Oregon's State Innovation Model Project
Progress Report
April 1, 2014–June 30, 2014

Appendices

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Oregon's Health System Transformation

2013 Performance Report

MEASUREMENT PERIOD
Baseline Year 2011 and
Calendar Year 2013

JUNE 24, 2014

Performance Metrics continued

Incentives for better services

The report lays out how Oregon's coordinated care organizations (CCO) performed on quality measures in 2013. This is the fourth such report since coordinated care organizations were launched in 2012 and the first to show a full year of data. This report also shows the quality measures broken out by race and ethnicity.

In addition, based on a full year's performance measurement, the coordinated care model is entering a new phase - for the first time part of the reimbursement for the services CCOs performed for Oregon Health Plan members will be based on how well they performed on 17 of these key health care measurements.

Under the coordinated care model, the Oregon Health Authority held back 2 percent of the monthly payments to the CCOs which were put into a common "quality pool." To earn their full payment, CCOs had to meet improvement targets on at least 12 of the 17 measures and have at least 60 percent of their members enrolled in a patient-centered primary care home. All CCOs showed improvements in some number of the measures and 10 out of 15 CCOs met 100 percent of their improvement targets.

In addition, coordinated care organizations are continuing to hold down costs. Oregon is staying within the budget that meets its commitment to the Centers for Medicare and Medicaid Services to reduce the growth in spending by 2 percentage points per member, per year.

Overall, the coordinated care model showed large improvements in the following areas for the state's Oregon Health Plan members:

- √ **Decreased emergency department visits.** Emergency department visits by people served by CCOs have decreased 17% since 2011 baseline data. The corresponding cost of providing services in emergency departments decreased by 19% over the same time period.

- √ **Decreased hospitalization for chronic conditions.** Hospital admissions for congestive heart failure have been reduced by 27%, chronic obstructive pulmonary disease by 32%, and adult asthma by 18%.

- √ **Developmental screening during the first 36 months of life.** The percentage of children who were screened for the risk of developmental, behavioral, and social delays increased from a 2011 baseline of 21% to 33% in 2013, an increase of 58%.

- √ **Increased primary care.** Outpatient primary care visits for CCO members' increased by 11% and spending for primary care and preventive services are up over 20%. Enrollment in patient-centered primary care homes has also increased by 52% since 2012, the baseline year for that program.

The report also shows areas where there has been progress but more gains need to be made, such as screening for risky drug or alcohol behavior and whether people have adequate access to health care providers. While there were gains in both areas, officials say that the state will put greater focus on them in the year to come. Access to care is particularly important with more than 340,000 new Oregon Health Plan members joining the system since January of 2014.

Oregon is at the beginning of its efforts to transform the health delivery system. By measuring our performance, sharing it publically and learning from our successes and challenges, we can see clearly where we started, where we are, and where we need to go next.

2013 Quality Pool

The Oregon Health Authority has established the quality pool -- Oregon's first incentive payments to coordinated care organizations. Each CCO is being paid for reaching benchmarks or making improvements on incentive measures. This is the first time Oregon has paid CCOs for better care, rather than just the volume of services delivered.

The first annual quality pool is $47 million. This represents two percent of the total amount all CCOs were paid in 2013. The quality pool is divided amongst all CCOs, based on their size (number of members) and their performance on the 17 incentive metrics.

Quality Pool: Phase One Distribution

CCOs could earn 100 percent of their quality pool in the first phase of distribution by:

* meeting the benchmark or improvement target on 12 of 16 measures; and

* meeting the benchmark or improvement target for the Electronic Health Record adoption measure (as one of the 12 measures above); and

* scoring at least 0.6 (60%) on the PCPCH enrollment measure.

CCOs must meet all three of these conditions to earn 100 percent of their quality pool.

Challenge Pool: Phase Two Distribution

The challenge pool includes funds remaining after quality pool funds are distributed in phase one. The first challenge pool is $2.4 million. Challenge pool funds were distributed to CCOs that met the benchmark or improvement target on four measures:

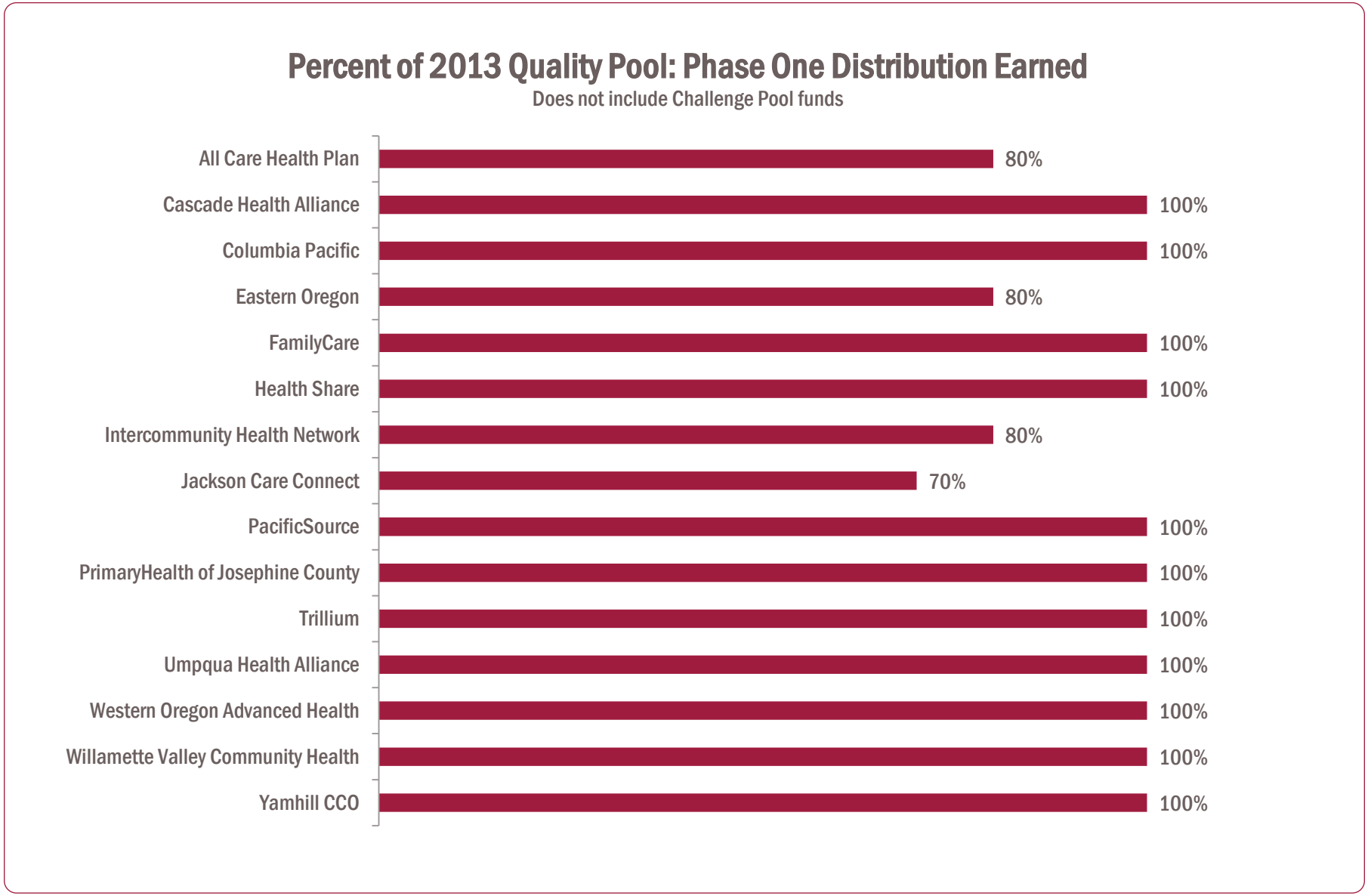
* Alcohol and drug misuse (SBIRT)
* Diabetes: HbA1c poor control
* Depression screening and follow up plan
* PCPCH enrollment

Through the challenge pool, some CCOs earned more than 100 percent of their maximum quality pool funds. The next pages show the percentage and dollar amounts earned by each CCO.

Coordinated Care Organization	Number of measures met*	Percent of total quality pool funds earned†	Total dollar amount earned	CCO Enrollment•	Which challenge pool measures were met
All Care Health Plan	11.6	84%	$2,239,160	27,878	Diabetes, Depression
Cascade Health Alliance^	13.7	100%	$748,517	10,153	Diabetes, Depression, PCPCH
Columbia Pacific	13.8	104%	$1,461,310	14,413	Diabetes, Depression, PCPCH
Eastern Oregon	11.6	83%	$1,961,432	29,234	Diabetes, PCPCH
FamilyCare	13.7	105%	$4,354,150	50,064	Diabetes, Depression, PCPCH
Health Share	12.8	104%	$13,720,133	148,201	Diabetes, Depression, PCPCH
Intercommunity Health Network	11.9	84%	$2,669,122	32,728	Diabetes, Depression, PCPCH
Jackson Care Connect	11.4	74%	$1,286,078	18,539	Diabetes, Depression
PacificSource	12.9	106%	$3,452,010	36,667	Diabetes, Depression, PCPCH, SBIRT
PrimaryHealth of Josephine County	13.0	102%	$1,024,938	5,957	Diabetes, Depression, PCPCH
Trillium	12.9	104%	$4,949,647	49,677	Diabetes, Depression, PCPCH
Umpqua Health Alliance	13.7	105%	$1,716,647	16,102	Diabetes, Depression, PCPCH, SBIRT
Western Oregon Advanced Health	14.7	104%	$1,282,648	11,664	Diabetes, Depression, PCPCH
Willamette Valley Community Health	14.9	107%	$4,987,244	64,044	Diabetes, Depression, PCPCH, SBIRT
Yamhill CCO	14.8	105%	$1,137,005	13,368	Diabetes, Depression, PCPCH

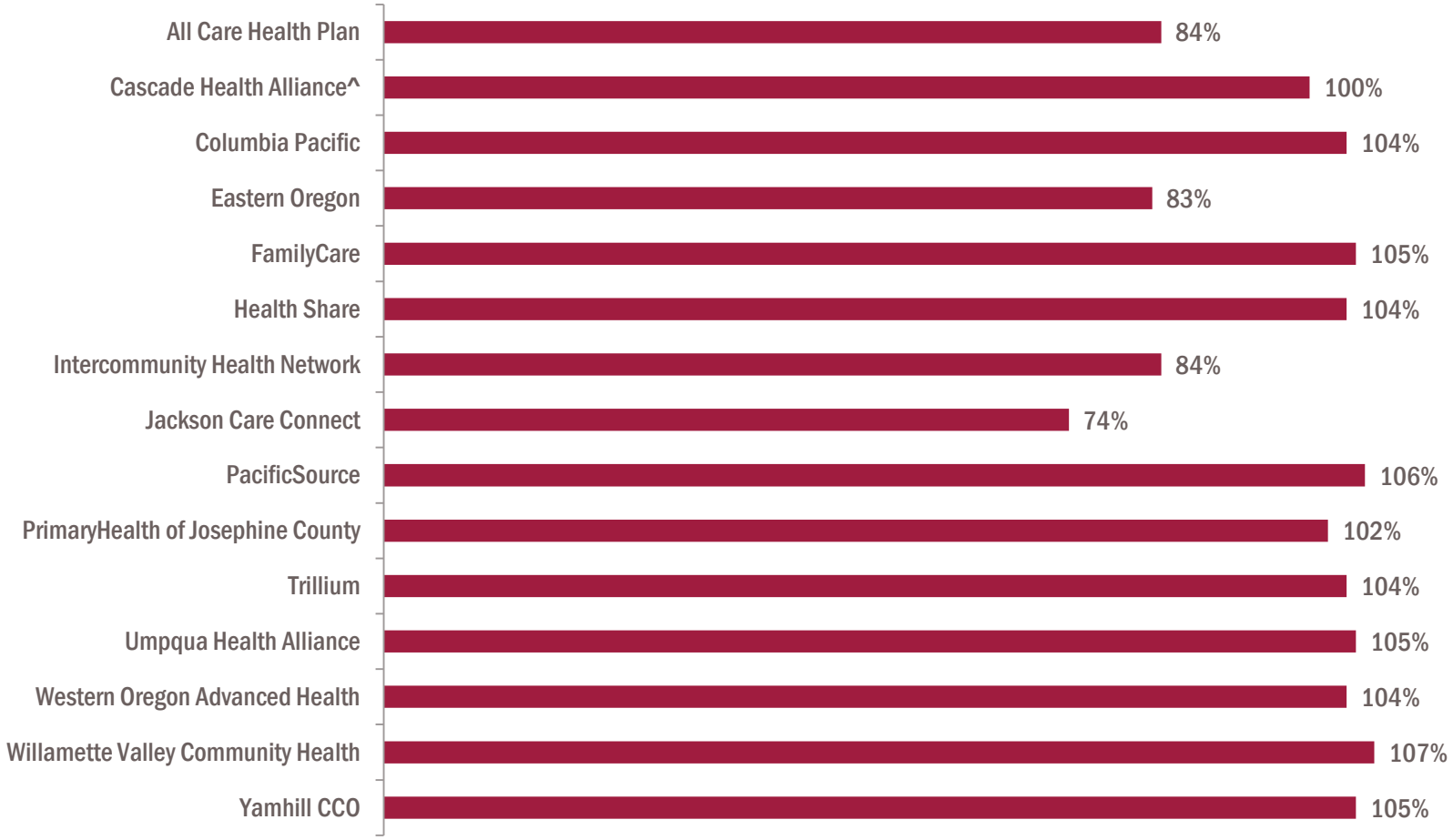
*Out of 17 total CCO incentive measures.
† Includes both phase one distribution and challenge pool.
^ Reflects prorated quality pool for partial year as CCO.
• CCO enrollment as of December 2013.

The 2013 quality pool distribution methodology is published online at:
http://www.oregon.gov/oha/CCOData/ReferenceInstructions.pdf


Percent of 2013 Quality Pool: Phase One Distribution Earned
Does not include Challenge Pool funds
All Care Health Plan
80%
Cascade Health Alliance
100%
Columbia Pacific
100%
Eastern Oregon
80%
FamilyCare
100%
Health Share
100%
Intercommunity Health Network
80%
Jackson Care Connect
70%
PacificSource
100%
PrimaryHealth of Josephine County
100%
Trillium
100%
Umpqua Health Alliance
100%
Western Oregon Advanced Health
100%
Willamette Valley Community Health
100%
Yamhill CCO
100%

Percent of 2013 Quality Pool Earned in Total

Includes both Phase One Distribution and Challenge Pool funds



^ Reflects prorated quality pool for partial year as CCO.

The 17 CCO incentive measures were chosen in an open and public process by the Metrics & Scoring Committee and approved by the Centers for Medicare and Medicaid Services (CMS). Challenge pool measures are marked with an asterisk below.

Access to care (CAHPS)
Adolescent well child visits
Alcohol or other substance misuse (SBIRT)*
Ambulatory care: emergency department utilization
Colorectal cancer screening
Controlling hypertension (clinical measure)
Depression screening and follow up plan* (clinical measure)
Developmental screening
Diabetes: HbA1c poor control* (clinical measure)
Early elective delivery
Electronic health record (EHR) adoption
Follow up after hospitalization for mental illness
Follow up care for children prescribed ADHD medication
Mental and physical health assessments for children in DHS custody
Patient centered primary care home (PCPCH) enrollment*
Prenatal and postpartum care: timeliness of prenatal care
Satisfaction with care (CAHPS)

Additional information about the Metrics & Scoring Committee available online at http://www.oregon.gov/oha/Pages/metrix.aspx

The subtitle indicates which measure set(s) the measure is part of

Measure title

Measure description:
Brief description of the measure.

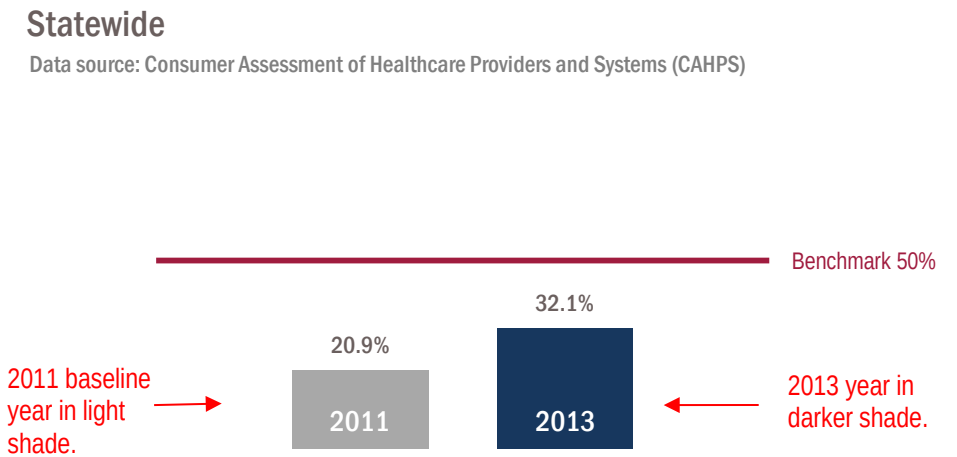
Purpose:
Brief summary of the importance of the measure.

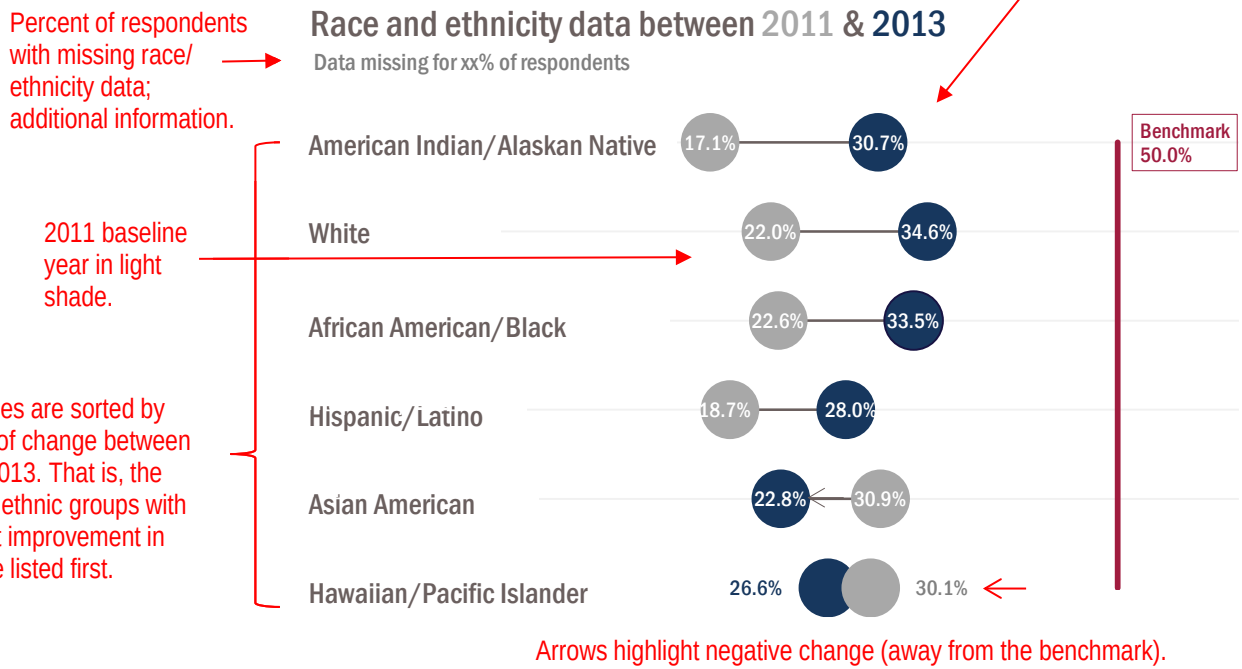
2013 data (n=XX,XXX)

Summary of 2013 data compared to 2011 baseline and the benchmark;

Overall comments on statewide and CCO performance.

Data source, benchmark source, and additional information.





CCO Incentive and State Performance Measure

Access to care (CAHPS)

Measure description: Percentage of patients (adults and children) who thought they received appointments and care when they needed them.

Purpose: Improving access to timely care and information helps increase the quality of care and reduce costs. Measuring access to care is also an important part of identifying disparities in health care and barriers to quality care, including a shortage of providers, lack of transportation, or long waits to get an appointment.

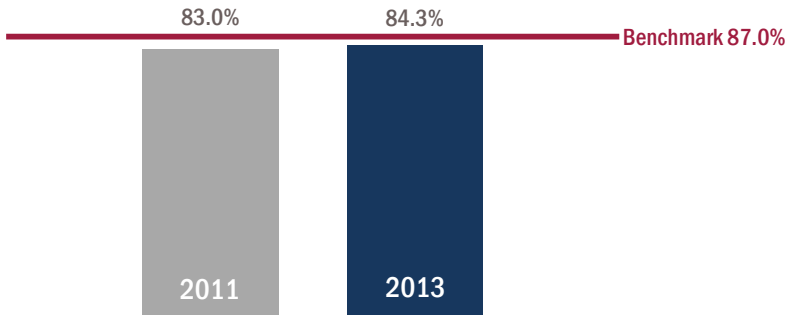
2013 data

The percentage of individuals reporting they were able to access care quickly increased from 83% in 2011 to 84% in 2013.

However, only five CCOs met the benchmark or improvement target showing that improving access to care may be a challenge for CCOs moving forward. Adult access to care decreased from 2011 to 2013 while access for children improved.

Statewide

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark source: 2012 National Medicaid 75th percentile



CCO Incentive and State Performance Measure

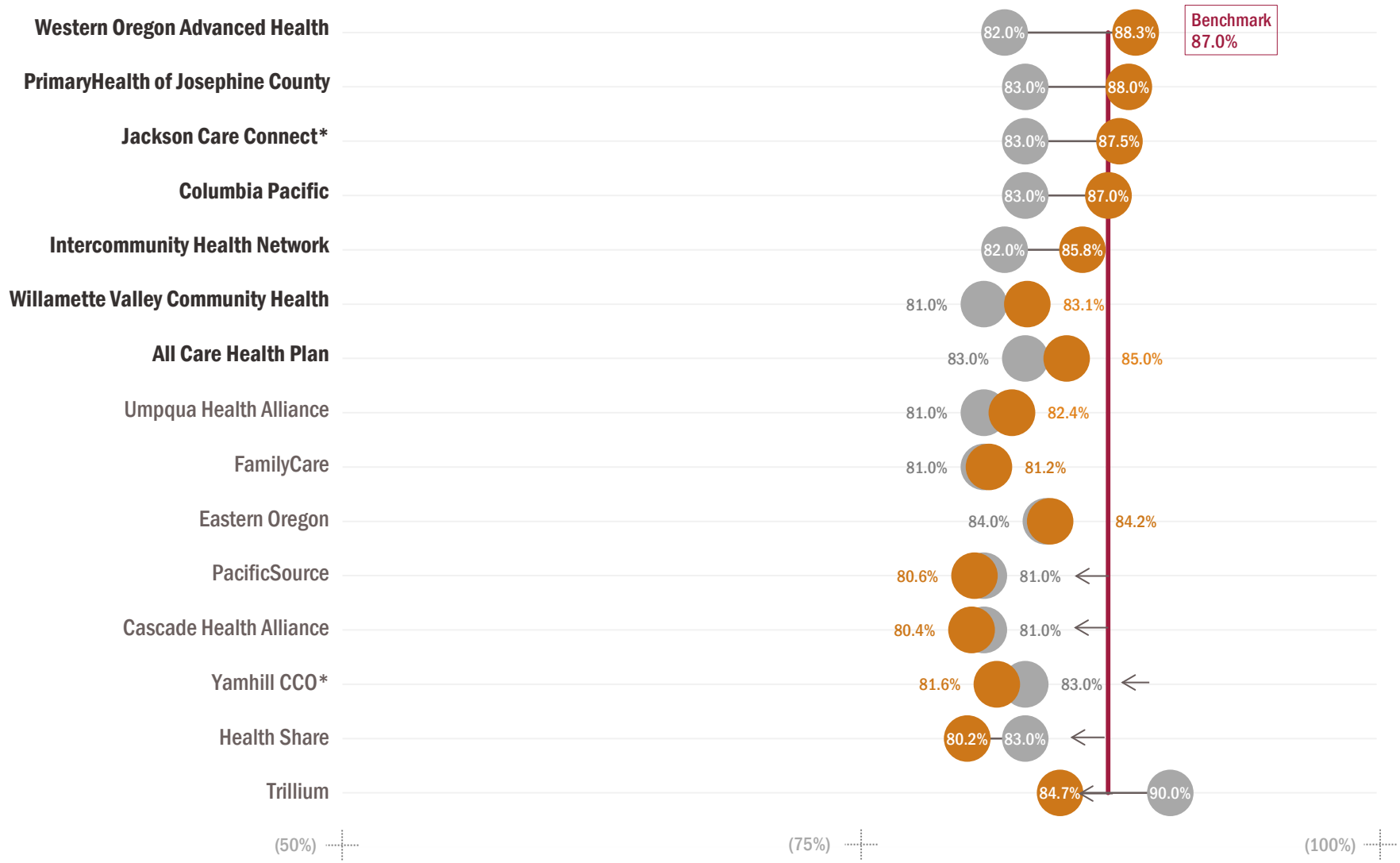
Race and ethnicity data between 2011 & 2013

CAHPS data by race and ethnicity will be available in future reports

CCO Incentive and State Performance Measure

Percentage of patients who thought they received appointments and care when needed in 2011 & 2013

Bolded names met benchmark or improvement target
*CCO baseline could not clearly be attributed to a past FCHP. Baseline provided is state average.



CCO Incentive and State Performance Measure

Adolescent well-care visits

Measure description: Percentage of adolescents and young adults (ages 12-21) who had at least one well-care visit.

Purpose: Youth who can easily access preventive health services are more likely to be healthy and able to reach milestones such as high school graduation and entry into the work force, higher education or military service.

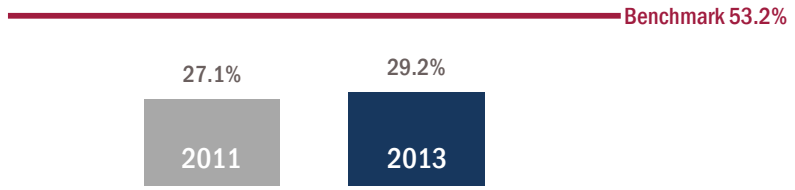
2013 data (n=97,125)

In 2013, 29.2% of adolescents ages 12-21 received a qualifying well-care visit compared to 27.1% in 2011. Some CCOs made progress with seven surpassing their improvement target.

While there has been progress in this measure, there are still improvements to be made to reach the benchmark of 53.2%.

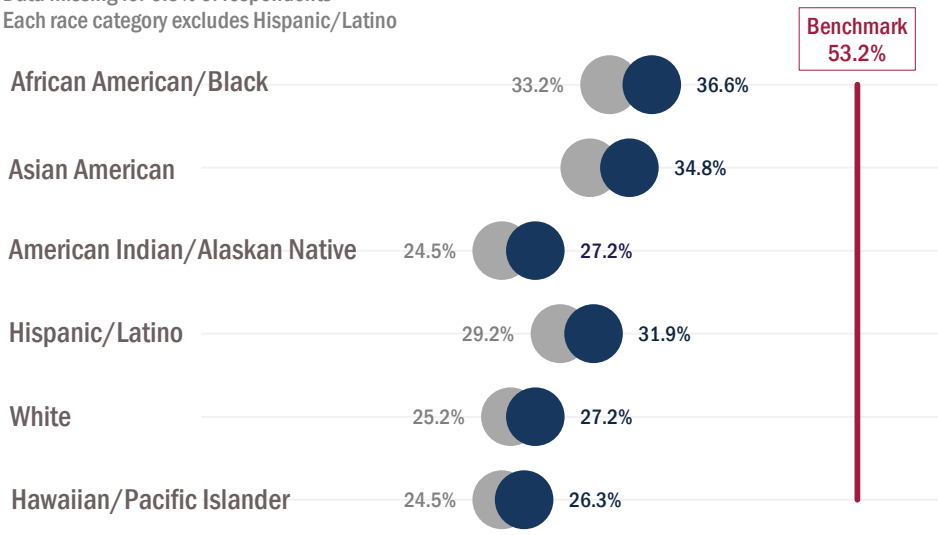
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75thh percentile (administrative data only)



Race and ethnicity data between 2011 & 2013

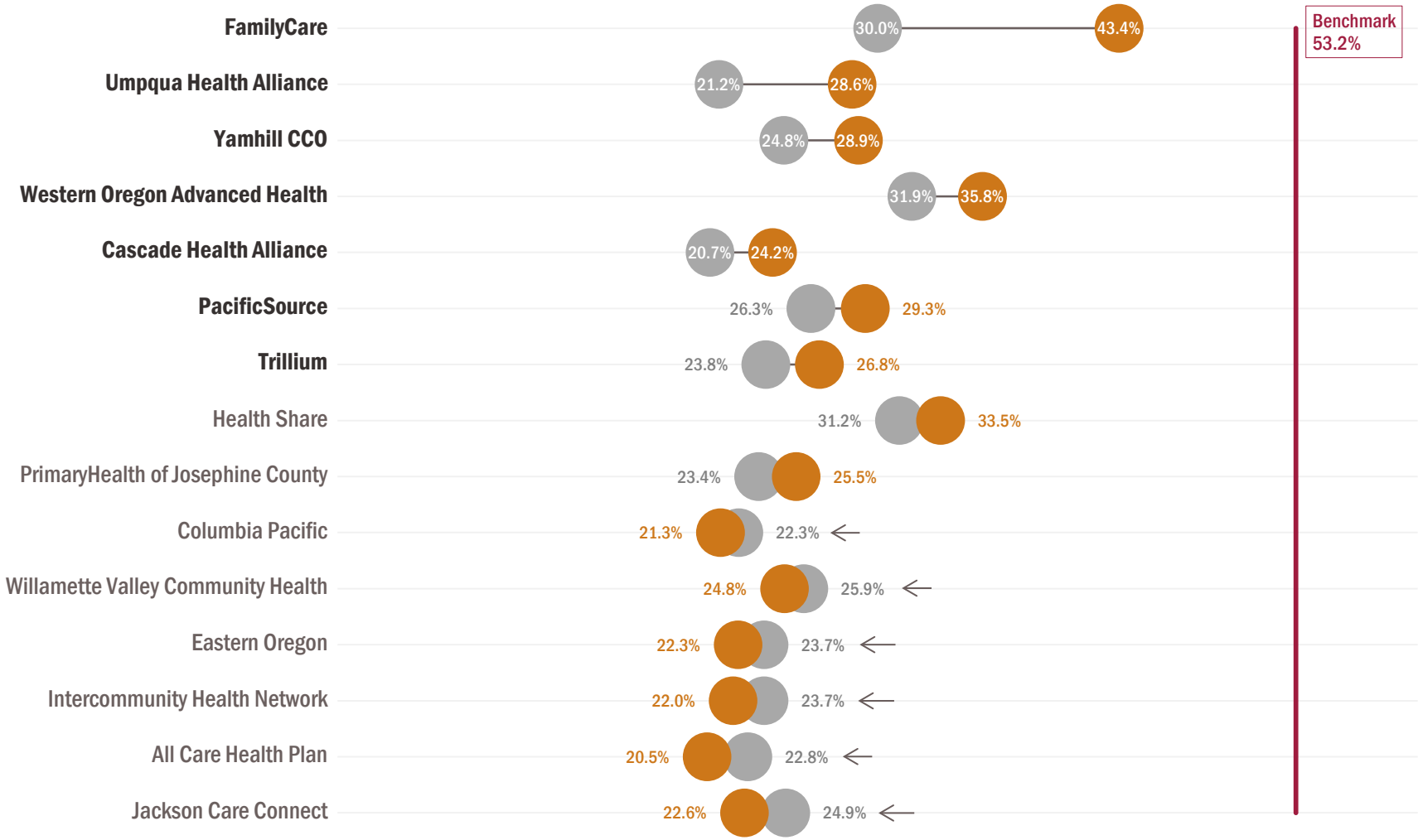
Data missing for 6.9% of respondents
Each race category excludes Hispanic/Latino



CCO Incentive and State Performance Measure

Percentage of adolescents and young adults (ages 12-21) who had at least one well-care during the last year in 2011 & 2013

Bolded names met benchmark or improvement target



CCO Incentive and State Performance Measure

Alcohol or other substance misuse (SBIRT)

Measure description: The SBIRT measure, or Screening, Brief Intervention, and Referral to Treatment, measures the percentage of adult patients (ages 18 and older) who had appropriate screening and intervention for alcohol or other substance abuse.

