Addictions and Mental Health Division, Karen Wheeler, 503-945-6191	



1. OUR STRATEGY

To deliver services promoting healthy youth by focusing on a holistic approach to treatment.

2. ABOUT THE TARGETS

The higher the rate the better.

3. HOW WE ARE DOING

Better than expected given the prior trend.

4. HOW WE COMPARE

This measure looks at academic performance; most national data available only tracks improvement in attendance. This makes comparison data at a state level difficult. Using past performance, positive strides were made this past year.

5. FACTORS AFFECTING RESULTS

Capacity of school counselors and other school personnel to refer youth to treatment and provide educational supports to youth who have accessed treatment.

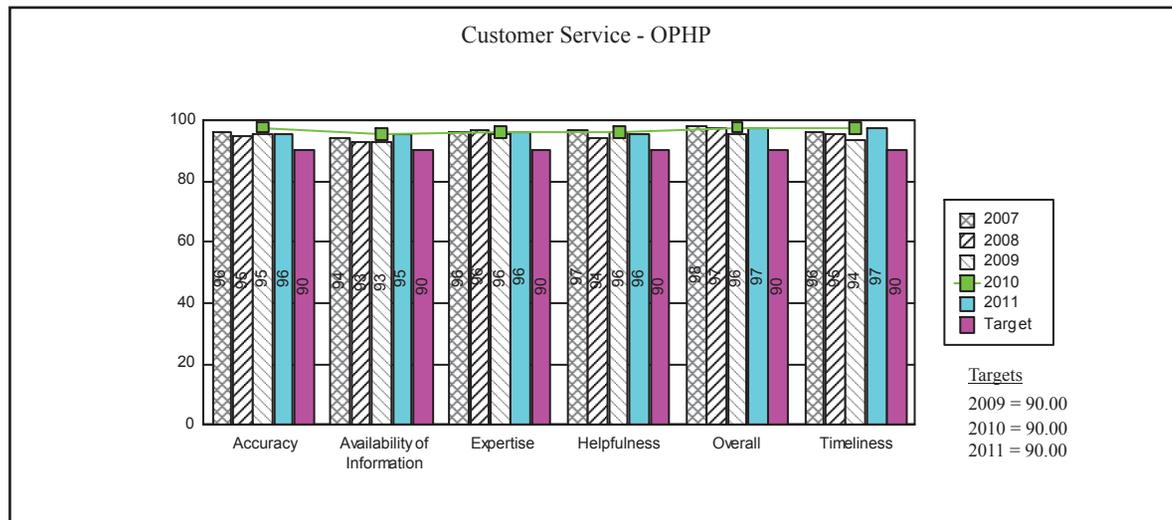
6. WHAT NEEDS TO BE DONE

More emphasis placed on youth specific co-occurring disorder treatment, additional case management services, recovery management services, and additional wraparound services. In addition, more coordination with school personnel including school counselors needs to occur.

7. ABOUT THE DATA

Data are extracted from the Division's Client Process Monitoring System (CPMS), which tracks all publicly funded substance abuse treatment services. The Division produces reports on this data regularly and travels to different areas of the state to insure through training that appropriate/accurate data are submitted to the CPMS. Data were corrected since the FY 2006 annual performance progress report. Targets were adjusted based on the corrected data. The included 2010 year used any youth receiving outpatient, intensive outpatient or residential treatment services and discharged from treatment during the calendar year. Academic performance improvement (yes/no) is reported at discharge.

KPM #4	CUSTOMER SERVICE – Percent of customers rating their satisfaction with the agency’s customer service as “good” or “excellent”: overall customer service, timeliness, accuracy, helpfulness, expertise and availability of information.	2006
Goal	Improve collaboration and deliver the highest level of customer service possible..	
Oregon Context	Oregon Benchmark #55 - Health Insurance	
Data Source	FHIAP Customer Survey Database	
Owner	OHA - OPHP, Cindy Bowman, Operations and Policy Analyst, 503-378-4674	



1. OUR STRATEGY

The agency surveys active FHIAP members using the statewide customer satisfaction survey created by the Oregon Progress Board and Customer Satisfaction Work Group . Active FHIAP members are surveyed quarterly in conjunction with the reapplication process. This measure reports specifically on customer service levels of the Family Health Insurance Assistance Program (FHIAP) within the Office of Private Health Partnerships. For this reporting cycle, the DHS customer service KPM covers both DHS (CAF and SPD) and OHA clients (specifically DMAP, AMH and PHD). As we complete the transition to DHS and OHA we will revisit how we gather customer service information and report accordingly.

2. ABOUT THE TARGETS

Targets are expressed as the percentage of responses that are good or excellent. The agency has always focused on providing excellent customer service to our members, and we anticipate a high return of Good or Excellent responses.

3. HOW WE ARE DOING

FHIAP began surveying in May 2006 and it has exceeded the target in every category since that time.

4. HOW WE COMPARE

OPHP is performing at a higher level than its comparative agencies.

5. FACTORS AFFECTING RESULTS

The agency is bound by some State and Federal regulations that are outside of the Agency's control. These regulations affect enrollment criteria, program design, and other elements that are a part of the client-agency interaction. The results of the customer service survey may be impacted by these elements that are outside the agency's control.

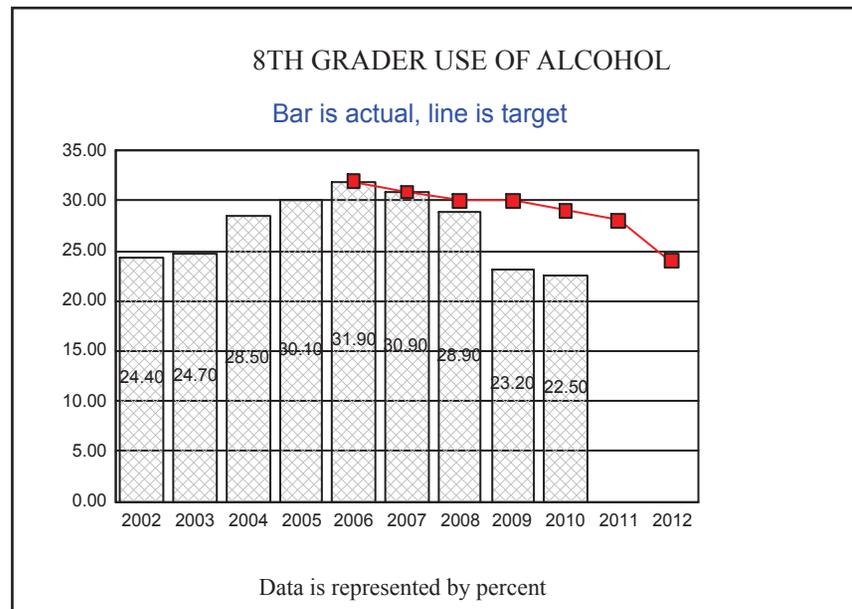
6. WHAT NEEDS TO BE DONE

The agency is doing well based on these measures and needs to continue performing at this high level.

7. ABOUT THE DATA

Survey Name: FHIAP Customer Satisfaction Survey Surveyor: Agency Staff Date Conducted: Regularly, beginning 5/1/2006. Population: Consumers Sampling Frame: About 25% of all active FHIAP members reapplying for subsidies, since the survey is mailed quarterly versus bi-weekly when the redetermination applications are mailed. Sampling Procedure: Systematic sample, Sample Characteristics: Population = ; Sample = ; Responses = ; Response Rate = Weighting: Single survey. No weighting required. Survey Questions: 1. How do you rate the timeliness of the services provided by FHIAP employees? 2. How do you rate the ability of FHIAP employees to provide services correctly the first time? 3. How do you rate the helpfulness of FHIAP employees? 4. How do you rate the knowledge and expertise of FHIAP employees? 5. How do you rate the availability of information at FHIAP? 6. How do you rate the overall quality of service provided by FHIAP? This KPM is measured by State Fiscal Year (July - June).

KPM #5	8TH GRADER USE OF ALCOHOL - The % of 8th graders who have used alcohol within the past 30 days	2009
Goal	People are healthy	
Oregon Context	Oregon Benchmark #50a - 8th Grade Substance Abuse (Alcohol)	
Data Source	Data are gathered annually through the Oregon Healthy Teens Survey and the Student Wellness Survey	
Owner	OHA – Addictions and Mental Health Division, Jon C. Collins, 503-945-6429	



1. OUR STRATEGY

Addictions and Mental Health Division (AMH) uses 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. These include 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 for their siblings concerning alcohol and other drug use. AMH will continue to provide community grants to implement programs to reduce underage drinking on the local level, utilizing Oregon Healthy Teens Survey data.

AMH currently funds a statewide public education effort which focuses primarily on radio and television advertising. Youth written and produced spots target messages to parents encouraging them to provide clear messages to youth regarding underage drinking, family expectations, and not providing alcohol to those under 21.

2. ABOUT THE TARGETS

The lower the rate the better.

3. HOW WE ARE DOING

The percent of 8th graders at risk of alcohol use declined for the fourth consecutive year, and is below the target.

4. HOW WE COMPARE

Oregon's rate of 8th grade alcohol use in the past 30 days is 63 percent higher than the national rate. In 2010, 13.8% of 8th graders in the United States reported using alcohol in the past 30 days, compared to 22.5% of Oregon 8th graders. U.S. data are published in Monitoring the Future 1975–2010, Volume I: Secondary school students (NIH Publication No. 08-6418A)

5. FACTORS AFFECTING RESULTS

Perceptions of youth to 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.

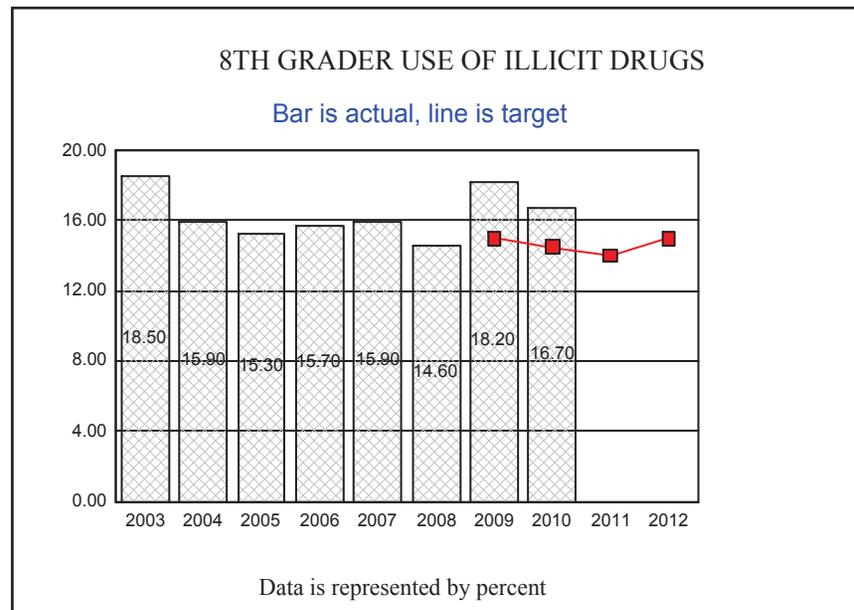
6. WHAT NEEDS TO BE DONE

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 are extracted from the Oregon Healthy Teens Survey in odd years and the Student Wellness Survey in even years. The Oregon Healthy Teens Survey is administered in odd years to 8th and 11th graders across the state. Beginning in 2010, the Student Wellness Survey is administered in even years in to 6th, 8th and 11th graders in public, private and charter schools.

KPM #6	8TH GRADER USE OF ILLICIT DRUGS - The % of 8th graders who have used illicit drugs within the past 30 days.	2009
Goal	People are healthy	
Oregon Context	Oregon Benchmark #50b - 8th Grade Substance Abuse (Illicit Drugs)	
Data Source	Data are gathered annually through the Oregon Healthy Teens Survey and the Student Wellness Survey	
Owner	OHA - Addictions and Mental Health Division, Jon C. Collins, 503-945-6429	



1. OUR STRATEGY

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. The assessment of progress on KPM #6 will utilize data from the Oregon Healthy Teens Survey and Student Wellness Survey.

2. ABOUT THE TARGETS

The lower the rate the better.

3. HOW WE ARE DOING

The percent of 8th graders at risk of drug use decreased from the previous year but it is above the target.

4. HOW WE COMPARE

Oregon’s rate of illicit drug use in the past 30 days is 76 percent higher than national rate of 9.5% for 2010. U.S. data are published in Monitoring the Future 1975–2010, Volume I: Secondary school students (NIH Publication No. 08-6418A).

5. FACTORS AFFECTING RESULTS

Oregon’s rate of illicit drug use in the past 30 days is 76 percent higher than national rate of 9.5% for 2010. U.S. data are published in Monitoring the Future 1975–2010, Volume I: Secondary school students (NIH Publication No. 08-6418A).

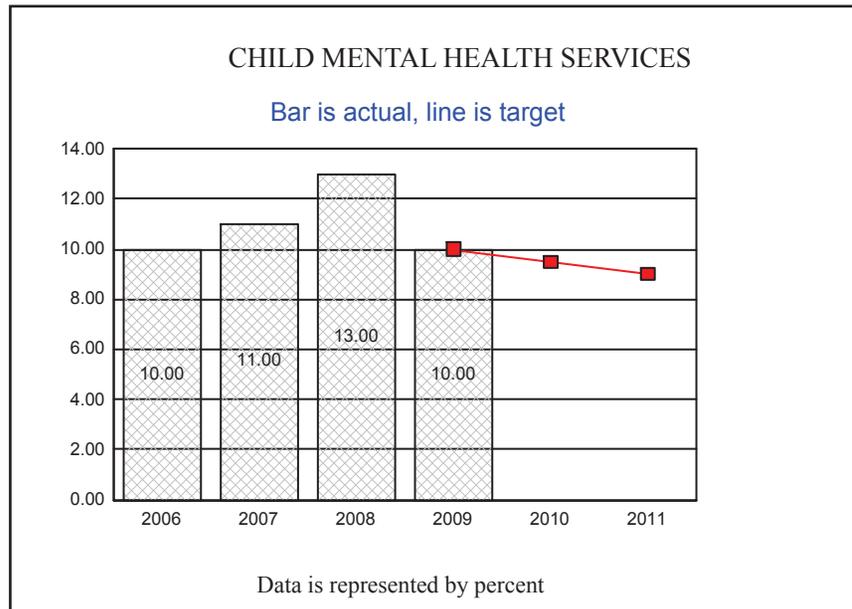
6. WHAT NEEDS TO BE DONE

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 are extracted from the Oregon Healthy Teens Survey in odd years and the Student Wellness Survey in even years. The Oregon Healthy Teens Survey is administered in odd years to 8th and 11th graders across the state. Beginning in 2010, the Student Wellness Survey is administered in even years in to 6th, 8th and 11th graders in public, private and charter schools.

KPM #7	CHILD MENTAL HEALTH SERVICES - The % of children receiving mental health services who are suspended or expelled from school	2009
Goal	People are healthy	
Oregon Context	School success	
Data Source	Youth Services Survey for Families and is based on reported data from a representative sample of caregivers of children receiving mental health services. This information is also reported to the Substance Abuse & Mental Health Services Administration as part of AMH's Community Mental Health Block Grant requirements.	
Owner	OHA - Addictions and Mental Health Division, Jon C. Collins, 503-945-6429	



1. OUR STRATEGY

The goal is to help keep children in school.

2. ABOUT THE TARGETS

The lower the percent the better.

3. HOW WE ARE DOING

This is roughly equivalent to the national rate for the standard population.

4. HOW WE COMPARE

See above.

5. FACTORS AFFECTING RESULTS

Children with severe emotional disorders are at higher risk for suspension/expulsion due to behavioral issues that are often difficult for school staff to deal with in the classroom.
The current rate suggests that Oregon is doing a good job.

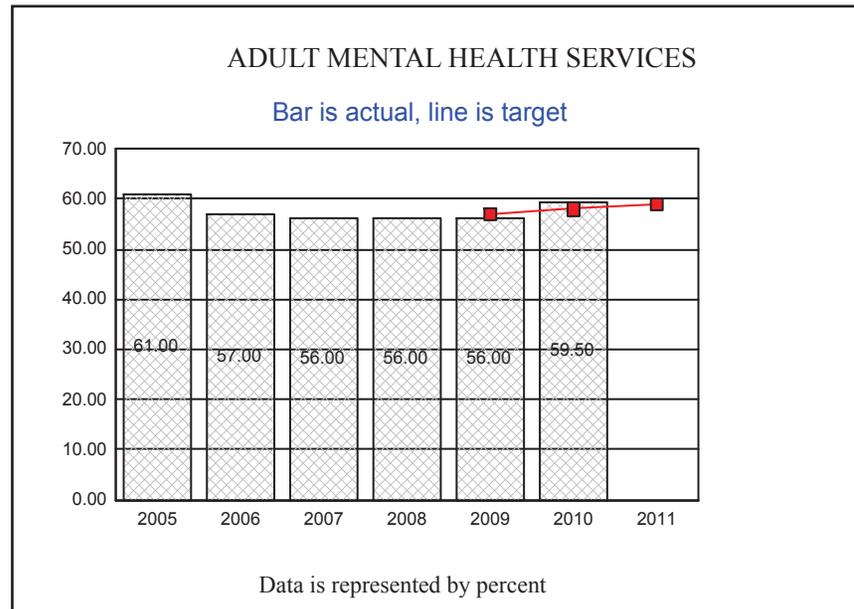
6. WHAT NEEDS TO BE DONE

Continued work at the local level between mental health authorities and education authorities will keep this rate low.

7. ABOUT THE DATA

The data is based on self-report through a statewide survey of caregivers of children receiving mental health services.

KPM #8	ADULT MENTAL HEALTH SERVICES - The % of adults receiving mental health services who report positively about the outcomes of those services.	2009
Goal	People are healthy	
Oregon Context	Improved functioning	
Data Source	Mental Health Statistics Improvement Program's Adult Consumer Survey and is based on reported data from a representative sample of adults receiving mental health services. This information is also reported to the Substance Abuse & Mental Health Services Administration as part of AMH's Community Mental Health Block Grant requirements.	
Owner	OHA - Addictions and Mental Health Division, Jon C. Collins, 503-945-6429	



1. OUR STRATEGY

To deliver services that promote recovery.

2. ABOUT THE TARGETS

The higher the percentage the better.

3. HOW WE ARE DOING

It is estimated that over half of the people receiving services are reporting better outcomes. Functional outcomes are related to improvement in housing, relationships, jobs, and other similar opportunities.

4. HOW WE COMPARE

National statistics show roughly 71% of adults indicate improved outcomes, as of 2007.

5. FACTORS AFFECTING RESULTS

Results have been consistent for several years and are low compared to combined data from other states. Factors associated with this outcome have to do with employment opportunities, housing, and other quality of life issues.