Purpose: By offering a simple but effective screening for alcohol or drug abuse during an office visit, providers can help patients get the care and information they need to stay healthy. If risky drinking or drug use is detected, a brief intervention, and in some cases referral, helps the patient recover more quickly and avoid serious health problems.

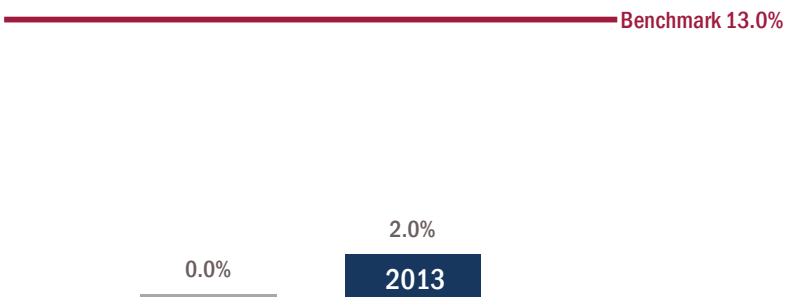
2013 data (n=200,135)

The percentage of adult patients (ages 18 and older) who had screening, brief intervention and referral for treatment (when appropriate) for alcohol or other substance abuse is a measurement where improvement is still needed across all CCOs. Providers are continuing to learn more about this measure and how to include screening in their daily practice and billing processes.

In 2011, the baseline was 0.0% for this new measure. In 2013, the statewide rate rose to 2.0%, a marked increase. Three CCOs met their improvement target, but much improvement is still possible.

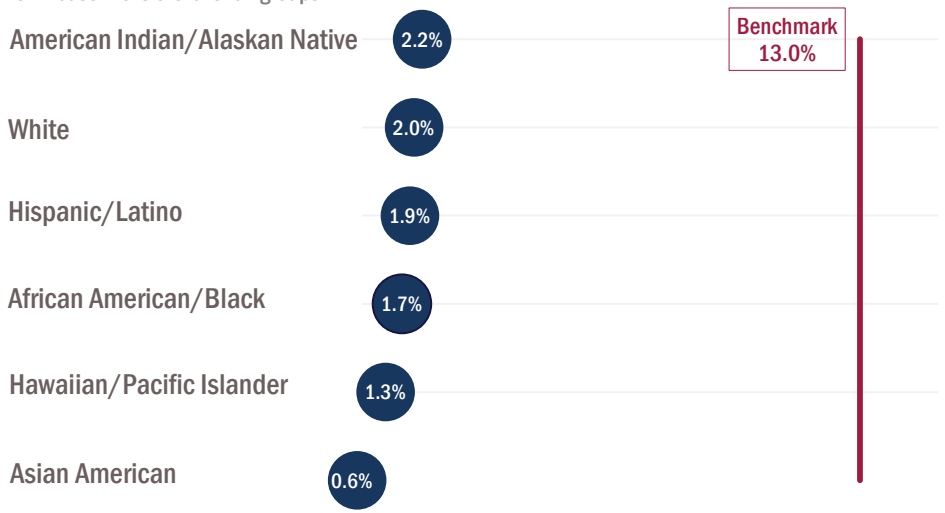
Statewide

Data source: Administrative (billing) claims
Benchmark source: Metrics and Scoring Committee consensus



Race and ethnicity data between 2011 & 2013

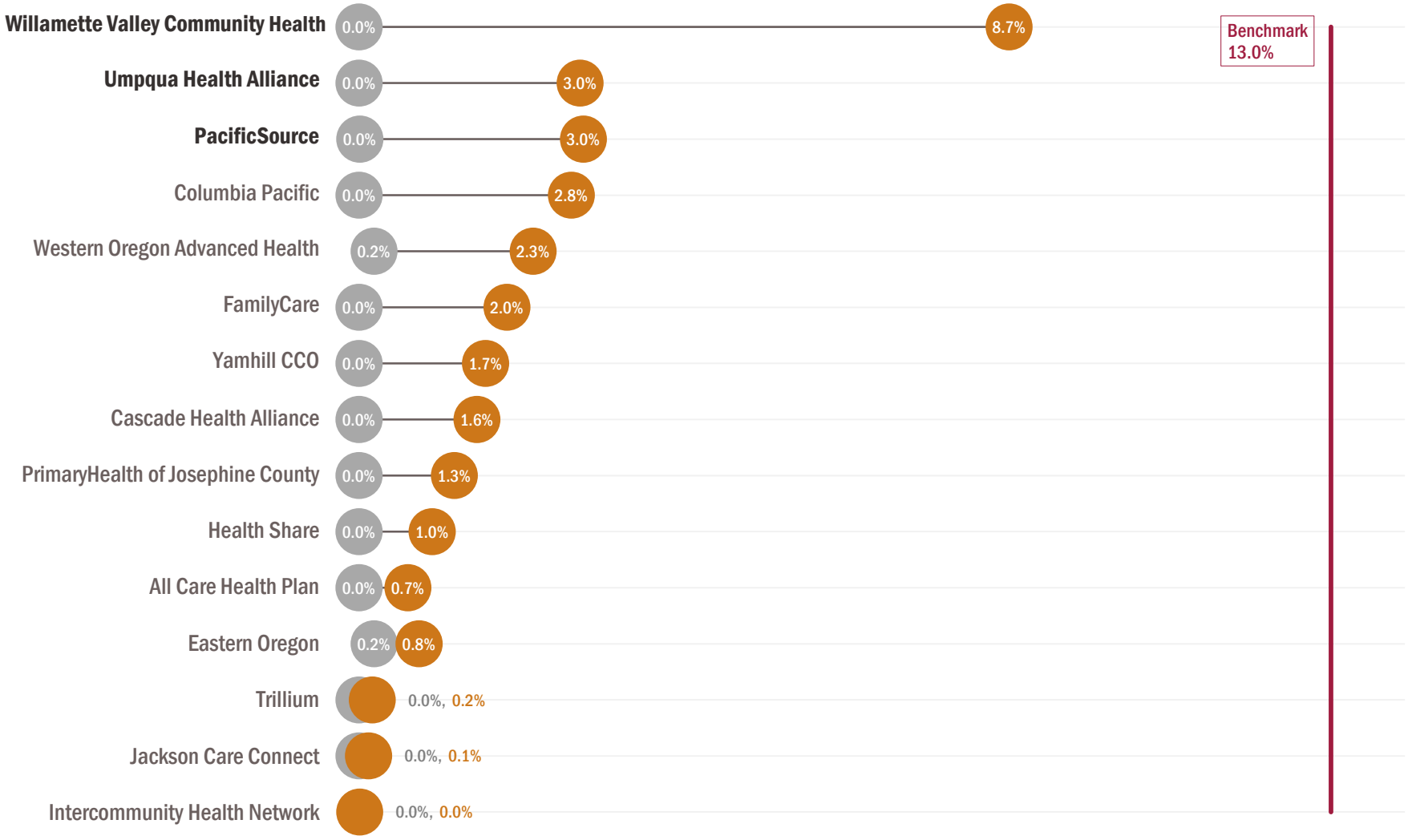
Data missing for 5.7% of respondents
Each race category excludes Hispanic/Latino
2011 baseline is 0.0% for all groups



CCO Incentive and State Performance Measure

Percentage of adult patients who had appropriate screening and intervention for alcohol or substance abuse (SBIRT) in 2011 & 2013

Bolded names met benchmark or improvement target



State Performance Measure

All-cause readmission

Measure description: Percentage of adult patients (ages 18 and older) who had a hospital stay and were readmitted for any reason within 30 days of discharge. A lower score for this measure is better.

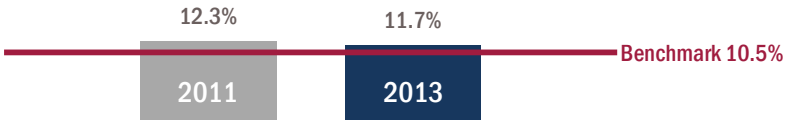
Purpose: Some patients who leave the hospital end up being admitted again shortly thereafter. Often times, these costly and burdensome "readmissions" are avoidable. Reducing the preventable problems that send patients back to the hospital is the best way to keep patients at home and healthy.

2013 data (n=19,878)

The 2013 data shows lowered (better) readmission rates. The percentage of adults who had a hospital stay and were readmitted for any reason within 30 days of discharge dropped from a 2011 baseline of 12.3% to 11.7% in 2013, a reduction of 5%.

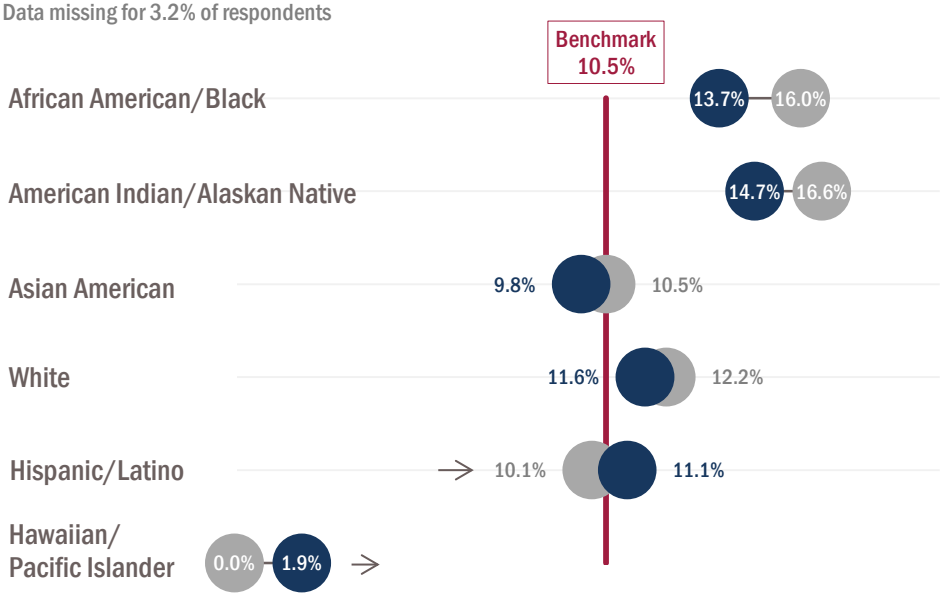
Statewide

(Lower scores are better)
Data source: Administrative (billing) claims
Benchmark source: Average of 2012 Commercial and Medicare 75th percentiles



Race and ethnicity data between 2011 & 2013

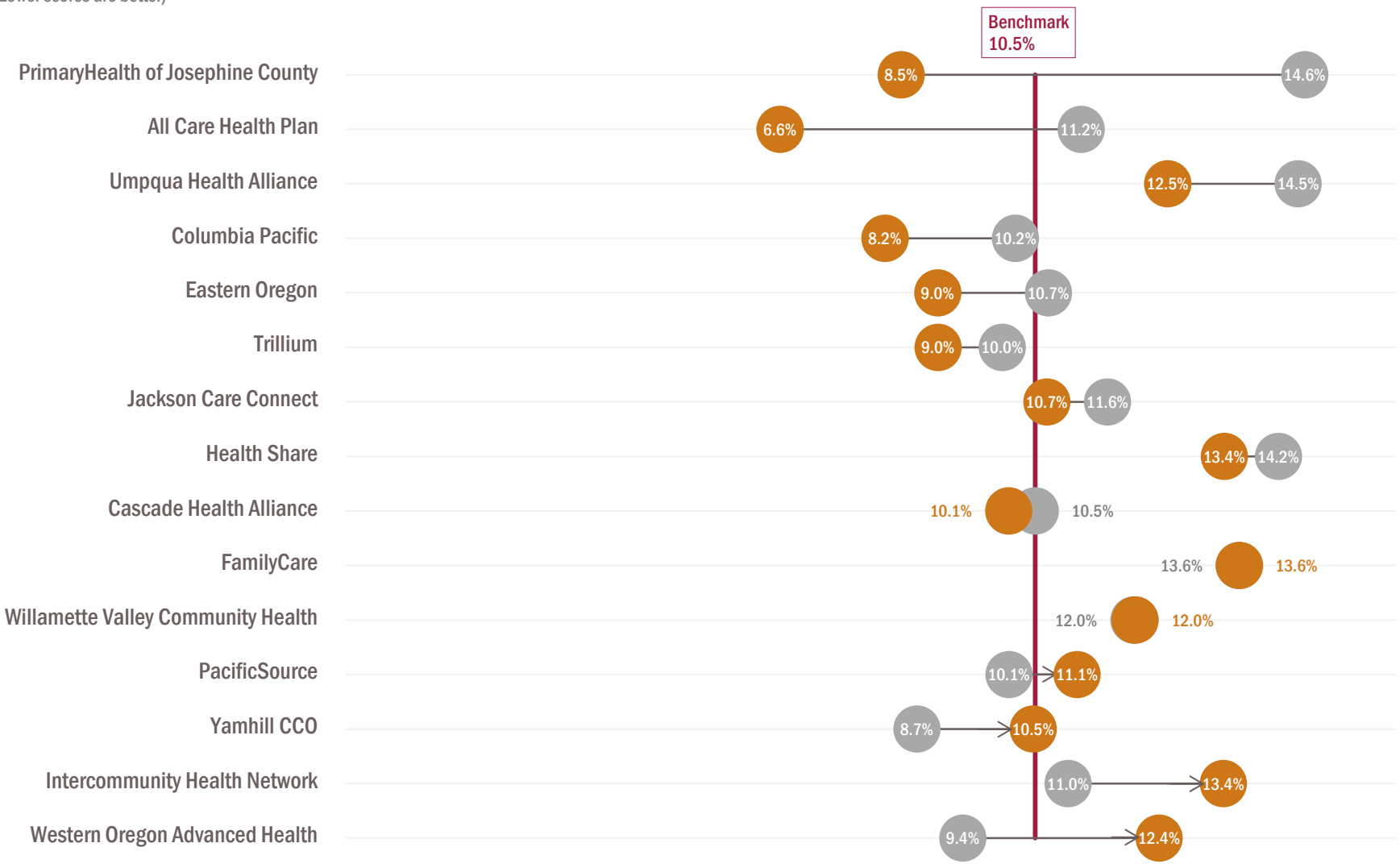
(Lower scores are better)
Data missing for 3.2% of respondents



State Performance Measure

Percentage of adult patients who had a hospital stay and were readmitted for any reason with 30 days of discharge in 2011 & 2013

(Lower scores are better)



CCO Incentive and State Performance Measure

Ambulatory care: emergency department utilization

Measure description: Rate of patient visits to an emergency department. Rates are reported per 1,000 member months and a lower number suggests more appropriate use of this care.

Purpose: Emergency departments are sometimes used for problems that could have been treated at a doctor's office or urgent care clinic. Reducing inappropriate emergency department use can help to save costs and improve the health care experience for patients.

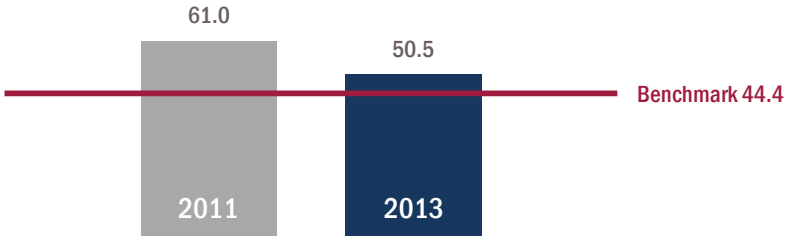
2013 data (n=6,476,701 member months)

This metric represents emergency department visits that occurred in 2013. Emergency department visits by people served by CCOs have decreased 17% since 2011 baseline data. Financial data (starting on page 81) is consistent in showing reduced emergency department visits.

All 15 CCOs met their improvement target on this measure showing a strong trend toward fewer emergency department visits and more coordinated care.

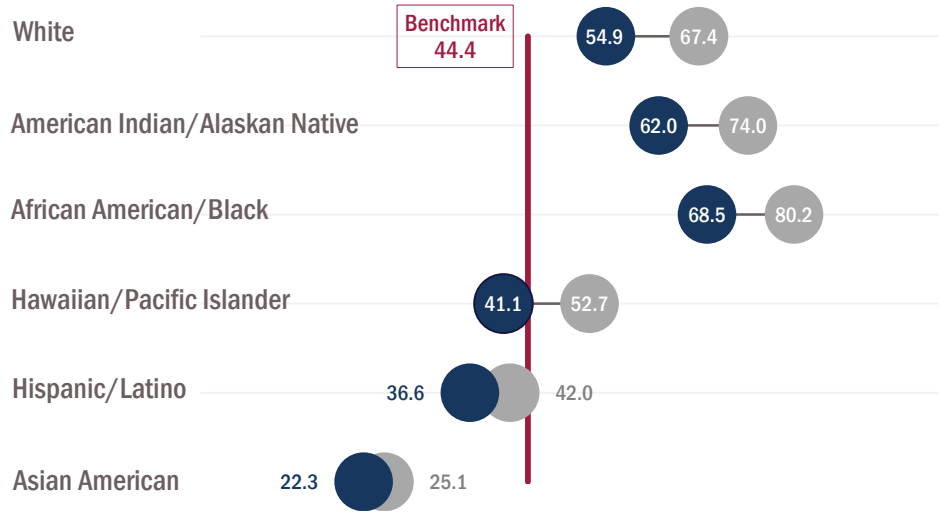
Statewide

(Lower scores are better)
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile



Race and ethnicity data between 2011 & 2013

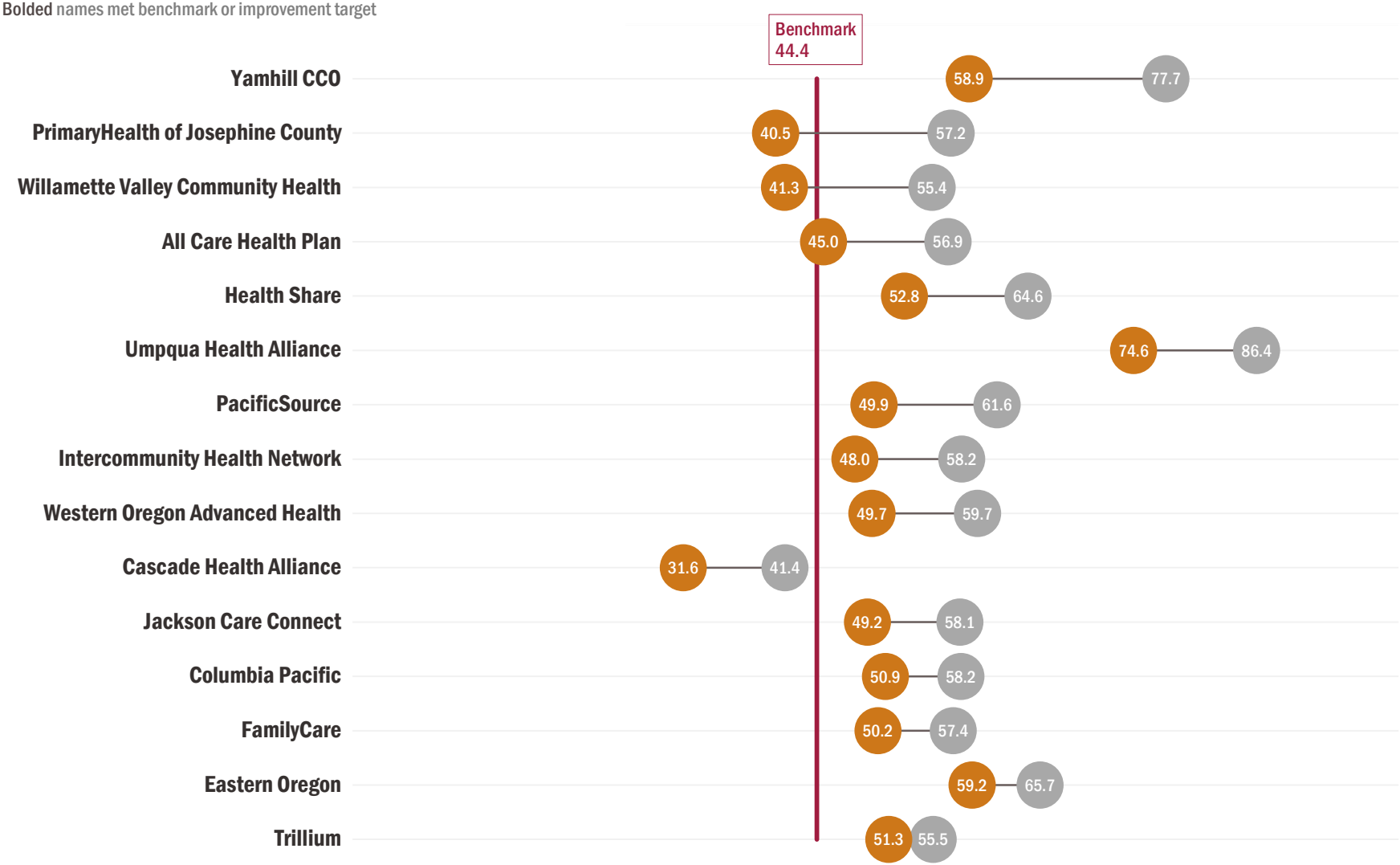
(Lower scores are better)
Data missing for 7.4% of respondents
Each race category excludes Hispanic/Latino



CCO Incentive and State Performance Measures

Rate of patient visits to an emergency department in 2011 & 2013

(Lower scores are better)
Bolded names met benchmark or improvement target



State Performance Measure

Ambulatory care: outpatient utilization

Measure description: Rate of outpatient services, such as office visits, home visits, nursing home care, urgent care and counseling or screening services. Rates are reported per 1,000 member months.

Purpose: Promoting the use of outpatient settings like a doctor's office or urgent care clinic is part of Oregon's goal of making sure patients are getting the right care in the right places and at the right times. Increasing the use of outpatient care helps improve health and lower costs by promoting prevention and keeping down rates of unnecessary emergency department use

2013 data (n=6,476,701 member months)

This metric represents outpatient visits that include office visits or routine visits to hospital outpatient departments, visits to primary care and specialists, as well as home and nursing home visits by people served by CCOs in 2013.

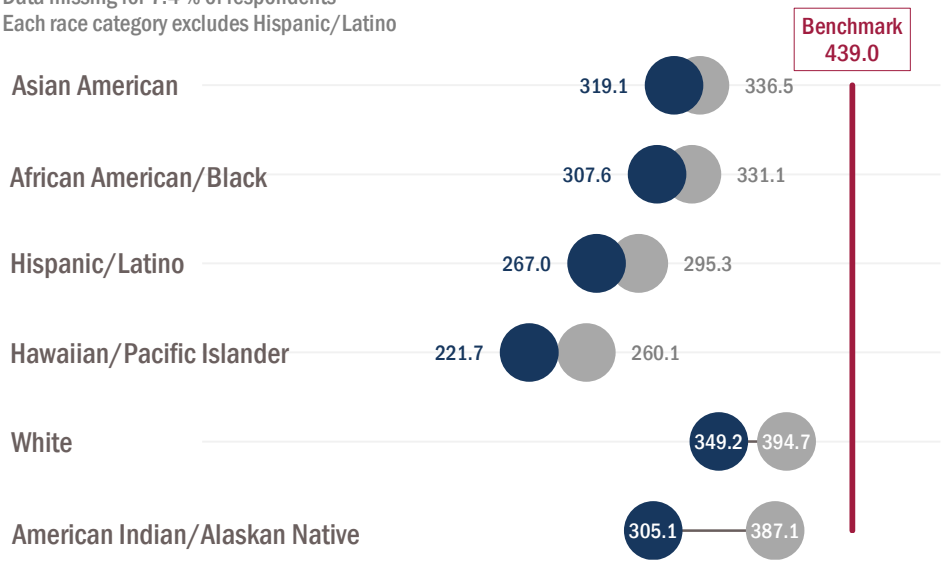
This metric shows a trend toward fewer outpatient visits; however, the financial data shown in this report point toward an increase in primary care visits.

Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

Race and ethnicity data between 2011 & 2013

Data missing for 7.4 % of respondents
Each race category excludes Hispanic/Latino

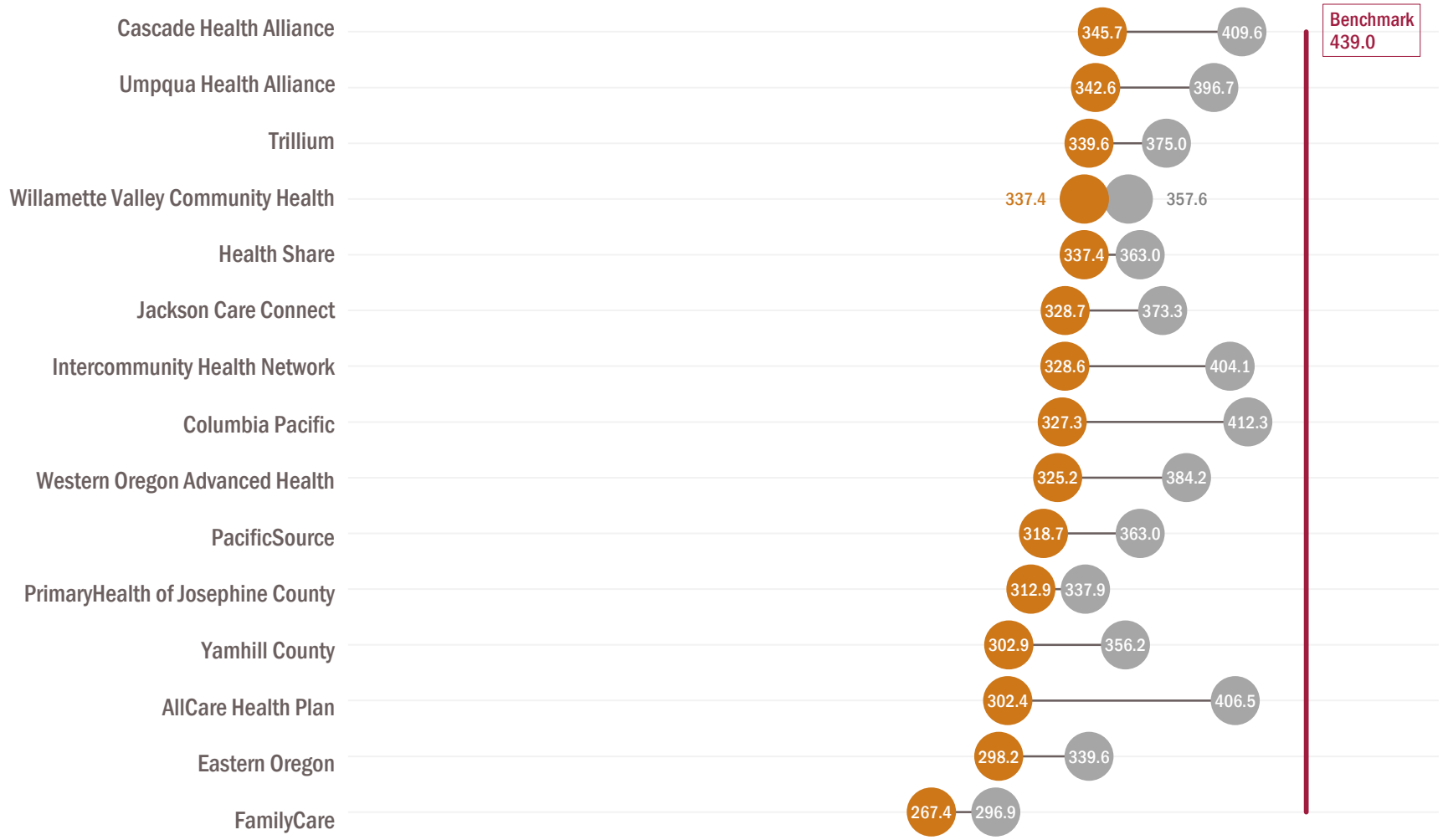


AMBULATORY CARE: OUTPATIENT UTILIZATION

State Performance Measure

Rate of patient visits to a doctor's office or urgent care in 2011 & 2013

Rates are reported per 1,000 member months



State Performance Measure

Appropriate testing for children with pharyngitis

Measure description: Percentage of children with a sore throat (pharyngitis) who were given a strep test before getting an antibiotic.

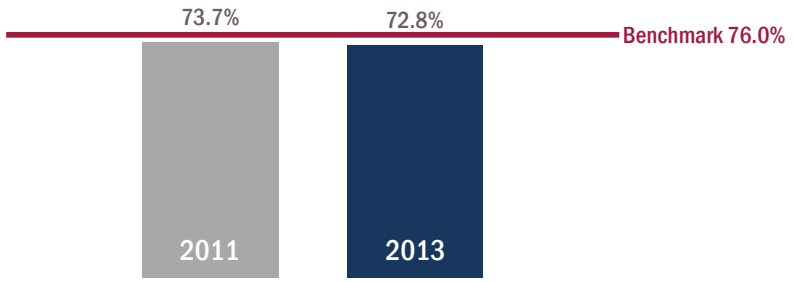
Purpose: A strep test helps determine whether or not a child will benefit from antibiotics for a sore throat (pharyngitis).This test can help reduce the overuse of antibiotics, which can improve care quality and ensure that antibiotics continue to work when they are needed.

2013 data (n=6,602)

This metric tracks the percentage of children with a sore throat (pharyngitis) who had a strep test before being prescribed antibiotics. The 2013 data is comparable to the 2011 baseline.