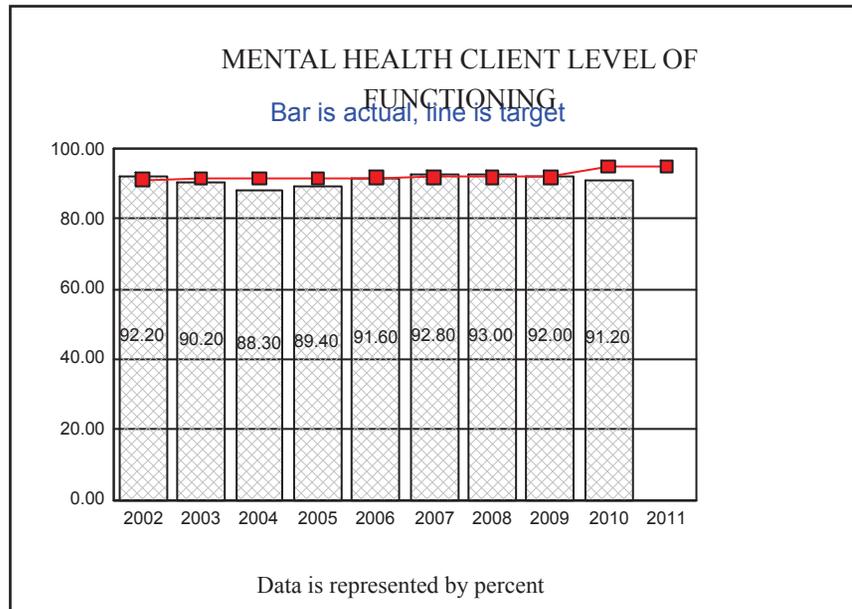
6. WHAT NEEDS TO BE DONE

AMH needs to continue to aggressively pursue outcomes that matter to its clients. This centers around recovery focused treatment that promotes independence and health.

7. ABOUT THE DATA

The data is collected through an annual standardized survey on adults receiving mental health residential and clinic based services.

KPM #9	MENTAL HEALTH CLIENT LEVEL OF FUNCTIONING – The percentage of mental health clients who maintain or improve level of functioning following treatment.	2002
Goal	People are healthy	
Oregon Context	Mental health consumer activities	
Data Source	Addictions and Mental Health Division, Client Process Monitoring System database	
Owner	OHA - Addictions and Mental Health Division, Program Analysis & Evaluation Unit Contact: Jon C. Collins, 503-945-6429	



1. OUR STRATEGY

To deliver services that promote recovery.

2. ABOUT THE TARGETS

The higher the rate the better.

3. HOW WE ARE DOING

It appears that many people are benefiting from mental health services. One concern is that this measure is not sensitive enough to truly assess improvement.

4. HOW WE COMPARE

We don't have any national data to compare.

5. FACTORS AFFECTING RESULTS

The tool used to measure level of functioning is not particularly sensitive. Addictions and Mental Health Division (AMH) is exploring the use of an alternative means to assess this measure.

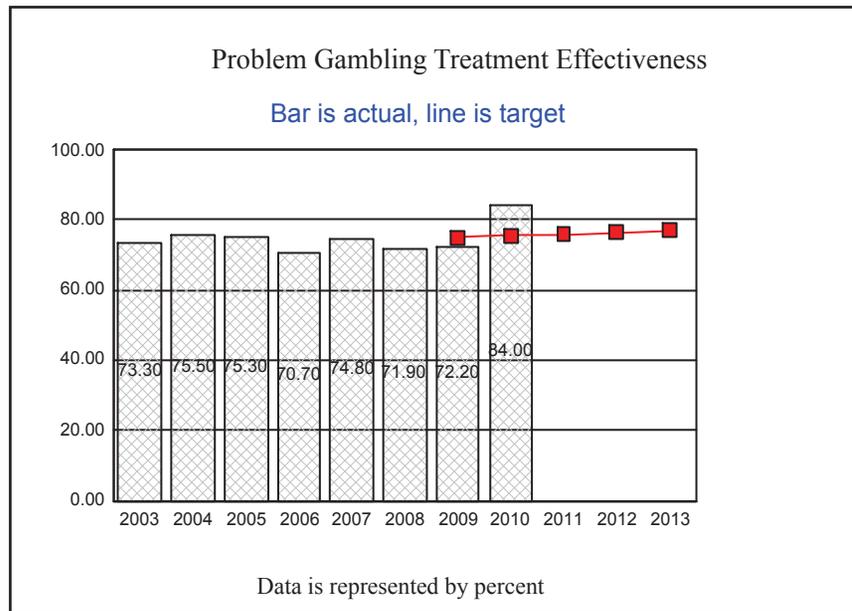
6. WHAT NEEDS TO BE DONE

AMH will continue quality improvement efforts and the encouragement of the use of evidence-based practices.

7. ABOUT THE DATA

Reporting cycle calendar year. Data are extracted from AMH's Client Process Monitoring System (CPMS), which tracks all publicly-funded substance abuse treatment services. AMH produces reports on this data regularly and travels to different areas of the state to insure, through training, that appropriate/accurate data are submitted to the CPMS.

KPM #10	Problem Gambling - The % of adults who gamble much less or not at all 180 days after ending problem gambling treatment.	2009
Goal	People are healthy	
Oregon Context	People are healthy	
Data Source	The data are collected by an independent contractor after the client has given permission to participate in a post-treatment outcomes assessment.	
Owner	OHA - Addictions and Mental Health Division, Jon Collins, 503-945-6429	



1. OUR STRATEGY

Problem gamblers and their families experience a complex array of mental health, social, financial and legal issues. The estimated social-economic cost of each pathological gambler is up to \$11,000 a year. Increasing the effectiveness of treatment contributes to the overall health of the community by eliminating these

social-economic costs by aiding those treated to remain abstinent from gambling. Our partners in this effort are county and private-not-for-profit community agencies who provide treatment for problem gamblers and their families.

2. ABOUT THE TARGETS

Our historical data shows a baseline trend between 70.7% and 75.5% of adults report gambling much less or not at all at 180 days post treatment. We chose to begin with a 75% target level, striving for a 0.5% per year improvement.

3. HOW WE ARE DOING

This year we significantly exceeded the target. Before this year, we had met the target in two out of the last seven years of reporting and have always remained within 5% of the target.

4. HOW WE COMPARE

There is very little national data regarding a similar measure to compare with Oregon. We will continue to monitor national treatment outcomes and analyze any possible comparisons when that data becomes available.

5. FACTORS AFFECTING RESULTS

Problem gambling treatment is a relatively new area of practice. The field lacks necessary standardized outcome measures. This makes it difficult to ensure that the appropriate measures are identified and changed as indicated. The current year increase may be attributable to the fact that we have made ongoing and consistent efforts at workforce development that are paying off in terms of client outcomes, and that in the current economic climate some clients may be more motivated in treatment so they can get their productive lives back.

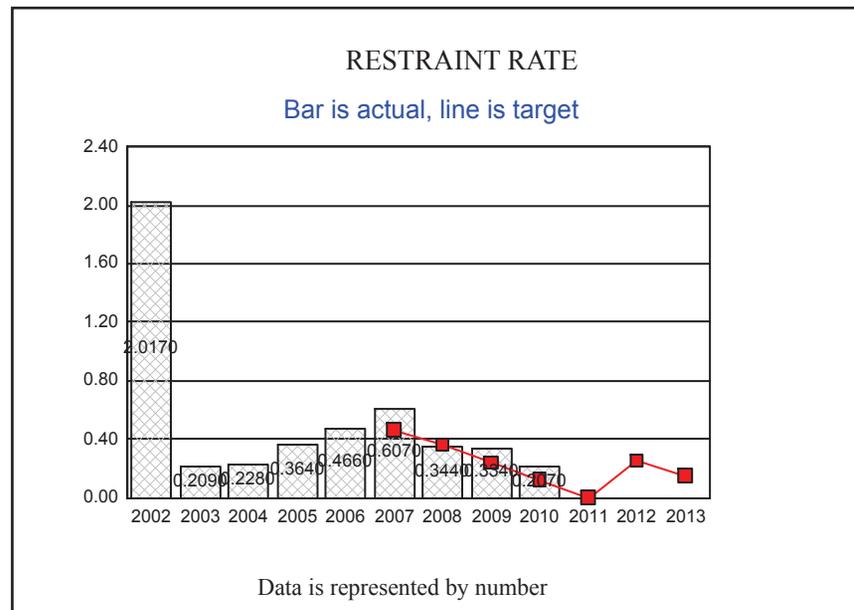
6. WHAT NEEDS TO BE DONE

Continuing to monitor this measure will provide Oregon with an indicator of the effectiveness of the treatment programs and will support continued investment.

7. ABOUT THE DATA

These data are collected and managed by Herbert & Louis, Thomas L. Moore, CEO. It is reported to AMH-Problem Gambling Services Manager as requested and at least annually. Much more data is contained in the Gambling Programs Evaluation Update authored annually by the contractor.

KPM #11	RESTRAINT RATE - Reduction in restraint hours per thousand patient hours at Oregon State Hospital.	2009
Goal	People are healthy. People are safe.	
Oregon Context	People are healthy and safe.	
Data Source	Data are tracked in a free-standing database at Oregon State Hospital.	
Owner	OHA - Addictions and Mental Health Division, Jon C. Collins, 503-945-6429	



1. OUR STRATEGY

Oregon State Hospital has a Seclusion/Restraint Review Committee which reviews aggregated data related to use of seclusion or restraint. During 2010 the Seclusion/Restraint Review Committee focused its reduction efforts on the units that were scheduled to move into the new hospital building in early 2011. That included the two maximum security units (48B and 48C) and 50J. A series of meetings were held on each unit including meetings with the unit managers, the unit treatment teams, unit staff members on all three shifts,

and patients. The purpose of the meetings was to discuss efforts to decrease the use of seclusion and restraints in the new building, and to solicit ideas to promote safety for both staff and patients. A total of 15 meetings were held. As a result of the meetings, a master list of ideas and suggestions was generated. Ideas included increased staff training in alternative approaches, changes to the environment, use of safety equipment, and the provision of other tools and resources for the staff.

2. ABOUT THE TARGETS

The target is to minimize the use of emergency restraint at Oregon State Hospital. Some restraint may be necessary for medical purposes (i.e. preventing a patient from self-harm, preventing a patient from removing stitches, preventing a patient from falling). However, the intent is to decrease and eliminate the use of emergency restraint to control aggressive behavior.

3. HOW WE ARE DOING

We have not achieved the target of .120 for 2010 but showed a reduction over the previous year. A very small number of patients account for more than half of the use of restraint at OSH. One patient in particular is considered an outlier, due to her frequent assaults on staff members and subsequent restraints. Several consultants have been used to strategize what can be done to help this patient.

4. HOW WE COMPARE

The hospital receives monthly comparative statistics reports from the National Research Institute, which is a branch of the National Association of State Mental Health Program Directors. The reports indicate that our restraint rate has been above the national mean for the last 12 months (January 2010 thru December 2010). Our restraint rate has been within one standard deviation of national means. The comparative statistics reports include other state hospitals, but it is difficult to determine the size or patient populations treated by those other hospitals. OSH has a high forensic patient population, which tends to have higher restraint rates due to patients with some diagnoses of antisocial personality disorders. In addition, the hospital serves patients with dementia, brain injuries, and severe and persistent mental illness. Some of those patients act out aggressively and assault staff. Restraint is used as a last resort, to maintain safety.

5. FACTORS AFFECTING RESULTS

A very small number of patients account for the majority of restraint hours used at OSH. One particular patient, who suffers from some brain damage, is considered an outlier due to her frequent assaults on staff members. Consultants have been used to review the cases of several difficult to manage patients. Some of the aggressive patient behavior, which sometimes leads to the use of restraint, is due to overcrowding and understaffing. The new hospital building will provide a safer environment for both staff and patients. Additional staff are being recruited and hired, which will also contribute to safety.

6. WHAT NEEDS TO BE DONE

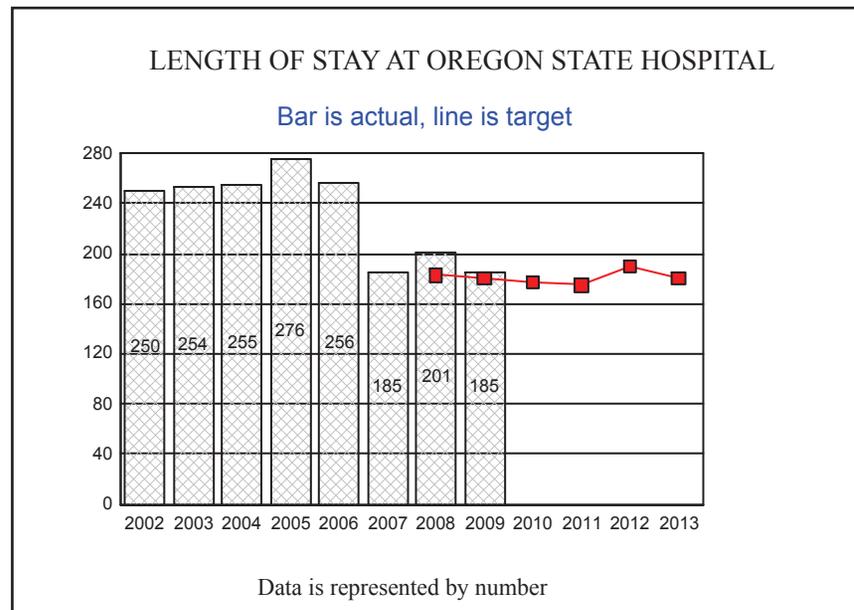
We continue to offer ProACT training, use consultants, and develop additional training modules that may help staff gain skills to intervene early with patients who may be

escalating. Building the new hospital facility and hiring additional staff are also anticipated to create a safer environment. The hospital has also stepped up its efforts to train all staff in the Recovery Model of care, and in Person-centered Care principles. The Seclusion and Restraint Review Committee is also working on plans to increase drills related to early interventions with aggressive patients. The Committee is also working on ways to improve processes for conducting debriefs following restraint events.

7. ABOUT THE DATA

The data reported here came from hospital databases and is dependent on reports made by staff. The data is accurate, within the limitations of our current data systems.

KPM #12	LENGTH OF STAY AT OSH - Reduction in overall length of stay at Oregon State Hospital	2009
Goal	People are healthy.	
Oregon Context	People are healthy.	
Data Source	Oregon Patient/Resident Care System (OP/RCS)	
Owner	OHA - Addictions and Mental Health Division, Jon C. Collins, 503-945-6429	



1. OUR STRATEGY

To delivery recovery oriented services.

2. ABOUT THE TARGETS

In general AMH would like to continue to lower the average length of stay in the Oregon State Hospital.

3. HOW WE ARE DOING

The overall trend is decreasing, which is good.

4. HOW WE COMPARE

There is not a direct comparison available.

5. FACTORS AFFECTING RESULTS

There are many factors that influence this outcome that are internal and external to the state hospital. AMH is working to increase the hours of active treatment patients receive while in the hospital to promote quicker recovery. In addition, AMH is attempting to align community resources to provide adequate care for patients discharged from the hospital to decrease the likelihood of return to the hospital.

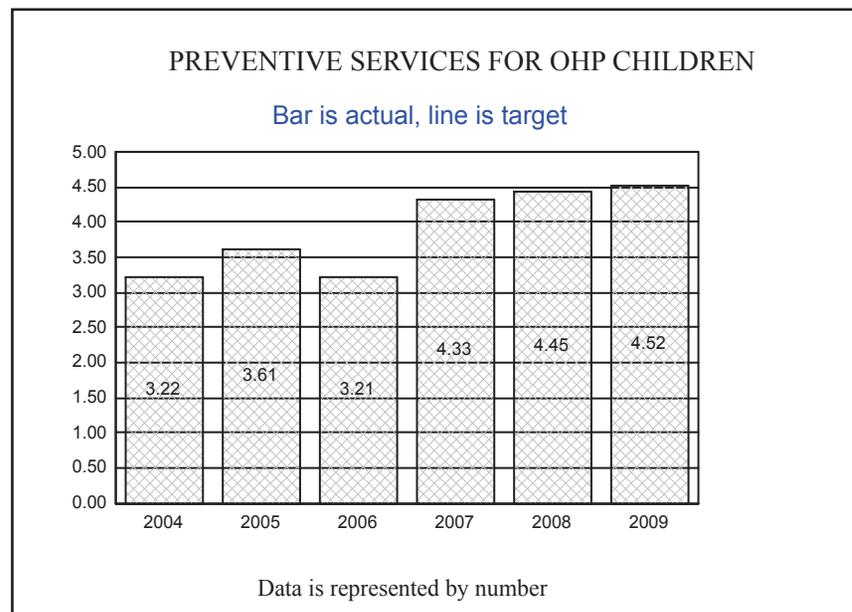
6. WHAT NEEDS TO BE DONE

See #5 above.

7. ABOUT THE DATA

Data are based on information available in the Oregon Patient Resident Care System. It should be noted that the averages are estimates based on projected length of stay at time of admission.

KPM #23	PREVENTIVE SERVICES FOR OHP CHILDREN - The utilization rate of preventive services for children birth through 10 years old covered by OHP	2009
Goal	People are healthy	
Oregon Context	Health care access	
Data Source	Medicaid Managed Information System (MMIS) EDS/HP database. Health Services Commission Prioritized List of Health Services April 1, 2009. Diagnosis and/CPT-HCPCS pairings on Line 3 for OHP client member years.	
Owner	OHA - Division of Medical Assistance Programs, Susan Arbor, 503-945-5958	



1. OUR STRATEGY

Preventive health care and managed care are cornerstones of the Oregon Health Plan (OHP).

People who have access to and use preventive care have improved health outcomes. Preventive health care is delivered in a cost-effective manner as diseases can be avoided or diagnosed early and treated before becoming serious and debilitating. In addition, preventive health screens and anticipatory guidance helps to promote healthy lifestyles and wellness.

Clients in managed care use preventive health care services at higher rates than clients not in managed care. Therefore, one way the Division of Medical Assistance Programs (DMAP) promotes preventive health care services is through enrollment in managed care. DMAP contracts with managed care plans to manage the care of over 83% of OHP clients. This KPM emphasizes providing preventive services to children based on OHP's unique list of prioritized health services from Line 3 that specifies children ten years old and younger. Managed care plans participate in quality improvement and prevention activities including performance improvement projects and measures. Past and present focuses relevant to this measure include early childhood cavity prevention, childhood immunizations, and promoting developmental screening in young children. With these activities, and others, DMAP works closely with many Public Health Division programs. Also, DMAP has preventive health care messages on the DHS website with links to public health information. Since this measure is based on DMAP's unique prioritized list of health services there are no comparable rates. Therefore, DMAP is requesting to delete this measure and add two child HEDIS® measures. HEDIS® measures are a national standard for quality health measurement. The two proposed HEDIS® measures are: 1) Well Child Visits in the First 15 Months of Life and 2) Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life. These measures include preventive services, as well as, other primary care services.

Several other major changes are on the horizon which will emphasize primary and preventive care. A major change is using Care Coordination Organizations (CCO) as the means of providing health services to OHP clients - instead of managed care plans. CCO reimbursement will be linked to specific outcomes, however, the specific set of outcomes has yet to be finalized. The second change is a focus on the "medical home" model which delivers care through a patient-centered primary care setting.

2. ABOUT THE TARGETS

Targets were set during a previous run of the data. The data has been re-run due to further revisions to the new Medicaid Managed Information System (MMIS). Therefore, the current data above and the former targets are not in alignment.

3. HOW WE ARE DOING

The trend for years 2004 through 2009 was mostly increasing which is the favorable direction for this measure. This measure has re-run since the previous rates were reported due to revisions to the MMIS database. All of the years 2004 through 2009 have been re-calculated due to database revisions.

4. HOW WE COMPARE

There are no comparative rates as this measure is based on Line 3 of OHP's unique prioritized list of health care services developed by the Oregon Health Services Commission. The main reason we are requesting to drop this measure and add HEDIS® measures is to be able to compare our rates to other entities.

5. FACTORS AFFECTING RESULTS

Increasing the proportion of clients enrolled in managed care and having a medical home facilitates this measure. Barriers include health care providers that do not accept Medicaid clients and a lack of understanding among some parents and caregivers that regular well child visits are necessary and important.

6. WHAT NEEDS TO BE DONE

Several initiatives to improve preventive services rates include: forming Care Coordination Organizations that are reimbursed based on outcomes, and promoting medical homes and developmental screening for young children. The ABCD projects (Assuring Better Childhood Development) are public-private partnerships working to improve the early identification and referral of children with developmental, behavioral, and social-emotional delays. The aim is to take care of childhood developmental problems early in order to avoid more complicated and expensive care later.

7. ABOUT THE DATA

Reporting cycle is calendar year. The rates above have all been re-calculated based on revisions to MMIS database.

For each measurement period (calendar year), the rate is calculated in the following way:

Numerator (upper number): the total number of Line 3 services provided to OHP clients birth through 10 years old

Divided by:

Denominator (lower number): the total number of member months for all clients birth through 10 years old

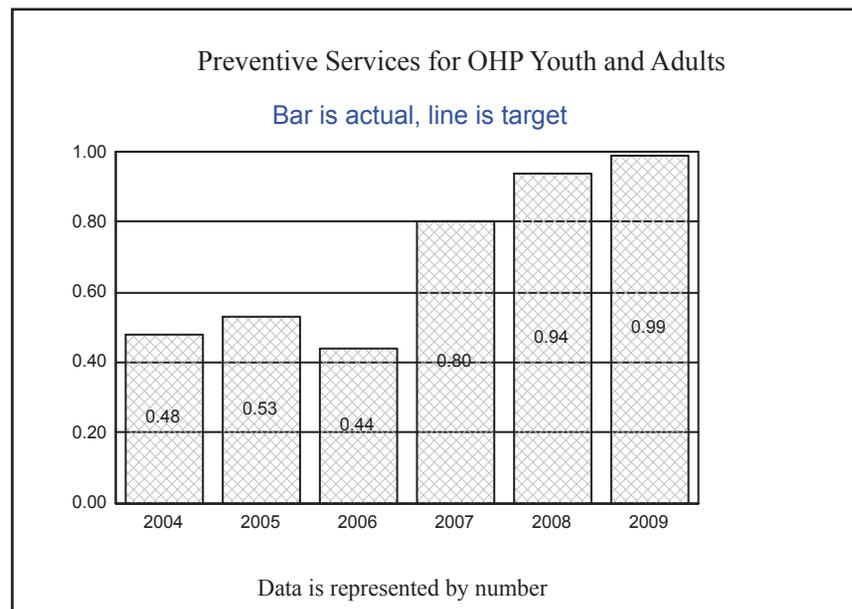
divided by 12 to calculate "member years". Note: The rates below have replaced the ones previously submitted. These rates have been re-calculated based on new revisions to the Medicaid Management Information System (MMIS) database.

Many clients are not enrolled in OHP for all twelve months of the calendar year so this measure is based on the actual months that clients are enrolled in the measurement period - their combined member months in the calendar year. To calculate total combined member months, the number of months that each client, 10 years old and younger, was enrolled in the measurement period is added together. This number is then divided by 12 to create a member year.

Health care claims/encounters are in the MMIS database. All data used for the calculations are pulled at least six months past the last day of the calendar year to take into account the amount of time needed by some medical claims/encounters to enter the MMIS database.

Although not shown here as a KPM, for quality improvement and management purposes, the measure is designed for additional analysis by subcategories of race and ethnicity and by delivery systems of specific managed care plan, primary care management, and fee for service. The HEDIS® measures will also allow analysis by delivery system type and by race and ethnicity.

KPM #24	PREVENTIVE SERVICES FOR OHP YOUTH AND ADULTS - The utilization rate of preventive services for youth and adults 11 years old and older covered by OHP	2009
Goal	People are healthy	
Oregon Context	Health care access	
Data Source	The rates and targets below have replaced the ones previously submitted. The ones below have been all re-calculated using the new Medicaid Managed Information System (MMIS) EDS/HP database. Health Services Commission Prioritized List of Health Services April 1, 2009. Diagnosis and/CPT-HCPCS pairings on Line 4 for OHP client member years.	
Owner	OHA - Division of Medical Assistance Programs, Susan Arbor, 503-945-5958	



1. OUR STRATEGY

Preventive health care and managed care are cornerstones of the Oregon Health Plan (OHP).

People who have access to and use preventive care have improved health outcomes. Preventive health care is delivered in a cost-effective manner as diseases can be avoided or diagnosed early and treated before becoming serious and debilitating. In addition, preventive health screens and anticipatory guidance helps to promote healthy lifestyles and wellness.

Clients in managed care use preventive health care services at higher rates than clients not in managed care. Therefore, one way the Division of Medical Assistance Programs (DMAP) promotes preventive health care services is through enrollment in managed care. DMAP contracts with managed care plans to manage the care of over 83% of Oregon HealthPlan clients. This Key Performance Measure (KPM) emphasizes providing preventive services to children based on OHP's unique list of prioritized health services from Line 4 that specifies youth and adults eleven years old and older.

Managed care plans participate in quality improvement and prevention activities including performance improvement projects and measures. Past and present focuses relevant to this measure include: tobacco cessation; asthma and diabetes care; and strengthening the collaboration between physical health and behavioral health. With these activities, and others, DMAP works closely with many Division of Public Health programs. DMAP has preventive health care messages on the DHS website with links to public health information.

Many fee-for-service clients not covered by managed care plans are managed by DMAP's contracted chronic disease management (and case management) vendor. Smoking cessation is emphasized. As recommended by evidence based medical guidelines, each client's smoking status is regularly assessed.

Since this measure is based on DMAP's unique prioritized list of health services there are no comparable rates. Therefore, DMAP is requesting to delete this measure and add two HEDIS® measures. HEDIS® measures are a national standard for quality health measurement. The two proposed HEDIS® measures are: 1) Adolescent Well Care Visits and 2) Adults' Access to Preventive/Ambulatory Health Services. These measures include preventive services, as well as, other primary care services.

Several other major changes are on the horizon which will emphasize primary and preventive care. A major change will be using Care Coordination Organizations (CCO) as the means of providing health services to OHP clients - instead of managed care plans. CCO reimbursement will be linked to specific outcomes, however, the specific set of outcomes has yet to be finalized. The second change is a focus on the "medical home" model which delivers care through a patient-centered primary care setting.

2. ABOUT THE TARGETS

Targets were set during a previous run of the data. The data has been re-run due to further revisions to the new Medicaid Managed Information System (MMIS). Therefore, the current data above and the former targets are not in alignment.

3. HOW WE ARE DOING

The trend for years 2004 through 2009 was mostly increasing which is the favorable direction for this measure. This measure has re-run since the previous rates were reported due to revisions to the MMIS database. All of the years 2004 through 2009 have been re-calculated due to database revisions.

4. HOW WE COMPARE

There are no comparative rates as this measure is based on Line 4 of OHP's unique prioritized list of health care services developed by the Oregon Health Services Commission. The main reason we are requesting to drop this measure and add HEDIS® measures is to be able to compare our rates to other entities.

5. FACTORS AFFECTING RESULTS

Increasing the proportion of clients enrolled in managed care and having a medical home facilitates this measure. Barriers include health care providers that do not accept Medicaid clients and a lack of understanding among some clients that routine medical exams are necessary and important.

6. WHAT NEEDS TO BE DONE

Several initiatives to improve preventive services rates include: forming Care Coordination Organizations (CCO) that are reimbursed based on outcomes and promoting medical homes. In the past, DMAP spearheaded performance improvement projects involving OHP's physical health and mental health managed care plans. These projects aimed to strengthen collaboration resulting in improved care for OHP clients receiving both mental and physical health services. This aim will be further advanced with the new CCO arrangement as CCO's are organized to ensure provision of both physical health and behavioral health.

7. ABOUT THE DATA

Reporting cycle is calendar year.

The rates above have all been re-calculated using the new MMIS database and new corresponding targets were set. Another major change that occurred since DMAP first calculated this measure was immunizations were added to Lines 4. This change was taken into account by using the same list – the prioritized list of April 1, 2009 – for all the years.

For each measurement period (calendar year), the rate is calculated in the following way:

Numerator (upper number): the total number of Line 4 services provided to OHP clients 11 years old and older

Divided by:

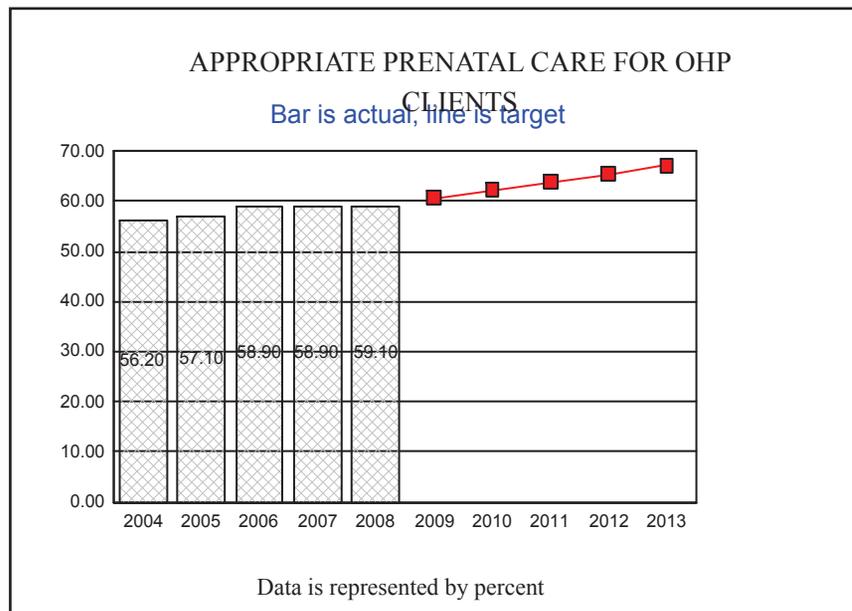
Denominator (lower number): the total number of member months for all clients 11 years old and older

divided by 12 to calculate "member years". Note: The rates below have replaced the ones previously submitted. These rates have been re-calculated based on new revisions to the Medicaid Management Information System (MMIS) database.

Many clients are not enrolled in OHP for all twelve months of the calendar year so this measure is based on the actual months that clients are enrolled in the measurement period - their combined member months in the calendar year. To calculate total combined member months, the number of months that each client, 11 years old and older, was enrolled in the measurement period is added together. This number is then divided by 12 to create a member year.

Numbers of services for health care claims/encounters are in the MMIS database. All data used for the calculations are pulled at least six months past the last day of the calendar year to take into account the amount of time needed by some medical claims/encounters to enter the MMIS database. Although not shown here as a Key Performance Measure, for quality improvement and management purposes, the measure is designed for additional analysis by subcategories of race and ethnicity and by delivery systems of specific managed care plan, primary care management, and fee for service.

KPM #25	APPROPRIATE PRENATAL CARE FOR OHP CLIENTS - The % of pregnant OHP clients who received an appropriate number of prenatal care visits while on OHP	2009
Goal	People are healthy	
Oregon Context	Health care access, Oregon Benchmark #40 - prenatal care	
Data Source	Medicaid Managed Information System (MMIS) EDS/HP database. Health Services Commission Prioritized List of Health Services April 1, 2009. Diagnosis and/CPT-HCPCS pairings on line 000 and line 001.	
Owner	OHA - Division of Medical Assistance Programs, Susan Arbor, 503-945-5958	



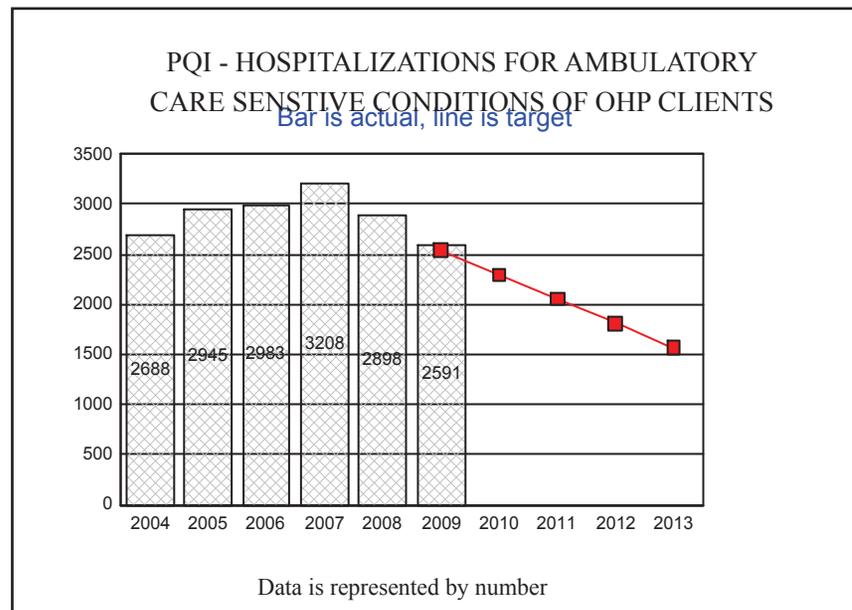
1. OUR STRATEGY

This measure, proposed for 2009-2011, has proven to be inherently immeasurable because of nearly universal use of global and bundled coding when billing for prenatal, delivery, and postpartum services.

In order to avoid costly chart reviews, DMAP uses administrative data from its claim processing system to calculate measures. At this time, DMAP does not have access to electronic medical records or any other data sources that would provide meaningful data for this measure. Therefore, DMAP has put this measure on hold until an accurate measurement process is available.

2. ABOUT THE TARGETS**3. HOW WE ARE DOING****4. HOW WE COMPARE****5. FACTORS AFFECTING RESULTS****6. WHAT NEEDS TO BE DONE****7. ABOUT THE DATA**

KPM #26	ACS HOSPITALIZATIONS OF OHP CLIENTS - The rate of ambulatory care sensitive condition hospitalizations of Oregon Health Plan clients	2009
Goal	People are healthy	
Oregon Context	Health care access	
Data Source	Medicaid Managed Information System (MMIS) database. This measure is a national Agency for Healthcare Research and Quality (AHRQ) Quality Indicator that makes use of readily available hospital inpatient administrative data.	
Owner	OHA - Division of Medical Assistance Programs, Susan Arbor, 503-945-5958	



1. OUR STRATEGY

DMAP’s strategy is to increase access to and quality of preventive and primary care in order to reduce unnecessary hospital admissions . With high-quality, primary care, hospitalization for some illnesses may be avoided. In addition to quality of care, a higher PQI rate can be an indication of an access to primary care concern.

The Oregon Health Plan prioritizes preventive health care services. DMAP has other KPMs that measure rates of preventive services for children, youth, and adults. Evidence suggests that good preventive care can reduce the risk of hospitalization for some chronic and acute conditions. These conditions are called ambulatory care sensitive conditions. “Ambulatory care” means medical office or clinic based health services, and “sensitive” means the condition can be treated in this setting.

The Prevention Quality Indicator is a nationally specified measure and represents hospital admission rates for clients 18 years old and older for the following 12 ambulatory care sensitive conditions:

- Diabetes, short-term complications
- Diabetes, long-term complications
- Uncontrolled diabetes
- Lower extremity amputations among patients with diabetes
- Adult asthma
- Angina without procedure
- Chronic obstructive pulmonary disease
- Hypertension
- Congestive heart failure
- Dehydration
- Bacterial pneumonia
- Urinary infections

Although not shown here as a Key Performance Measure, for quality improvement and management purposes, the measure is designed for additional analysis by subcategories of race and ethnicity and by delivery systems of specific managed care plan, primary care management, and fee for service.

Over 83% of Oregon Health Plan clients are enrolled in managed care plans. Many of our fee-for-service clients not covered by managed care plans are managed by DMAP’s contracted chronic disease management (and case management) vendor.

Care Coordination Organizations are on the horizon as the means of providing health services to OHP clients instead of managed care plans. CCO reimbursement will be linked to specific outcomes based on a set of proposed measures. The PQI measure is included in this set of proposed measures.

Delivering care through a patient-centered primary care home (or medical home) is another new way to emphasize primary care, coordinate specialty care and thereby decrease avoidable hospitalizations.

In addition, this measure was chosen because it makes use of a free software program and can be used by care organizations and our disease management vendor to calculate their own rates using their own readily available administrative data. In this way, the measure can be used more easily by the entities that are contracted to manage the care of OHP clients.

2. ABOUT THE TARGETS

Avoiding hospital admissions is preferable, and results in a low favorable direction for this measure. The PQI measure represents possibly unnecessary hospitalizations and may reflect a lack of primary care services. It can be seen as an inverse of DMAP’s preventive care KPM measures.

Therefore, to develop targets for the PQI measure, projections were made to 2015, rather than 2013, in order to allow time for preventive services to increase. Low income populations have higher PQI rates than the general population. So, DMAP’s 2015 target is the 2007 PQI rate for the population of Oregon. Next, we assigned yearly targets reflecting equally proportioned increases projected to 2015.

3. HOW WE ARE DOING

In 2009, the rate continues to show a slight favorable decline that started in 2008 which contrasts with the 2004 through 2007 trend of slightly increasing unfavorable rates. This measure has changed since the previous rates were calculated due to the replacement of the previous database with an entirely new MMIS database and subsequent revisions to the database. All of the years, 2004 through 2009, have been recalculated using the new database. Since the revised numbers are fairly similar to the previous report calculations the targets set in last report remain the same. The 2009 rate is close but slightly higher (less favorable) than the 2009 target.