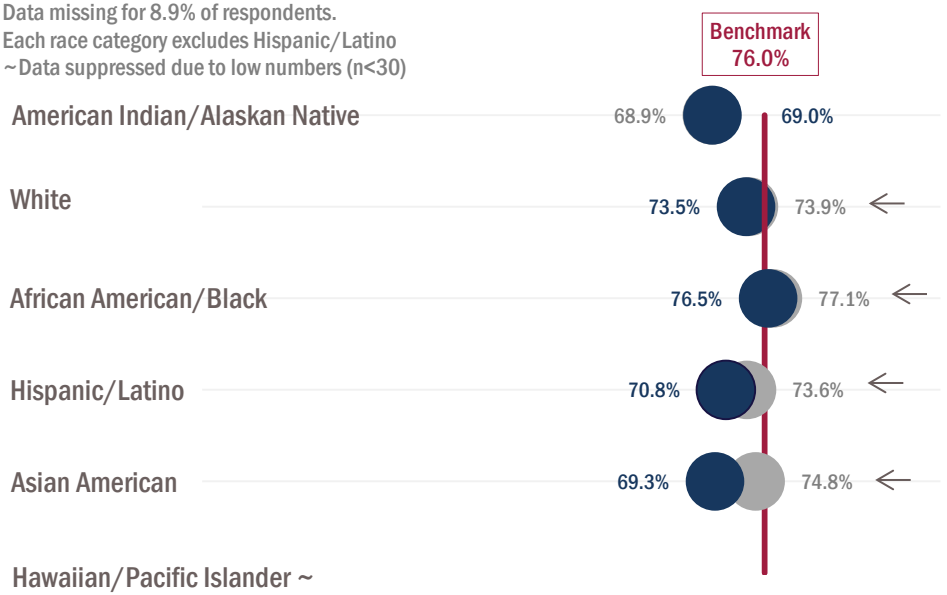
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile



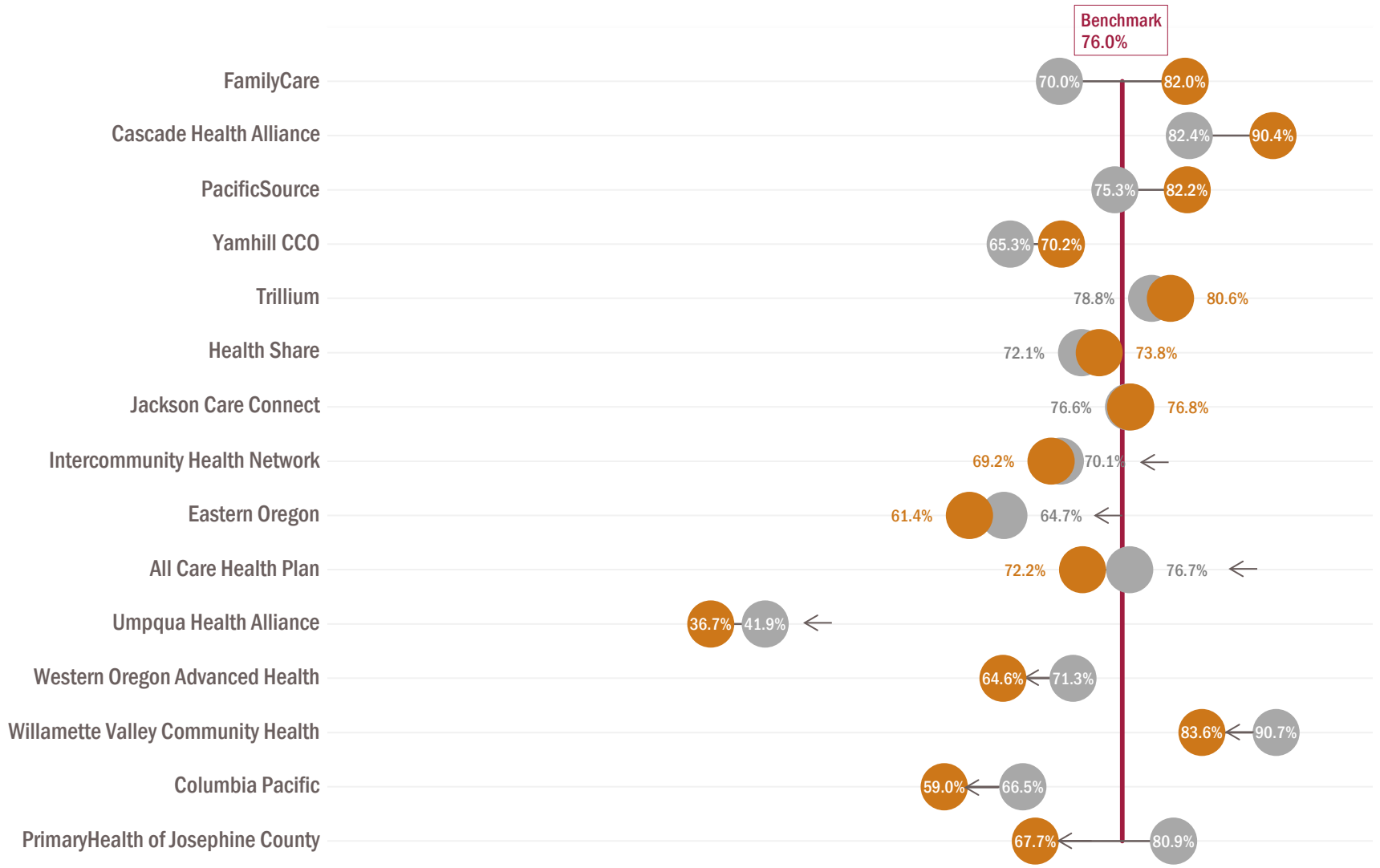
Race and ethnicity data between 2011 & 2013

Data missing for 8.9% of respondents.
Each race category excludes Hispanic/Latino
~Data suppressed due to low numbers (n<30)



State Performance Measure

Percentage of children with a sore throat who were given a strep test before getting an antibiotic in 2011 & 2013



State Performance Measure

Cervical cancer screening

Measure description: Percentage of women patients (ages 21 to 64) who got one or more Pap tests for cervical cancer during the past three years.

Purpose: A Pap test helps find early signs of cancer in the cervix when the disease is easier and less costly to treat. Treating cervical cancer in its earliest stages also increases the five-year survival rate to 92 percent, according to the American Cancer Society.

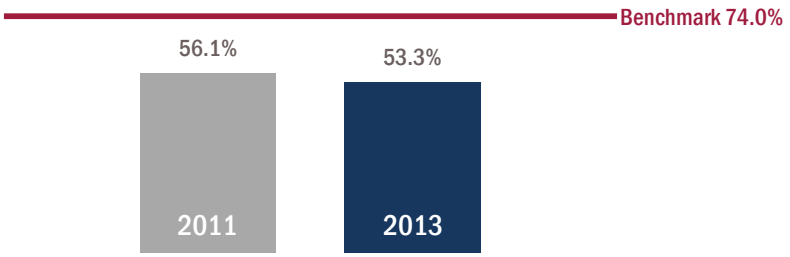
2013 data (n=71,364)

This metric tracks the percentage of women (ages 21 to 64) who had one or more Pap tests for cervical cancer in the past three years.

The 2013 data shows there is room for further development and attention for cervical cancer screening. The 2013 percentage is lower than the percentage of women screened in 2011. The lowered screening rates may be due to a number of factors including national guideline changes reported in 2012 for cervical cancer screening.

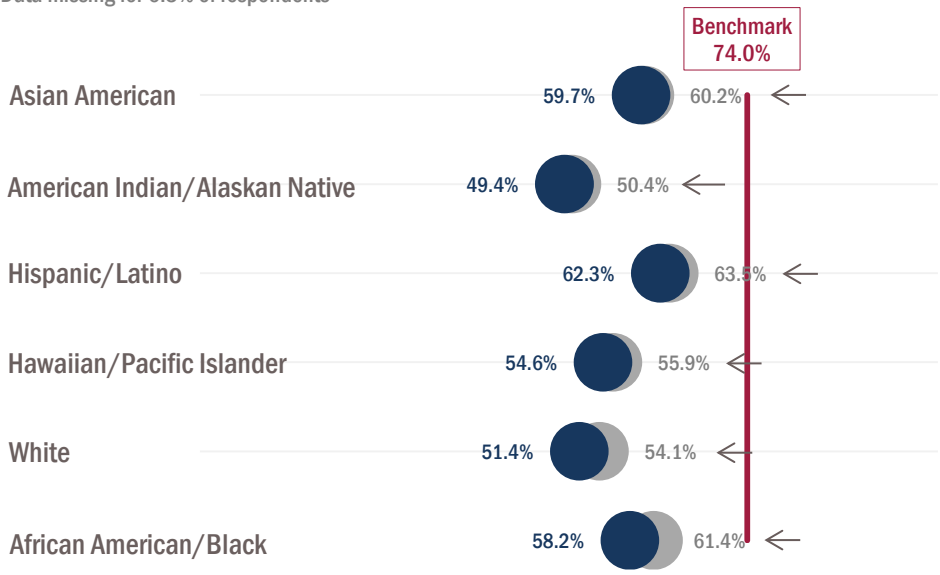
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile



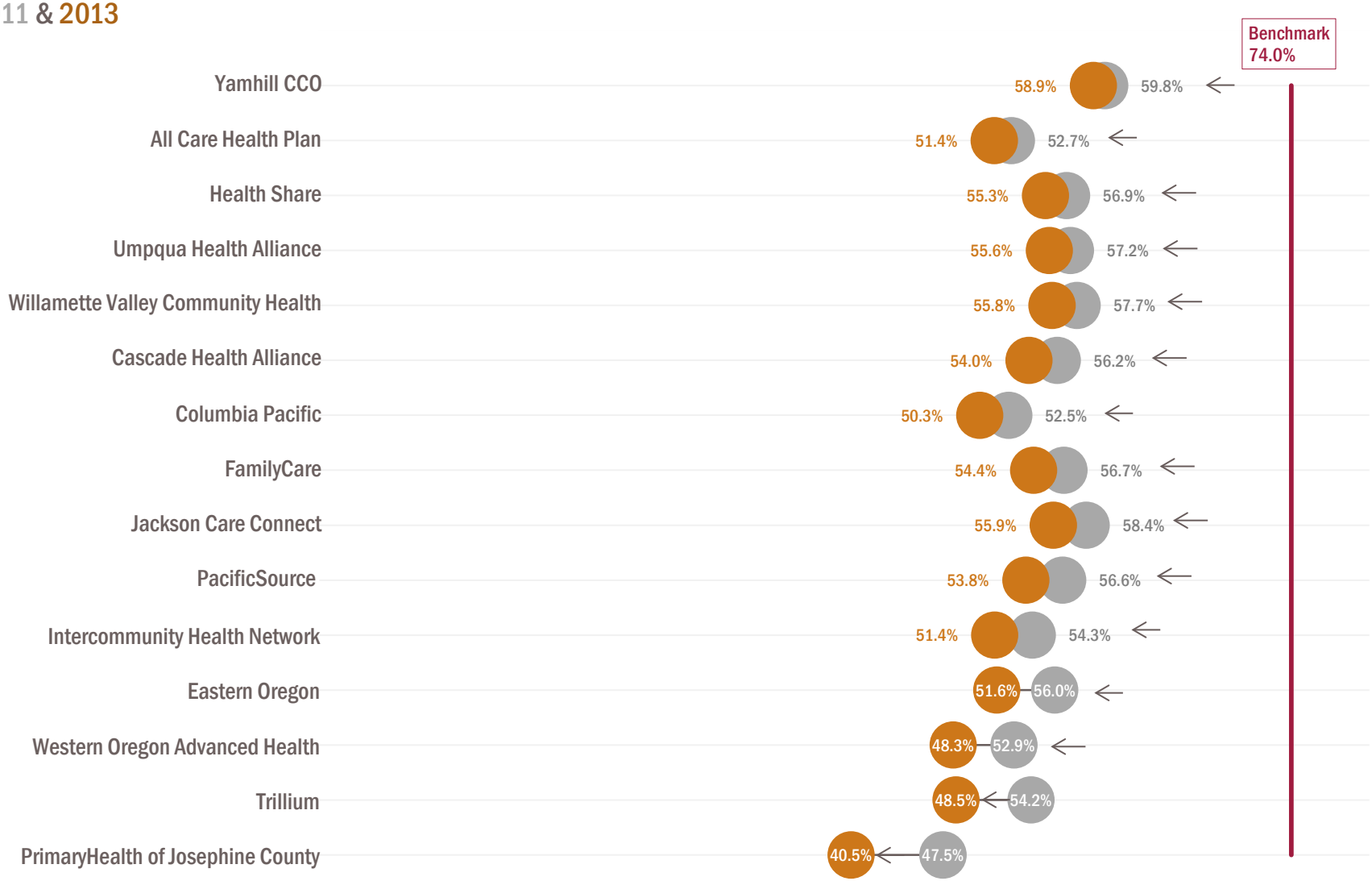
Race and ethnicity data between 2011 & 2013

Data missing for 6.3% of respondents



State Performance Measure

Percentage of women patients (age 21 to 64) who got one or more Pap tests for cervical cancer in the past three years in 2011 & 2013



State Performance Measure

Childhood and adolescent access to primary care providers (all ages)

Measure description: Percentage of children and adolescents (ages 12 months – 19 years) who had a visit with a primary care provider.

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

2013 data (n=283,928)

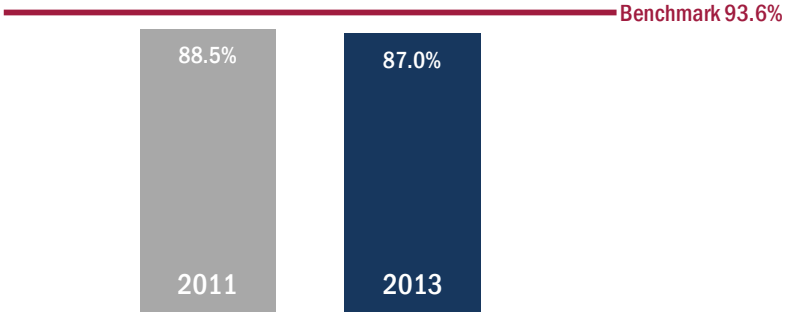
This measure tracks child and adolescent access to primary care providers by measuring the percentage of children who had a visit with a primary care provider during the last year. The measure is split into five categories: all ages, 12-24 months, 26 months - 6 years, 7-11 years, and 12-19 years.

This set of measures shows an area with an opportunity for improvement. In 2013 statewide, there was not improvement on these measures when compared to 2011.

This measure cannot be reported at the CCO level for 2013.

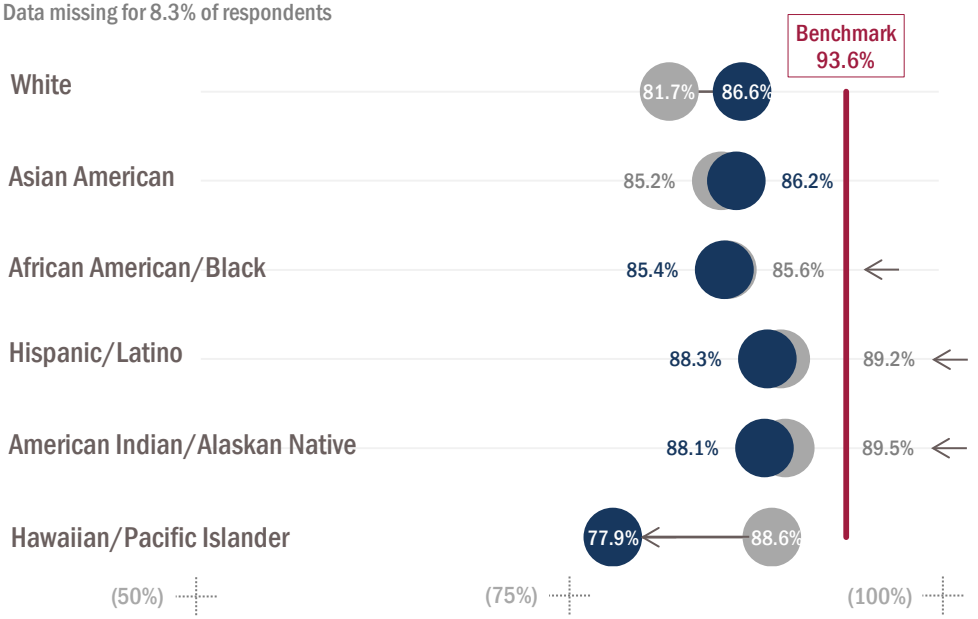
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 75th percentile (average of the four age breakouts for this measure)



Race and ethnicity data between 2011 & 2013

Data missing for 8.3% of respondents



State Performance Measure

Childhood and adolescent access to primary care providers (12 - 24 months)

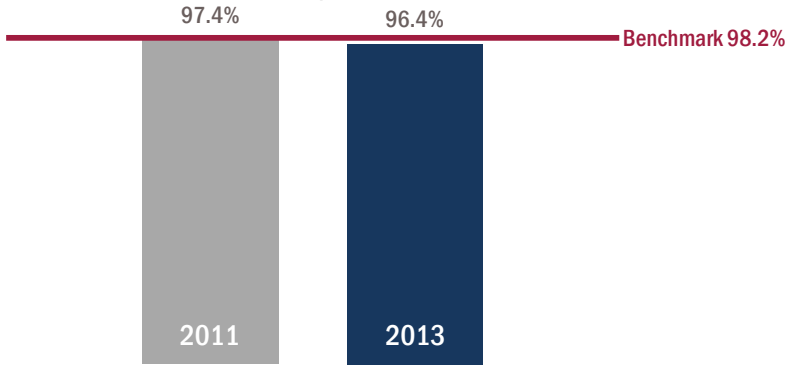
Measure description: Percentage of children and adolescents (ages 12- 24 months) who had a visit with a primary care provider.

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

2013 data (n=21,184)

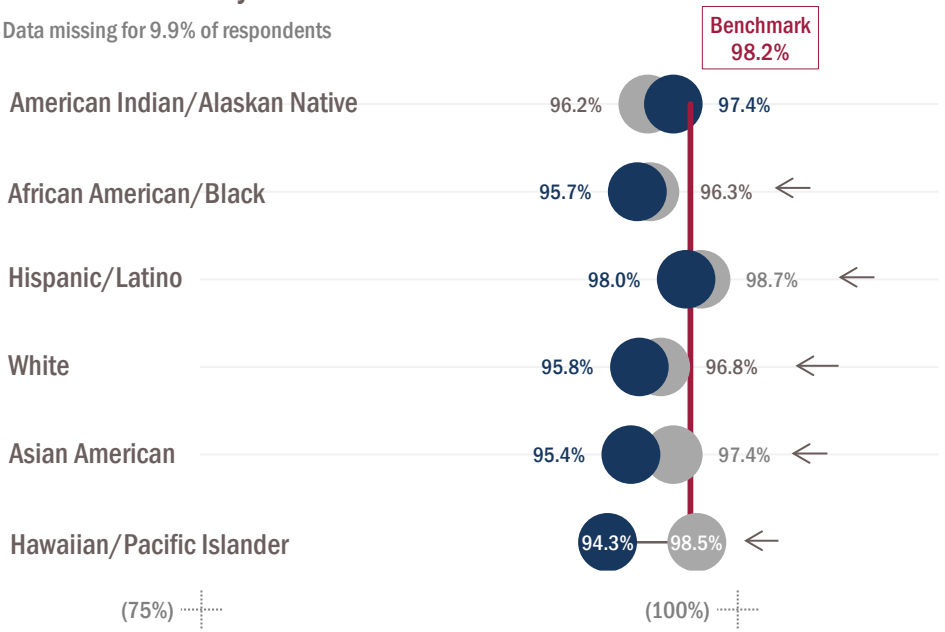
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 75th percentile



Race and ethnicity data between 2011 & 2013

Data missing for 9.9% of respondents



State Performance Measure

Childhood and adolescent access to primary care providers (25 months - 6 years)

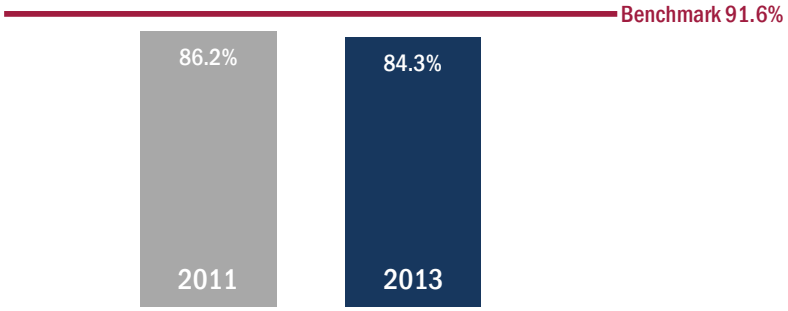
Measure description: Percentage of children and adolescents (ages 25 months – 6 years) who had a visit with a primary care provider.

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

2013 data (n=96,722)

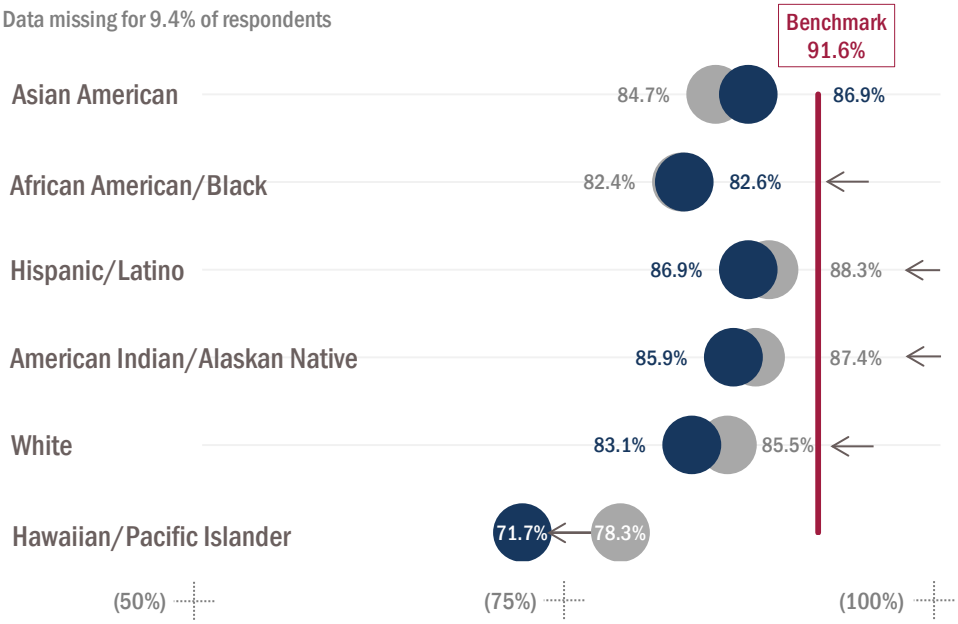
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 75th percentile



Race and ethnicity data between 2011 & 2013

Data missing for 9.4% of respondents



State Performance Measure

Childhood and adolecsent access to primary care providers (7 - 11 years)

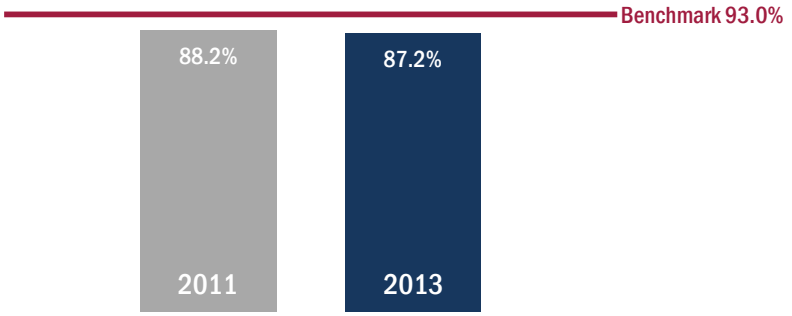
Measure description: Percentage of children and adolescents (ages 7 - 11 years) who had a visit with a primary care provider.

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

2013 data (n=75,393)

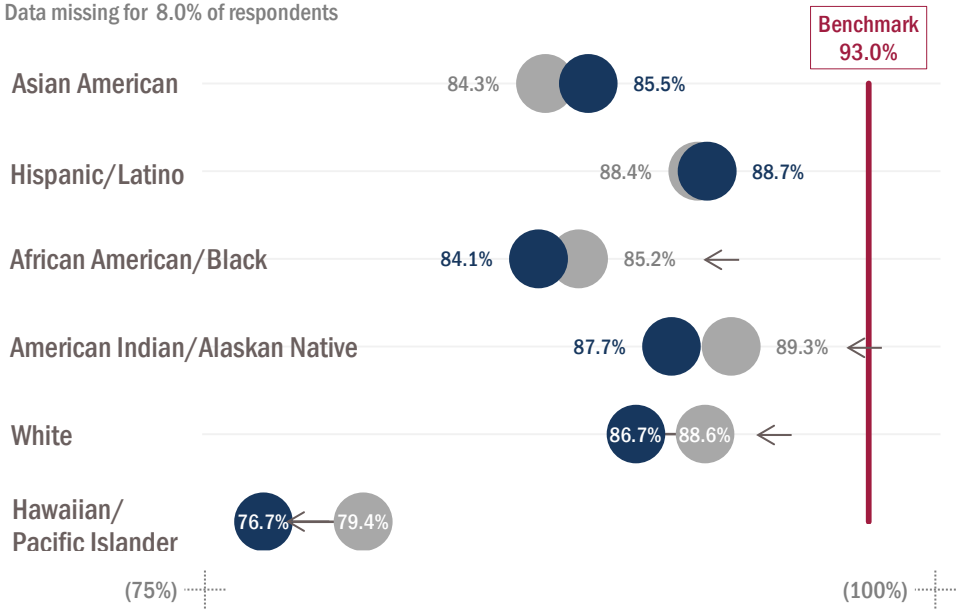
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 75th percentile



Race and ethnicity data between 2011 & 2013

Data missing for 8.0% of respondents



State Performance Measure

Childhood and adolescent access to primary care providers (12 - 19 years)

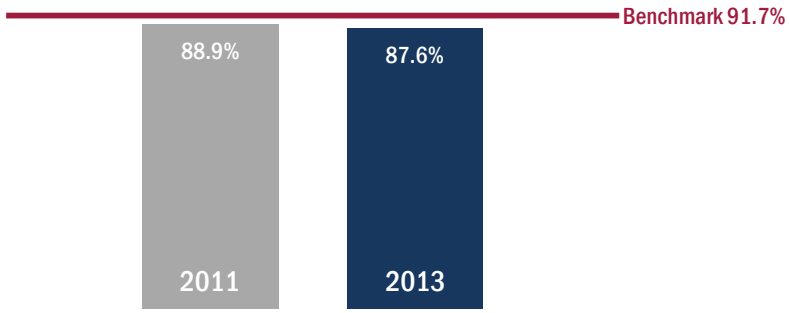
Measure description: Percentage of children and adolescents (ages 12 - 19 years) who had a visit with a primary care provider.

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

2013 data (n=90,629)

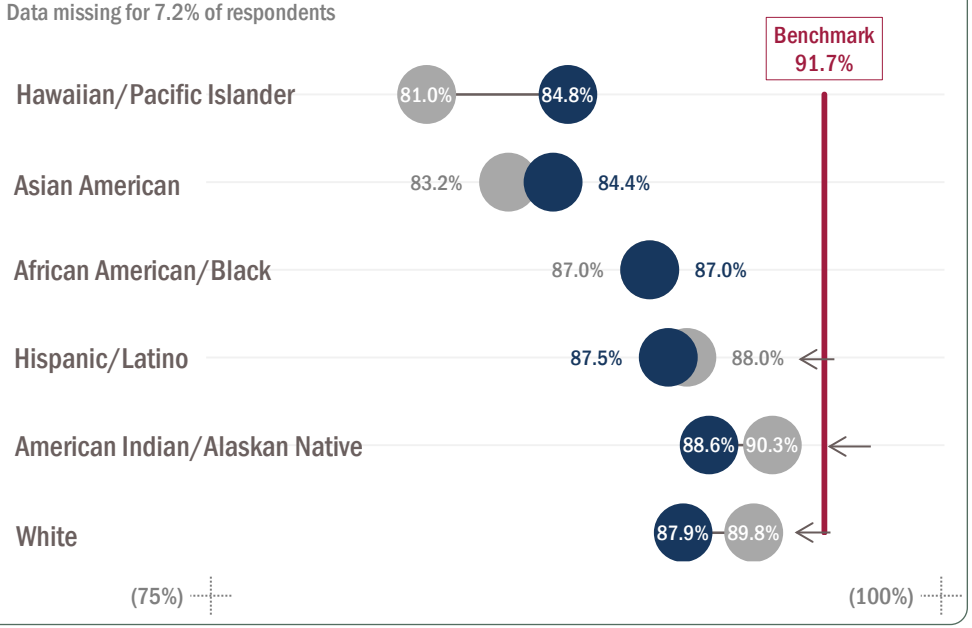
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 75th percentile



Race and ethnicity data between 2011 & 2013

Data missing for 7.2% of respondents



State Performance Measure

Childhood immunization status

Measure description: Percentage of children who received recommended vaccines before their 2nd birthday.

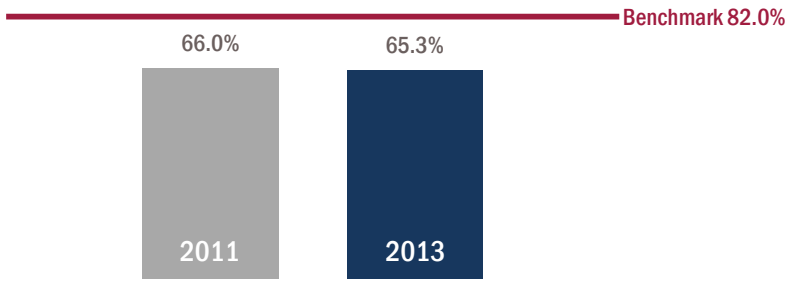
Purpose: Vaccines are one of the safest, easiest and most effective ways to protect children from potentially serious diseases. Vaccines are also cost-effective tools that help to prevent the spread of serious diseases which can sometimes lead to widespread public health threats.

2013 data (n=7,581)

This metric tracks the percentage of children who received their recommended vaccines before their 2nd birthday. The 2013 data shows mixed results. While some CCOs improved the percentage of children up to date on immunizations, the statewide rate is slightly lower than 2011.