4. HOW WE COMPARE

Rates for 2009, both for OHP clients and for the Oregon general population rate have dropped favorably. DMAP's 2009 rate for the OHP clients dropped to 2,591. In 2009, the overall rate in Oregon fell to 928.2. Low income populations consistently have higher PQI rates than total population rates. Another difference between this measure and the Oregon general population calculation is that DMAP's rate uses 100,000 member years, each member year may represent one or several members, while the general population rate uses 100,000 people. So, it is not an exact comparison; however, it is as close of a comparison as possible.

5. FACTORS AFFECTING RESULTS

As mentioned previously, nationally low income populations, which includes those on Medicaid, consistently have higher (unfavorable) PQI rates than general population PQI rates. Many of these conditions are affected by long term tobacco use, obesity, and other social determinants of health which occurs disproportionately among low income people.

6. WHAT NEEDS TO BE DONE

The agency needs to promote the use of this measure by the new Care Coordinated Organizations and continue promoting the use by the disease management vendor, which serve many fee-for-service OHP members. The disease management vendor includes PQI measures in their list of indicators.

7. ABOUT THE DATA

Reporting cycle is calendar year.

Note: For each calendar year, the rate is calculated in the following way:

· Numerator (upper number): the total number of PQI ambulatory care hospital admissions for OHP clients 18 years old and older.

· Divided by:

Denominator (lower number): the total number of member years for all clients 18 years old and older

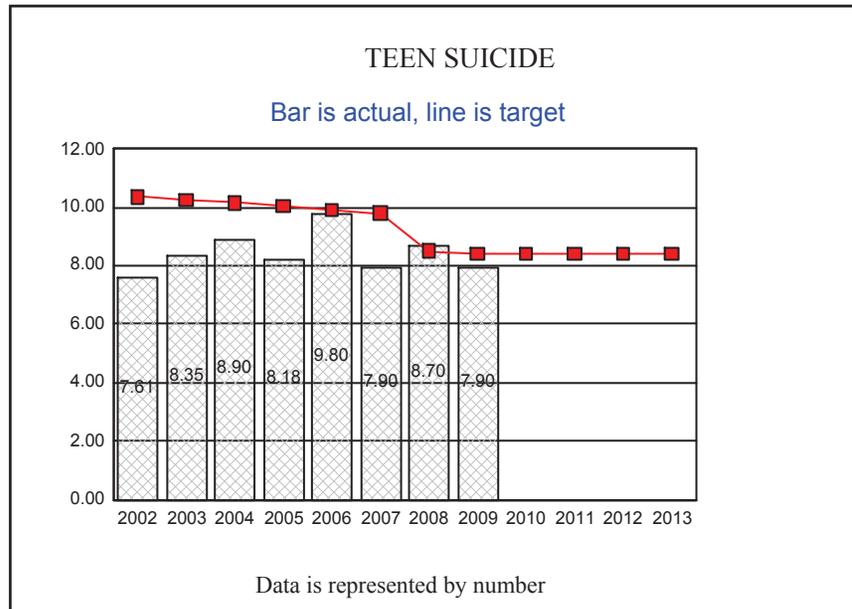
· Multiply resulting number by 100,000.

· The rates below have replaced the ones previously submitted. The rates below have been all re-calculated based on new revisions to the Medicaid Managed Information System (MMIS) database.

Many clients are not enrolled in OHP for all twelve months of the calendar year, so this measure is based on the actual months that clients are enrolled in the measurement period -- their combined member months in the calendar year. To calculate total combined member months, we add together the number of months that each client, 18 years older, was enrolled in the measurement period. This number is then divided by 12 to create a member year. Because hospital admissions are relatively rare, the numerator is quite a small number. However, the combined total number of member years of all adult clients is a very large number. So, in order to calculate a comprehensible rate, the number resulting from the numerator divided by the denominator is multiplied by 100,000 to create a rate approximately comparable to 100,000 people.

Rates are based on hospital admission claims and encounter data contained in the MMIS database. All rates are calculated at least six months past the last day of the calendar year to take into account the amount of time some medical claims and encounters need to enter the MMIS database. Although not shown here as a Key Performance Measure, for quality improvement and management purposes, the measure is designed for additional analysis by subcategories of race and ethnicity and by delivery systems of specific care plan, primary care management, and fee for service. The State of Equity Report has 2009 rates separated by race and ethnicity categories. DMAP has run the measure by specific managed care plan and has begun to present the results to the plans.

KPM #27	TEEN SUICIDE – The rate of suicides among adolescents per 100,000.	2002
Goal	People are safe. People are healthy.	
Oregon Context	Oregon Benchmark #45 - Preventable Death	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (Death Certificates) and Portland State University, Population Research Center (Population Estimates)	
Owner	OHA - Public Health Division, Office of Disease Prevention & Epidemiology, Injury Prevention & Epidemiology Program, Lisa Millet, 971-673-1059	



1. OUR STRATEGY

The agency strategy is to encourage local organizations and agencies to integrate best practices and evidence based practices in suicide prevention into existing infrastructure in schools, non-profit organizations and agencies. In addition, the agency is leveraging resources from federal agencies and foundations to support building projects. Projects

include public health surveillance, development of interventions that will reduce risk factors and increase protective factors identified by data in individuals, families, communities and on the societal level, evaluate projects, and disseminate results broadly.

2. ABOUT THE TARGETS

Reducing suicides among youth will occur over time. The long-range target of reducing deaths is dependent upon:

- developing resources to fund prevention activities
- increasing awareness of the problem
- increasing community readiness to adopt suicide prevention strategies
- increasing the number of people working with youth who can intervene in suicidal behavior
- supporting parents in learning to monitor moods and communicate with youth
- teaching youth to take suicide talk seriously and report it to an adult
- establishing procedures and policies in schools
- providing health education on depression and suicide to youth and families
- providing bereavement support in communities
- enhancing crisis response
- increasing the number of school based health centers with enhanced ability to provide behavioral health services
- providing teens with problem solving and coping skills
- reducing the stigma associated with behavioral health care and with suicide
- improving screening and assessment that can identify youth at risk in all settings where youth are typically assessed
- providing training for professionals in health, behavioral health, and social services on suicide

Oregon's suicide rate among youth has been higher than the nation for over a decade. The rates in Oregon are comparable to rates in other Western states.

3. HOW WE ARE DOING

With 3-year grant funding received by the Public Health Division from the Garrett Lee Smith Memorial Act (GLS) through the Substance Abuse and Mental Health Services Administration (SAMHSA) in October 2009, youth suicide prevention activities are being implemented in 20 Oregon counties. Those counties are actively training new trainers in gatekeeper skills, holding trainings, implementing the comprehensive high school-based program, RESPONSE, working with local coalitions on youth suicide prevention, and increasing public awareness. There are now over 100 QPR (Question, Persuade, Refer) trainers in Oregon; over 60 trainers in Applied Suicide Intervention Skills Training (ASIST); and over 60 high schools implementing RESPONSE. The grant provides funds to initiate outreach in 5 counties to determine how best to prevent suicides among Latino youth. The state's strategy is to increase local capacity and build sustainability for youth suicide prevention. A consortium of 8 colleges and universities are implementing suicide prevention on campuses. The Native American Rehabilitation Association (NARA) is in the final year of its 3-year GLS funding and has applied for another grant. The Confederated Tribes of Warm Springs has implemented a program known as Native Hope; all 9 federally-recognized tribes in Oregon collaborate on a youth summer camp to provide adult mentors, increase youth leadership, and teach traditional practices to youth. The School Based Health Centers are receiving support to serve students on campuses funded to provide enhanced mental health services. Public Health is working with Addictions & Mental Health, NARA, the 9 tribes, the Commission on Children and Families, and many private organizations to increase skills, knowledge, and training. Data collected through Oregon's Violent Death Reporting System and the Injury Epidemiology Program help inform prevention priorities.

4. HOW WE COMPARE

Oregon's youth suicide rate (ages 10-24) ranks 23rd among states. The state rate of 8.1 per 100,000 (2007 most recent national comparison data) is greater than the national rate of 6.81 per 100,000. The state rate of suicide among youth aged 10-24 in 2009 is 7.9 per 100,000.

5. FACTORS AFFECTING RESULTS

Funding for efforts is dependent on special grants and foundation awards with no assurance they will be funded in the long term. There are not enough staff and resources to implement comprehensive efforts statewide. While some communities have been able to develop prevention activities, there are big regions of the state where no efforts have been implemented. Funding for efforts is dependent on special grants and foundation awards. Access to behavioral health care and stigma about that care are barriers to intervention with youth and families in acute crisis. Lack of awareness about the problem of depression and suicide among youth is a barrier to engaging communities in investing in prevention strategies.

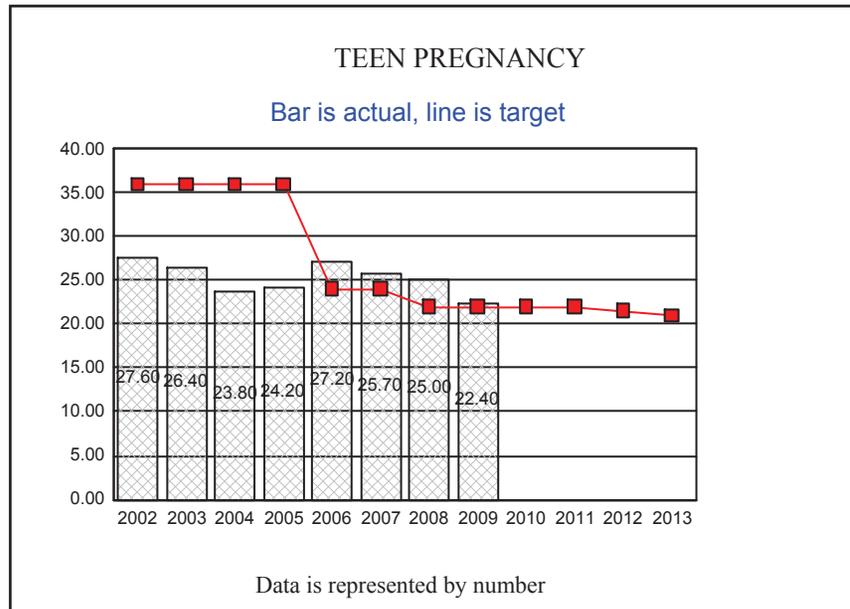
6. WHAT NEEDS TO BE DONE

Increase implementation of a comprehensive school-based program, RESPONSE; continue to build capacity of intervention skills training among mental health professionals, healthcare providers, school staff and others who work with youth; and assure sustainability of the efforts made to date. Use evaluation results from the GLS grant and data from ORVDRS and Injury to provide information on how to broaden those efforts.

7. ABOUT THE DATA

Reporting cycle – calendar year. The data are provided by the Oregon Violent Death Reporting System from the Center for Health Statistics death certificate database, medical examiner reports, and local police agencies. The data include youth aged 10-24 years of age. Some suicides may be excluded as local medical examiners may hesitate to rule a death a suicide due to stigma. Deaths are verified in two ways: through Oregon's Child Fatality Review system and through Oregon's Violence Death Reporting System.

KPM #28	TEEN PREGNANCY – The number of female Oregonians ages 15 – 17, per 1,000 who are pregnant.	2000
Goal	Helping people achieve optimum physical, mental and social well-being.	
Oregon Context	This performance measure links to the OHA Goal to “Improve the lifelong health of all Oregonians .” This measure also links to Oregon Benchmark #39 and two Title V Performance Measures; “Rate of birth (per 1000) for teenagers aged 15 through 17 years” and “percent of births that are intended.”	
Data Source	Oregon Center of Health Statistics and PSU Center for Population and Census estimates. Based on births and induced terminations. Population estimates provided by the Center for Population and Census.	
Owner	OHA - Public Health Division, Office of Family Health, Adolescent Health Program, Bob Nystrom, 971-673-0243	



1. OUR STRATEGY

The Oregon Youth Sexual Health Plan (the plan) is the guiding document for teen pregnancy prevention activities. The plan emphasizes adults’ responsibility to ensure availability of accurate information, skill-building opportunities, and quality health services for all youth. It also recognizes that youth must be centrally involved in defining their own needs

and identifying programs and policies that support their health. The Oregon Youth Sexual Health Partnership (OYSHP) is a statewide public-private partnership charged with supporting and coordinating activities that promote youth sexual health and reduce the risk of early, unintended pregnancy and other negative outcomes. OYSHP members include:

- Department of Human Services/Children, Adults and Families Division (CAF)
- Oregon Commission on Children and Families
- Oregon Teen Pregnancy Task Force
- Oregon Health Authority/Public Health Division, Office of Family Health and Office of Disease Prevention & Epidemiology
- Planned Parenthood of Southwestern Oregon
- Planned Parenthood of Columbia-Willamette
- Multnomah County Health Department, Adolescent Health Promotion
- Oregon Department of Education
- Attorney General's Sexual Assault Task Force
- Cascade AIDS Project
- Confederated Tribes of the Grand Ronde

2. ABOUT THE TARGETS

Teen pregnancy is closely linked to a number of other critical issues, including poverty, income disparity, high school completion, and overall child and family well-being. In Oregon, the estimated annual cost associated with teen pregnancy (ages 15-19) is \$110 million (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2011). Reducing teen pregnancy would reduce the risk of negative social, education, and health outcomes and lead to cost savings.

Oregon uses the 15-17 year-old group for its teen pregnancy KPM. Although teen pregnancy rates are often reported for 15-19 year olds, the 15-17 year old rate is of more concern as this group of teens is more vulnerable to the negative outcomes of pregnancy than older teens. 15-17 year olds are also able to access prevention education and services through school and other programs more readily than 18-19 year olds.

This target is based on a desired downward trend. Reducing the rate to 22 per 1,000 by 2011 would put the state on a positive trajectory.

3. HOW WE ARE DOING

Preliminary data for 2009 shows the lowest teen pregnancy rate since data have been reported. The preliminary rate of 22.4 per 1,000 shows a significant decrease from 2008 to 2009. The teen pregnancy rate did not change from 2007 to 2008 (25.7 per 1,000 both years). Oregon had the first increase in teen pregnancy rates in 10 years in 2005 (from 23.8 to 24.2 per 1,000). There was another increase in 2006 to 27.2 per 1,000. Among 15-17 year-olds in Oregon, the pregnancy rate fell almost 50% between 1990 and 2007.

4. HOW WE COMPARE

The State's teen pregnancy rate has consistently been lower than the national rate. In 2006 (the most recent national data available), Oregon's 15-17 year old teen pregnancy rate was 27.2 per 1,000 and the national rate was 38.9 per 1,000.

5. FACTORS AFFECTING RESULTS

Teen pregnancy is tied to social, economic and educational factors. Sexual behaviors that may lead to teen pregnancy are influenced by poverty, discrimination, gender inequities, and gender role expectations. Barriers to reducing teen pregnancy include lack of access to medically accurate, age-appropriate sexuality education and reproductive health services. Facilitators to preventing teen pregnancy include providing reproductive health care and offering comprehensive sexuality education, as outlined in ORS 336.455. Oregon supports the provision or referral of reproductive health care to youth at School-Based Health Centers and provides comprehensive services at Title X and CCare supported family planning clinics throughout the state. Oregon has a strong comprehensive sexuality education law; decisions on how to provide that education are made at the local level.

6. WHAT NEEDS TO BE DONE

The Oregon Health Authority will continue to support communities in implementing activities that align with the Oregon Youth Sexual Health Plan. More work can be done in understanding and addressing racial and ethnic disparities in teen pregnancy rates.

7. ABOUT THE DATA

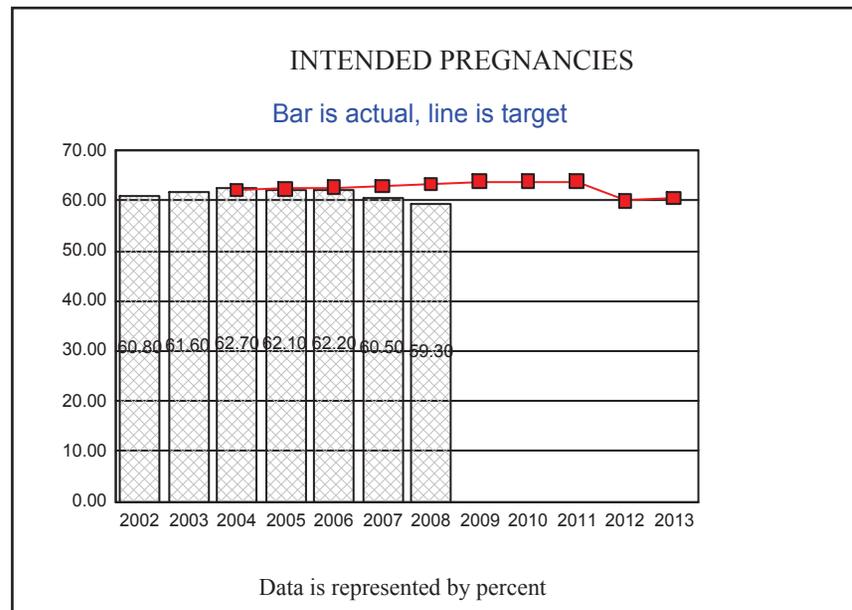
Reporting cycle - calendar year. The data are generally 1 ½ to 2 years behind. In Oregon, pregnancy numbers specific to racial/ethnic groups are reported only over a three-year cumulative period, rather than annually, due to the challenges of small numbers and reliability of race/ethnicity reporting (<http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/TeenPregnancy/Pages/tprace.aspx>). It is important to note that the Oregon-reported teen pregnancy rate reflects the number of births and abortions. National teen pregnancy rates often include miscarriages and still births in the pregnancy rate; therefore, comparing Oregon and National data is not always an exact comparison. Oregon data is available at:

<http://public.health.oregon.gov/BIRTHDEATHCERTIFICATES/VITALSTATISTICS/TEENPREGNANCY/Pages/index.aspx>.

National pregnancy data is available from the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics at:

<http://www.cdc.gov/nchs/data/databriefs/db58.pdf>.

KPM #29	INTENDED PREGNANCY – The percentage of births where mothers report that the pregnancy was intended.	2006
Goal	People are healthy.	
Oregon Context	Oregon Benchmark #39 - Teen pregnancy	
Data Source	OHA - Public Health Division, Office of Family Health, Pregnancy Risk Assessment Monitoring System (PRAMS) survey	
Owner	OHA - Public Health Division, Office of Family Health, Reproductive Health Program, Rian Frachele 971-673-0364	



1. OUR STRATEGY

Through a network of approximately 160 county health department clinics, private providers, and other local agencies, the state Reproductive Health program provides contraceptive services and supplies to enable all individuals to plan and space their pregnancies as desired.

2. ABOUT THE TARGETS

Modest targets have been set given limited program budget and the complex nature of pregnancy intent. The target is based on a desired upward trend.

3. HOW WE ARE DOING

Between 2002 and 2006, there was a slight increase in the percentage of births where mothers reported that the pregnancy was intended. There has been a slight decrease in 2007 and 2008, but none of these changes have been statistically significant since tracking of the outcome began in 2002.

4. HOW WE COMPARE

Oregon currently ranks 14th (among the 29 states that participate in PRAMS) for rates of pregnancies that are intended, the highest being New York State at 70.4% and the lowest being Mississippi at 41.7%. The Healthy People 2020 objective related to intended pregnancy (Objective FP-1) sets the target of 56.0% of all pregnancies that are intended, which is significantly lower than the ambitious goal of 70% set for Healthy People 2010 (Objective 9-1). Oregon is currently meeting the new goal set by Healthy People 2020, but still falls behind comparative states, such as Washington and Colorado, where rates are slightly higher (63.3% and 63.1%, respectively).

5. FACTORS AFFECTING RESULTS

Pregnancy intention is a complex variable, and is affected by numerous environmental, social and psychological factors. One potential factor impacting the rate of intended pregnancy is the current state of the economy.

6. WHAT NEEDS TO BE DONE

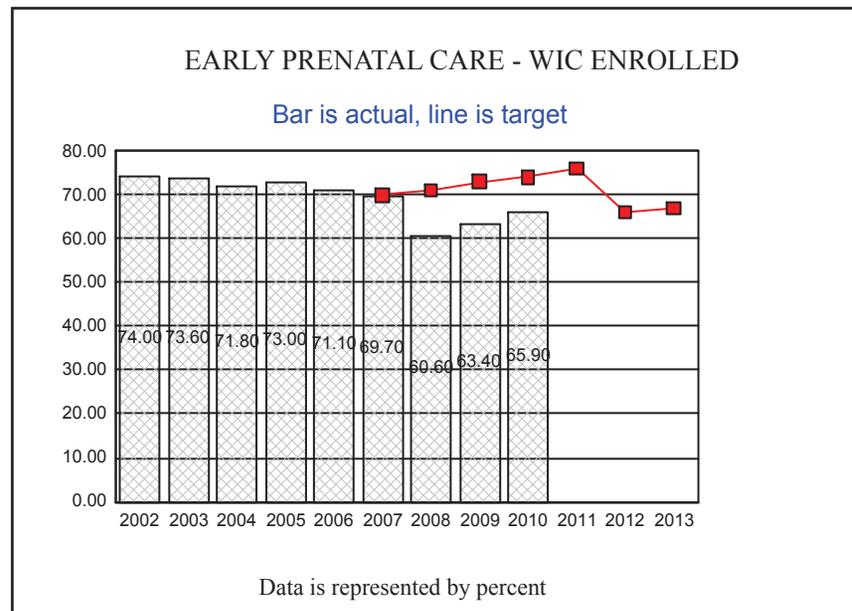
Current family planning activities should continue and every effort should be made to expand funding and reduce barriers to access to free or low -cost contraceptive services for low-income individuals. Furthermore, an increased focus on preconception care within the context of family planning visits will help women to plan and space healthy pregnancies. Specifically, more preconception and interconception care may lead to better long-term reproductive care planning (such as improving the quality of contraceptive methods used). Providers should be educating women about optimal health and family planning methods, as well as increasing emphasis on postpartum care to minimize subsequent unintended pregnancies. Providers should also increase preventive counseling to women about the availability of emergency contraception (EC). Finally, reproductive health messages should be integrated into existing reproductive health promotion campaigns.

7. ABOUT THE DATA

Reporting cycle - calendar year: data are aggregated based on respondents' child's year of birth . (Oregon data is available at: <http://www.oregon.gov/DHS/ph/pnh/prams/index.shtml>). The foremost strength of the data is that they directly reflect women's own reports of pregnancy intent ; the population-based design and high response rate of the PRAMS survey are also strengths. The primary limitation of the data is that the complexity of women's

feelings about pregnancy and childbearing can make pregnancy intent difficult to measure accurately .

KPM #30	EARLY PRENATAL CARE - The % of low-income women who initiated prenatal care in the first 3 months of pregnancy compared to non low-income women.	2009
Goal	People are healthy	
Oregon Context	Early prenatal care	
Data Source	OHA, Office of Disease Prevention & Epidemiology, Center for Health Statistics (Birth Certificates)	
Owner	OHA - Public Health Division, Office of Family Health, Cate Wilcox (971) 673-0299	



1. OUR STRATEGY

The goal of this measure is to increase access to early prenatal care for all women and reduce the disparity in access between low-income and the general population. The gap in access to prenatal care has been widening between low-income and all other births, even as prenatal care rates are stable for the whole population. The PHD, Office of Family

Health (OFH), promotes early prenatal care through the Oregon MothersCare Program, Family Planning, and the Preconception Health Initiative. Other state and community services and private health care providers also promote early access to prenatal care in coordination with PHD programs. This KPM will evaluate the effectiveness of the state and local system of services and programs that provide, promote, and coordinate prenatal care for all pregnant women, especially for low-income and underserved women. Office of Family Health (OFH) is continuing to provide funding and technical support for Oregon MothersCare (OMC), a program that collaborates with the Division of Medical Assistance Programs (DMAP), the agency that administers the Oregon Health Plan (OHP), to assist pregnant women in entering early prenatal care. The OMC program has expanded from five sites serving fewer than 1,000 low-income women in 2000 to 29 sites that served 4,817 women in 2010 with 17,942 referrals to prenatal care and other services. OFH also supports SafeNet, the toll-free hotline for referrals to local prenatal services. In addition, DMAP expedites applications for OHP from pregnant women. Weekly, DMAP sends its contracted managed care plans a download of members from which the plan can identify pregnant women. Plans use this information to make timely contact and help arrange the first prenatal visit. DMAP places regular messages on the monthly medical card emphasizing the importance of initiating early prenatal care.

2. ABOUT THE TARGETS

The targets were developed for a different data source (survey) that yielded slightly higher rates. The present rates are 4 to 7 percentage points below these targets. The National Title V Performance Measure and the Healthy People 2010 target for early prenatal care is 90% of infants born to pregnant women, **of all income ranges**, initiating prenatal care in the first trimester.

3. HOW WE ARE DOING

There has been an increase (from 13 percentage points to 15 percentage points) in the gap between early prenatal care for WIC and non-WIC women from 2002-2010. There has been a small decrease in early prenatal care for non-WIC women (2002-2010). There has been a larger decrease in early prenatal care for WIC women (2002-2010). Birth certificate changes in 2008 make it hard to compare trends from before 2008 to after 2010. Since most WIC-enrolled women are enrolled in Medicaid, there is a similar gap in early prenatal care for Medicaid and non-Medicaid enrolled women.

4. HOW WE COMPARE

The lives of low-income women have more complexity than non-low-income women's (e.g., transportation, high attention to basic living needs) giving them less time to focus on their own health care. Although this measure is for women entering prenatal care in the first 3 months of pregnancy, a comparison between OMC clients (where 85% of clients apply for OHP) and OHP clients in general illustrates the importance of supporting these women in accessing services. In 2010, approximately 82% of women receiving services through OMC during their first trimester entered prenatal care during the first trimester or within 15 days of their OMC visit. This includes women who are low-income but ineligible for Oregon Health Plan (OHP) coverage. Among women who report OHP/Medicaid as their delivery payment source, the percent of first trimester care is consistently slightly less than 70%. Although OHP applications from pregnant women are expedited, Oregon does not have Medicaid presumptive eligibility for pregnant women. Presumptive eligibility allows pregnant women to make an initial prenatal care appointment while their Medicaid eligibility is being processed. Nationally, thirty-one states have Medicaid presumptive eligibility. According to the National Academy for State Health Policy, "Early prenatal care plays a critical role in the health of pregnant women and their babies. Access to early prenatal care can lead to better birth outcomes, healthier babies, and reduced health care costs. Presumptive eligibility in Medicaid has become an important strategy for improving access to prenatal care for low-income pregnant women" (2008)

5. FACTORS AFFECTING RESULTS

When low-income women who are not already covered by Medicaid become pregnant, they must apply for OHP after they find out they're pregnant. It is likely some of them do not know immediately that they can now qualify because they are pregnant, especially if they were recently told they were ineligible for OHP due to income. Again, presumptive eligibility would allow pregnant women to make an initial prenatal care appointment while their Medicaid eligibility is being processed. The Prenatal Care Expansion Program provides OHP Plus coverage for prenatal services in 14 participating counties as of July 2011 to pregnant women who would otherwise be eligible for OHP except for their immigration status. These are women who would qualify for CAWEM coverage. While we do not know exactly the extent of this population, the Hispanic population is the largest community with potential immigration status barriers. The number of Hispanic births in Oregon has stayed relatively constant over the past five years (19.9% in 2005 to 20.2% in 2010).

6. WHAT NEEDS TO BE DONE

- 1) Presumptive eligibility should be considered as a policy option in the Coordinated Care Organization (CCO) structure.
- 2) Continue to fund PHD, DMAP and OHA initiatives.
- 3) Continue to work with partners to effectively communicate the importance of early prenatal care.
- 4) OFH and DMAP will continue to collaborate through the Oregon MothersCare program.

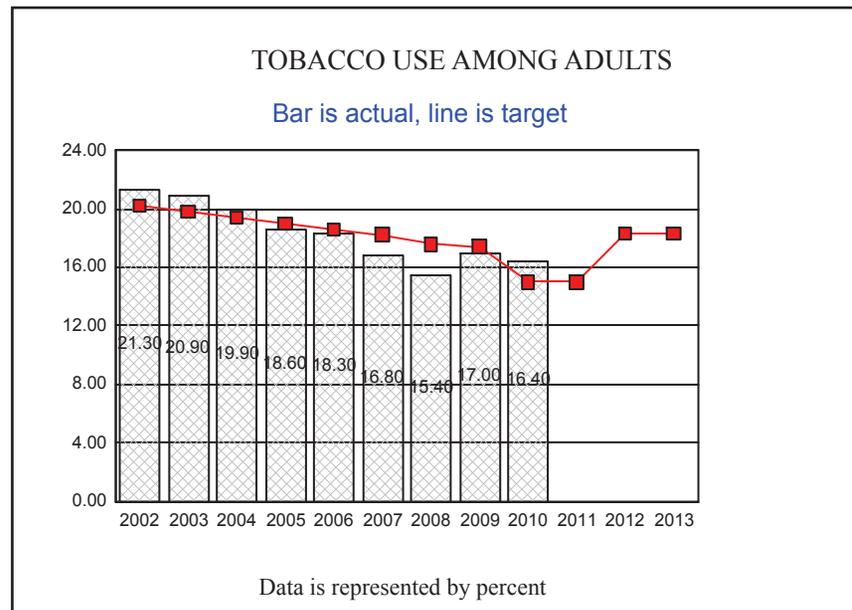
7. ABOUT THE DATA

OFH will use birth certificate record information reported by the mother about her pregnancy collected into a dataset used nationally to monitor trends in birth outcomes. For monitoring trends for disparity in access to early prenatal care from this data source, a proxy for low-income and non-low-income women is the number of women reporting that they were enrolled, or not enrolled, in the Supplemental Nutrition Program (WIC) for one or more months during pregnancy. Eligibility for enrollment requires a family income of $\leq 185\%$ Federal Poverty Level (FPL) and is the best available data for estimating low-income status in pregnancy.

The measure has two parts: a) Low-income women with first trimester care: the numerator is the number of live births whose mothers report prenatal care in the first 3 months and who report enrollment in WIC during pregnancy, and the denominator is all mothers who report enrollment in WIC during pregnancy; and b) Non-low-income women with first trimester care: the numerator is the number of live births whose mothers report prenatal care in the first 3 months and who report not being enrolled in WIC during pregnancy, and the denominator is all mothers who reported not enrolled in WIC during pregnancy.

Non-Low Income Women: Year, Actual, Target
 2002, 86.5%, -2003, 86.1%, -2004, 86.3%, -2005, 86.3%, -2006, 84.7%, -2007, 83.8%, 84.0%
 2008, 78.5%, 85.0%
 2009, 78.5%, 86.0%
 2010, 80.1%, 86.0%
 2011, -, 87.0%

KPM #31a	TOBACCO USE – Tobacco use among adults.	2002
Goal	People are healthy.	
Oregon Context	Oregon Benchmarks:#44 - Adult non-smokers#45 - Preventable death#50 - 8th grade substance abuse#53 - Tobacco abstinence during pregnancy	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (BRFSS, OR Healthy Teens Survey, Birth Certificates)	
Owner	OHA - Public Health Division, Tobacco Prevention and Education Program, Stacey Schubert, 971-673-1099	



1. OUR STRATEGY

The goals of the Tobacco Prevention and Education Program (TPEP) include reducing tobacco use by youth, adults and pregnant women. These goals are accomplished through county and tribal-based programs, the Oregon Tobacco Quit Line, multicultural outreach and education, a statewide public awareness and education program, program evaluation

and statewide coordination and leadership. No single component of the TPEP is solely responsible for reducing tobacco use – it takes a comprehensive approach 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. Studies show that 90 percent of adult smokers started smoking before they were 18 years old. Preventing youth from starting to smoke will lead to lower smoking rates among adults in the years ahead. A woman's use of tobacco during pregnancy is associated with serious, at times fatal health problems for the child, ranging from low birth weight and premature births, to stillbirth and Sudden Infant Death Syndrome (SIDS). Successful efforts by TPEP to decrease the prevalence of tobacco use among youth, adults and pregnant women will lead to reduced morbidity and mortality - contributing substantially toward the DHS goal "People are healthy" in both the short-term and long-term.

3. HOW WE ARE DOING

Among Oregon adults, the prevalence of smoking was 16.4% in 2010. The prevalence of smoking among 8th grade adolescents was 9.9% in 2009 (in 2010, these data were not collected). Finally, among women who had a live birth (pregnant women), the prevalence of smoking was 13.4% in 2009. Designated targets were not reached for any of the population groups, however, the data on tobacco use during pregnancy are now collected using a different method than when this measure was originally proposed (the change was enacted in January 2008). Although it was anticipated that the newly measured prevalence would be higher, the extent of the difference could not be determined, so the targets were kept static despite underlying change in the measurement.

4. HOW WE COMPARE

For adult smoking prevalence, the Healthy People 2010 target was 12%. This target remained unchanged in the revamped, updated Healthy People 2020. By dedicating substantial resources to tobacco prevention, Oregon may be able to meet this target by 2020, but current resources are likely insufficient to enable Oregon to reach this target.

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, and to eliminate nonsmokers' exposure to secondhand smoke. 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 \$2.2 billion lost to medical care and lost productivity annually in Oregon.

During the 2009-2011 biennium, Oregon spent \$3.18 per capita for tobacco prevention from all funding sources, which equates to 27% of CDC's recommended funding for tobacco prevention. While this investment is less than optimal, it nonetheless represents a temporary increase from previous biennia because Oregon successfully sought one-time funding through the American Recovery and Reinvestment Act to enhance its tobacco prevention work. During the 2007-2009 biennia, Oregon was funded at \$2.10 per capita for tobacco

prevention from all funding sources. For most of the 2001-2003 biennium, TPEP received approximately \$2.87 per capita per year, although from April 2003 through the end of the biennium the program was shuttered when the Legislature redirected monies that had been allocated to TPEP. 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.

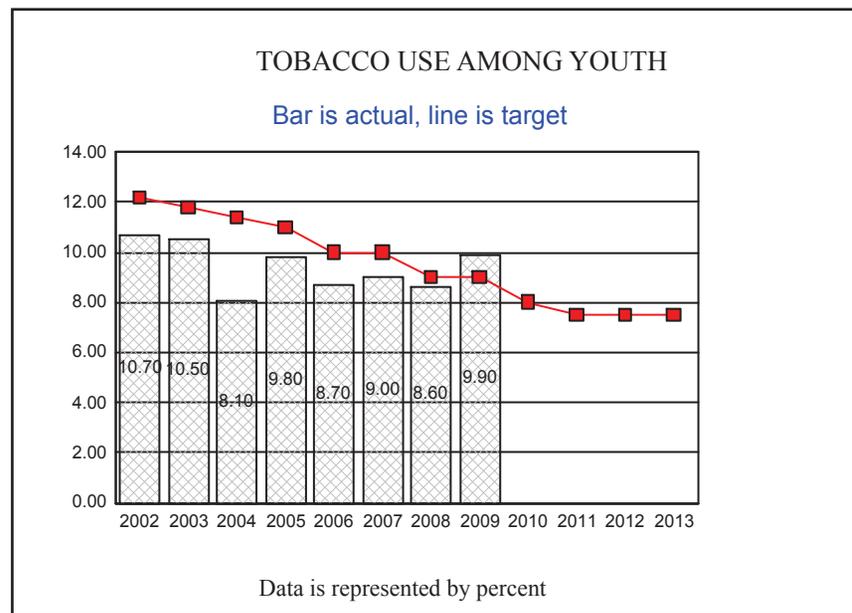
6. WHAT NEEDS TO BE DONE

Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use. To reverse troubling tobacco use trends, funding for comprehensive tobacco control needs to be increased and stabilized. Prior successes in Oregon and a substantial evidence-base from elsewhere tell us that a comprehensive program is the most effective means to counter these trends.

7. ABOUT THE DATA

Smoking prevalence among adult Oregonians is on an annual reporting cycle, computed once per calendar year. The estimate is derived from the Oregon Behavioral Risk Factor Surveillance System, 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 comparisons. Disadvantages associated with BRFSS include its reliance upon telephone landlines, which are increasingly less common among younger age groups, people with low income, and certain racial and ethnic populations. Estimates calculated in for 2011 and later will account for these factors, and thus will be higher than estimates calculated for 2010 and earlier.

KPM #31b	TOBACCO USE – Tobacco use among youth.	2002
Goal	People are healthy.	
Oregon Context	Oregon Benchmarks: #45 - Preventable death#50 - 8th grade substance abuse	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (BRFSS, OR Healthy Teens Survey, Birth Certificates)	
Owner	OHA - Public Health Division, Tobacco Prevention and Education Program, Stacey Schubert, 971-673-1099	



1. OUR STRATEGY

The goals of the Tobacco Prevention and Education Program (TPEP) include reducing tobacco use by youth, adults and pregnant women. These goals are accomplished through county and tribal-based programs, the Oregon Tobacco Quit Line, multicultural outreach and education, a statewide public awareness and education program, program evaluation

and statewide coordination and leadership. No single component of the TPEP is solely responsible for reducing tobacco use – it takes a comprehensive approach 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. Studies show that 90 percent of adult smokers started smoking before they were 18 years old. Preventing youth from starting to smoke will lead to lower smoking rates among adults in the years ahead. A woman's use of tobacco during pregnancy is associated with serious, at times fatal health problems for the child, ranging from low birth weight and premature births, to stillbirth and Sudden Infant Death Syndrome (SIDS). Successful efforts by TPEP to decrease the prevalence of tobacco use among youth, adults and pregnant women will lead to reduced morbidity and mortality - contributing substantially toward the DHS goal "People are healthy" in both the short-term and long-term.