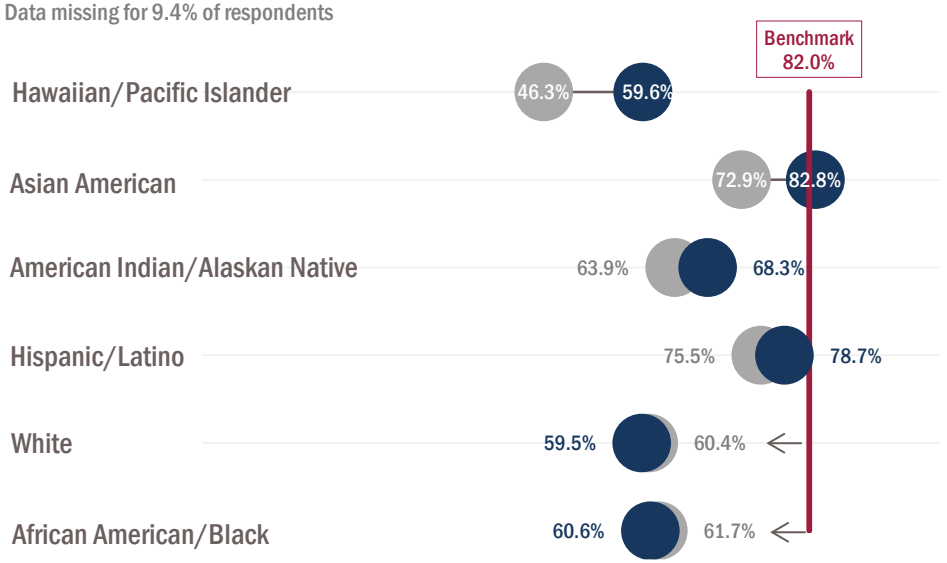
Statewide

Data source: Administrative (billing) claims and ALERT Immunization Information System
Benchmark source: 2012 National Medicaid 75th percentile



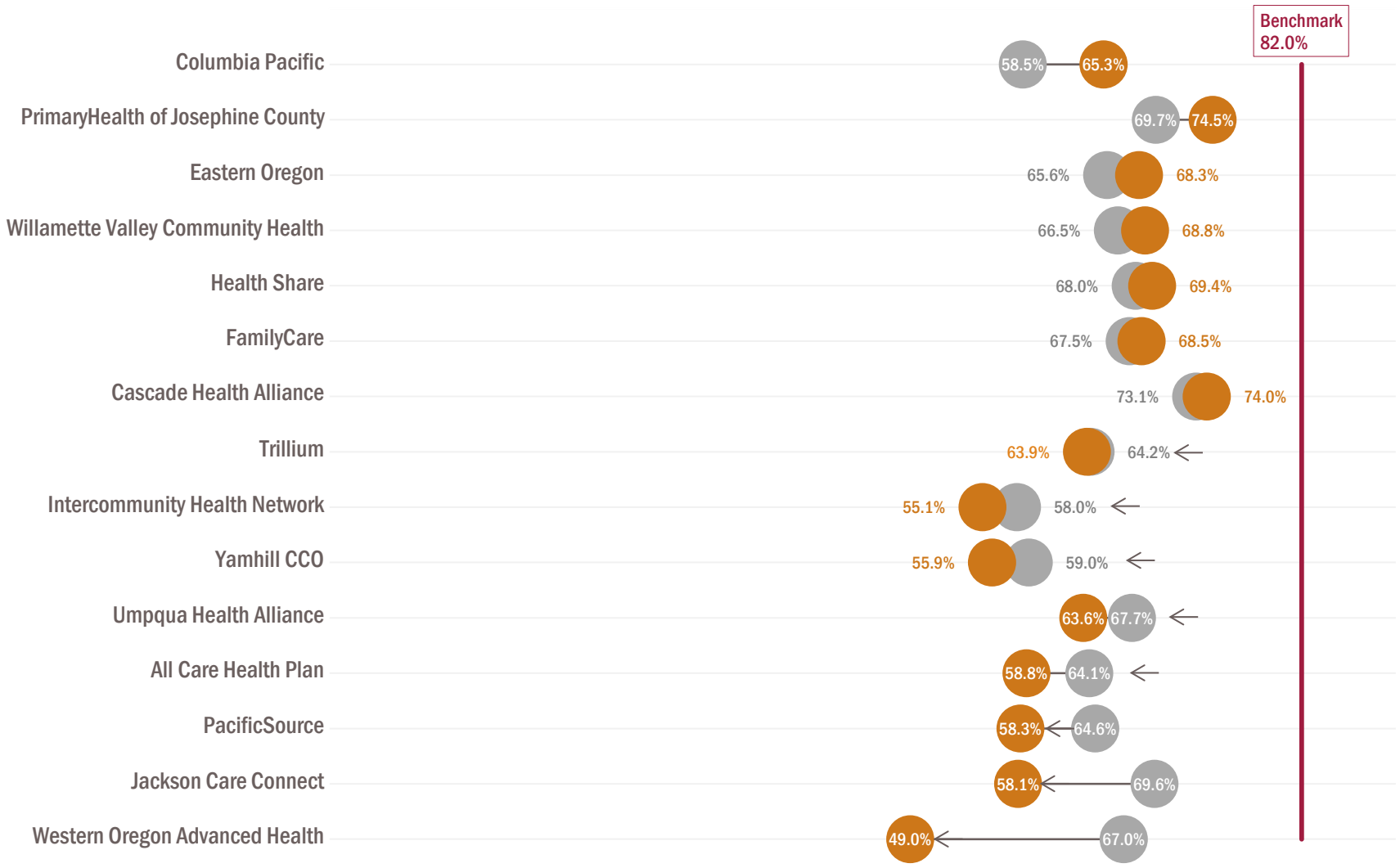
Race and ethnicity data between 2011 & 2013

Data missing for 9.4% of respondents



State Performance Measure

Percentage of children who received recommended vaccines before their 2nd birthday in 2011 & 2013



State Performance Measure

Chlamydia screening in women ages 16-24

Measure description: Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection.

Purpose: Chlamydia is the most common reportable illness in Oregon. Since there are usually no symptoms, routine screening is important to find the disease early so that it can be treated and cured with antibiotics. If chlamydia is not found and treated, it can lead to pelvic inflammatory disease, which can cause infertility.

2013 data (n=18,636)

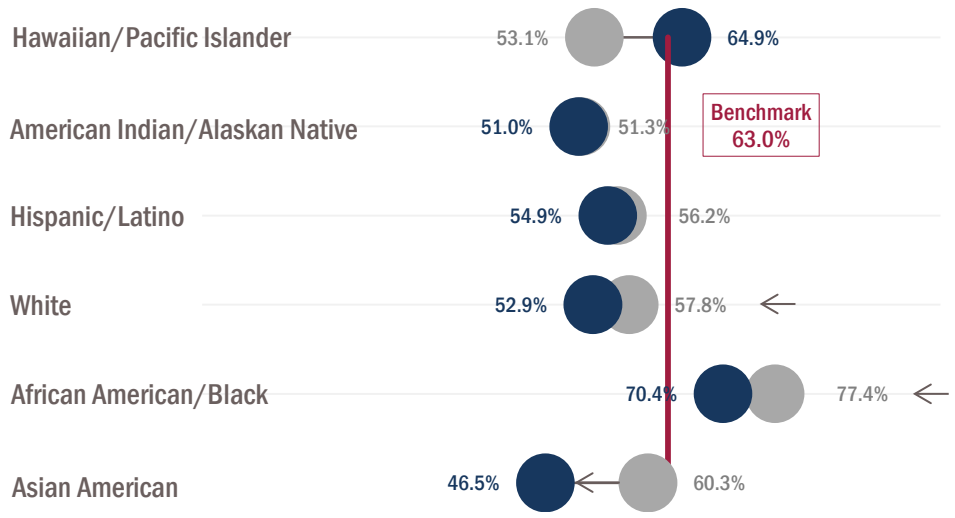
This metric tracks the percentage of sexually active women ages 16-24 who were tested for chlamydia infection. The 2013 data show a decrease in chlamydia screening across the state when compared to 2011.

Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile

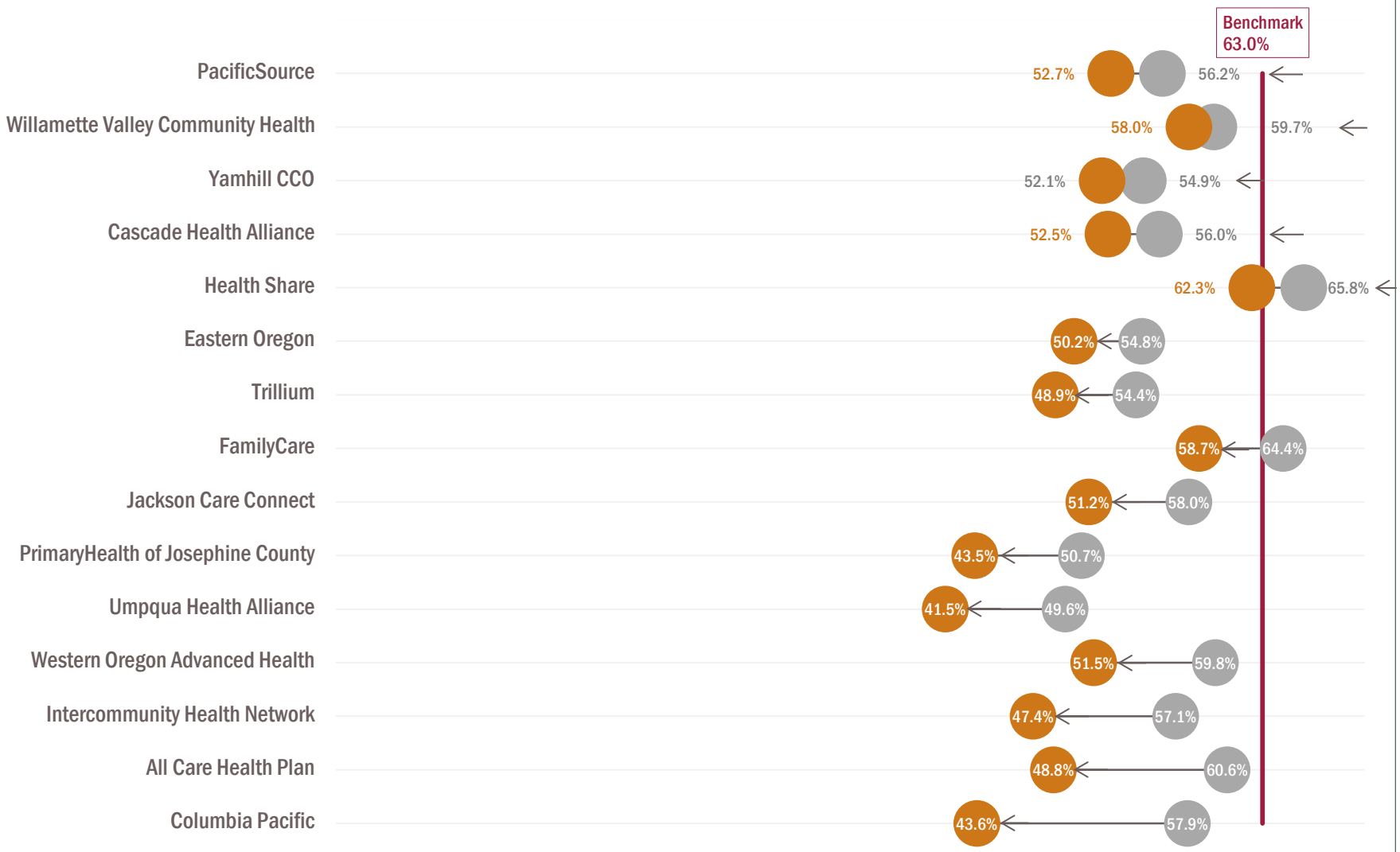
Race and ethnicity data between 2011 & 2013

Data missing for 7.8% of respondents



State Performance Measure

Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection in 2011 & 2013



CCO Incentive and State Performance Measure

Colorectal cancer screening

Measure description: Rate of adult patients (ages 50-75) who had appropriate screenings for colorectal cancer during the measurement year. Rates are reported per 1,000 member months.

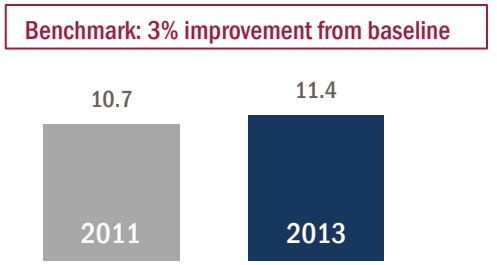
Purpose: Colorectal cancer is Oregon's second leading cause of cancer deaths. With appropriate screening, abnormal growths in the colon can be found and removed before they turn into cancer. Colorectal cancer screening saves lives, while also keeping overall health care costs down.

2013 data (n=648,070 member months)

The colorectal cancer screening metric represents screenings that have occurred in 2013 for eligible members (those between 50 and 75 years of age). In 2013, the colorectal cancer screening rate was 11.4 screenings per 1,000 member months, an increase from 10.7 in 2011. Overall, six CCOs exceeded their improvement target.

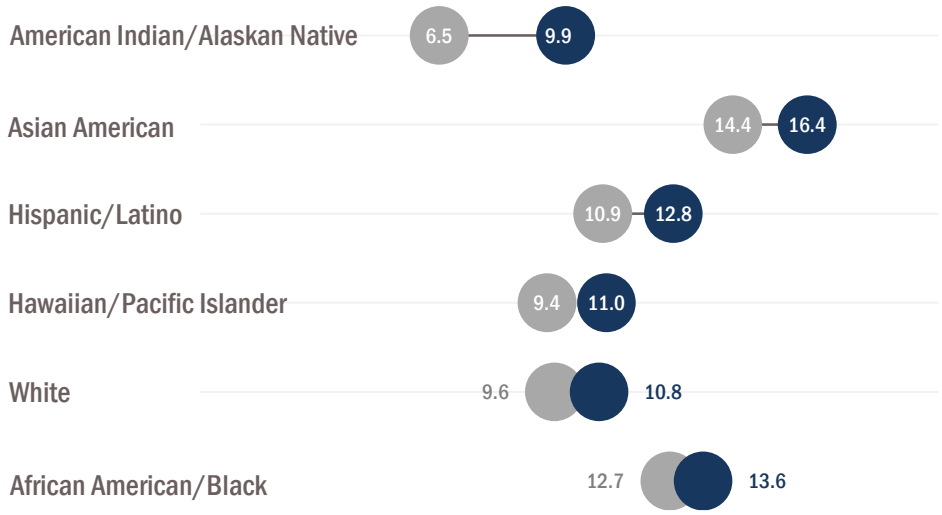
Statewide

Data source: Administrative (billing) claims
Benchmark source: Metrics and Scoring Committee consensus



Race and ethnicity data between 2011 & 2013

Data missing for 2.1% of respondents



CCO Incentive and State Performance Measure

Rate of adult patients who had appropriate screenings for colorectal cancer during the measurement year in 2011 & 2013

Bolded names met invidvidual benchmark (3% above baseline)
Rates are per 1,000 member months

State Performance Measure

Comprehensive diabetes care: HbA1c testing

Measure description: Percentage of adult patients (ages 18-75) with diabetes who received at least one A1c blood sugar test.

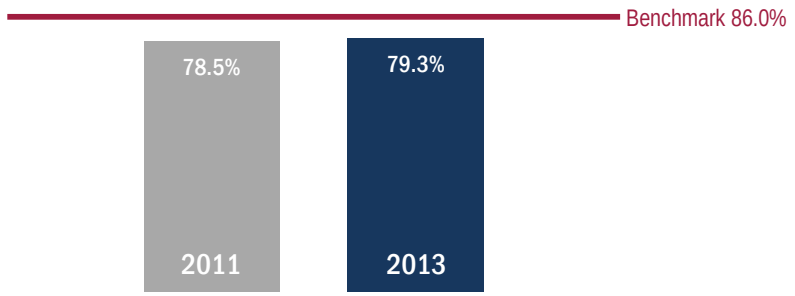
Purpose: Controlling blood sugar levels is important to help people with diabetes manage their disease. It is also a key way to assess the overall effectiveness of diabetes care in Oregon. By improving the quality of care for diabetes, Oregon can help patients avoid complications and hospitalizations that lead to poor health and high costs.

2013 data (n=20,105)

This metric tracks the percentage of adult patients with diabetes who received at least one A1c blood sugar test during 2013. The 2013 data is comparable to baseline.

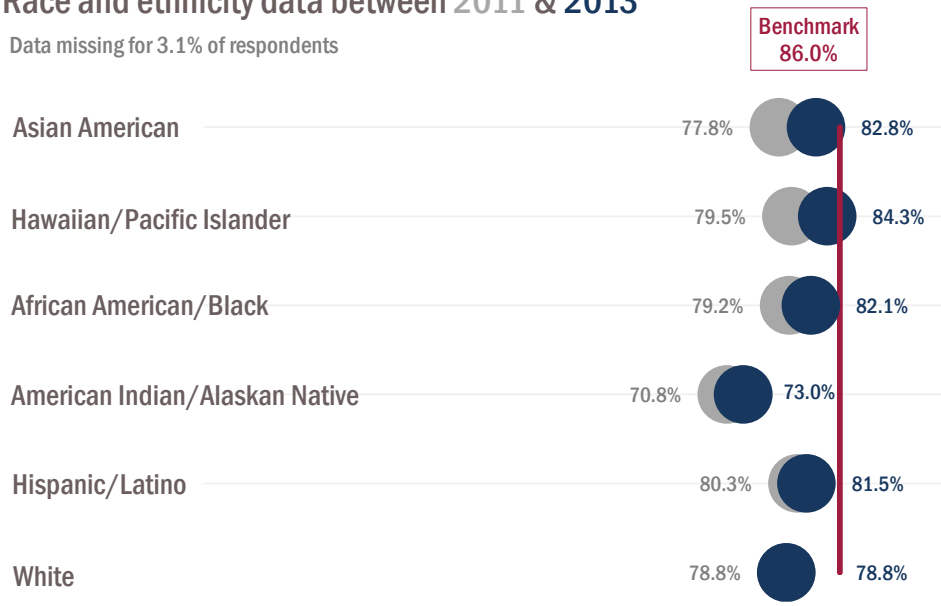
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile



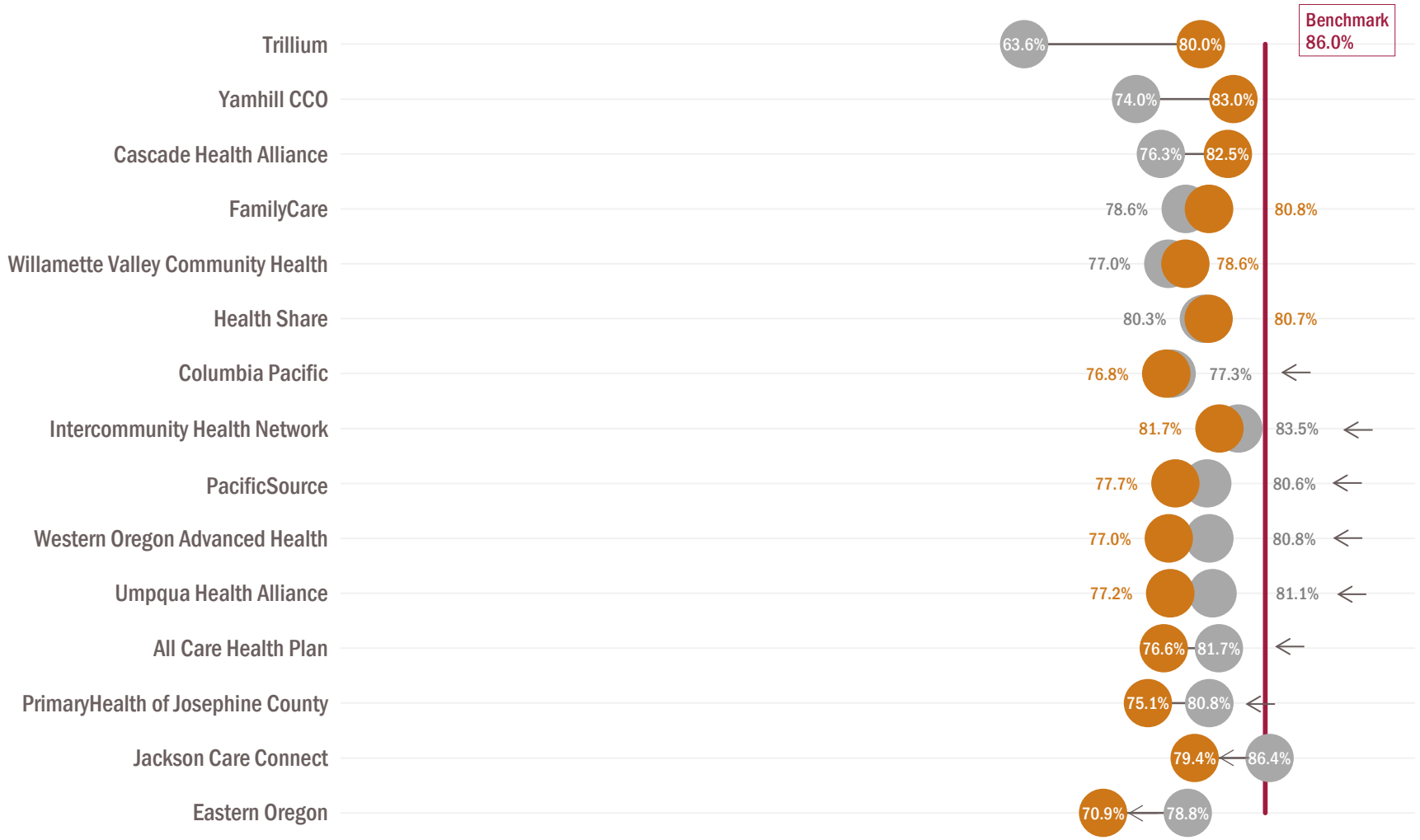
Race and ethnicity data between 2011 & 2013

Data missing for 3.1% of respondents



State Performance Measure

Percentage of adult patients with diabetes who received at least one A1c blood sugar test in 2011 & 2013



State Performance Measure

Comprehensive diabetes care: LDL-C screening

Measure description: Percentage of adult patients (ages 18-75) with diabetes who received an LDL-C (cholesterol) test.

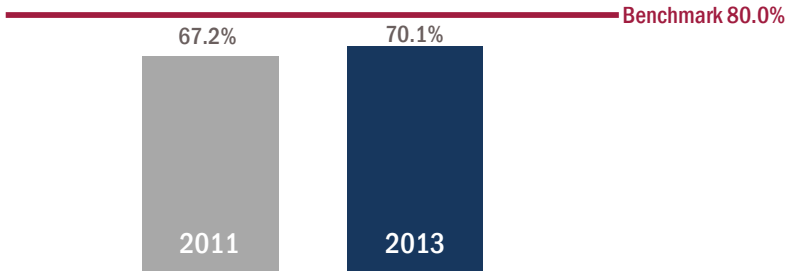
Purpose: This test helps people with diabetes manage their condition by measuring the level of 'bad cholesterol' (LDL-C) in the blood. Managing cholesterol levels can help people with diabetes avoid problems such as heart disease and stroke.

2013 data (n=20,105)

This metric tracks the percentage of adult patients with diabetes who received an LDL-C (cholesterol) test during 2013. The 2013 statewide data shows a 5% improvement from baseline.

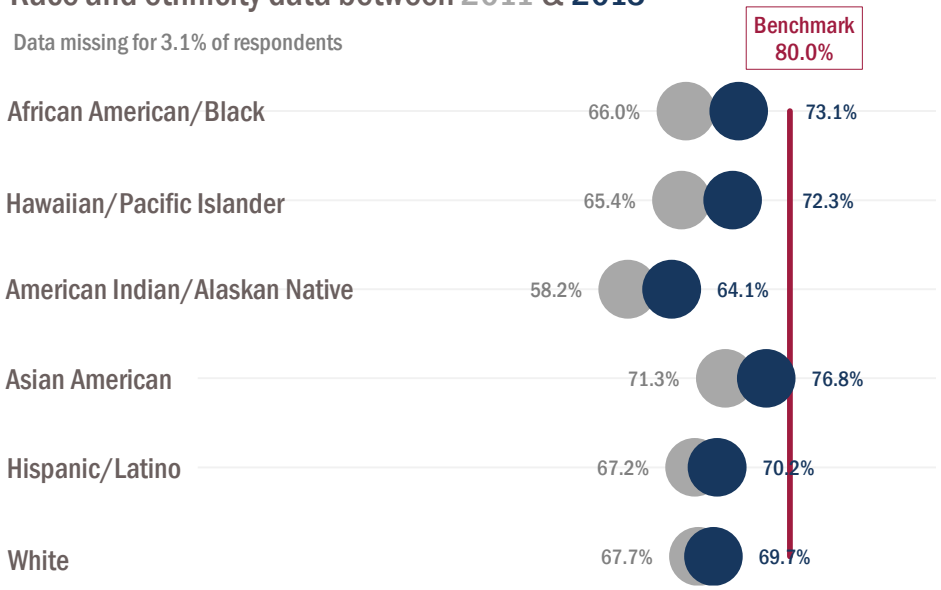
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile



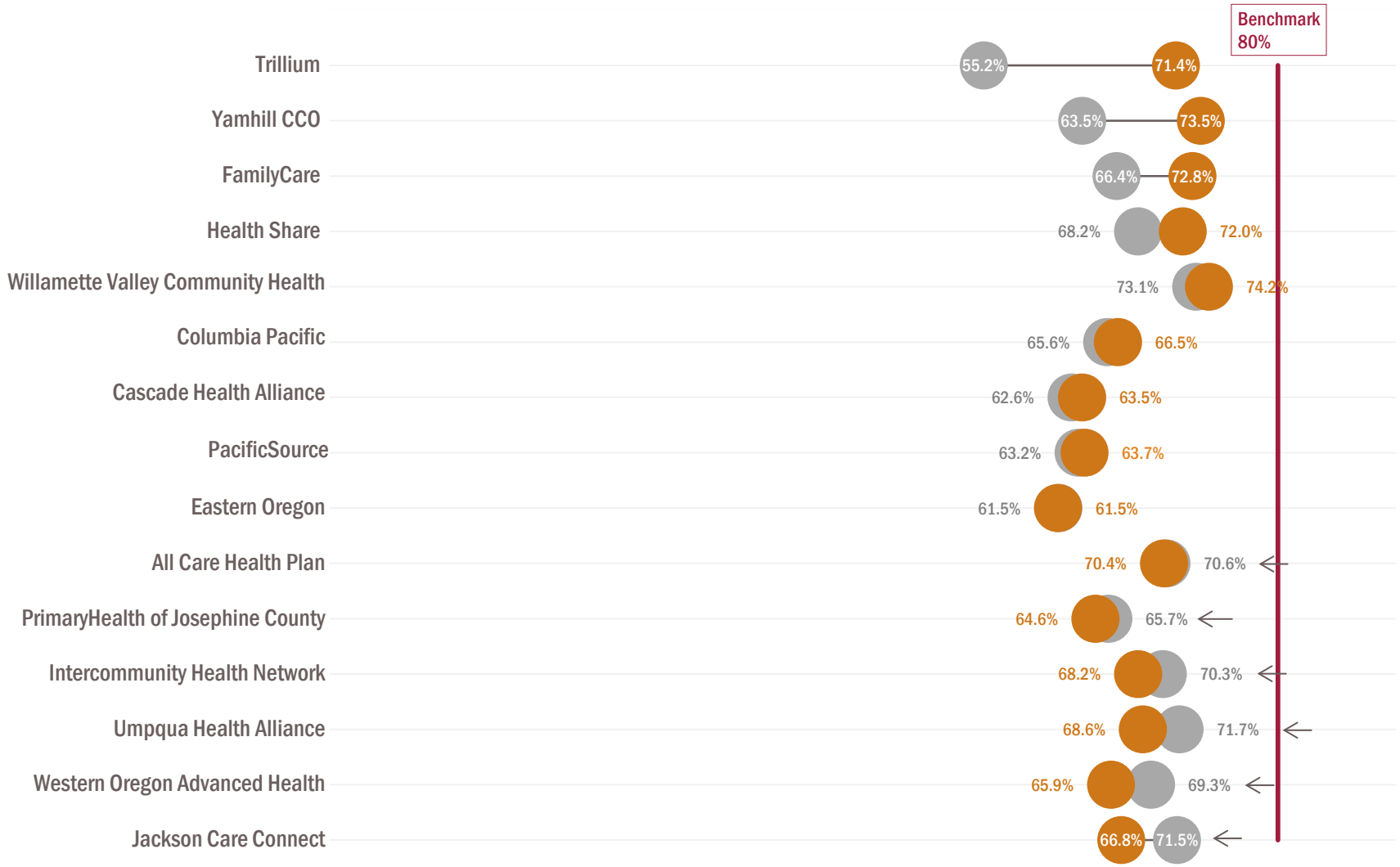
Race and ethnicity data between 2011 & 2013

Data missing for 3.1% of respondents



State Performance Measure

Percentage of adult patients (ages 18-85) with diabetes who received an LDL-C (cholesterol) test in 2011 & 2013



CCO Incentive and State Performance Measure

Developmental screening in the first 36 months of life

Measure description: Percentage of children who were screened for risks of developmental, behavioral and social delays using standardized screening tools in the 12 months preceding their first, second or third birthday.

Purpose: Early childhood screening helps find delays in development as early as possible, which leads to better health outcomes and reduced costs. Early developmental screening provides an opportunity to refer children to the appropriate specialty care before problems worsen. Often, developmental delays are not found until kindergarten or later – well beyond the time when treatments are most helpful.

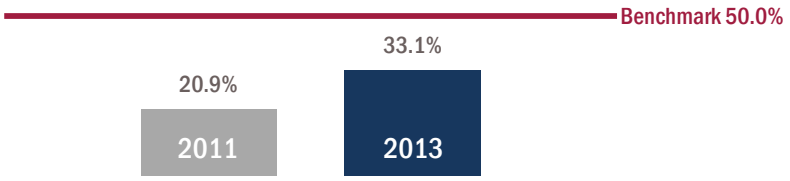
2013 data (n=20,043)

The percentage of children who were screened for the risk of developmental, behavioral, and social delays increased from a 2011 baseline of 20.9% to 33.1% in 2013, an increase of 58%.

In 2013, all CCOs exceeded their improvement target and four surpassed the benchmark of 50%. There have been marked gains in this measure across Oregon.