3. HOW WE ARE DOING

Among Oregon adults, the prevalence of smoking was 16.4% in 2010. The prevalence of smoking among 8th grade adolescents was 9.9% in 2009 (in 2010, these data were not collected). Finally, among women who had a live birth (pregnant women), the prevalence of smoking was 13.4% in 2009. Designated targets were not reached for any of the population groups, however, the data on tobacco use during pregnancy are now collected using a different method than when this measure was originally proposed (the change was enacted in January 2008). Although it was anticipated that the newly measured prevalence would be higher, the extent of the difference could not be determined, so the targets were kept static despite underlying change in the measurement.

4. HOW WE COMPARE

For adolescent smoking prevalence, the Healthy People 2010 target was 16%. This target remained unchanged in the revamped, updated Healthy People 2020. The Health Authority's measurement represents 8th graders, but the 11th grade-smoking rate was 14.9% in Oregon in 2009. If this trend continues, Oregon's 11th grade smoking rates will likely remain lower than Healthy People 2020's 16% target.

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, and to eliminate nonsmokers' exposure to secondhand smoke. 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 \$2.2 billion lost to medical care and lost productivity annually in Oregon.

During the 2009-2011 biennium, Oregon spent \$3.18 per capita for tobacco prevention from all funding sources, which equates to 27% of CDC's recommended funding for tobacco prevention. While this investment is less than optimal, it nonetheless represents a temporary increase from previous biennia because Oregon successfully sought one-time funding

through the American Recovery and Reinvestment Act to enhance its tobacco prevention work. During the 2007-2009 biennium, Oregon was funded at \$2.10 per capita for tobacco prevention from all funding sources. For most of the 2001-2003 biennium, TPEP received approximately \$2.87 per capita per year, although from April 2003 through the end of the biennium the program was shuttered when the Legislature redirected monies that had been allocated to TPEP. 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.

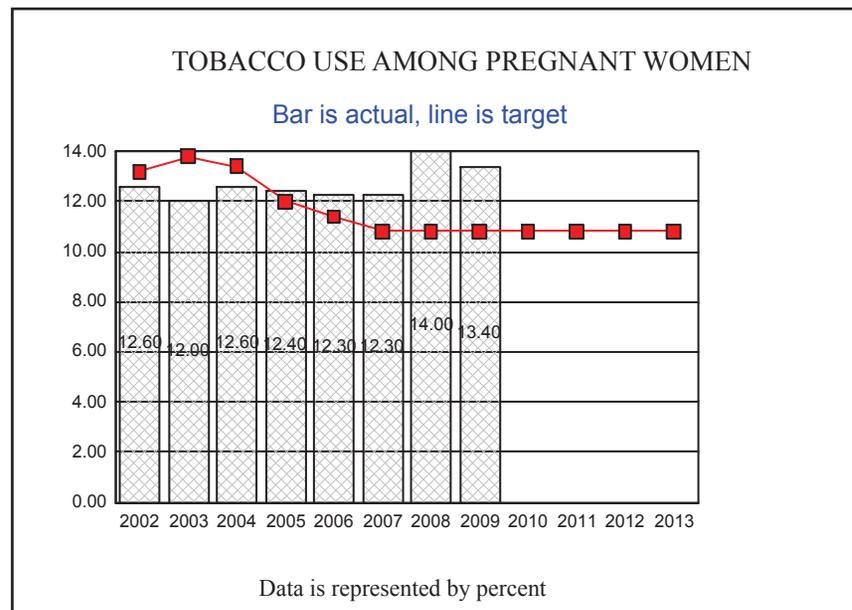
6. WHAT NEEDS TO BE DONE

Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use. To reverse troubling tobacco use trends, funding for comprehensive tobacco control needs to be increased and stabilized. Prior successes in Oregon and a substantial evidence-base from elsewhere tell us that a comprehensive program is the most effective means to counter these trends.

7. ABOUT THE DATA

Smoking prevalence among 8th graders in Oregon is now on a biennial reporting cycle, computed for odd years. This estimate comes from the Oregon Healthy Teens survey, a pencil and paper survey administered to students at school.

KPM #31c	TOBACCO USE – Tobacco use among pregnant women.	2002
Goal	People are healthy.	
Oregon Context	Oregon Benchmarks#45 - Preventable Death#53b - Tobacco Abstinence During Pregnancy	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (BRFSS, OR Healthy Teens Survey, Birth Certificates)	
Owner	OHA - Public Health Division, Tobacco Prevention and Education Program, Stacey Schubert, 971-673-1099	



1. OUR STRATEGY

The goals of the Tobacco Prevention and Education Program (TPEP) include reducing tobacco use by youth, adults and pregnant women. These goals are accomplished through county and tribal-based programs, the Oregon Tobacco Quit Line, multicultural outreach and education, a statewide public awareness and education program, program evaluation

and statewide coordination and leadership. No single component of the TPEP is solely responsible for reducing tobacco use – it takes a comprehensive approach 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. Studies show that 90 percent of adult smokers started smoking before they were 18 years old. Preventing youth from starting to smoke will lead to lower smoking rates among adults in the years ahead. A woman's use of tobacco during pregnancy is associated with serious, at times fatal health problems for the child, ranging from low birth weight and premature births, to stillbirth and Sudden Infant Death Syndrome (SIDS). Successful efforts by TPEP to decrease the prevalence of tobacco use among youth, adults and pregnant women will lead to reduced morbidity and mortality - contributing substantially toward the DHS goal "People are healthy" in both the short-term and long-term.

3. HOW WE ARE DOING

Among Oregon adults, the prevalence of smoking was 16.4% in 2010. The prevalence of smoking among 8th grade adolescents was 9.9% in 2009 (in 2010, these data were not collected). Finally, among women who had a live birth (pregnant women), the prevalence of smoking was 13.4% in 2009. Designated targets were not reached for any of the population groups, however, the data on tobacco use during pregnancy are now collected using a different method than when this measure was originally proposed (the change was enacted in January 2008). Although it was anticipated that the newly measured prevalence would be higher, the extent of the difference could not be determined, so the targets were kept static despite underlying change in the measurement.

4. HOW WE COMPARE

Data on tobacco use during pregnancy are now collected using a different methodology than when this measure was originally proposed (the change was enacted in Oregon in January 2008). Although it was anticipated that the newly measured prevalence would be higher (and the data have indeed been higher), the extent of the difference could not be determined, so the targets remained static despite the underlying change in the measurement. National data isn't yet available using this new data collection methodology. It is therefore currently not possible to assess how Oregon's measure compares to the nation.

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, and to eliminate nonsmokers' exposure to secondhand smoke. 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 \$2.2 billion lost to medical care and lost productivity annually in Oregon. During the 2009-2011 biennium, Oregon spent \$3.18 per capita for tobacco prevention from all funding sources, which equates to 27% of CDC's recommended funding for tobacco prevention. While this investment is less than optimal, it nonetheless represents a temporary increase from previous biennia because Oregon successfully sought one-time funding through the American Recovery and Reinvestment Act to enhance its tobacco prevention work. During the 2007-2009 biennia, Oregon was funded at \$2.10 per capita for tobacco prevention

from all funding sources. For most of the 2001-2003 biennium, TPEP received approximately \$2.87 per capita per year, although from April 2003 through the end of the biennium the program was shuttered when the Legislature redirected monies that had been allocated to TPEP. 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.

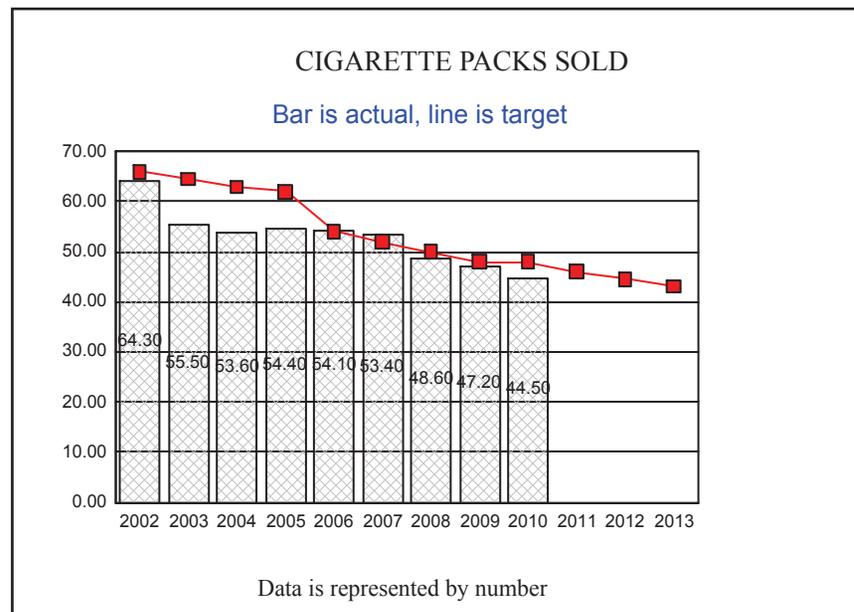
6. WHAT NEEDS TO BE DONE

Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use. To reverse troubling tobacco use trends, funding for comprehensive tobacco control needs to be increased and stabilized. Prior successes in Oregon and a substantial evidence-base from elsewhere tell us that a comprehensive program is the most effective means to counter these trends.

7. ABOUT THE DATA

Smoking prevalence among pregnant women is on an annual reporting cycle, computed once per calendar year. These data come from the birth certificates issued to all newborns in Oregon, which include parental demographic information, conditions of the newborn, and medical factors during the pregnancy (including mothers' smoking status). Advantages of these data are that they represent a census of information (that is, all births) and are not prone to sampling error, as are surveys. One disadvantage is that the federal requirements for collecting data via the birth file changed in 2003, and in Oregon this change took effect in 2008.

KPM #32	CIGARETTE PACKS SOLD – Number of cigarette packs sold per capita.	2002
Goal	People are healthy.	
Oregon Context	Oregon Benchmarks#44 - Adult Non-Smokers#45 - Preventable Death#50c - 8th Grade Substance Abuse (cigarettes)#53b - Tobacco Abstinence During Pregnancy	
Data Source	Oregon Department of Revenue (Cigarette Tax Receipts); Portland State University, Population Research Center (Population Estimates)	
Owner	OHA - Public Health Division, Tobacco Prevention and Education Program, Stacey Schubert, 971-673-1099	



1. OUR STRATEGY

One of the main goals of the Tobacco Prevention and Education Program (TPEP) is to reduce tobacco use by Oregonians. This goal is accomplished through county and tribal-based programs, the Oregon Tobacco Quit Line, multicultural outreach and education, a statewide public awareness and education program, program evaluation and

statewide coordination and leadership. No single component of the TPEP is solely responsible for reducing per capita cigarette consumption – it takes a comprehensive approach 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 or reducing the amount smoked has significant health benefits. Reductions in the number of cigarette packs sold per capita results from two distinct phenomena: an increase in former smokers, and a decrease in the quantity of cigarettes smoked among continuing smokers. It is clear that reducing the per capita packs of cigarettes sold will lead to substantial improvement in people's health, both in the short and long-term.

3. HOW WE ARE DOING

In 2010, 44.5 packs of cigarette packs were sold for every Oregon resident. This measure surpasses the target for 2010. Moreover, from 2008 onward, these data points have represented a welcome change compared with 2003-07, a period during which per capita cigarette packs sold stagnated.

4. HOW WE COMPARE

In 1997, prior to the TPEP's inception, Oregon had greater per capita sales of cigarette packs than the rest of the country (92.1 – Oregon, 87.2 – U.S.). In 2010, conversely, U.S. per capita sales of cigarette packs was 44.5 (2.8 packs per capita higher than Oregon). The current difference between Oregon and the U.S. represents a much steeper decline in per capita cigarette sales in Oregon, on average, than in the rest of the country.

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, and to eliminate nonsmokers' exposure to secondhand smoke. 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 \$2.2 billion lost to medical care and lost productivity annually in Oregon. During the 2009-2011 biennium, Oregon spent \$3.18 per capita for tobacco prevention from all funding sources, which equates to 27% of CDC's recommended funding for tobacco prevention. While this investment is less than optimal, it nonetheless represents a temporary increase from previous biennia because Oregon successfully sought one-time funding through the American Recovery and Reinvestment Act to enhance its tobacco prevention work. During the 2007-2009 biennia, Oregon was funded at \$2.10 per capita for tobacco prevention from all funding sources, and for most of the 2001-2003 biennium, the TPEP received approximately \$2.87 per capita per year. TPEP also had to shutter its program from April 2003 through the end of the biennium when the Legislature redirected monies that had been allocated to TPEP. 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.

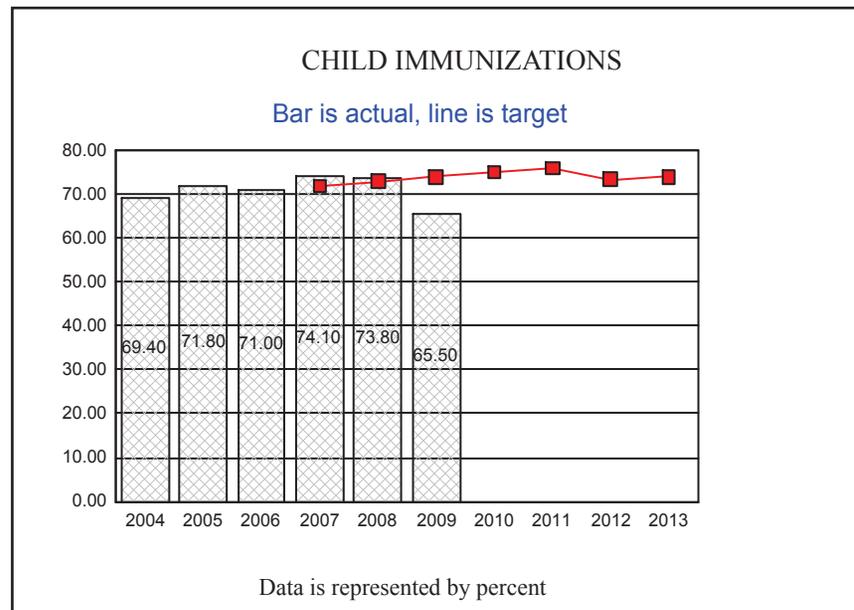
6. WHAT NEEDS TO BE DONE

Studies in Oregon and in other states have shown that decreases in funding for tobacco prevention lead to decreased success in reducing tobacco use. To reverse troubling tobacco use trends, funding for comprehensive tobacco control needs to be increased and stabilized. Prior successes in Oregon and a substantial evidence-base from elsewhere tell us that a comprehensive program is the most effective means to counter these trends.

7. ABOUT THE DATA

Average per capita cigarette consumption is estimated from tobacco tax revenue data. An economic consulting firm, Orzechowski and Walker, collects these data from states' revenue departments and issues monthly and annual summary reports. As the summary reports describe fiscal year pack sales, monthly reports are summed to determine calendar year sales for each state. The total number of cigarettes sold for each state is divided by the U.S. Census population estimate to determine per capita consumption. Advantages associated with these data are that they allow comparisons with national and other state estimates of consumption, which similarly rely on tax revenue data and population estimates. In addition, this estimator does not depend upon accurate self-reporting of smoking behavior. A disadvantage associated with this estimator is that the per capita consumption is based on the entire state population, including non-smokers, so it does not depict actual smokers' consumption levels. Another disadvantage is that packs of cigarettes purchased by Oregon consumers without taxes being collected (i.e., over the Internet, through mail order, in other states, or illegally in Oregon without tax) are not counted in this estimate. Surveillance data collected by TPEP indicates that untaxed cigarettes represent a small fraction of the cigarettes Oregon smokers consume, however.

KPM #33	CHILD IMMUNIZATIONS – The percentage of 24-35 month old children who are adequately immunized.	2002
Goal	People are healthy.	
Oregon Context	Oregon Benchmark #41 - Infant Mortality, Oregon Benchmark #42 - Immunizations, Child mortality	
Data Source	Public Health Division, Office of Family Health (ALERT Registry)	
Owner	Public Health Division, Office of Family Health, Immunization Program, Lorraine Duncan, 971-673-0283	



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 clinical database of all reported vaccine for provider reference and identifies all shots due. Vaccines, funds, and technical assistance are provided annually to local health departments to improve immunization coverage rates for children. Education and training opportunities are held for providers throughout the year to provide

up-to-date information about vaccine efficacy, safety, reporting, as well as storage and handling.

2. ABOUT THE TARGETS

The goal is to increase immunization rates to meet the Healthy People 2010 objective of 90%.

3. HOW WE ARE DOING

Oregon two-year old immunization rates have seen incremental improvement since population-based data assessments began in 2004 through 2008. 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; and one or more doses of varicella (4:3:1:3:3:1)

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), a phone survey of a limited sample of Oregon residents 19-35 months of age. However, the national NIS rate for the 4:3:1:3:3:1 series was 69.9% (+/- 1.2%), with 64.8% (+/- 6.3%) for Oregon, 70.3% (+/- 5.4%) for Washington and 51.7% (+/- 7.7%) for Idaho.

5. FACTORS AFFECTING RESULTS

The percentage of Oregon two year olds who are adequately immunized has seen modest growth from 2004-2008. However, our 2009 rates saw a notable decline compared to 2008 (decrease from 73.8% to 65.5%) for coverage among 24-35 months old with the same vaccine series as assessed in previous years. The reason for this decline can be directly attributed to the national shortage of Hib vaccine that occurred from December 2007 through July 2009. Children included in the 2009 rate assessment were directly impacted by this vaccine shortage, as demonstrated by the fact that our up-to-date rate for the series excluding Hib continues to be at 73%. 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, public providers, 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.