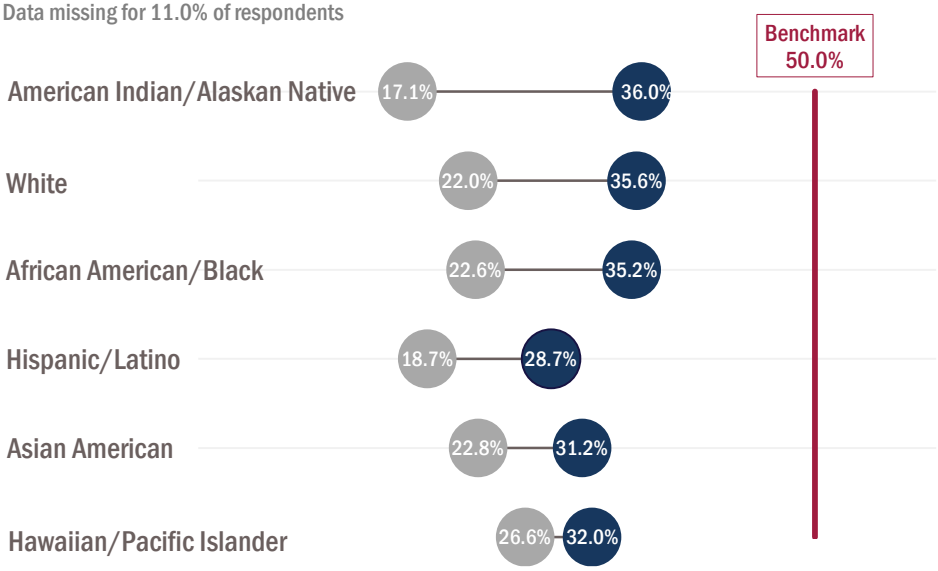
Statewide

Data source: Administrative (billing) claims
Benchmark source: Metrics and Scoring Committee consensus



Race and ethnicity data between 2011 & 2013

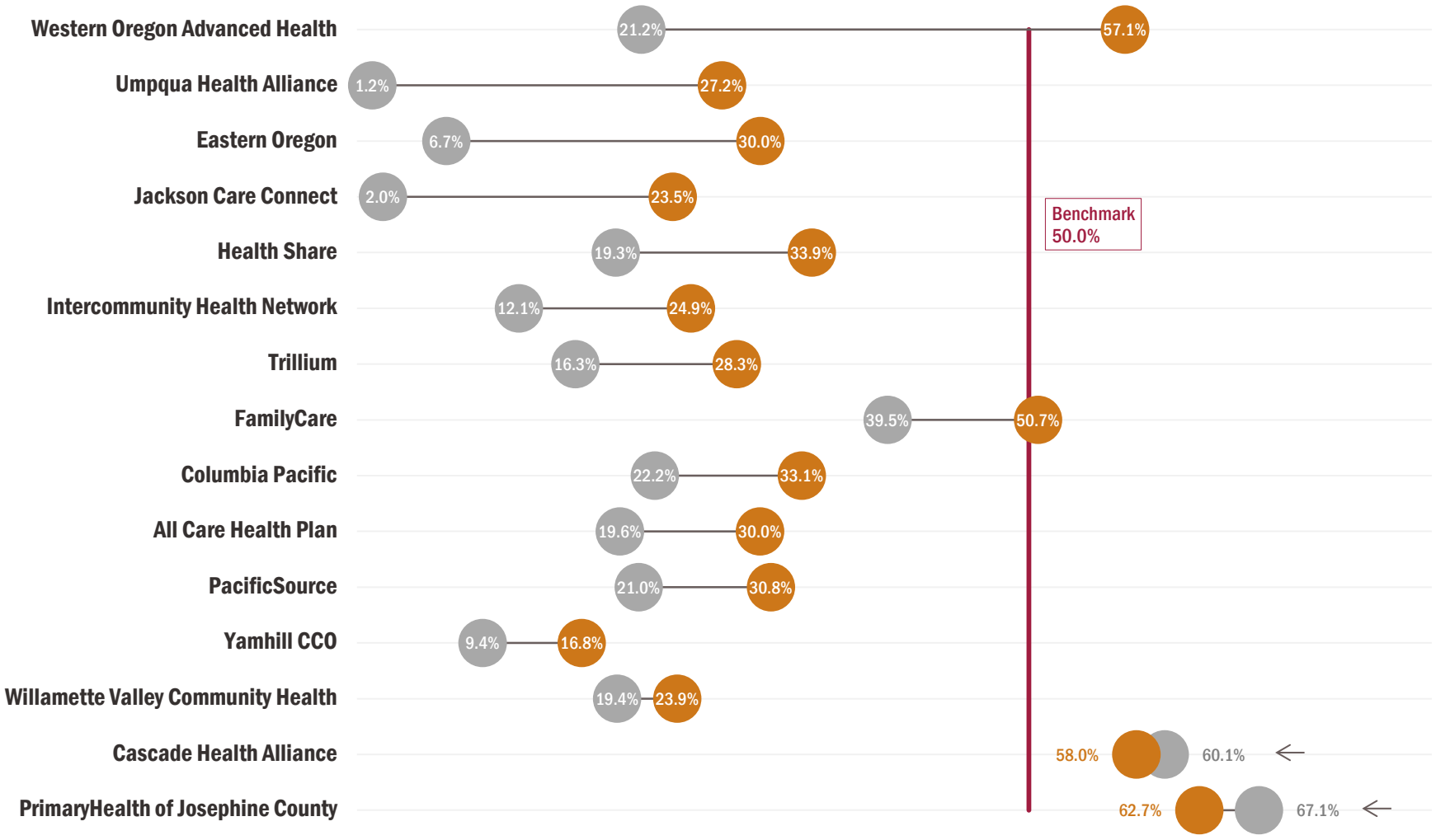
Data missing for 11.0% of respondents



CCO Incentive and State Performance Measure

Percentage of children up to three-years-old screened for developmental delays in 2011 & 2013

Bolded names met benchmark or improvement target



CCO Incentive and State Performance Measure

Early Elective Delivery

Measure description: Percentage of women who had an elective delivery between 37 and 39 weeks of gestation. (A lower score is better.)

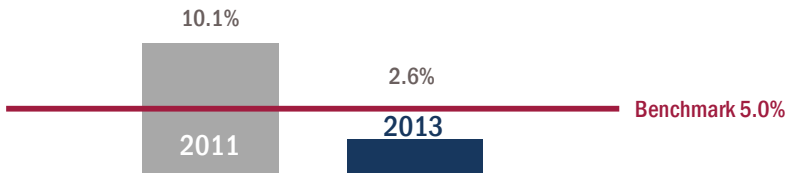
Purpose: There is a substantial body of evidence showing that an infant born at 37 weeks has worse health outcomes than one born at 40 weeks. Specifically, stays at the neonatal intensive care unit are higher in children at 37-38 weeks than children who completed at least 39 weeks. Because of this, it has become a national and state priority to limit elective deliveries to pregnancies that have completed at least 39 weeks gestation.

2013 data

Elective deliveries before 39 weeks have decreased 74% across the state, from a 2011 baseline of 10.1% to 2.6% in 2013. All CCOs were below the benchmark of 5% for this measure, showing a success across Oregon for better and safer care for mothers and babies.

Statewide

(Lower scores are better)
Data source: Administrative (billing) claims, Vital Records, and hospitals
Benchmark source: Metrics and Scoring Committee consensus



Race and ethnicity data between 2011 & 2013

Race and ethnicity data for this measure are not available

CCO Incentive and State Performance Measures

Percentage of women who had an elective delivery between 37 and 39 weeks of gestation in 2011 & 2013

(Lower scores are better)
Bolded names met benchmark or improvement target

CCO Incentive and State Performance Measure

Electronic Health Record (EHR) adoption

Measure description: Percentage of eligible providers within a CCO's network and service area who qualified for a "meaningful use" incentive payment during the measurement year through Medicaid, Medicare, or Medicare Advantage EHR Incentive Programs.

Purpose: Electronic health records have the potential to improve coordination of care, increase patient safety, reduce medical error, and contain health care costs by reducing costly, duplicative tests. Physicians who use electronic health records use information available to make the most appropriate clinical decisions.

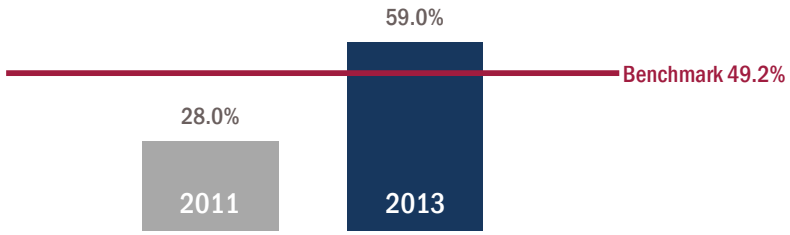
2013 data (n=8,236 eligible providers)

Electronic Health Record Adoption measures the percentage of eligible providers who received a "meaningful use" payment for EHR adoption. Electronic health record adoption among measured providers has doubled. In 2011, 28% of eligible providers had adopted certified EHRs. By the end of 2013, 59% of eligible providers had adopted certified EHRs, an increase of 110%.

All CCOs met their improvement target or surpassed the benchmark of 49.2%.

Statewide

Data source: state and federal EHR Incentive Program
Benchmark source: federal assumed rate for non-hospital based EHR adoption and Meaningful Use by 2014



Race and ethnicity data between 2011 & 2013

Electronic Health Record adoption will not be stratified by race and ethnicity

CCO Incentive and State Performance Measure

Percentage of providers who qualified for an EHR incentive payment during the measurement year in 2011 & 2013

Bolded names met benchmark or improvement target

CCO Incentive and State Performance Measure

Follow-up after hospitalization for mental illness

Measure description: Percentage of patients (ages 6 and older) who received a follow-up with a health care provider within seven days of being discharged from the hospital for mental illness.

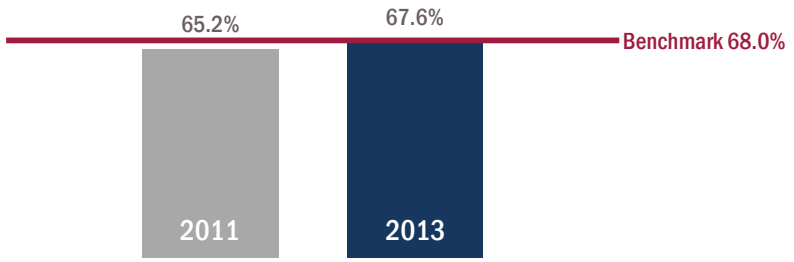
Purpose: Follow-up care is important to help patients make progress and feel better after being in the hospital for mental illness. This measure addresses an emerging issue for children and adults by suggesting follow up for patients ages 6 and up. Additionally, research shows that follow-up care helps keep patients from returning to the hospital, providing an important opportunity to reduce health care costs and improve health.

2013 data (n=1,825)

This metric represents follow-up visits within seven days after patients were discharged from a hospital with a mental health diagnosis. In 2013, the percentage of patients with a follow-up visit was 67.6%, approaching the benchmark of 68.0%. Eight CCOs exceeded the benchmark for this measure, showing progress.

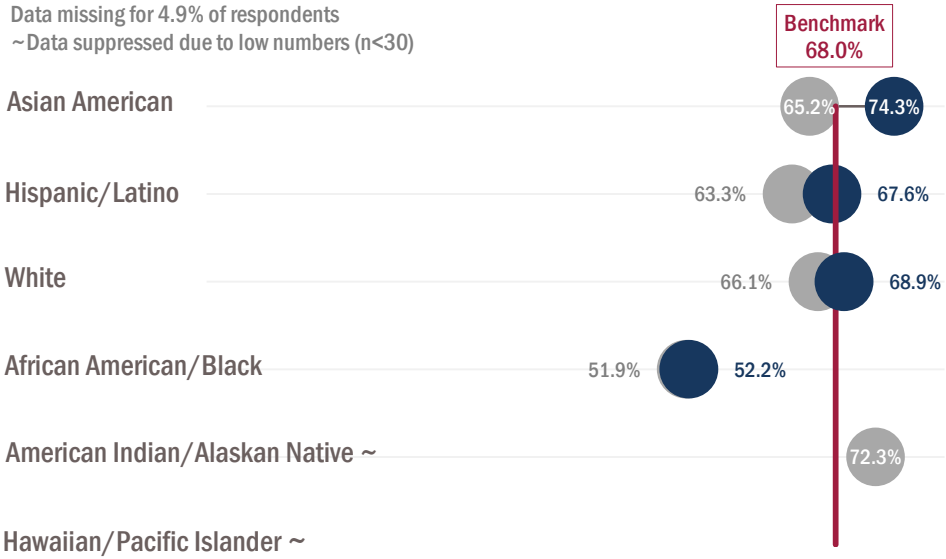
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile



Race and ethnicity data between 2011 & 2013

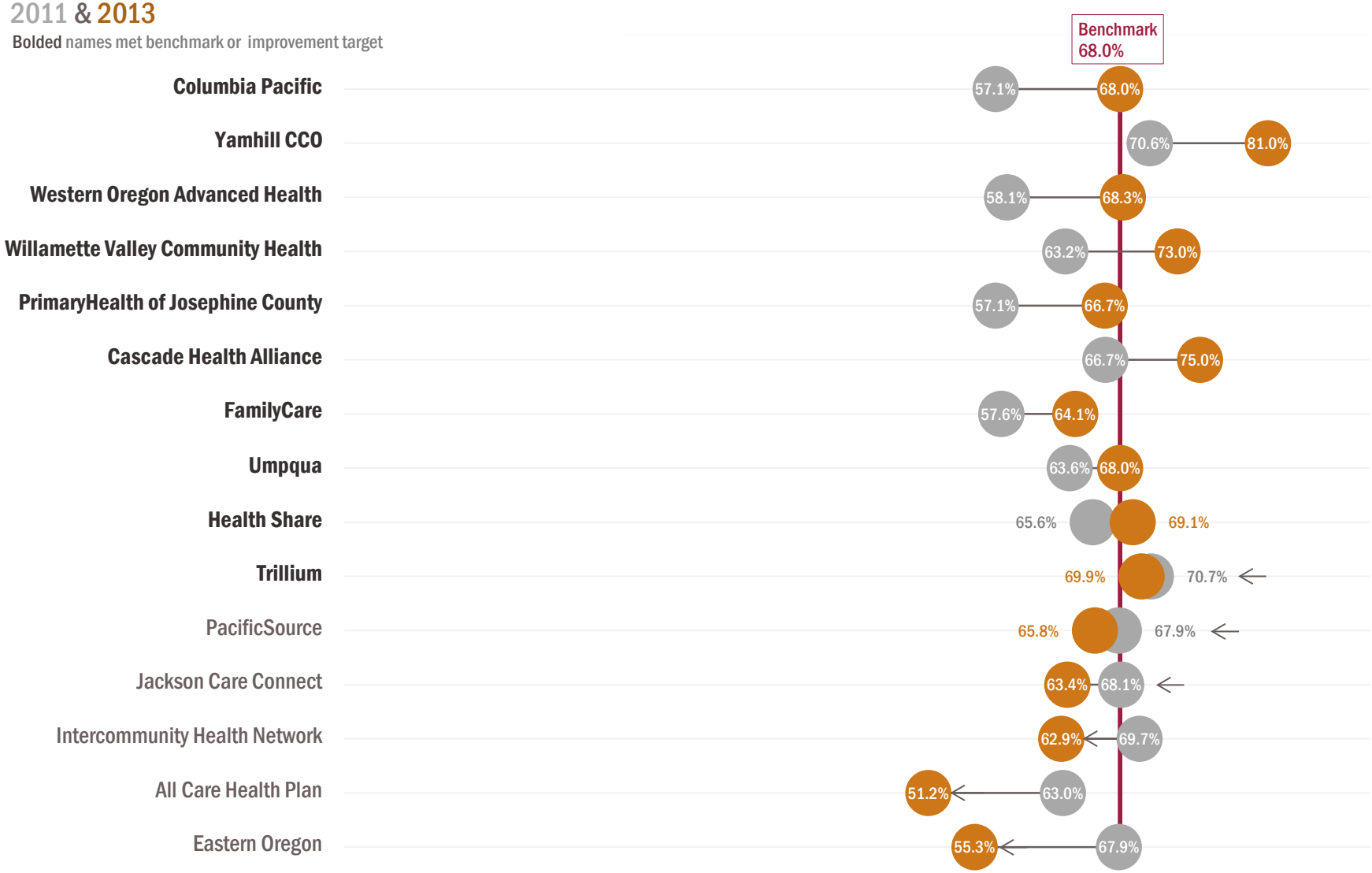
Data missing for 4.9% of respondents
~Data suppressed due to low numbers (n<30)



CCO Incentive and State Performance Measure

Percentage of patients who received follow-up care within 7 days of being dishcarged from the hosptital for mental illness in 2011 & 2013

Bolded names met benchmark or improvement target



Follow-up care for children prescribed ADHD medication (initiation phase)

Measure description: Percentage of children (ages 6-12) who had at least one follow-up visit with a provider during the 30 days after receiving a new prescription for attention deficit hyperactivity disorder (ADHD) medication.

Purpose: Children with attention deficit hyperactivity disorder can be greatly helped by ADHD medication. One critical component of care is that children have follow-up visits once they are on the medication. After a child receives ADHD medication, a primary care provider should continue to assess learning and behavior and help manage the condition. ADHD treatment is an important emerging issue for children.

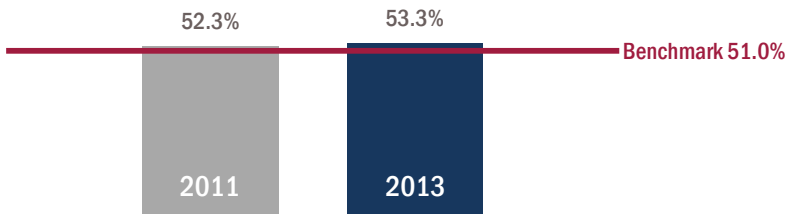
2013 data (n=2,403)

This metric represents the percentage of children prescribed ADHD medication who had a follow-up visit within 30 days after receiving a new prescription.

In 2013, the benchmark was exceeded statewide (53.3% versus 51.0%). Additionally, over two-thirds of the CCOs exceed the benchmark for this measure.

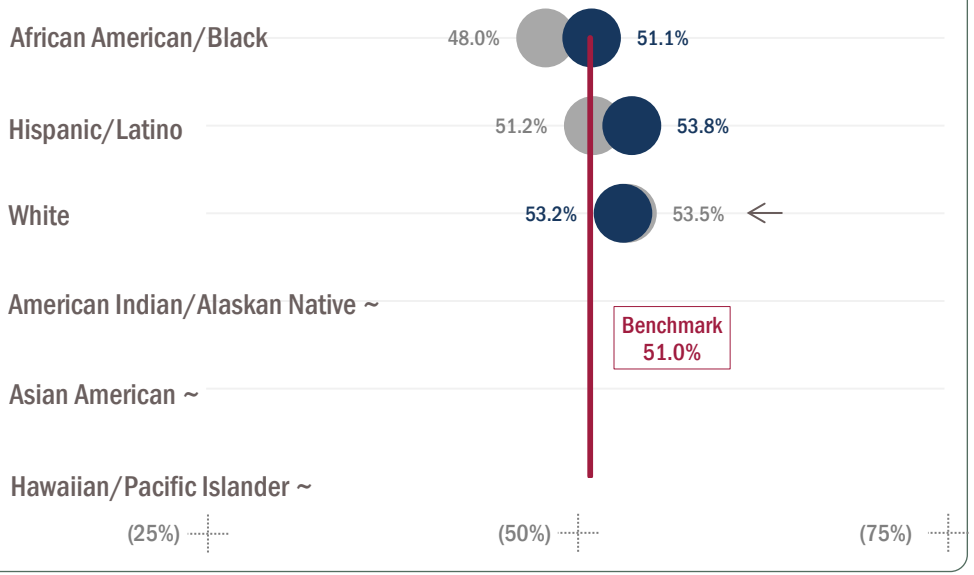
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile



Race and ethnicity data between 2011 & 2013

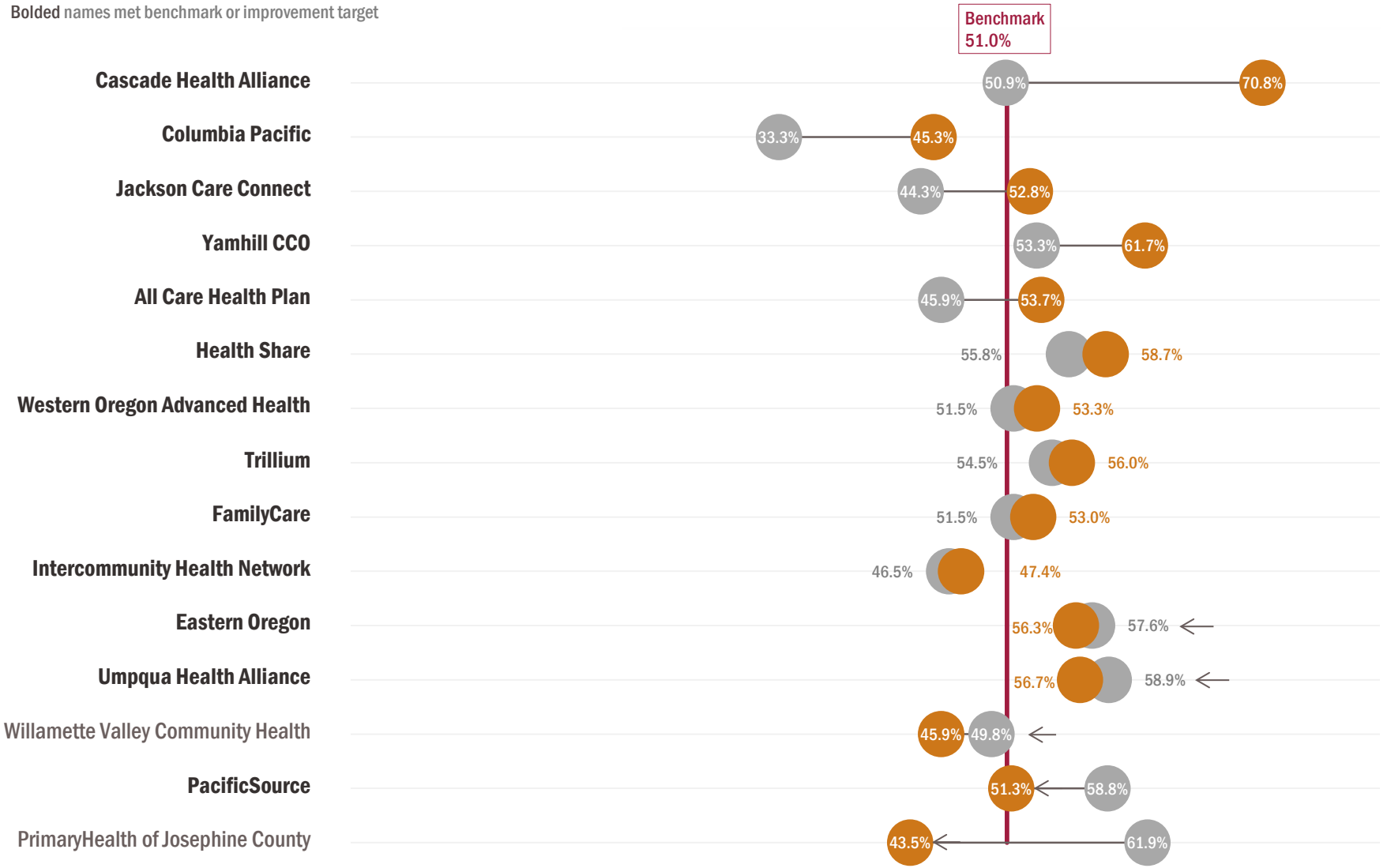
Data missing for 8.4% of respondents.
~Data suppressed due to low numbers (n<30)



CCO Incentive and State Performance Measure

Percentage of children (ages 6-12) who had one follow-up visit with a provider during the 30 days after receiving a new prescription for ADHD medication in 2011 & 2013

Bolded names met benchmark or improvement target



CCO Incentive and State Performance Measure

Follow-up care for children prescribed ADHD medication (continuation and maintenance phase)

Measure description: Percentage of children (ages 6-12) who remained on attention deficit hyperactivity disorder (ADHD) medication for 210 days after receiving a new prescription and who had at least two follow-up visits with a provider within 270 days after the initiation phase (see page 47).

Purpose: Children with attention deficit hyperactivity disorder can be greatly helped by ADHD medication. One critical component of care is that children have follow-up visits once they are on the medication. After a child receives ADHD medication, a primary care provider should continue to assess learning and behavior and help manage the condition. ADHD treatment is an important emerging issue for children.

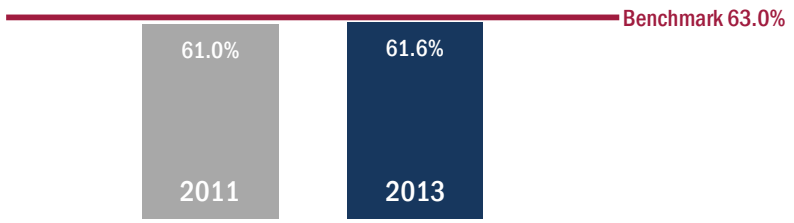
2013 data (n=1,080)

This metric represents the percentage of children prescribed ADHD medication who remained on the medication for 210 days and had at least two follow-up visits with a provider within 270 days of the prescription. To date, 2013 data are similar to baseline rates.

This measure cannot be reported at the CCO level for 2013.

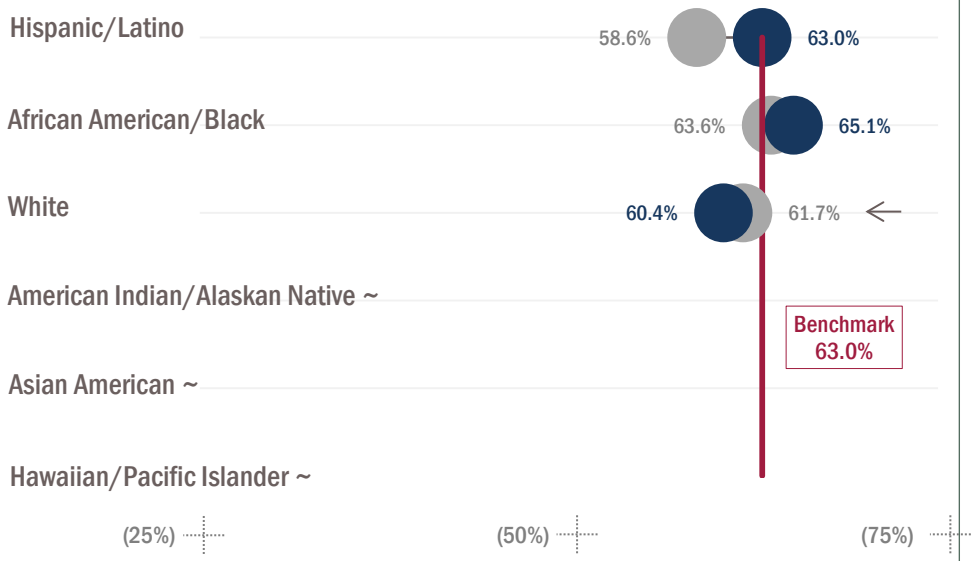
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile



Race and ethnicity data between 2011 & 2013

Data missing for 8.4% of respondents
~Data suppressed due to low numbers (n<30)



Immunization for adolescents

Measure description: Percentage of adolescents who received recommended vaccines before their 13th birthday.

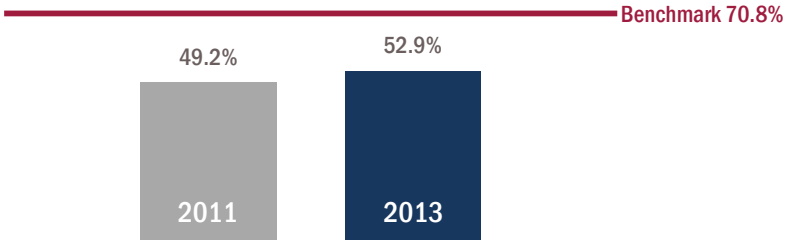
Purpose: Like young children, adolescents also benefit from immunizations. Vaccines are a safe, easy and cost-effective way to prevent serious disease. Vaccines are also cost-effective tools that help to prevent the spread of serious and sometimes fatal diseases.

2013 data (n=6,381)

The 2013 data shows CCOs are doing better at making sure recommended vaccines are up to date, compared to 2011 baseline. This trend is consistent with the CCOs improvement in providing more adolescent well care visits.

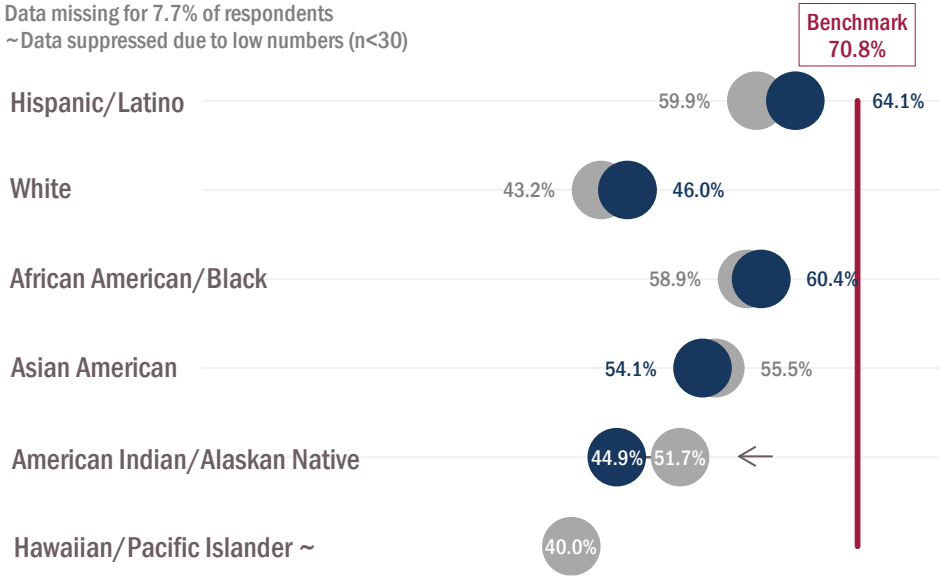
Statewide

Data source: Administrative (billing) claims and ALERT Immunization Information System Benchmark source: 2012 National Medicaid 75th percentile



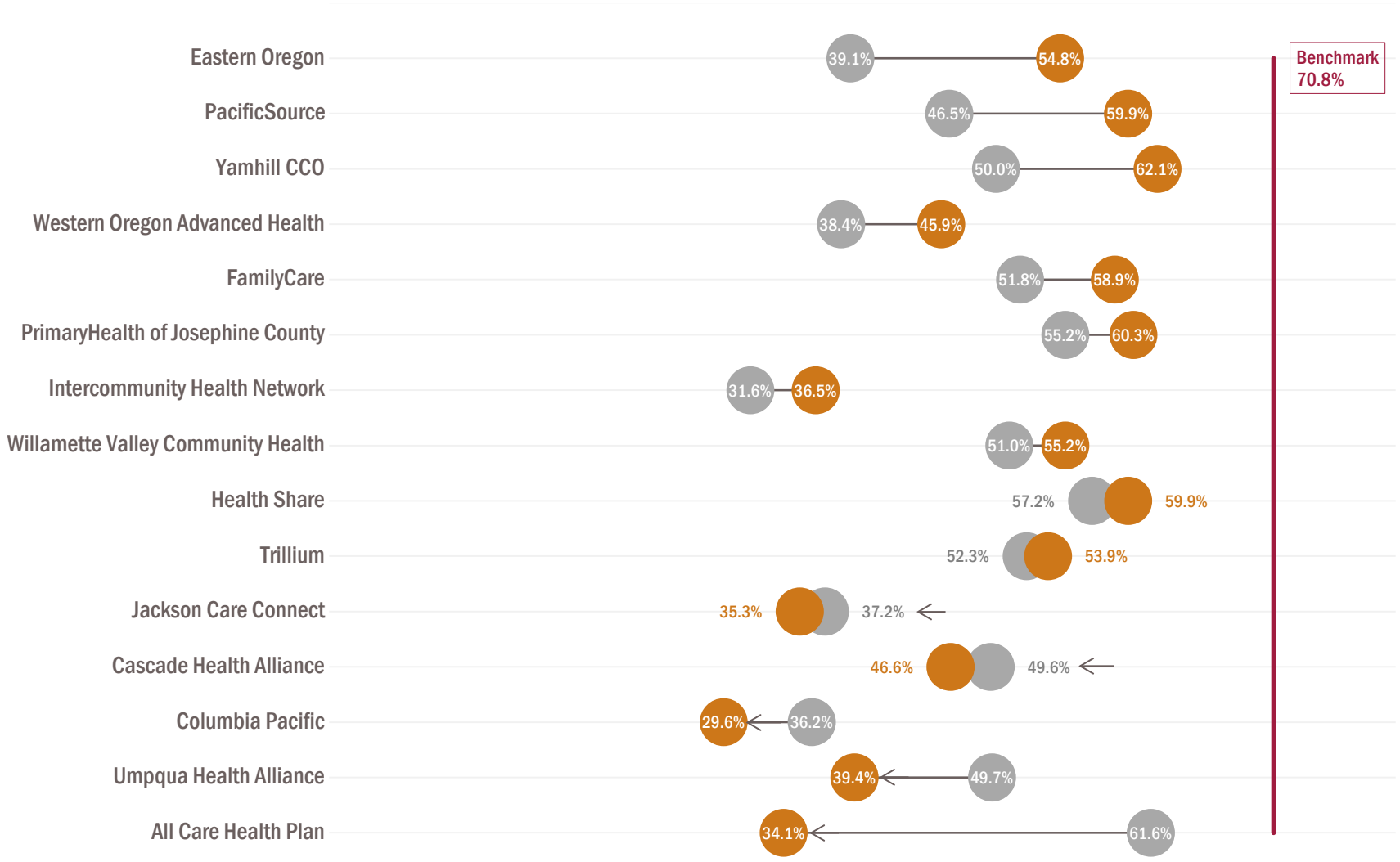
Race and ethnicity data between 2011 & 2013

Data missing for 7.7% of respondents
~Data suppressed due to low numbers (n<30)



State Performance Measure

Percentage of adolescents who received recommended vaccines before their 13th birthday in 2011 & 2013



State Performance Measure

Medical assistance with smoking and tobacco use cessation

Component 1: Percentage of adult tobacco users advised to quit by their doctor.