6. WHAT NEEDS TO BE DONE

To continue our success, OHA needs to:

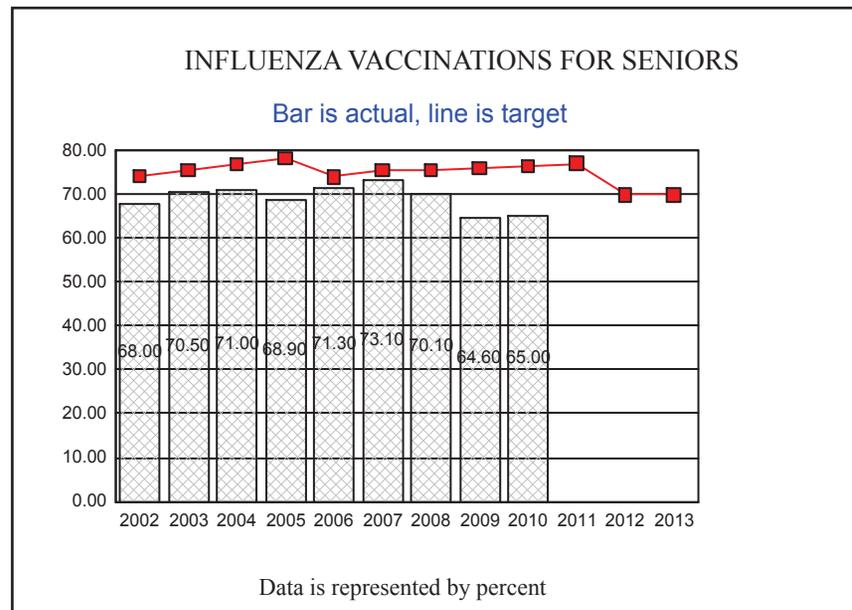
- Continue to provide funding, vaccines, and consultation to all local health department;
- Increase private provider participation in the statewide ALERT immunization registry in order to improve providers' ability to identify under-immunized children;

- 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; and
- Continue to work with the Centers for Disease Control (CDC), vaccine manufacturers, and providers to assure that appropriate strategies are in place for a potential vaccine shortage.

7. ABOUT THE DATA

Reporting cycle – calendar year. This measures the statewide immunization rate for children 24 to 35 months of age. The data source is the ALERT immunization information system, our statewide IIS, that records reported immunization data from 100% of public providers and 88% of private providers. The immunizations assessed include 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, and 1 Varicella (4:3:1:3:3:1). Annual data are generally available in June.

KPM #34	INFLUENZA VACCINATIONS FOR SENIORS – The percentage of adults aged 65 and over who receive an influenza vaccine.	2002
Goal	People are healthy	
Oregon Context	Oregon Benchmark #45 - Preventable Death	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, Center for Health Statistics (BRFSS)	
Owner	OHA - Public Health Division, Office of Family Health, Immunization Program, Lorraine Duncan 971-673-0283	



1. OUR STRATEGY

Strategies include promoting adult immunizations through the DHS-funded Oregon Adult Immunization Coalition (OAIC), promotion of hospital standing orders, and technical support to public and private provider. Additionally, influenza vaccinations are promoted and supported by local health departments.

2. ABOUT THE TARGETS

The goal is to continue to increase immunization rates to meet the Healthy People 2010 objective of 90%.

3. HOW WE ARE DOING

In 2010, the statewide senior flu vaccination rate was 65%. This measure has shown little progress and has been below targets since its introduction in 2002.

4. HOW WE COMPARE

In 2010, the national immunization rate for persons 65 and older was 67.5%, with state rates ranging from 59.3% in Nevada to 72.4% in Massachusetts.

5. FACTORS AFFECTING RESULTS

Immunization rates are influenced by public perception of need and efficacy of the vaccine. Factors that negatively impact rates include: absence of policies in place that motivate health systems to routinely vaccinate all clients, limited funding for adult immunizations, limited funding to support continued hosting of the annual Flu Summit, and challenges around increasing provider use of the ALERT Immunization Information System (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 to a lifespan registry, and during the 2011 legislative session, HB 2371 passed stating that VFC and 317 providers need to report to ALERT. Work on this new requirement is beginning, with the first step being the development of administrative rules, followed by an implementation plan. Over the next few years as the registry collects and processes data, this information will be available to healthcare providers, helping them identify candidates for vaccine and potentially sending out reminders to clients to seek out immunization every year.

6. WHAT NEEDS TO BE DONE

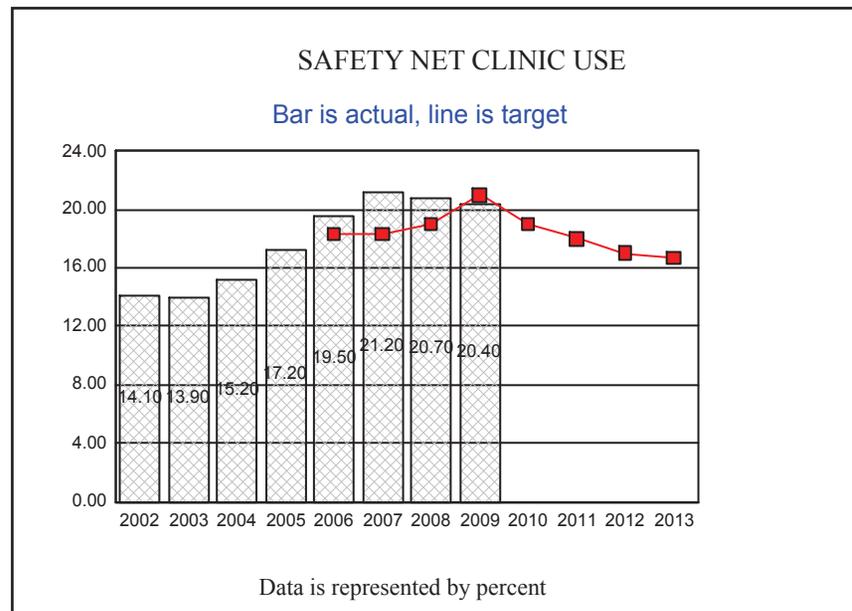
With the support of OAIC and depending on available resources, we plan on the following:

- Continue to work with hospitals to increase the number of patients, age 65 and older, who are immunized against influenza prior to discharge;
- Continue to support efforts to increase vaccination of health care workers;
- Assess adult population capture in the IIS to produce near real-time estimates of coverage, by county, throughout the flu season; and
- Continue to promote the administration of influenza vaccine whenever immunization providers give any other immunization, such as pneumococcal vaccine or tetanus/diphtheria vaccine, in all health care settings.

7. ABOUT THE DATA

Reporting period - calendar year. This measures the percent of adults, 65 years and older, which 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?]. The data are generally available in May. This KPM was audited in 2008 and was certified as "verified" meaning that performance reported is consistently accurate within plus or minus five percent and adequate controls are in place to ensure consistency and accuracy in collection of all supporting data and subsequent reports.

KPM #35	SAFETY NET CLINIC USE – The percentage of uninsured Oregonians served by safety net clinics.	2002
Goal	People are healthy	
Oregon Context	Health care access	
Data Source	Oregon Primary Care Association, Oregon Population Survey, 2008 American Community Survey, and Portland State University	
Owner	OHA – Office of Health Policy and Research, Satenik Hackenbruck 503-373-1931	



1. OUR STRATEGY

Safety net clinics provide health care services to vulnerable populations such as uninsured people, Medicaid and Medicare clients, many of whom face multiple barriers to health care not only due to income status. This has been a critical role especially in economically challenging

times. Oregon Health Policy and Research (OHPR) monitors policy implications and staffs the Safety Net Advisory Council. OHPR determines health professional shortage areas and areas of unmet need and makes that information available to communities. OHPR provides technical assistance to communities and sites interested in establishing or expanding sites. OHPR assists communities with workforce needs in underserved areas of the state.

2. ABOUT THE TARGETS

This key performance measure shows the proportion of total uninsured in Oregon served by safety net clinics. However, due to the lack of data for all types of safety net clinics, we use Federally Qualified Health Centers (FQHC) as a proxy for all safety net clinics:

In 2002, FQHCs served 69,400 uninsured Oregonians. By 2009 that number had risen to 132,000, which is a 90 percent increase compared to 2002. At the same time the number of total uninsured in Oregon had increased by 32 percent from 490,700 to 647,200. This indicates that over time the proportion of uninsured people receiving care at FQHCs is increasing at a higher rate than the growth of uninsured population in general. This is not surprising given the rapid growth of FQHC sites; the number of FQHC sites grew by 75 percent from 106 in 2002 to 186 in 2009.

Due to the implementation of state and federal health care reforms, the number of uninsured in Oregon is expected to decline. However, it's hard to predict what will happen to the number of uninsured seen by FQHCs. On one hand we have seen an upward trend in the past, due to the increased capacity of safety net clinics. On the other hand, many of the current uninsured seen by FQHCs will gain insurance coverage as a result of the reform. In the end, we expect the number of uninsured served by FQHCs to decline at a higher rate than the overall number of uninsured, due to the fact that the uninsured seen by safety net clinics are more likely to gain insurance coverage compared to those not seen in safety net clinics. Often times, the challenge with insuring low income uninsured individuals is in finding them, thus those seen by safety net have an instant advantage of being found and enrolled. Therefore, we expect the key performance measure to decrease slightly in 2012-2013.

3. HOW WE ARE DOING

Percentages served by the safety net have been consistently increasing since 2003. With the implementation of health care reform these percentages are expected to drop. Assuming that the purpose of the safety net is to provide care to a significant number of uninsured whatever the barriers they face then one would have to conclude that the safety net is doing its job. This is especially true given that the safety net providers also serve Medicaid and Medicare patients and are part of the capacity equation for these populations as well. Of some concern from a policy perspective is the fact that the safety net has served increasing numbers of uninsured without corresponding increases in revenue. Additionally, there are capacity needs in the current Medicare and Medicaid programs that will be strained as more baby boomers retire. While the safety net is a critical part of the state's health care access equation it is also vulnerable to the same workforce "pipeline", recruitment and retention challenges faced by the rest of the delivery system.

As mentioned above, uninsured is not the only category of people relying on safety net clinics. An increasing number of communities are reporting Medicaid and Medicare related access problems. Safety net clinics report serving over 125,000 Medicaid and Medicare clients in 2009 and therefore represent an important

component of primary care access for these populations. As a result, OHP is proposing two additional measures for the 2011-13 biennium: the percentages of Medicaid and Medicare patients served by safety net clinics. These additional measures will help to better understand the utilization of the safety net by various groups of people, and its implications for public policy.

4. HOW WE COMPARE

There are no comparative data available in Oregon or for other states, although safety net roles and dynamics are believed to be similar in other states.

5. FACTORS AFFECTING RESULTS

Factors have been noted above in #2 and #3.

6. WHAT NEEDS TO BE DONE

Targets need to be changed to absolute numbers rather than percentages or at least both need to be included to document the role of the safety net and to highlight capacity needs and challenges for serving the increasing number of individuals.

Understanding the shifting payer source for safety net providers will be important to understand the role the safety net can and should play in an environment where many more people are covered. In that light one needs to understand the relative proportions of uninsured, Medicaid, and Medicare served by the safety net. Medicare access is increasingly problematic in Oregon and Fully Capitated Health Plans depend to a good extent on the safety net as part of their panel to assure access. Until fee-for service rates improve, the safety net is likely to remain a critical part of this access solution. Workforce shortages will also play a part in understanding both the contribution of the safety net and the challenges it faces. It is important to understand the role the safety net plays as a part of total health system capacity to provide care to both those who are uninsured (assuming there will always be some) and those who are covered by Medicare or Medicaid.

7. ABOUT THE DATA

This measure is calculated from three data sources: The Oregon Primary Care Association, Uniform Data System (number of uninsured served by FQHC clinics), the American Community Survey (total uninsured rates), and Portland State University, Population Research Center (population estimates). All data are reported by calendar year except the population estimates, which represent a mid-year average. The 2008 figure has been corrected from 19.7% to 20.7% due to a change in the methodology of calculating the total uninsured population in Oregon.

The Uniform Data System (UDS) collects data on all clinics in the U.S. receiving federal funds through section 330 of the Public Health Service (PHS) Act and administered by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC). These clinics are known as Federally Qualified Health Centers (FQHC's). The Oregon Primary Care Association (OPCA) provides annual calendar year figures of the total number of uninsured persons in Oregon served by these clinics. For more information about the UDS see <http://bphc.hrsa.gov/uds/>. In the calculation of this measure FQHC's are used as a proxy for the entire safety-net clinic system in Oregon. However, this undercounts the number of people served by the safety-net because it does not include some other types of safety-net clinics such as: community sponsored clinics, Indian/Tribal clinics, rural health clinics, and school based health centers.

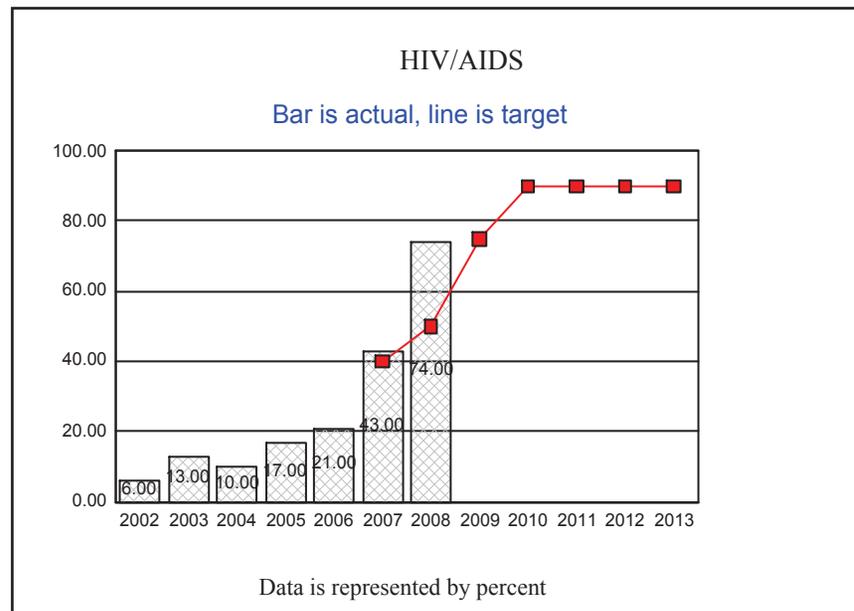
Unfortunately, a comparable data system does not exist for these other types of clinics.

Previously, the values for years 2000 to 2004 incorporated an estimate of the number of uninsured persons served by non-Federally Qualified Health Centers (FQHCs) safety net clinics as well as the number served by FQHC clinics from the Uniform Data System (UDS). FQHCs serve the largest number of both Medicaid and uninsured of all safety net entities and have the most robust reporting system as a federal requirement. Both figures were provided by the Oregon Primary Care Association (OPCA). However, the non-FQHC component has not actually been calculated since 2001 and the calculation is not replicable because other safety net clinics (ex. School Based Health Centers, Rural Health Clinics) do not have a data system similar to the UDS. Because the only known available data is from the Uniform Data System, clinics included in that database must be proxies for all safety net clinics in Oregon. This methodological change has resulted in a decrease in the estimate of safety net coverage. However, this new method will continue to be replicable in the future because the data source used is well-established and reliable.

The Census Bureau's American Community Survey (ACS) is the largest nationwide survey producing comprehensive data on demographic, social, economic, and housing characteristics. The ACS surveys three million addresses per year, including roughly 35,000 Oregonians. More details about the methodology and data can be obtained at: http://www.oregon.gov/OHA/OHPR/RSCH/docs/Uninsured/OregonUninsured_2009FinalReport.pdf

The Population Research Center at Portland State University publishes annual estimates of the total Oregon population based on births, deaths and migration on their website at: <http://www.pdx.edu/prc/>. These estimates are widely used by the state and local governments, various organizations and agencies for revenue sharing, funds allocation, and planning purposes.

KPM #36	HIV/AIDS - The proportion of reported HIV/AIDS cases interviewed by a local or state public health professional and offered assistance with partner notification and referral to HIV treatment.	2009
Goal	People are healthy	
Oregon Context	Oregon Benchmark #43 - HIV diagnosis, Communicable disease	
Data Source	Public Health Division, Office of Disease Prevention & Epidemiology, HIV/AIDS Reporting Systems (HARS) database & PSU Census	
Owner	OHA - Public Health Division, Office of Disease Prevention & Epidemiology, HIV/STD/TB Program, DHS, Sean Schafer, MD, 971-673-0181	



1. OUR STRATEGY

The HIV Programs of Oregon’s HIV/STD/TB (HST) Program in the Public Health Division aim to reduce new HIV infections. One important way to accomplish this is by finding and testing sex and needle partners of newly reported cases, treating and counseling them if infected and counseling about HIV avoidance if not infected.

Governmental partners include the Centers for Disease Control and Prevention and local health authorities. Non-governmental partners include clinical laboratories, health practitioners and health care facilities that report cases, and non-governmental HIV prevention agencies.

2. ABOUT THE TARGETS

During 2006, HST began redirecting some prevention resources to focus on direct interviews of people with newly reported cases of HIV to identify and test exposed partners. In all likelihood, interviewing 100% of all patients will never be achieved. Nevertheless, in pursuit of this, HST aims to interview at least 90% of case patients by 2010 and sustain that level during 2011.

3. HOW WE ARE DOING

During 2005, approximately 21% of newly reported cases had been interviewed. This had increased to 74% by 2008 because of redoubled efforts and resource allocation.

4. HOW WE COMPARE

Centers for Disease Control and Prevention recommends that all reported HIV cases be interviewed and offered partner notification services. No explicit industry standards exist for this measure. A 2001 national survey indicated that fewer than a third of newly reported HIV cases were being interviewed or offered partner notification services.

5. FACTORS AFFECTING RESULTS

A completed interview of a person with a newly diagnosed case of HIV infection requires efficient functioning of several public health systems. First, Oregon's HIV/AIDS case monitoring system must identify, in a timely way, all new cases by collecting reports from laboratories of all clinical tests that might be indicative of HIV infection and from health practitioners about newly recognized cases. State and local public health staff must compare these to previously reported cases, identifying the new cases and initiating case investigations. When a new case is confirmed, specially trained disease intervention specialists attempt to locate and interview the individual. In particular the interviewers try to collect locating information about sex and needle partners who may have been exposed, then locate these partners for testing and counseling. Some patients may not be successfully located and interviewed. This can happen when laboratory or practitioner reporting is delayed, public health staff are not timely at recognizing new cases or initiating case investigations, interviewers are unavailable or ineffective, or patients refuse to respond or cannot be located.

6. WHAT NEEDS TO BE DONE

HST will compare the proportion of newly identified cases interviewed with the targets above. If the targets are not met, the program will examine the contributing public health systems such as timeliness of reporting by laboratories and health practitioners, interviewer performance, and methods used to locate and contact

patients looking for opportunities to increase interview performance. If targets are repeatedly met, the program will consider raising the target or proposing a new performance measure within the line of sight of reduction of new HIV cases.

7. ABOUT THE DATA

HST collects data from interviews of patients with reported cases of HIV, including number of partners contacted, in an existing public health database. These interviews are collected throughout the year, whenever a new case is reported. HST uses stored data to generate reports of numbers of cases interviewed biannually during the calendar year, or more often if needed. Estimates of the total number of reported cases per year that will serve as the denominator for this proportion will be estimated from the HIV/AIDS Reporting System (HARS), maintained by HST.

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

Contact Phone: 503-945-5855

Alternate: John Britton

Alternate Phone: 503-945-6597

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

As a result of Transformation efforts, there is an emphasis on using metrics to identify where improvements are needed, make changes, and track and report results to make sure improvements are sustained. The department has been training work units in the Lean Daily Management System® (LDMS®) which includes a component for developing metrics at the work unit level for the team’s main processes. Key Performance Measures provide a high-level picture of our results, but the underlying metrics provide a more meaningful and actionable management tool.