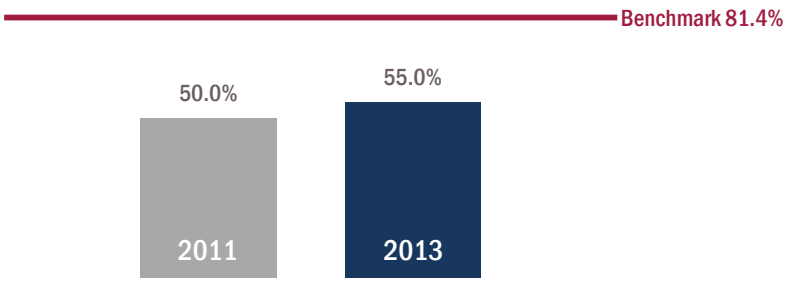
Purpose: Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

2013 data

This set of metrics measures the proportion of adult tobacco users who were advised by their doctor to quit, provided strategies to quit, and recommended medication to quit. All three metrics in this set show improvement in 2013 over baseline.

Statewide

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark source: 2012 National Medicaid 90th percentile



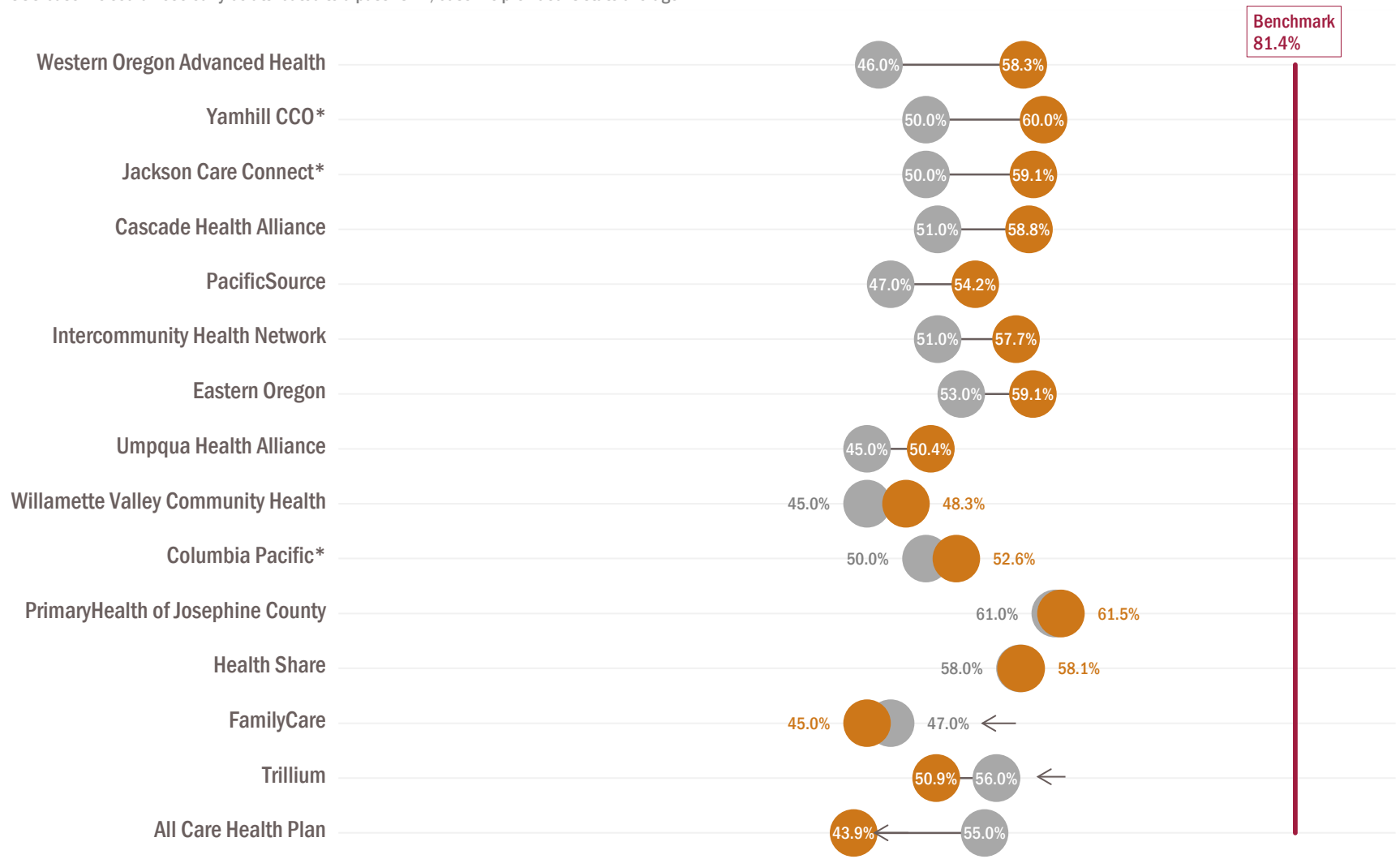
Race and ethnicity data between 2011 & 2013

CAHPS data by race and ethnicity will be available in future reports

State Performance Measure

Smoking and tobacco use cessation: Percentage of adult tobacco users advised to quit by a doctor in 2011 & 2013

*CCO baseline could not clearly be attributed to a past FCHP; baseline provided is state average.



State Performance Measure

Medical assistance with smoking and tobacco use cessation

Component 2: Percentage of adult tobacco users whose doctor discussed or recommended medication to quit smoking.

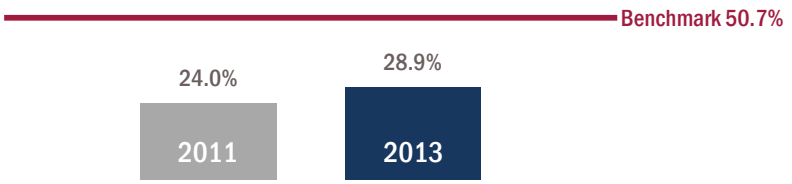
Purpose: Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

2013 data

This set of metrics measures the proportion of adult tobacco users who were advised by their doctor to quit, provided strategies to quit, and recommended medication to quit. All three metrics in this set show improvement in 2013 over baseline.

Statewide

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark source: 2012 National Medicaid 90th percentile



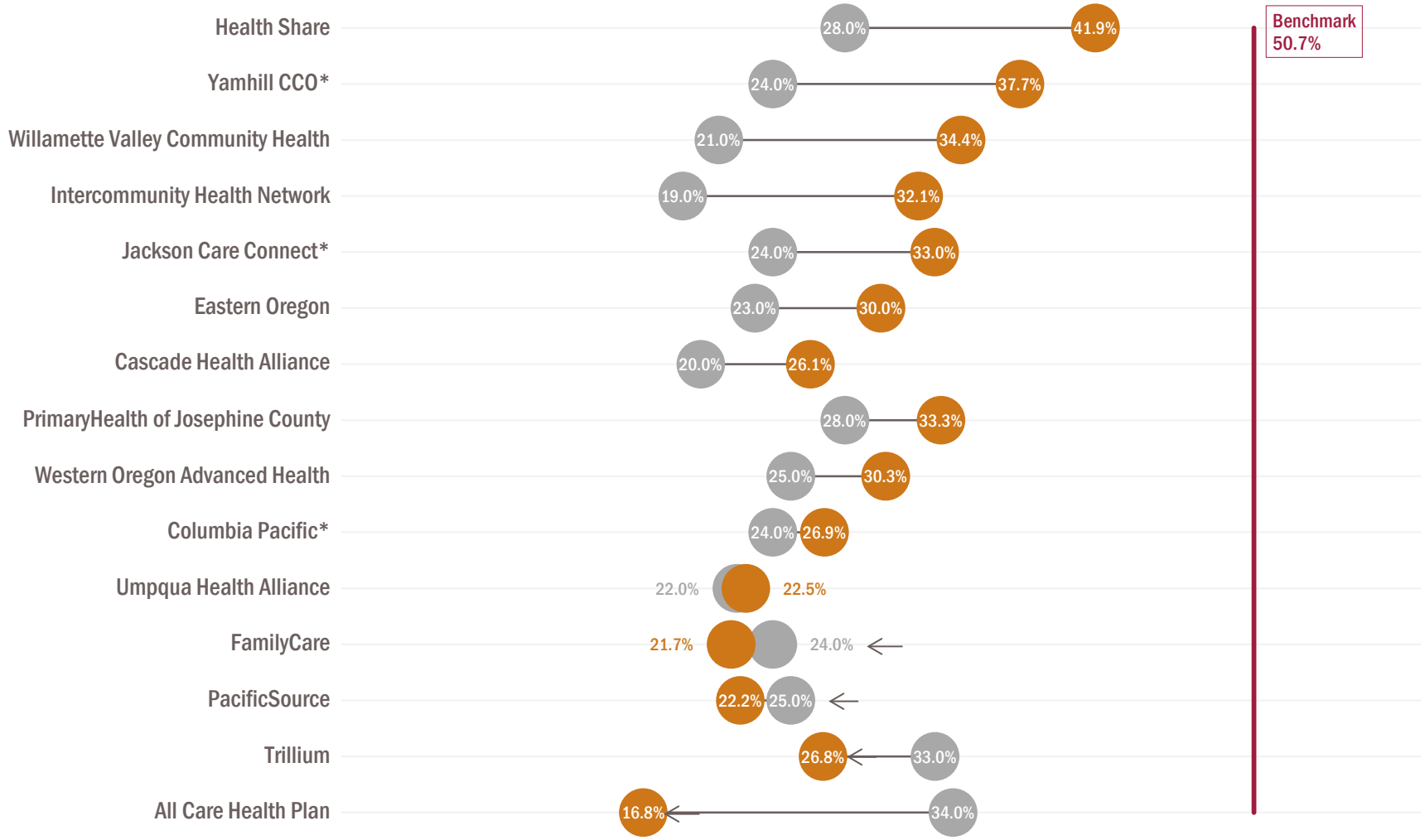
Race and ethnicity data between 2011 & 2013

CAHPS data by race and ethnicity will be available in future reports

State Performance Measure

Smoking and tobacco use cessation: Percentage of adult tobacco users whose doctor discussed or recommended medication to quit smoking in 2011 & 2013

*CCO baseline could not clearly be attributed to a past FCHP; baseline provided is state average.



Medical assistance with smoking and tobacco use cessation

Component 3: Percentage of adult tobacco users whose doctor discussed or recommended strategies to quit smoking.

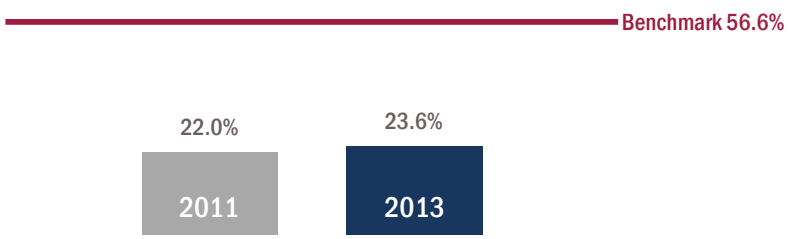
Purpose: Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

2013 data

This set of metrics measures the proportion of adult tobacco users who were advised by their doctor to quit, provided strategies to quit, and recommended medication to quit. All three metrics in this set show improvement in 2013 over baseline.

Statewide

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark source: 2012 National Medicaid 90th percentile



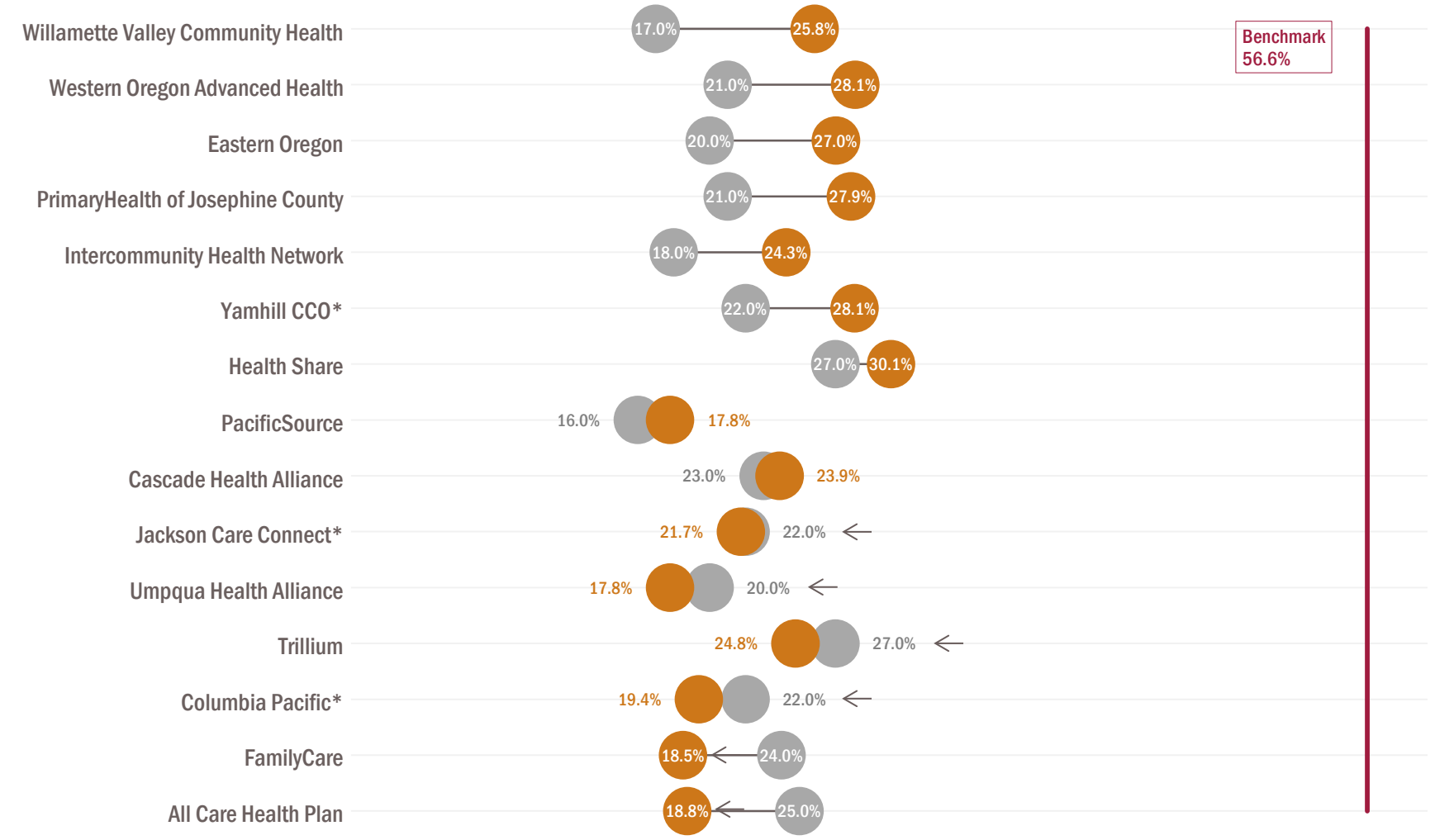
Race and ethnicity data between 2011 & 2013

CAHPS data by race and ethnicity will be available in future reports

State Performance Measure

Smoking and tobacco use cesastion: Percentage of adult tobacco users whose doctor discussed or recommended strategies to quit smoking in 2011 & 2013

*CCO baseline could not clearly be attributed to a past FCHP; baseline provided is state average.



CCO Incentive Measure

Mental and physical health assessment within 60 days for children in DHS custody

Measure description: Percentage of children age 4+ who receive a mental health assessment and physical health assessment within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care). Physical health assessments are required for children under age 4, but not mental health assessments.

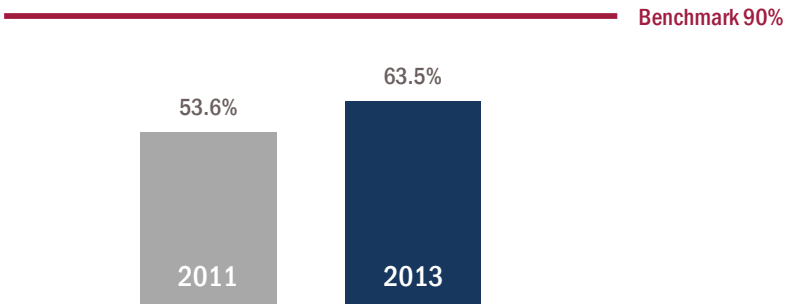
Purpose: Children who have been placed in foster care should have their mental and physical health checked so that an appropriate care plan can be developed. Mental and physical health assessments are a requirement for the foster program because of their importance to improving the health and well-being of a child in a trying situation.

2013 data (n=137)

This metric has systematic challenges that can make it difficult to measure. For example, CCOs are still building relationships with local field offices to quickly identify children that enter the foster care system. OHA and the CCOs are continuing to work together on the methodology to improve data collection and reporting for this measure. Nonetheless, 12 CCOs exceeded the benchmark or their improvement target for this measure, showing progress.

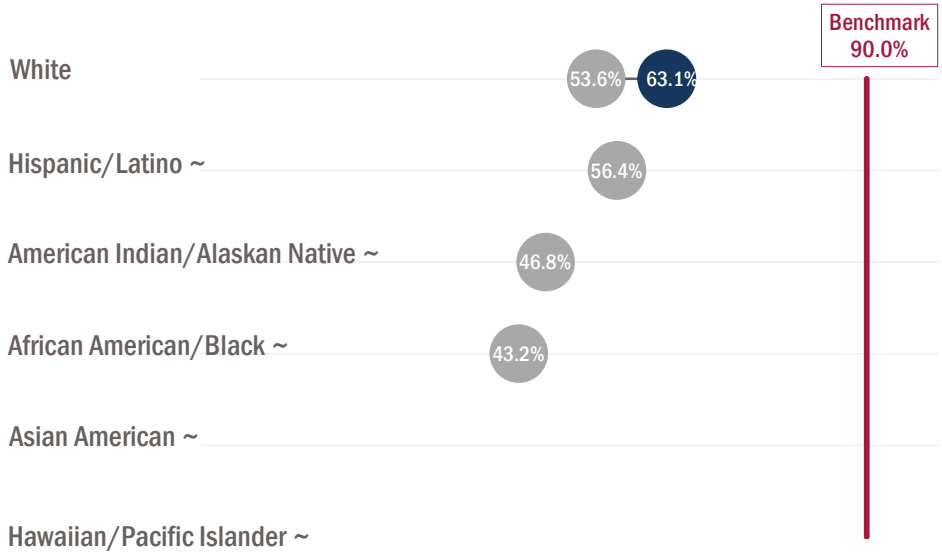
Statewide

Data source: Administrative (billing) claims + ORKids
Benchmark source: Metrics and Scoring Committee consensus



Race and ethnicity data between 2011 & 2013

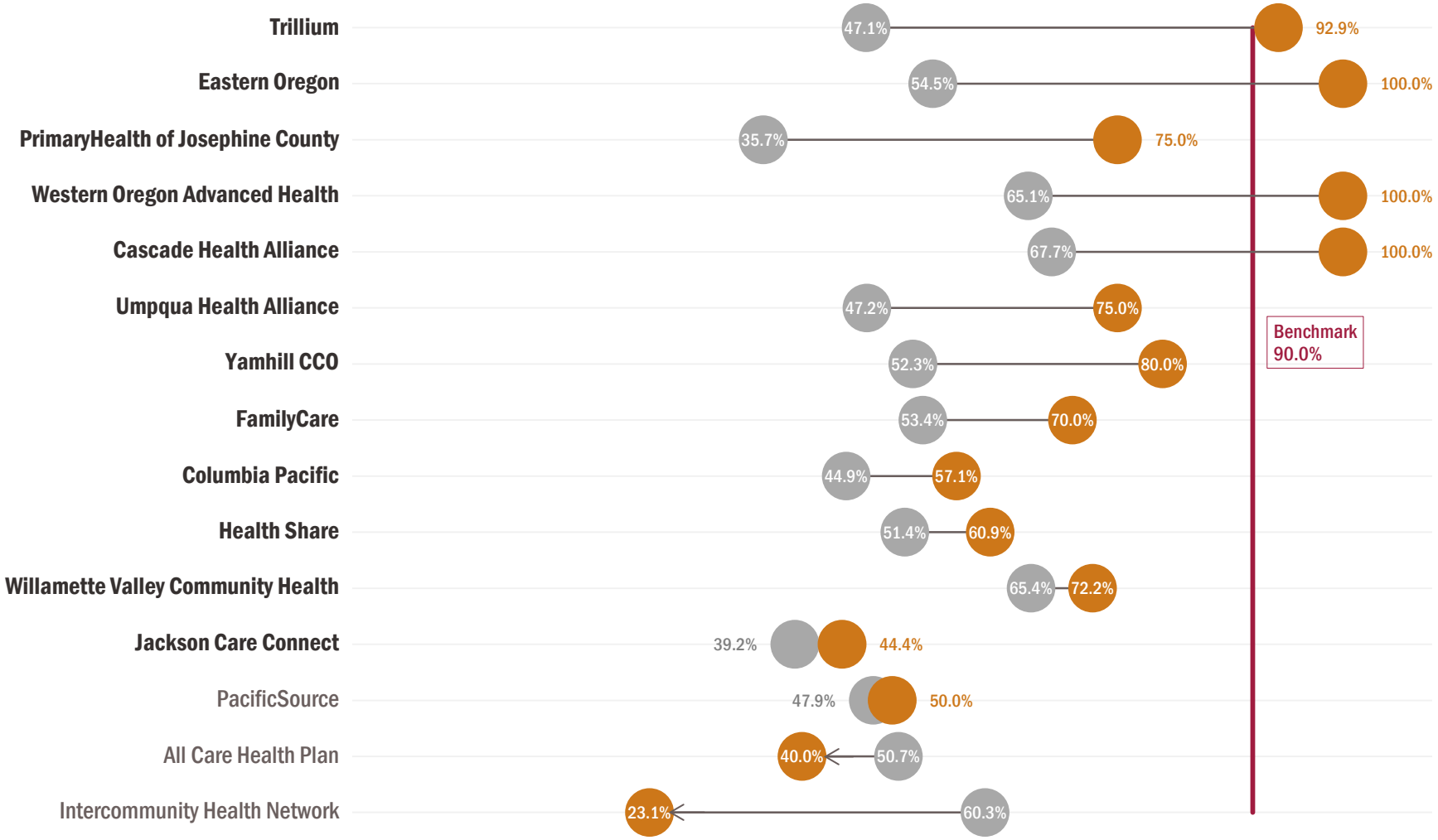
Data missing for 60.0% of respondents



CCO Incentive Measure

Percentage of children in DHS custody who received a mental and physical health assessment within 60 days in 2011 & 2013

Bolded names met benchmark or improvement target



CCO Incentive and State Performance Measure

Patient-centered primary care home enrollment

Measure description: Percentage of patients who were enrolled in a recognized patient-centered primary care home (PCPCH).

Purpose: Patient-centered primary care homes are clinics that have been recognized for their commitment to quality, patient-centered, coordinated care. Patient-centered primary care homes help improve a patient's health care experience and overall health.

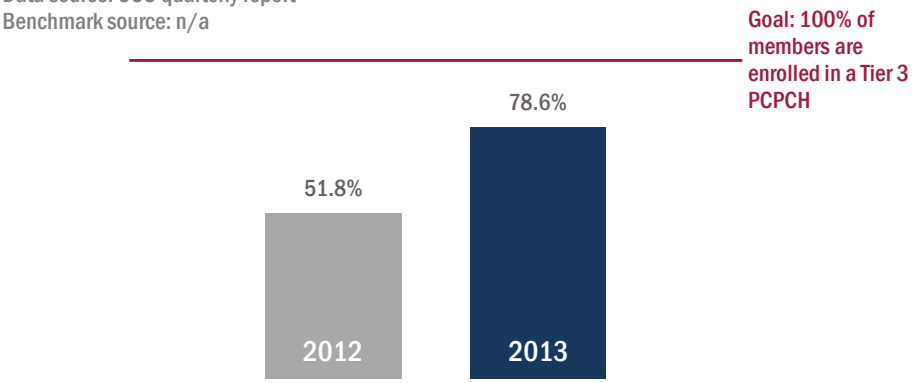
2013 data (n=528,689)

This metric tracks the percentage of CCO members who are enrolled in a recognized patient-centered primary care home. Enrollment in patient-centered primary care homes has increased by 52% since 2012, the baseline year for this program.

Fourteen CCOs show an increase in members enrolled in a patient-centered primary care home.

Statewide

Data source: CCO quarterly report
Benchmark source: n/a

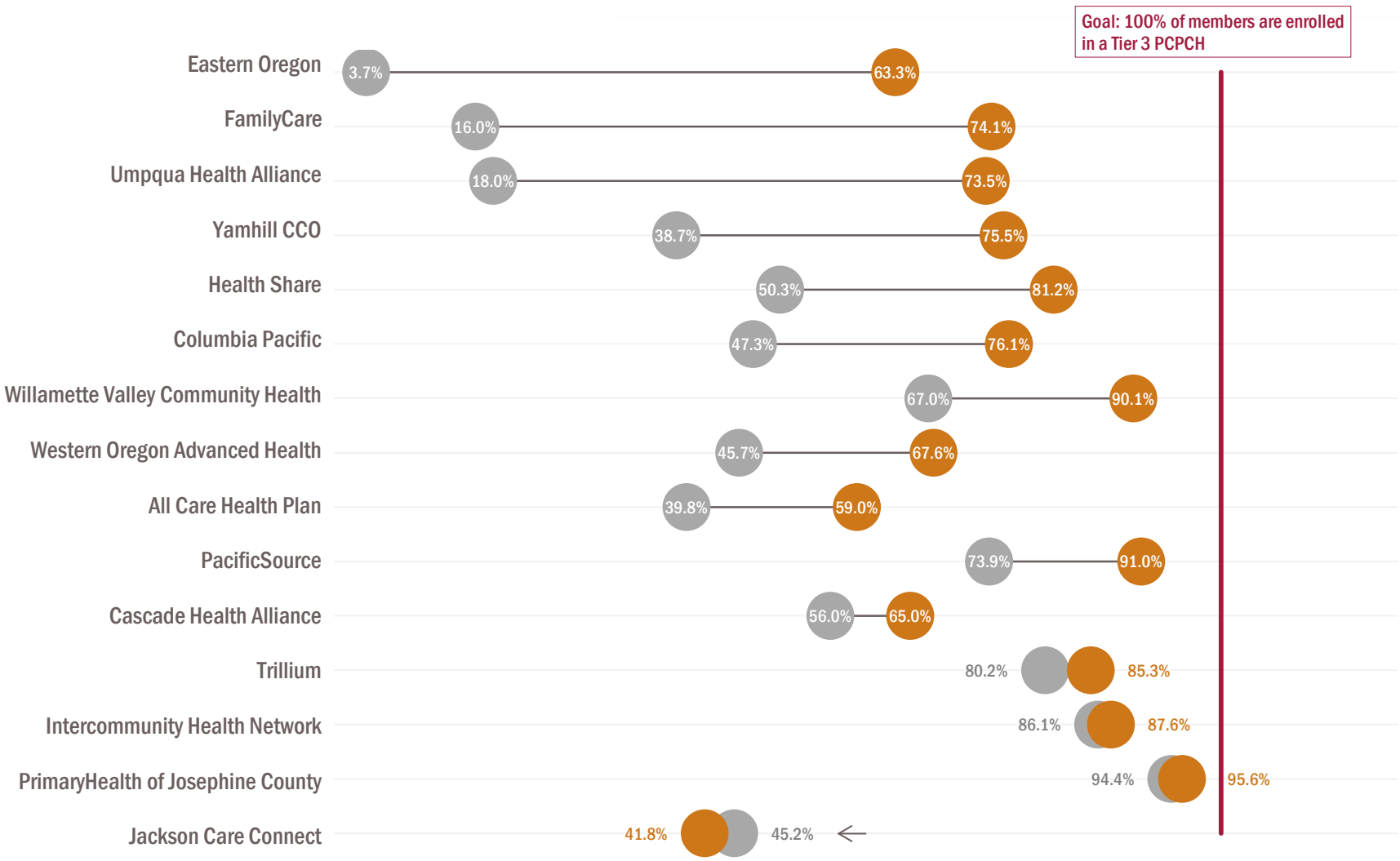


Race and ethnicity data between 2012 & 2013

Patient-centered primary care home enrollment will not be stratified by race and ethnicity

CCO Incentive and State Performance Measure

Percentage of patients who were enrolled in a recognized patient-centered primary care home in 2012 & 2013



State Performance Measure

Diabetes short term complications admission rate

Measure description: Rate of adult patients (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease. Rates are reported per 100,000 member years. A lower score is better.

PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

Purpose: Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce the costs of health care.

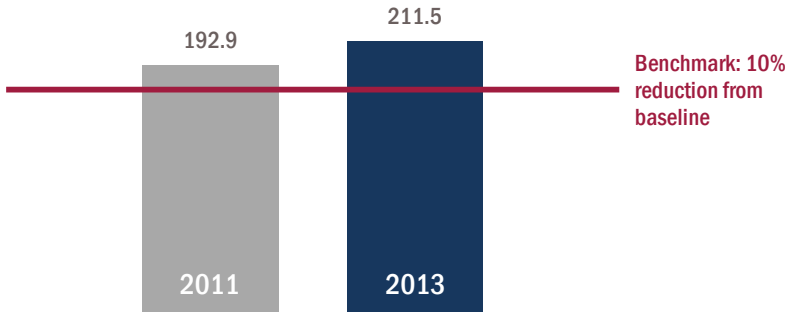
2013 data (n=2,672,059 member months)

This metric tracks hospital use for adult patients with diabetes who could be better treated with good disease management. The rates for this measure are reported per 100,000 member years and a lower rate is better.

The 2013 rate shows an increase compared to 2011, suggesting an area of care that could benefit from better management.

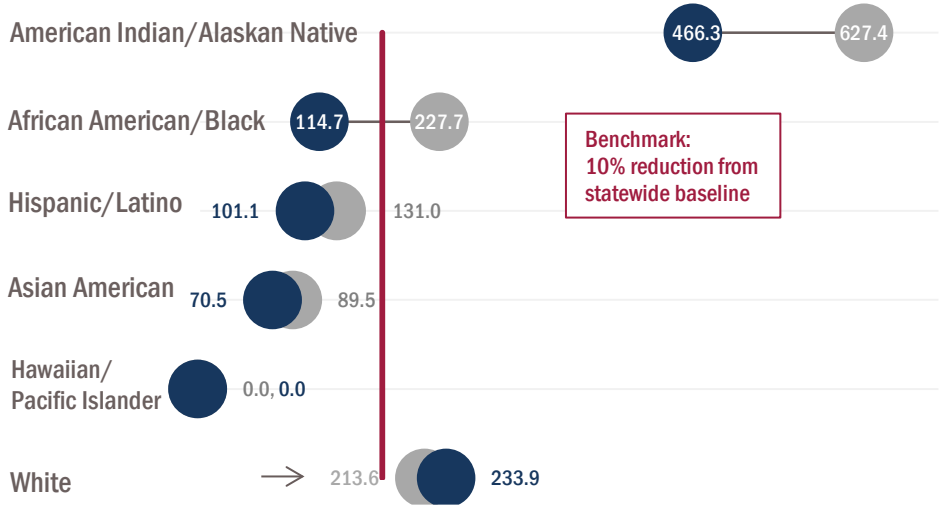
Statewide

Lower scores are better
Data source: Administrative (billing) claims
Benchmark source: OHA consensus, based on prior performance trend



Race and ethnicity data between 2011 & 2013

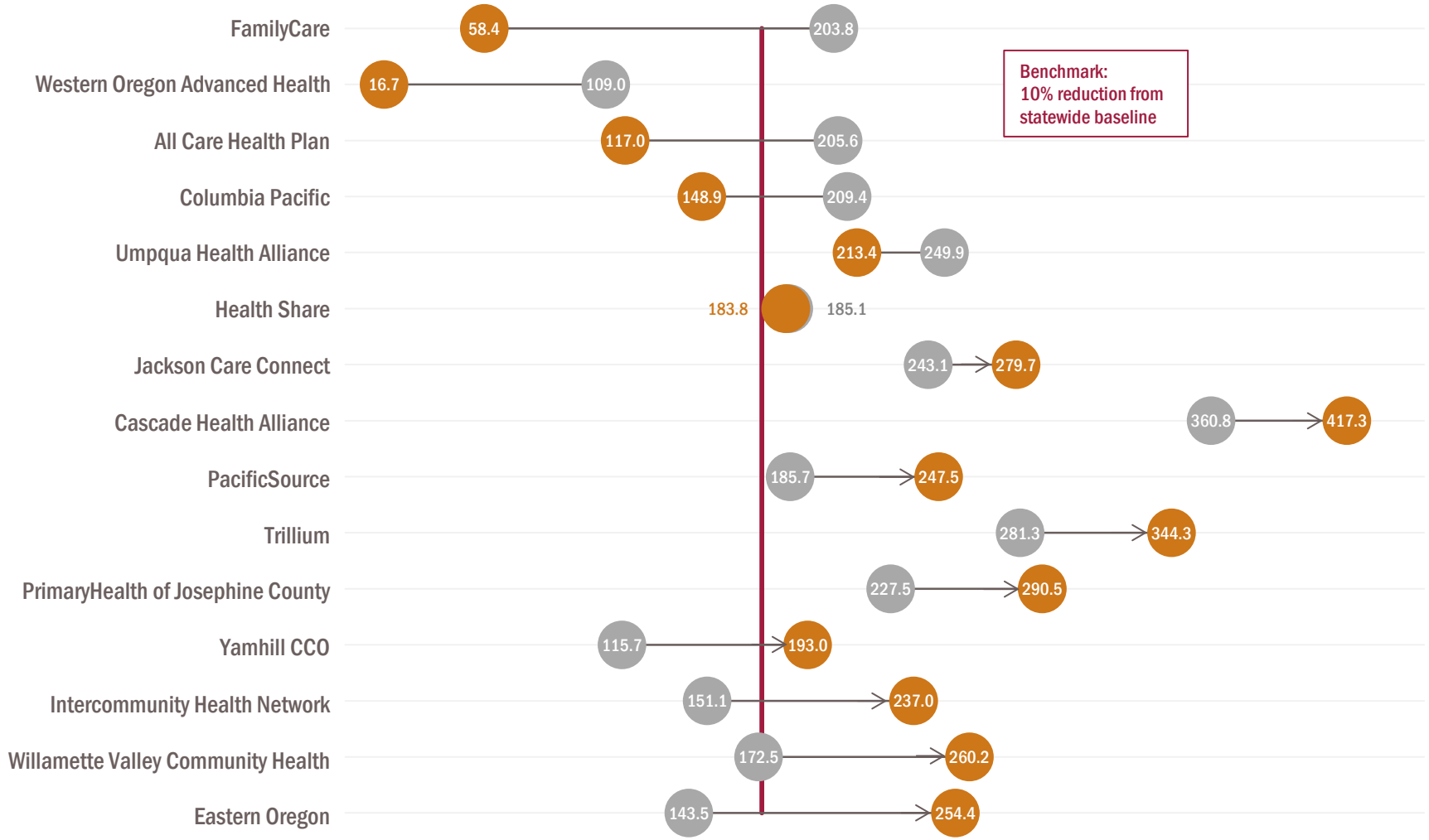
Lower scores are better
Data missing for 5.6% of respondents



State Performance Measure

PQI 01: Rate of adult patients with diabetes who had a hospital stay because of a short-term problem with their disease in 2011 & 2013

(Lower scores are better)
Rates are per 100,000 member years
PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators



State Performance Measure

Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate

Measure description: Rate of adult patients (ages 40 and older) who had a hospital stay because of chronic obstructive pulmonary disease or asthma. Rates are reported per 100,000 member years. A lower score is better.

PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

Purpose: Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce health care costs.

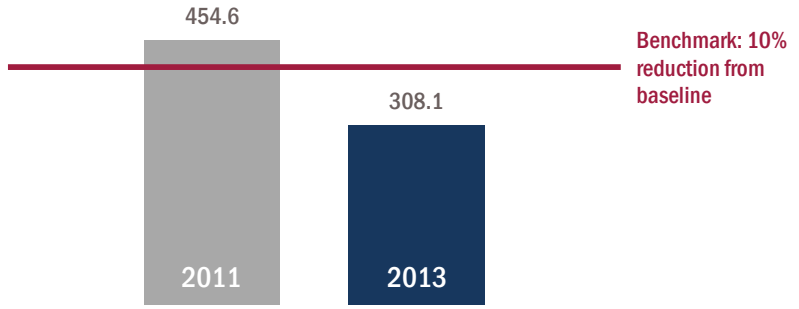
2013 data (n=2,672,059 member months)

This metric tracks hospital use for older adults with chronic obstructive pulmonary disease or asthma - diseases that could be better treated with good disease management. The rates for this measure are reported per 100,000 member years and a lower rate is better.

Statewide, CCOs performed below the benchmark for 2013, showing improvement in disease management care.

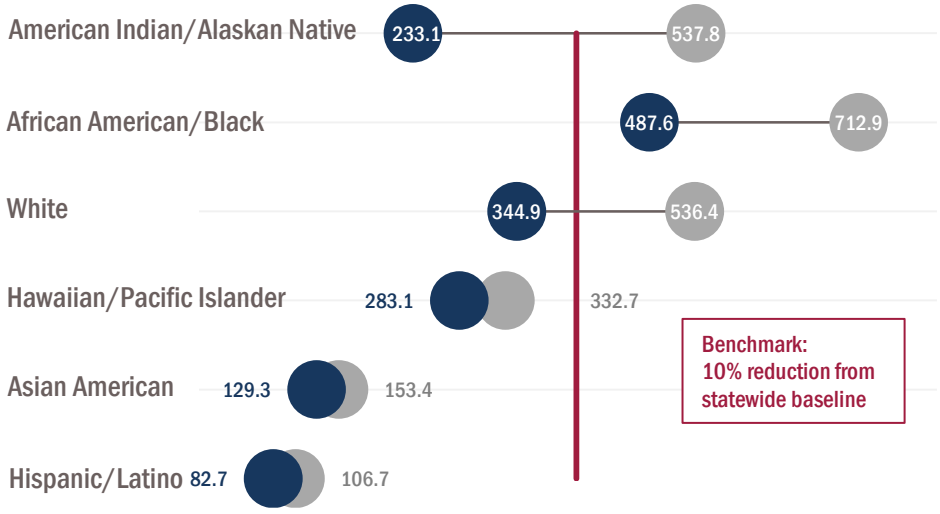
Statewide

(Lower scores are better)
Data source: Administrative (billing) claims
Benchmark source: OHA consensus, based on prior performance trend



Race and ethnicity data between 2011 & 2013

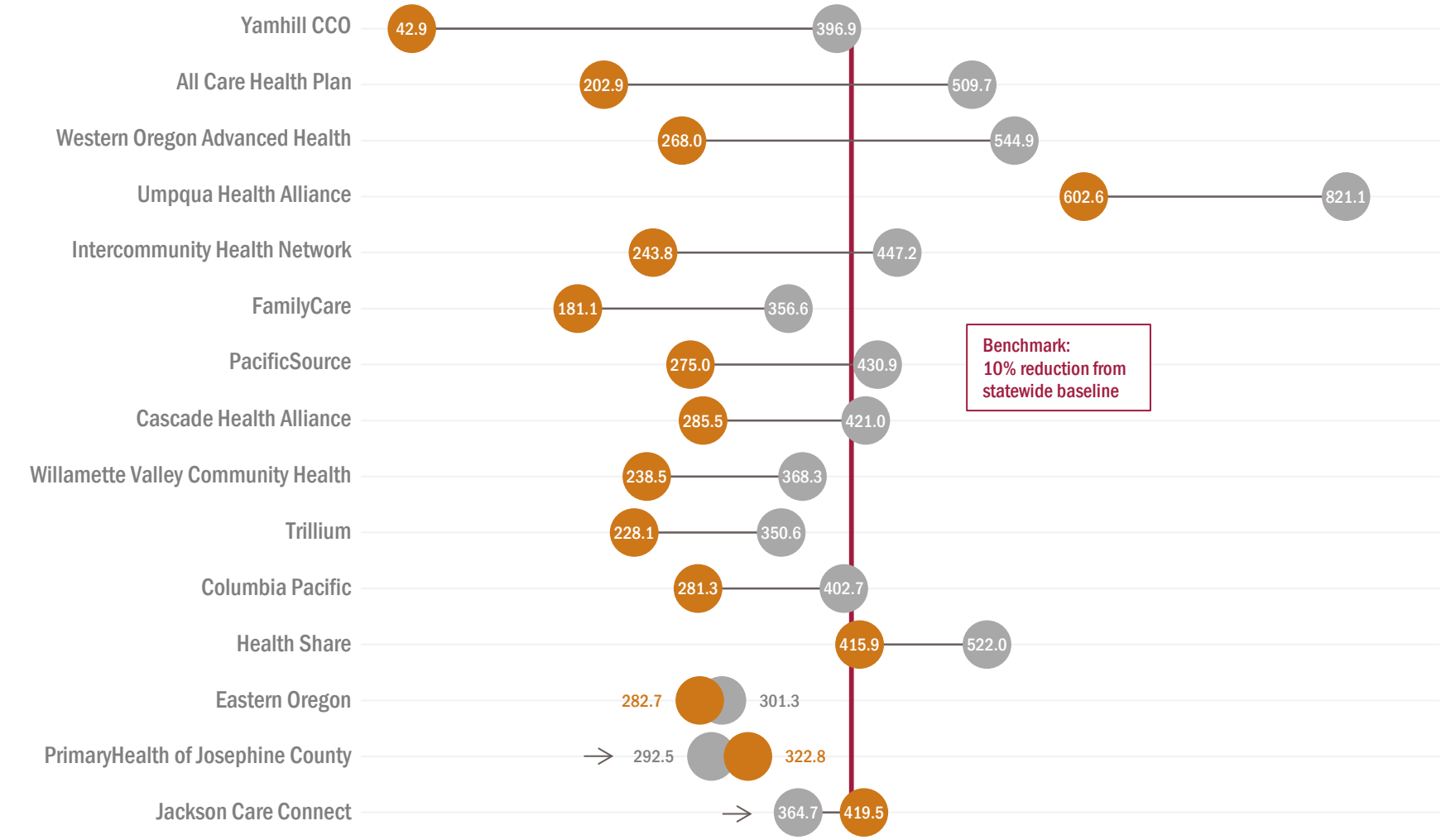
(Lower scores are better)



State Performance Measure

PQI 05: Rate of adult patients (age 40 and older) who had a hospital stay because of asthma or chronic obstructive pulmonary disease in 2011 & 2013

(Lower scores are better)
Rates are per 100,000 member years
PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators



State Performance Measure

Congestive heart failure admission rate

Measure description: Rate of adult patients (ages 18 and older) who had a hospital stay because of congestive heart failure. Rates are reported per 100,000 member years. A lower score is better.

PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

Purpose: Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce health care costs.

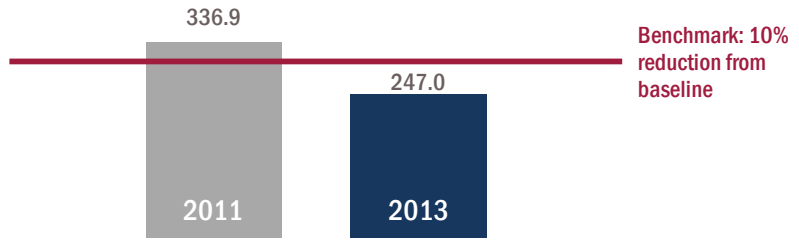
2013 data (n=2,672,059 member months)

This metric tracks hospital use for adults with congestive heart failure that could be better treated with good disease management. The rates for this measure are reported per 100,000 member years and a lower rate is better.

Statewide, CCOs performed below the benchmark for 2013, showing improvement in disease management care.

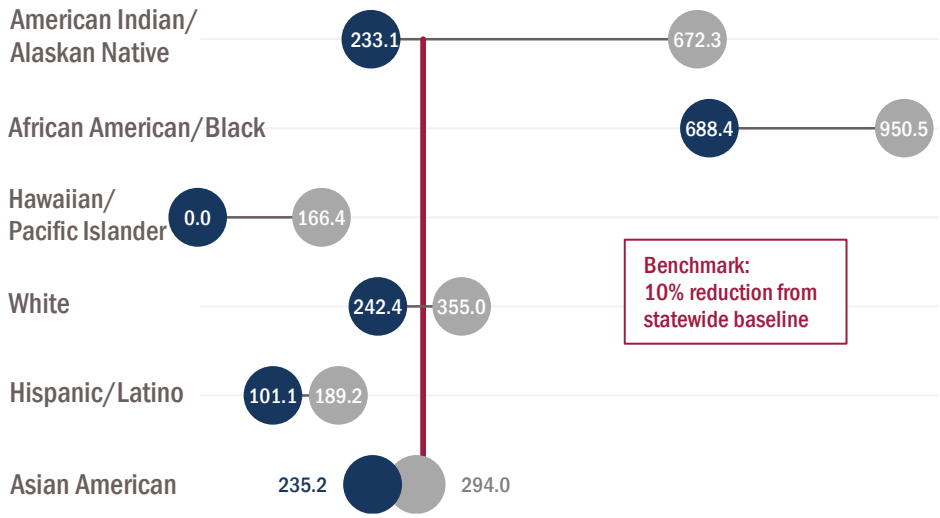
Statewide

(Lower scores are better)
Data source: Administrative (billing) claims
Benchmark source: OHA consensus, based on prior performance trend



Race and ethnicity data between 2011 & 2013

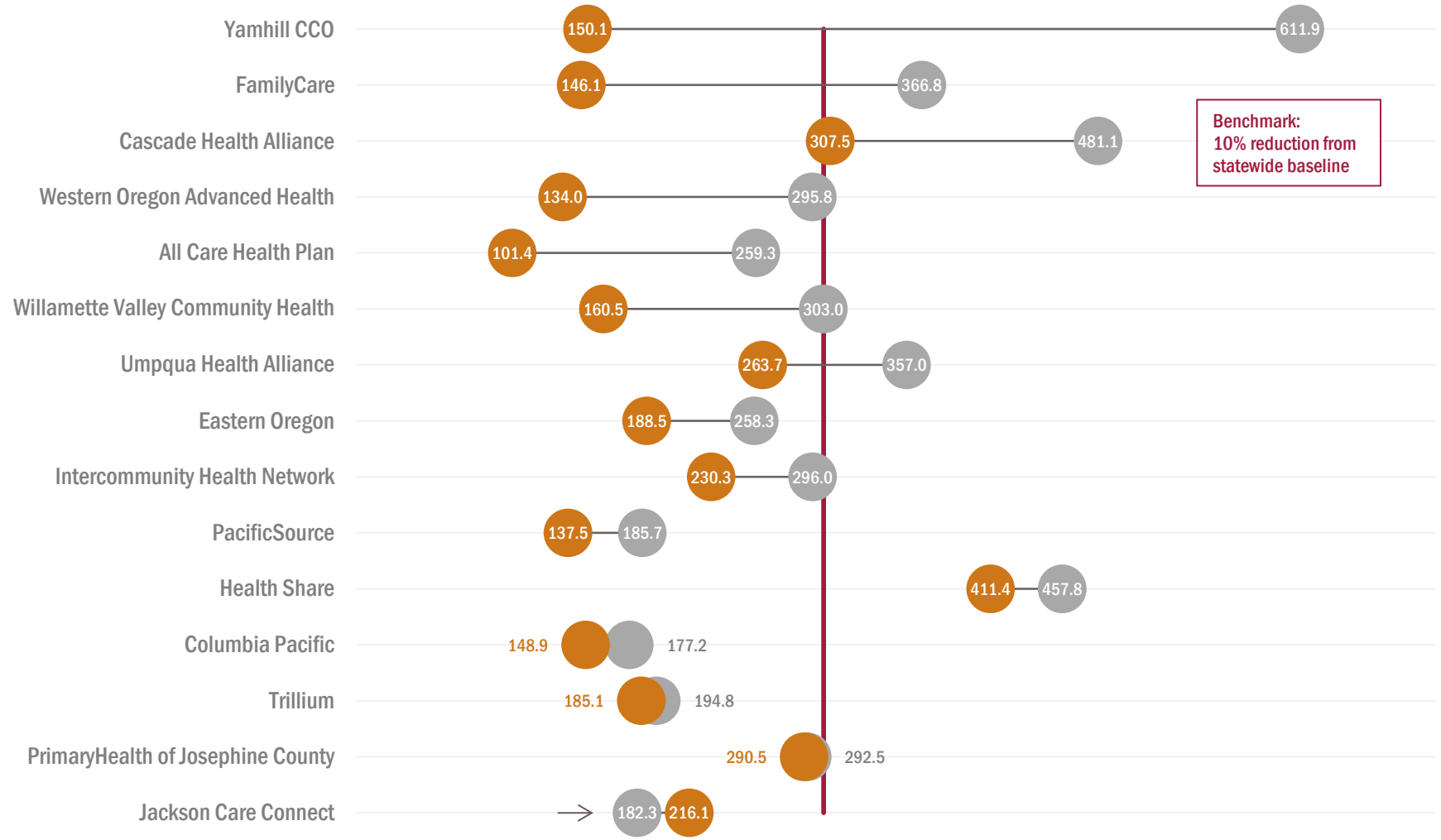
(Lower scores are better)



State Performance Measure

PQI 08: Rate of adult patients who had a hospital stay because of congestive heart failure in 2011 & 2013

(Lower score is better)
Rates are per 100,000 member years
PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators



State Performance Measure

Adult (ages 18-39) asthma admission rate

Measure description: Rate of adult patients (ages 18-39) who had a hospital stay because of asthma. Rates are reported per 100,000 member years. A lower score is better.

PQIs come from the Agency for Healthcare Research andQuality, Prevention Quality Indicators.

Purpose: Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospitalization. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce health care costs

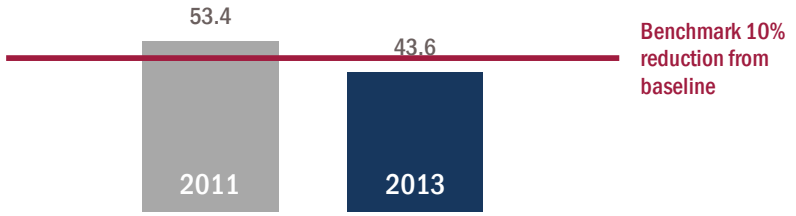
2013 data (n=2,672,059 member months)

This metric tracks hospital use for adults with asthma that could be better treated with good disease management. The rates for this measure are reported per 100,000 member years and a lower rate is better.

Statewide, CCOs performed below the benchmark for 2013 showing improvement in asthma care.

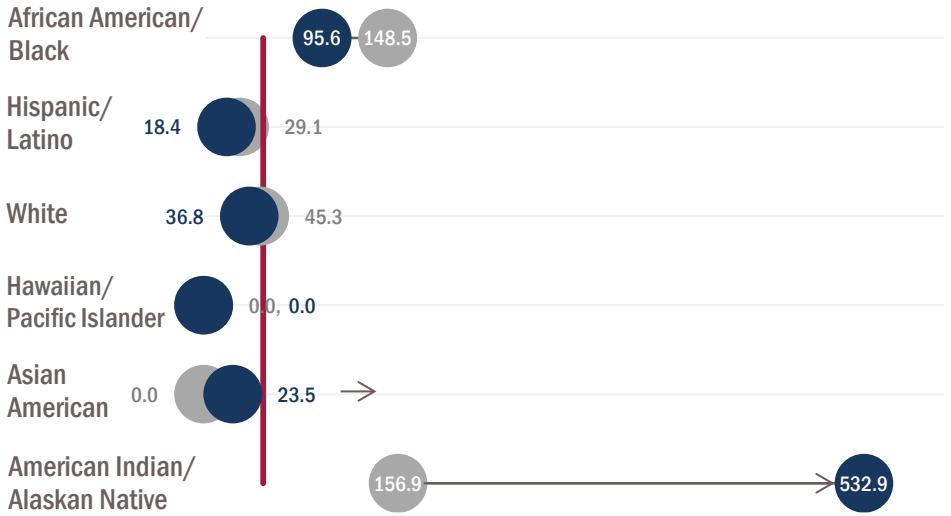
Statewide

(Lower scores are better)
Data source: Administrative (billing) claims
Benchmark source: OHA consensus, based on prior performance trend



Race and ethnicity data between 2011 & 2013

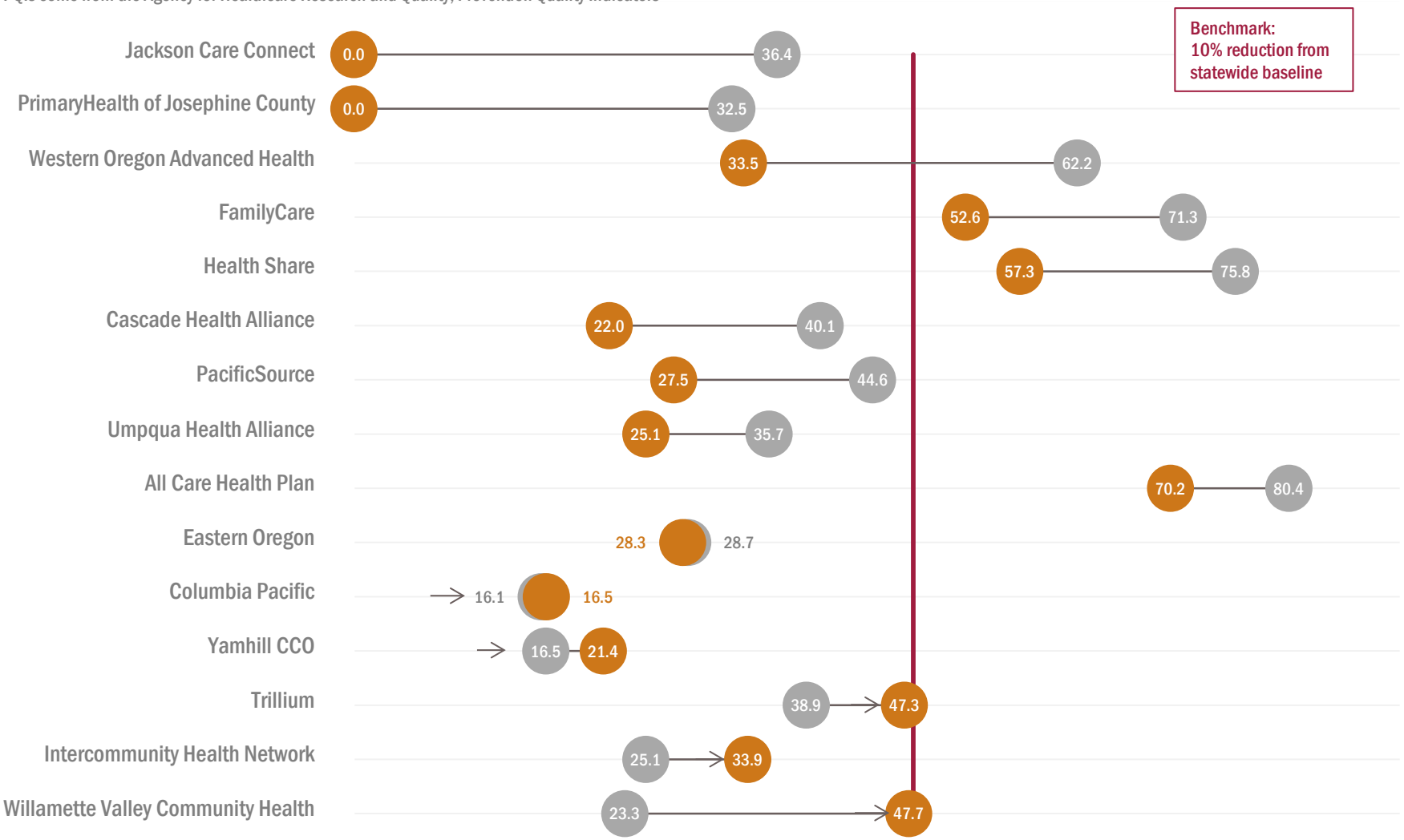
(Lower scores are better)
Data missing for 5.6% of respondents



State Performance Measure

PQI 15: Rate of adult patients (age 18-39) who had a hospital stay because of asthma in 2011 & 2013

(Lower score is better)
Rates are per 100,000 member years
PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators



CCO Incentive and State Performance Measure

Timeliness of prenatal care

Measure description: Percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days of enrollment in Medicaid.

Purpose: Care during a pregnancy (prenatal care) is widely considered the most productive and cost-effective way to support the delivery of a healthy baby. This measure helps ensure timeliness by tracking the percentage of women who receive an early prenatal care visit (in the first trimester). Improving the timeliness of prenatal care can lead to significantly better health outcomes and cost savings - as more than 40 percent of all babies born in Oregon are covered by Medicaid.

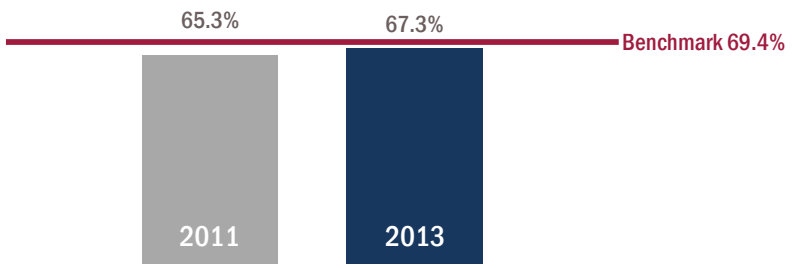
2013 data (n=5,598)

This metric tracks the percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days or enrollment in Medicaid. The 2013 data show an improvement over baseline and are approaching the statewide benchmark.

Twelve CCOs met their improvement target or exceeded the benchmark for this measure.

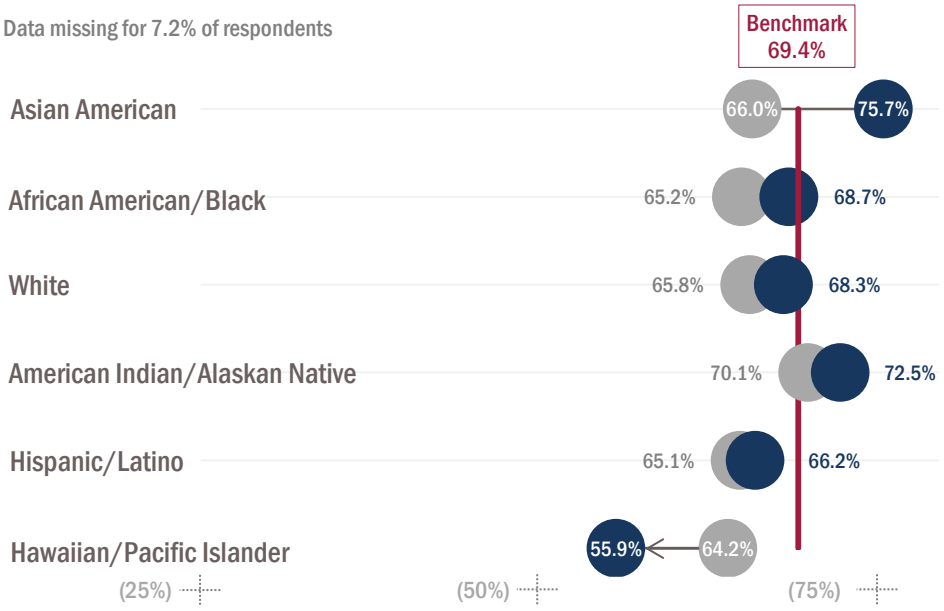
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile (administrative data only)



Race and ethnicity data between 2011 & 2013

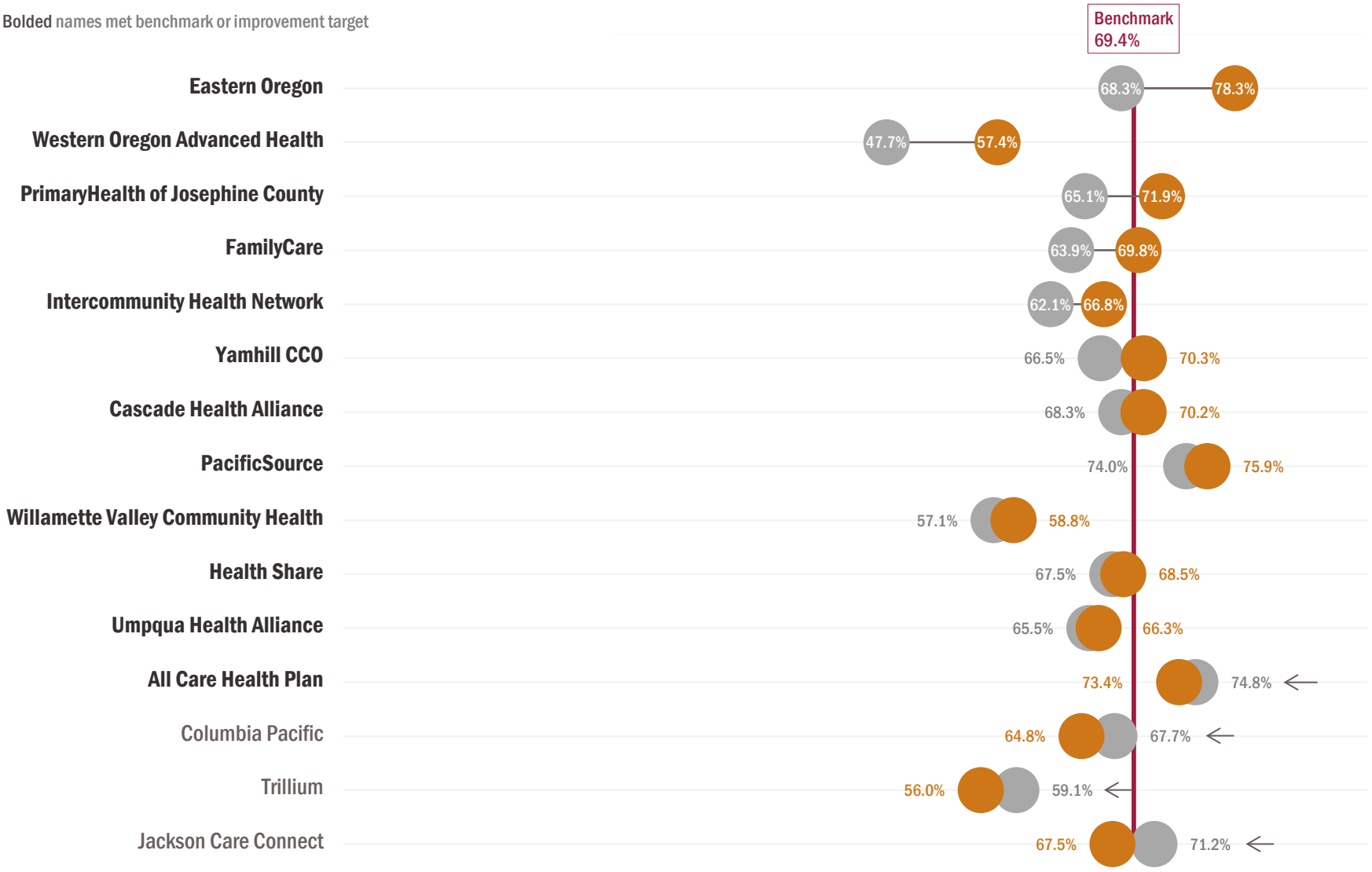
Data missing for 7.2% of respondents



CCO Incentive and State Performance Measure

Percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days of enrollment in Medicaid in 2011 & 2013

Bolded names met benchmark or improvement target



State Performance Measure

Postpartum care

Measure description: Percentage of women who had a postpartum care visit on or between 21 and 56 days after delivery.