3 STAFF TRAINING

Management and staff continue to receive training related to transformation and continuous improvement. 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 process 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 information to inform our strategies and decision-making.

	<p>Required courses for managers teach about creating a culture of continuous improvement to achieve results to become a world-class organization and sustain the transformation. Workshops help prepare managers to assist their work groups to establish and sustain LDMS® 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. One goal of the Transformation Initiative is to make data and metrics more visible at all levels of the organization. As work units begin using the Lean Daily Management System® (LDMS®), they create visual display boards to post in their areas that include data and metrics about the team’s work to provide current information about the results they are achieving and goals they are working toward. Work unit members meet in front of the display board regularly to review metrics, share information, set priorities and problem-solve when needed.</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>

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Agency: **OREGON HEALTH AUTHORITY**

	Green = Target to -5%	Yellow = Target -6% to -15%	Red = Target > -15%	Pending	Exception Can not calculate status (zero entered for either Actual or Target)
Summary Stats:	50.00%	21.88%	15.63%	12.50%	0.00%

Detailed Report:

KPMs	Actual	Target	Status	Most Recent Year	Management Comments
- CUSTOMER SERVICE (OHA) - Percentage of customers rating their overall satisfaction with OHA above average or excellent.	72.80		Pending	2008	We exceeded our target for 2008. New data will be available in fall 2011. As we have transitioned to DHS and OHA, we will be developing a coordinated plan for a comprehensive measurement of customer service that adequately represents all our customers and clients.
- OPHP TRAINING - Percentage of attendees rating the training received as 'meets or exceeds learning experience expectations'.	100	85	Green	2011	The IEO unit of OPHP is providing relevant and helpful information to key partners and stakeholders in healthcare. The current reservation list for the FHIAP program includes over 50,000 individuals, which is due in part to the clear communications and training efforts of IEO.

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KPMs	Actual	Target	Status	Most Recent Year	Management Comments
1 - COMPLETION OF ALCOHOL AND DRUG TREATMENT – The percentage of engaged clients who complete alcohol and other drug (AOD) abuse treatment and are not abusing AOD.	64.20	65.50	Green	2010	The completion rate has been hovering around 64% for the past several years. The Division is working with providers to continue this trend through a quality improvement process and by incorporating this measure into performance based contracting. A number of factors affect this measure including referral source (legal referrals are more likely to complete), type of service being delivered (residential compared to outpatient completion), and the quality of services (varies by provider and by type of service delivered). It should be noted that this measurement refers to single episodes of treatment, not completion of a full-range of treatment and recovery services. AMH is moving forward on several system redesign initiatives that better align clinical, administrative, and financing approaches with a recovery-oriented system of care model. This approach emphasizes effective transitions between levels of service and retention in services throughout various modalities rather than completion of one single episode of service (e.g residential or outpatient). The data system used by addiction treatment providers is currently a barrier to capturing meaningful data toward the new aim. AMH has outlined functional requirements that need to be incorporated in a new, modern data system that are aligned with administering and managing a recovery-oriented system of care. AMH will continue quality improvement and process improvement efforts to improve completion rates.

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KPMs	Actual	Target	Status	Most Recent Year	Management Comments
2 - ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of adults employed after receiving Alcohol and Drug treatment.	52.30	73.00	Red	2010	Oregon has been doing well regarding employment at discharge but due to the economy and employment conditions in Oregon, beginning in 2008, it is expected that the employment percentage at discharge will decrease compared to previous 2-3 years. Factors such as limited treatment capacity, lack of insurance for treatment, limited transportation, and young children requiring care contribute are major barriers to obtaining treatment. Investments need to be made in treatment, increased emphasis on co-occurring disorder treatment, additional case management services, and recovery management services.
2 - FHIAP Administration Percentage – FHIAP administrative expenses as a percentage of total cost.	14.93	9.00	Red	2009	This measure currently evaluates only the Family Health Insurance Assistance Program (FHIAP) administrative expenditure percentage. However, OPHP operations include FHIAP, Healthy KidsConnect (HKP), and the Oregon Medical Insurance Pool (OMIP). There are several staff members that perform duties that serve more than one of these programs, and one shared facility that serves them all. There is a proposal in place to change the existing FHIAP administration measure to an OPHP administration measure that will more accurately reflect the overall administrative efficiency and performance of the agency.

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KPMs	Actual	Target	Status	Most Recent Year	Management Comments
3 - ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of parents who have their children returned to their custody after receiving alcohol and drug treatment.	49.20	55.00	Yellow	2010	The trend in this measure is moving in the right direction. AMH has focused attention and resources on making sure the investments, services, and system coordination as related to addiction treatment and recovery services for parents involved in the child welfare system are working to produce the most positive and sustainable outcomes. While the trend is positive, more can be done to promote use of and invest in recovery supports designed to maximize the investments made in addition treatment and to sustain long-term recovery and family stability.
4 - ALCOHOL & DRUG TREATMENT EFFECTIVENESS – The percentage of children whose school performance improves after receiving alcohol and drug treatment.	78.10	71.00	Green	2010	We have exceeded the target for the past three years. Need to continue emphasis on youth specific co-occurring disorder treatment, additional case management services, recovery management services, and additional wraparound services. In addition, more coordination with school personnel including school counselors needs to occur.
4 - CUSTOMER SERVICE – Percent of customers rating their satisfaction with the agency’s customer service as “good” or “excellent”: overall customer service, timeliness, accuracy, helpfulness, expertise and availability of information.	97.10	90.00	Green	2011	Customer Satisfaction is very important to OPHP. All of the members enrolled in FHIAP pay at least a portion of their premium for the health insurance that they are enrolled in. These members are stakeholders in FHIAP, and it is important that they receive excellent customer service. The results of this Key Performance Measure are one of the ways that we measure the level of our customer service.

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KPMs	Actual	Target	Status	Most Recent Year	Management Comments
5 - 8TH GRADER USE OF ALCOHOL - The % of 8th graders who have used alcohol within the past 30 days	22.50	29.00	Green	2010	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.
6 - 8TH GRADER USE OF ILLICIT DRUGS - The % of 8th graders who have used illicit drugs within the past 30 days.	16.70	14.50	Yellow	2010	The percent of 8th graders using illicit drugs increased after many years of decline and it is above the target. At this point it would be premature to note this as a reverse in the trend or a one-year anomaly. 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 - CHILD MENTAL HEALTH SERVICES - The % of children receiving mental health services who are suspended or expelled from school	10.00	10.00	Green	2009	Our results are roughly equivalent to the national rate for the standard population. Continued work at the local level between mental health authorities and education authorities will keep this rate low.

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KPMs	Actual	Target	Status	Most Recent Year	Management Comments
8 - ADULT MENTAL HEALTH SERVICES - The % of adults receiving mental health services who report positively about the outcomes of those services.	59.50	58.00	Green	2010	It is estimated that over half of the people receiving services are reporting better outcomes. Functional outcomes are related to improvement in housing, relationships, jobs, and other similar opportunities. AMH needs to continue to aggressively pursue outcomes that matter to its clients. This centers around recovery focused treatment that promotes independence and health.
9 - MENTAL HEALTH CLIENT LEVEL OF FUNCTIONING – The percentage of mental health clients who maintain or improve level of functioning following treatment.	91.20	95.00	Green	2010	It appears that many people are benefiting from mental health services. One concern is that this measure is not sensitive enough to truly assess improvement. Addictions and Mental Health Division will continue quality improvement efforts and the encouragement of the use of evidence-based practices.
10 - Problem Gambling - The % of adults who gamble much less or not at all 180 days after ending problem gambling treatment.	84.00	75.50	Green	2010	One performance measure has been reported here out of many more available at the program level. AMH-Problem Gambling Services is unique in that post-treatment outcomes indicators have been collected for nearly 15 years. This provides Oregon with a rich database that will guide the decision-making process.
11 - RESTRAINT RATE - Reduction in restraint hours per thousand patient hours at Oregon State Hospital.	0.2070	0.1200	Red	2010	We continue to make progress to reduce the use of restraint at the hospital.

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KPMs	Actual	Target	Status	Most Recent Year	Management Comments
12 - LENGTH OF STAY AT OSH - Reduction in overall length of stay at Oregon State Hospital	185	180	Green	2009	The overall trend in length of stay is decreasing, which is good. There are many factors that influence this outcome that are internal and external to the state hospital. AMH is working to increase the hours of active treatment patients receive while in the hospital to promote quicker recovery. In addition, AMH is attempting to align community resources to provide adequate care for patients discharged from the hospital to decrease the likelihood of return to the hospital.
23 - PREVENTIVE SERVICES FOR OHP CHILDREN - The utilization rate of preventive services for children birth through 10 years old covered by OHP	4.52		Pending	2009	<p>Due to budget cuts, reimbursement rates for all health service types will be reduced except for primary care. Increased use of primary care is a desired result.</p> <p>The proposed child HEDIS® measures were chosen because they are an industry standard and comparisons can be made to other populations.</p> <p>The proposed child HEDIS® measures are included in a list of recommended child health care quality measures issued by the Center for Medicare and Medicaid Services (CMS) as part of recent child health insurance program legislation (CHIPRA).</p>

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KPMs	Actual	Target	Status	Most Recent Year	Management Comments
24 - PREVENTIVE SERVICES FOR OHP YOUTH AND ADULTS - The utilization rate of preventive services for youth and adults 11 years old and older covered by OHP	0.99		Pending	2009	<p>Due to budget cuts, reimbursement rates for all health service types will be reduced except for primary care. Increased use of primary care is a desired result.</p> <p>The proposed adolescent and adult HEDIS® measures were chosen because they are an industry standard and comparisons can be made to other populations.</p> <p>The proposed adolescent HEDIS® measures is included in a list of recommended child health care quality measures issued by the Center for Medicare and Medicaid Services (CMS) as part of recent child health insurance program legislation (CHIPRA).</p>
25 - APPROPRIATE PRENATAL CARE FOR OHP CLIENTS - The % of pregnant OHP clients who received an appropriate number of prenatal care visits while on OHP	59.10		Pending	2008	<p>This measure, proposed for 2009-2011, has proven to be inherently immeasurable because of nearly universal use of global and bundled coding when billing for prenatal, delivery, and postpartum services.</p> <p>In order to avoid costly chart reviews, DMAP uses administrative data from its claim processing system to calculate measures. At this time, DMAP does not have access to electronic medical records or any other data sources that would provide meaningful data for this measure. Therefore, DMAP is asking to drop this measure until an accurate measurement process is available.</p>

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KPMs	Actual	Target	Status	Most Recent Year	Management Comments
26 - ACS HOSPITALIZATIONS OF OHP CLIENTS - The rate of ambulatory care sensitive condition hospitalizations of Oregon Health Plan clients	2,591	2,536	Green	2009	<p>The PQI measure was chosen because it is an actionable, national, standardized measure using a readily available free software program. Approximate comparisons can be made to other populations.</p> <p>The PQI measure is included in a list of recommended adult health care quality measures issued by the Center for Medicare and Medicaid Services (CMS) as part of national health care reform.</p> <p>DMAP's disease management vendor that serves many fee-for-service OHP members uses this measure to assess program effectiveness. Additionally, this measure is proposed for the Care Coordination Organizations.</p> <p>Due to budget cuts, reimbursement rates for all health service types will be reduced except for primary care. Increased use of primary care is the desired result.</p>
27 - TEEN SUICIDE – The rate of suicides among adolescents per 100,000.	7.90	8.40	Green	2009	<p>There are not enough staff and resources to implement the strategies outlined in the state plan. The state will use lessons learned from the implementation of a three-year federal grant that enables communities to implement a multifaceted suicide prevention program. Evaluation of these efforts will provide information on how to broaden those efforts. The state lacks funds to improve data collection from hospital emergency departments for the Adolescent Suicide Attempt Data System and to analyze that data, which would help inform prevention activities in collaboration with local hospitals.</p>

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KPMs	Actual	Target	Status	Most Recent Year	Management Comments
28 - TEEN PREGNANCY – The number of female Oregonians ages 15 – 17, per 1,000 who are pregnant.	22.40	22.00	Green	2009	Oregon’s teen pregnancy rate has consistently been lower than the national rate and Oregon has made progress in reducing it even further over the past decade, and preliminary 2009 data shows Oregon is within reach of this KPM. The factors affecting teen pregnancy are complicated and impacted by many issues. These factors take time and cannot be changed quickly; factors that contribute to a change in pregnancy trends include both human behaviors and environments that contribute to adolescents making healthy choices about sexuality.
29 - INTENDED PREGNANCY – The percentage of births where mothers report that the pregnancy was intended.	59.30	63.40	Yellow	2008	Oregon rates have been flat for years. Moving this KPM requires movement along a complex set of social, cultural and economic factors. Current family planning funding maintains the current numbers, but does not provide for significant change.
30 - EARLY PRENATAL CARE - The % of low-income women who initiated prenatal care in the first 3 months of pregnancy compared to non low-income women.	65.90	74.00	Yellow	2010	The previous measure “Early Prenatal Care for Low-Income Pregnant Women” was shared by the Public Health Division’s Office of Family Health (OFH) and DMAP and is being replaced by two new measures – one from the OFH and one from DMAP. Both DMAP and OFH struggled with this measure because the data sources did not align with the program efforts of each agency.

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KPMs	Actual	Target	Status	Most Recent Year	Management Comments
31 a - TOBACCO USE – Tobacco use among adults.	16.40	15.00	Yellow	2010	Studies in Oregon and other states have shown that sufficient funding for tobacco prevention leads to decreased tobacco use. Oregon today spends only about 27% of what the Centers for Disease Control and Prevention recommends on tobacco prevention. Prior successes in Oregon, and a substantial and growing body of evidence from other jurisdictions, inform us that a well-funded, comprehensive program is the most effective means to counter the substantial health and economic effects of tobacco on Oregon.
31 b - TOBACCO USE – Tobacco use among youth.	9.90	9.00	Yellow	2009	Studies in Oregon and other states have shown that sufficient funding for tobacco prevention leads to decreased tobacco use. Oregon today spends only about 27% of what the Centers for Disease Control and Prevention recommends on tobacco prevention. Prior successes in Oregon, and a substantial and growing body of evidence from other jurisdictions, inform us that a well-funded, comprehensive program is the most effective means to counter the substantial health and economic effects of tobacco on Oregon.
31 c - TOBACCO USE – Tobacco use among pregnant women.	13.40	10.80	Red	2009	Studies in Oregon and other states have shown that sufficient funding for tobacco prevention leads to decreased tobacco use. Oregon today spends only about 27% of what the Centers for Disease Control and Prevention recommends on tobacco prevention. Prior successes in Oregon, and a substantial and growing body of evidence from other jurisdictions, inform us that a well-funded, comprehensive program is the most effective means to counter the substantial health and economic effects of tobacco on Oregon. Due to previously described data source changes, this portion of the tobacco use measure will be developmental for 2009-11.

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KPMs	Actual	Target	Status	Most Recent Year	Management Comments
32 - CIGARETTE PACKS SOLD – Number of cigarette packs sold per capita.	44.50	48.00	Green	2010	In 2010, the number of cigarette packs sold in Oregon was 44.5 packs per capita. This measure is better than the desired target for 2010. Moreover, from 2008 onward these data have compared favorably with an earlier period (2003-2007) during which per capita cigarette packs sold stagnated. Studies in Oregon and other states have shown that sufficient funding for tobacco prevention leads to decreased tobacco use. Oregon today spends only about 27% of what the Centers for Disease Control and Prevention recommends on tobacco prevention. Prior successes in Oregon, and a substantial and growing body of evidence from other jurisdictions, inform us that a well-funded, comprehensive program is the most effective means to counter the substantial health and economic effects of tobacco on Oregon.
33 - CHILD IMMUNIZATIONS – The percentage of 24-35 month old children who are adequately immunized.	65.50	74.00	Yellow	2009	Two-year old immunization rates are influenced by a variety of factors, including parent and provider knowledge, attitudes and practices, as well as vaccine availability. The Oregon Immunization Program (OIP) works closely with stakeholders to ensure that parents/guardians receive the information they need to make informed decisions about childhood vaccinations. OIP also offers health care providers multiple opportunities for continuing education, technical support and patient educational tools. While most parents/guardians are supportive of childhood immunizations, a small percentage are reluctant to immunize their children.

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KPMs	Actual	Target	Status	Most Recent Year	Management Comments
34 - INFLUENZA VACCINATIONS FOR SENIORS – The percentage of adults aged 65 and over who receive an influenza vaccine.	65.00	76.50	Red	2010	Improving the senior influenza immunization rate has proven a difficult challenge. In the future, Oregon needs to refocus efforts on use of hospital standing orders and facility-level interventions to increase uptake.
35 - SAFETY NET CLINIC USE – The percentage of uninsured Oregonians served by safety net clinics.	20.40	21.00	Green	2009	Percentages served by the safety net have remained high since 2002 with an overall upward trend. The 2008-2009 recession is a significant contributing factor to increases in the number of uninsured seen by the safety net. The passage of HB 2116 added coverage for about 80,000 children and 35,000 adults under the Oregon Health Plan (OHP) and another 15,000 children gained insurance through sliding-scale premium assistance program. This provision of insurance to 115,000 low income people is expected to decrease the proportion of uninsured served by safety net. Assuming that the purpose of the safety net is to enable the state to provide at least primary care to a significant number of uninsured whatever the barriers they face then one would have to agree that the safety net is substantially performing this function. This is especially true given that the safety net providers also serve Medicaid and Medicare patients and are part of the capacity equation for these populations.

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KPMs	Actual	Target	Status	Most Recent Year	Management Comments
36 - HIV/AIDS - The proportion of reported HIV/AIDS cases interviewed by a local or state public health professional and offered assistance with partner notification and referral to HIV treatment.	74.00	50.00	Green	2008	HIV prevention efforts in Oregon should continue to focus on effective strategies to reduce behaviors that increase risk of infection, such as unprotected sex, sex with multiple partners, and injection drug use or sharing and reuse of drug paraphernalia. HIV testing should remain readily available to enable those at risk to obtain early diagnosis and, if infected, get into treatment. Barriers to HIV testing should be removed. Technology to shorten the interval between infection and positive laboratory tests should be adopted. More newly infected people should receive counseling about reducing the risk of transmission to sex and drug use partners. People with HIV infection need to be encouraged and assisted to identify a stable source of medical care, which has the potential to reduce risk of transmission through counseling and, while not offering a cure, through reduction of infectivity to others.

This report provides high-level performance information which may not be sufficient to fully explain the complexities associated with some of the reported measurement results. Please reference the agency's most recent Annual Performance Progress Report to better understand a measure's intent, performance history, factors impacting performance and data gather and calculation methodology.