Purpose: Having a timely postpartum care visit helps increase the quality of maternal care and reduces the risks for potential health complications associated with pregnancy. Women who have a visit between 21 and 56 days after delivery can have their physical health assessed and can consult with their provider about infant care, family planning and breastfeeding.

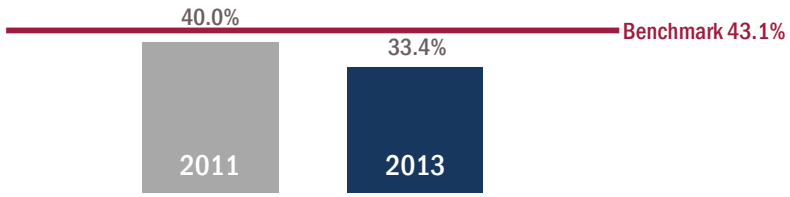
2013 data (n=13,385)

This metric tracks the percentage of women who had a timely postpartum care visit after delivery. Results for 2013 show a decrease in this measure when compared to 2011.

This measure cannot be reported at the CCO level for 2013.

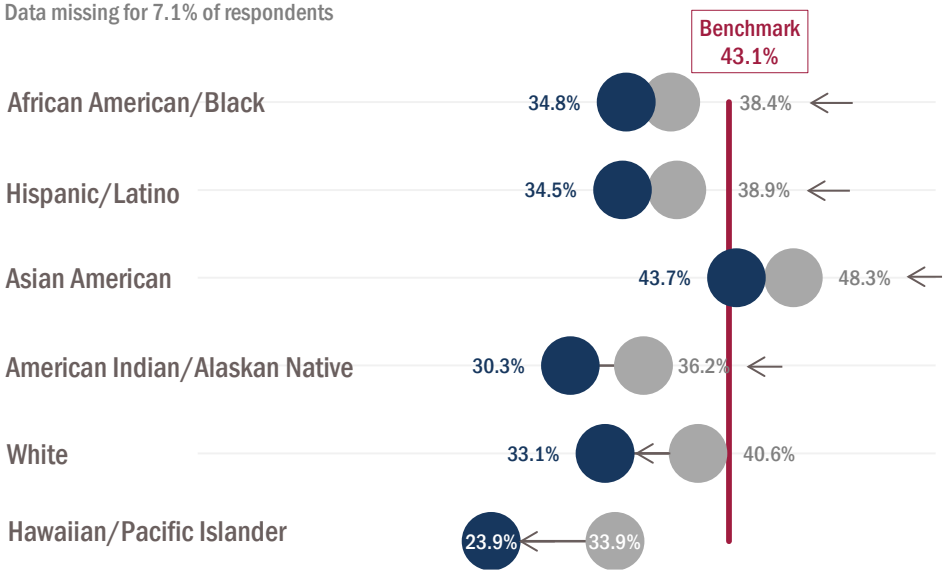
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 75th percentile (administrative data only, adjusted)



Race and ethnicity data between 2011 & 2013

Data missing for 7.1% of respondents



State Performance Measure

Component 1: Extent to which primary care providers are accepting new Medicaid patients

Measure description: Percentage of primary care providers who are accepting new Medicaid/Oregon Health Plan patients.

Component 2: Extent to which primary care providers currently see Medicaid patients

Definition: Percentage of primary care providers who currently care for Medicaid/Oregon Health Plan participants. This information does not include "don't know" or missing survey responses.

Component 3: Current payer mix at primary care practices

Definition: This measure will provide a breakdown of payer mix at primary care practices. This data will be available in a future report.

Purpose: Access to primary care leads to better health outcomes and more affordable health care. Improving primary care access for low-income Oregonians can also help reduce health disparities and overall health care costs

2013 data

The Oregon Physician Workforce Survey was not fielded in 2013. Updated data from the 2014 survey will be available in early 2015.

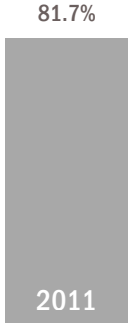
This measure cannot be stratified by race and ethnicity, nor reported at the CCO level.

Statewide: Component 1

Data source: Oregon Physician Workforce Survey
Benchmark TBD

Statewide: Component 2

Data source: Oregon Physician Workforce Survey
Benchmark TBD



CCO Incentive and State Performance Measure

Satisfaction with care (CAHPS)

Measure description: Percentage of patients (adults and children) who received needed information or help and thought they were treated with courtesy and respect by customer service staff.

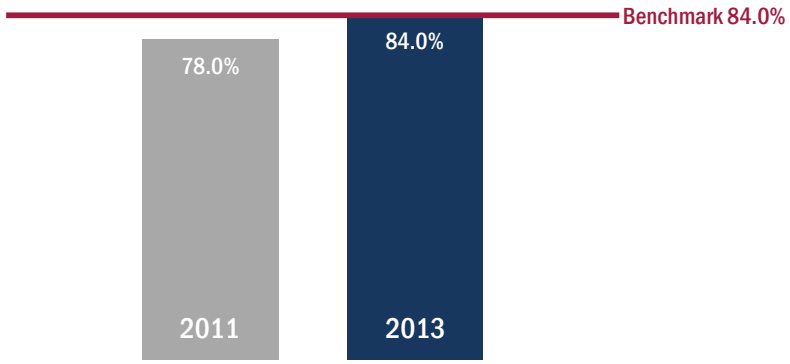
Purpose: A patient's satisfaction and overall experience with their care is a critical component of quality health care. Data show that healthier patients tend to report being more satisfied with the care they receive. Patients who are not satisfied with their care may miss appointments.

2013 data

The percentage of individuals reporting satisfaction with their health plan increased from 78% in 2011 to 84% in 2013, an increase of six percentage points. Overall, the statewide rate reached the benchmark for 2013. Additionally, seven of the 15 CCOs met the benchmark for this measure.

Statewide

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark source: 2012 National Medicaid 90th percentile



CCO Incentive and State Performance Measure

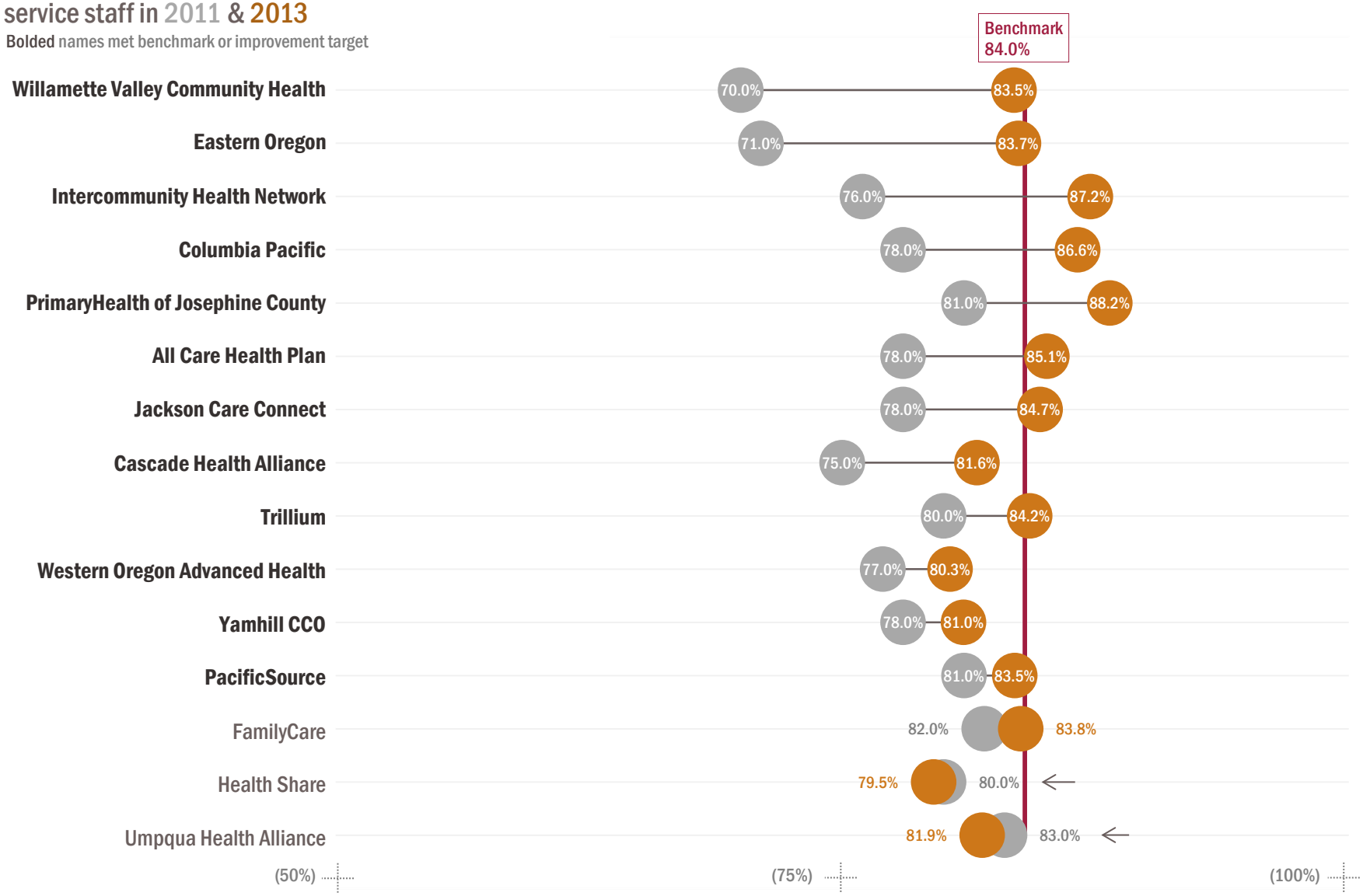
Race and ethnicity data between 2011 & 2013

CAHPS data by race and ethnicity will be available in future reports

CCO Incentive and State Performance Measure

Percentage of patients who received needed information and thought they were treated with courtesy and respect by customer service staff in 2011 & 2013

Bolded names met benchmark or improvement target



State Performance Measure

Well-child visits in the first 15 months of life

Measure description: Percentage of children up to 15 months old who had at least six well-child visits with a health care provider.

Purpose: Regular well-child visits are one of the best ways to detect physical, developmental, behavioral and emotional problems in infants. They are also an opportunity for providers to offer guidance and counseling to parents.

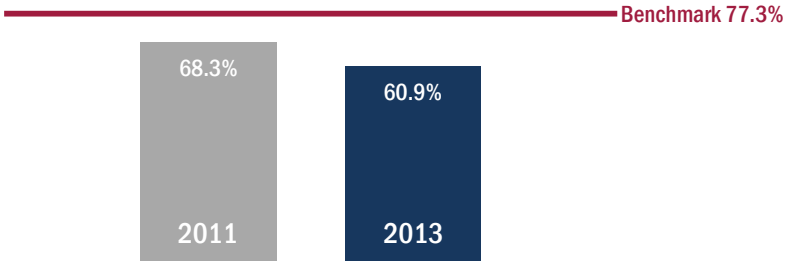
2013 data (n=4,120)

This metric tracks the percentage of children up to 15 months old who had at least six well-child visits with a health care provider. The 2013 percentage shows a decrease in this metric when compared to 2011.

Two CCOs increased the percentage of children who had at least six well child-visits, providing an opportunity to learn about their best practices.

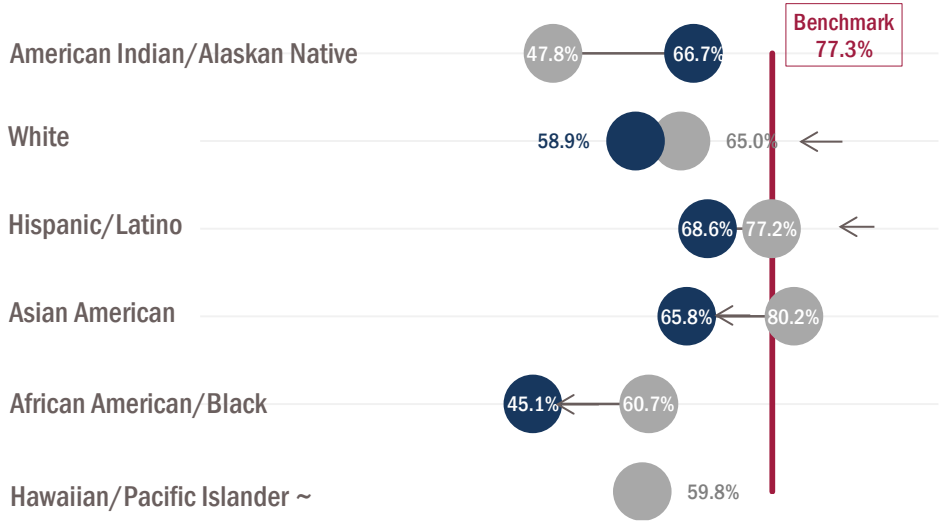
Statewide

Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile



Race and ethnicity data between 2011 & 2013

Data missing for 12.3% of respondents



State Performance Measure

Percentage of children up to 15 months old who had at least six well-child visits with a health care provider in 2011 & 2013

Approach

In order to reduce administrative burden and improve quality, OHA intends to leverage increasing capabilities for electronic reporting of clinical quality measure data. These capabilities are enabled through the use of Electronic Health Records (EHRs). OHA is pursuing a phased-in approach to electronic reporting of three CCO incentive measures: depression screening and follow up plan, diabetes HbA1c poor control, and controlling hypertension. In 2013, OHA required CCOs to submit a year one technology plan and proof of concept data in order to earn quality pool payments associated with these three measures.

Year One Technology Plans

The technology plans provide an environmental scan of the CCOs current technological capacity, including EHR adoption, health information exchange (HIE), and health information technology (HIT) projects underway. The technology plans also outline how CCOs will develop infrastructure to support electronic reporting of clinical quality data. CCOs received an advance distribution of quality pool funds (equaling 75 percent of 3/17ths of their quality pool total) once OHA had reviewed and approved their technology plans.

Proof of Concept Data

The proof of concept data submission is a sample of electronic clinical quality data, representing at least 10 percent of CCO membership, for each of the three clinical measures. CCOs received credit for the measure once OHA had reviewed and approved the submitted proof of concept data. The following page provides an overview of CCO results.

Additional Information

Supporting documentation for the year one technology plans and proof of concept data submission is available online at: http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

		Proof of Concept Data Approved		
Coordinated Care Organization	Year One Technology Plan Approved	Depression Screening	Diabetes Control	Hypertension Control
All Care Health Plan	√	√	√	√
Cascade Health Alliance	√	√	√	√
Columbia Pacific	√	√	√	√
Eastern Oregon	√	-	√	√
FamilyCare	√	√	√	√
Health Share	√	√	√	√
Intercommunity Health Network	√	√	√	√
Jackson Care Connect	√	√	√	√
PacificSource	√	√	√	√
PrimaryHealth of Josephine County	√	√	√	√
Trillium	√	√	√	√
Umpqua Health Alliance	√	√	√	√
Western Oregon Advanced Health	√	√	√	√
Willamette Valley Community Health	√	√	√	√
Yamhill CCO	√	√	√	√

Overview

OHA implemented a new software system used for grouping various claims into specific categories in the spring of 2014. Working with OHA's contractor, Milliman, we are using the MedInsight HCG (Health Cost Guidelines) Grouper. This is a proprietary classification system developed by Milliman. This is the same grouping software that is used to classify Commercial and Medicare Advantage claims in the All-Payer, All-Claims database system. Using the same software allows us to integrate reporting of CCO and other Medicaid data with the reports produced from All-Payer, All-Claims, database making the data comparable.

As a result, this report is generally not comparable with previous Health System Transformation Quarterly Reports. This report includes twelve quarters of data, using the new grouping system, which has been characterized in a similar manner to enable comparison of data over time.

Notes

This report includes claims data received and processed by OHA through 5/30/14. At this point, there are no data on services that have happened, but have yet to be recorded or invoiced. This dashboard may be incomplete due to lags in submitting data to OHA. Future dashboards will be updated when more complete data is submitted.

The cost and utilization information includes data from before health transformation began and CCOs were formed. Calendar year 2013 is the first full year of CCO data.

Utilization data statewide (table 1 of 3)

Category	Jan - Mar 2011	Apr - Jun 2011	Jul - Sep 2011	Oct - Dec 2011	Annual 2011
Utilization Data (annualized / 1,000 members)					
Inpatient -- Medical / General -- Patient Days	202.8	176.3	160.8	156.1	173.7
Inpatient -- Surgical -- Patient Days	98.5	88.4	80.8	81.1	87.1
Inpatient -- Maternity / Normal Delivery -- Patient Days	43.7	47.4	47.0	42.8	45.2
Inpatient -- Maternity / C-Section Delivery -- Patient Days	27.2	27.7	27.5	26.2	27.2
Inpatient -- Maternity / Non-Delivery -- Patient Days	9.6	10.2	9.5	9.3	9.7
Inpatient -- Newborn / Well -- Patient Days	39.8	42.6	41.8	37.6	40.5
Inpatient -- Newborn / With Complications -- Patient Days	55.6	45.5	51.5	49.9	50.6
Inpatient -- Mental Health / Psychiatric -- Patient Days	54.9	57.2	49.3	49.7	52.7
Inpatient -- Mental Health / Alcohol and Drug Abuse -- Patient Days	5.2	4.7	6.3	5.0	5.3
Inpatient -- Physician Procedures	412.5	399.0	382.5	365.7	389.7
Outpatient -- Primary Care Medical Visits	2,977.9	2,741.4	2,368.9	2,486.9	2,640.1
Outpatient -- Specialty Care Visits	1,666.5	1,613.5	1,467.7	1,492.6	1,558.8
Outpatient -- Mental Health Visits	2,085.1	2,114.2	1,929.2	1,939.1	2,015.7
Outpatient -- Dental Procedures	3,134.5	3,095.2	2,991.6	2,911.1	3,031.5
Outpatient -- Emergency Department Visits (see ED utilization metric)					
Outpatient -- Pharmacy Prescriptions Filled	10,191.0	########	9,139.9	9,542.2	9,717.3
Outpatient -- Imaging Visits	259.7	247.0	233.1	226.9	241.5
Outpatient -- Lab Bills	601.8	567.8	528.5	527.9	556.0
Outpatient -- Surgery (Hospital and ASC) Cases	92.7	94.4	81.6	75.7	86.0

Utilization data statewide (table 2 of 3)

Category	Jan - Mar 2012	Apr - Jun 2012	Jul - Sep 2012	Oct - Dec 2012	Annual 2012
Utilization Data (annualized / 1,000 members)					
Inpatient -- Medical / General -- Patient Days	186.9	170.9	150.7	161.0	167.2
Inpatient -- Surgical -- Patient Days	88.1	77.0	79.2	84.5	82.2
Inpatient -- Maternity / Normal Delivery -- Patient Days	41.9	44.7	43.6	37.7	41.9
Inpatient -- Maternity / C-Section Delivery -- Patient Days	24.8	23.4	29.0	23.1	25.0
Inpatient -- Maternity / Non-Delivery -- Patient Days	8.2	7.9	8.1	7.0	7.8
Inpatient -- Newborn / Well -- Patient Days	36.9	35.8	33.8	34.8	35.3
Inpatient -- Newborn / With Complications -- Patient Days	45.0	49.7	48.1	46.9	47.4
Inpatient -- Mental Health / Psychiatric -- Patient Days	48.0	48.3	46.3	45.5	47.0
Inpatient -- Mental Health / Alcohol and Drug Abuse -- Patient Days	5.6	4.9	4.8	6.3	5.4
Inpatient -- Physician Procedures	376.2	368.5	361.0	314.3	354.4
Outpatient -- Primary Care Medical Visits	2,857.1	2,675.1	2,439.3	2,782.4	2,689.0
Outpatient -- Specialty Care Visits	1,483.6	1,429.8	1,324.4	1,122.6	1,337.0
Outpatient -- Mental Health Visits	2,086.4	2,165.8	2,124.6	2,261.8	2,161.9
Outpatient -- Dental Procedures	2,972.3	2,933.0	2,770.9	2,737.7	2,853.2
Outpatient -- Emergency Department Visits (see ED utilization metric)					
Outpatient -- Pharmacy Prescriptions Filled	9,533.7	9,610.9	8,488.1	8,897.6	9,128.1
Outpatient -- Imaging Visits	240.2	227.0	214.6	213.8	223.7
Outpatient -- Lab Bills	566.6	541.8	509.8	496.6	528.2
Outpatient -- Surgery (Hospital and ASC) Cases	77.8	80.7	76.1	72.4	76.7

Utilization data statewide (table 3 of 3)

Category	Jan - Mar 2013	Apr - Jun 2013	Jul - Sep 2013	Oct - Dec 2013	Annual 2013
Utilization Data (annualized / 1,000 members)					
Inpatient -- Medical / General -- Patient Days	187.3	157.6	151.8	157.9	163.6
Inpatient -- Surgical -- Patient Days	79.3	76.7	84.3	79.5	79.9
Inpatient -- Maternity / Normal Delivery -- Patient Days	42.8	41.2	41.0	39.4	41.1
Inpatient -- Maternity / C-Section Delivery -- Patient Days	23.3	22.4	25.0	22.5	23.3
Inpatient -- Maternity / Non-Delivery -- Patient Days	7.9	8.4	7.7	8.0	8.0
Inpatient -- Newborn / Well -- Patient Days	38.5	37.2	33.0	26.9	33.9
Inpatient -- Newborn / With Complications -- Patient Days	41.4	51.3	49.0	40.5	45.6
Inpatient -- Mental Health / Psychiatric -- Patient Days	46.4	45.3	39.8	43.2	43.7
Inpatient -- Mental Health / Alcohol and Drug Abuse -- Patient Days	4.9	5.7	5.6	6.0	5.6
Inpatient -- Physician Procedures	301.6	314.8	328.4	310.2	313.8
Outpatient -- Primary Care Medical Visits	3,215.5	2,947.7	2,745.0	2,825.9	2,933.6
Outpatient -- Specialty Care Visits	1,289.6	1,232.2	1,178.7	1,181.7	1,220.6
Outpatient -- Mental Health Visits	2,183.6	2,165.4	1,943.8	1,920.5	2,053.9
Outpatient -- Dental Procedures	3,005.7	3,133.8	3,081.6	2,927.4	3,037.4
Outpatient -- Emergency Department Visits (see ED utilization metric)					
Outpatient -- Pharmacy Prescriptions Filled	9,433.2	8,827.7	8,994.3	9,133.9	9,096.8
Outpatient -- Imaging Visits	229.3	229.4	221.1	217.7	224.4
Outpatient -- Lab Bills	512.7	504.2	483.4	457.5	489.5
Outpatient -- Surgery (Hospital and ASC) Cases	79.4	82.1	78.1	74.0	78.4

Cost data statewide (table 1 of 3)

Category	Jan - Mar 2011	Apr - Jun 2011	Jul - Sep 2011	Oct - Dec 2011	Annual 2011
Cost Per Member Per Month (PMPM)					
Inpatient -- Medical / General	$ 29.91	$ 26.82	$ 26.84	$ 23.59	$ 26.76
Inpatient -- Surgical	$ 23.11	$ 22.34	$ 22.57	$ 18.96	$ 21.73
Inpatient -- Maternity / Normal Delivery	$ 6.42	$ 6.77	$ 6.93	$ 5.79	$ 6.48
Inpatient -- Maternity / C-Section Delivery	$ 4.21	$ 4.58	$ 4.60	$ 3.98	$ 4.35
Inpatient -- Maternity / Non-Delivery	$ 1.31	$ 1.41	$ 1.35	$ 1.12	$ 1.30
Inpatient -- Newborn / Well	$ 2.27	$ 2.46	$ 2.32	$ 1.90	$ 2.24
Inpatient -- Newborn / With Complications	$ 7.44	$ 7.05	$ 7.07	$ 6.98	$ 7.13
Inpatient -- Mental Health / Psychiatric	$ 3.81	$ 4.21	$ 3.71	$ 3.68	$ 3.85
Inpatient -- Mental Health / Alcohol and Drug Abuse	$ 0.42	$ 0.42	$ 0.58	$ 0.46	$ 0.47
Inpatient -- Physician Services	$ 13.49	$ 13.02	$ 13.41	$ 12.54	$ 13.11
Outpatient -- Primary Care and Preventive Services	$ 20.75	$ 18.85	$ 17.77	$ 18.58	$ 18.97
Outpatient -- Specialty Care	$ 14.15	$ 13.67	$ 13.51	$ 13.07	$ 13.59
Outpatient -- Mental Health	$ 23.36	$ 23.24	$ 21.28	$ 21.48	$ 22.33
Outpatient -- Dental	$ 12.73	$ 12.71	$ 12.04	$ 11.28	$ 12.18
Outpatient -- Emergency Department (Professional and Technical)	$ 27.24	$ 26.03	$ 25.89	$ 20.70	$ 24.94
Outpatient -- Pharmacy Prescriptions	$ 32.86	$ 32.50	$ 31.08	$ 32.84	$ 32.31
Outpatient -- Imaging (Professional and Technical)	$ 10.72	$ 10.15	$ 9.87	$ 8.30	$ 9.75
Outpatient -- Labs (Professional and Technical)	$ 7.09	$ 6.66	$ 6.43	$ 5.55	$ 6.43
Outpatient -- Surgery (Hospital and ASC/Professional and Technica	$ 19.10	$ 19.59	$ 18.37	$ 14.42	$ 17.86
Outpatient -- Other Hospital Services	$ 8.55	$ 8.62	$ 8.80	$ 7.89	$ 8.46
Outpatient -- All Other	$ 22.16	$ 22.09	$ 22.79	$ 23.05	$ 22.53

Cost data statewide (table 2 of 3)

Category	Jan - Mar 2012	Apr - Jun 2012	Jul - Sep 2012	Oct - Dec 2012	Annual 2012
Cost Per Member Per Month (PMPM)					
Inpatient -- Medical / General	$ 26.59	$ 25.49	$ 22.98	$ 24.63	$ 24.92
Inpatient -- Surgical	$ 20.34	$ 18.73	$ 18.52	$ 20.62	$ 19.56
Inpatient -- Maternity / Normal Delivery	$ 5.33	$ 5.79	$ 5.93	$ 5.56	$ 5.65
Inpatient -- Maternity / C-Section Delivery	$ 3.64	$ 3.24	$ 3.90	$ 3.63	$ 3.61
Inpatient -- Maternity / Non-Delivery	$ 0.91	$ 0.85	$ 0.83	$ 0.85	$ 0.86
Inpatient -- Newborn / Well	$ 1.83	$ 1.75	$ 1.78	$ 1.97	$ 1.84
Inpatient -- Newborn / With Complications	$ 6.07	$ 6.58	$ 6.86	$ 6.01	$ 6.38
Inpatient -- Mental Health / Psychiatric	$ 3.28	$ 3.56	$ 2.99	$ 3.08	$ 3.23
Inpatient -- Mental Health / Alcohol and Drug Abuse	$ 0.45	$ 0.49	$ 0.39	$ 0.54	$ 0.47
Inpatient -- Physician Services	$ 12.81	$ 12.60	$ 12.76	$ 11.86	$ 12.50
Outpatient -- Primary Care and Preventive Services	$ 20.52	$ 19.33	$ 18.19	$ 20.55	$ 19.66
Outpatient -- Specialty Care	$ 13.34	$ 12.99	$ 12.26	$ 11.38	$ 12.48
Outpatient -- Mental Health	$ 22.43	$ 22.67	$ 21.44	$ 22.35	$ 22.24
Outpatient -- Dental	$ 10.61	$ 8.10	$ 7.62	$ 7.59	$ 8.47
Outpatient -- Emergency Department (Professional and Technical)	$ 21.94	$ 21.29	$ 20.78	$ 20.11	$ 21.02
Outpatient -- Pharmacy Prescriptions	$ 34.46	$ 37.91	$ 31.06	$ 32.57	$ 33.98
Outpatient -- Imaging (Professional and Technical)	$ 8.55	$ 8.05	$ 7.80	$ 8.14	$ 8.13
Outpatient -- Labs (Professional and Technical)	$ 5.87	$ 5.69	$ 5.38	$ 5.47	$ 5.60
Outpatient -- Surgery (Hospital and ASC/Professional and Technica	$ 14.86	$ 15.64	$ 14.94	$ 14.24	$ 14.91
Outpatient -- Other Hospital Services	$ 7.67	$ 7.38	$ 7.25	$ 7.36	$ 7.41
Outpatient -- All Other	$ 23.52	$ 22.48	$ 22.75	$ 23.23	$ 23.00

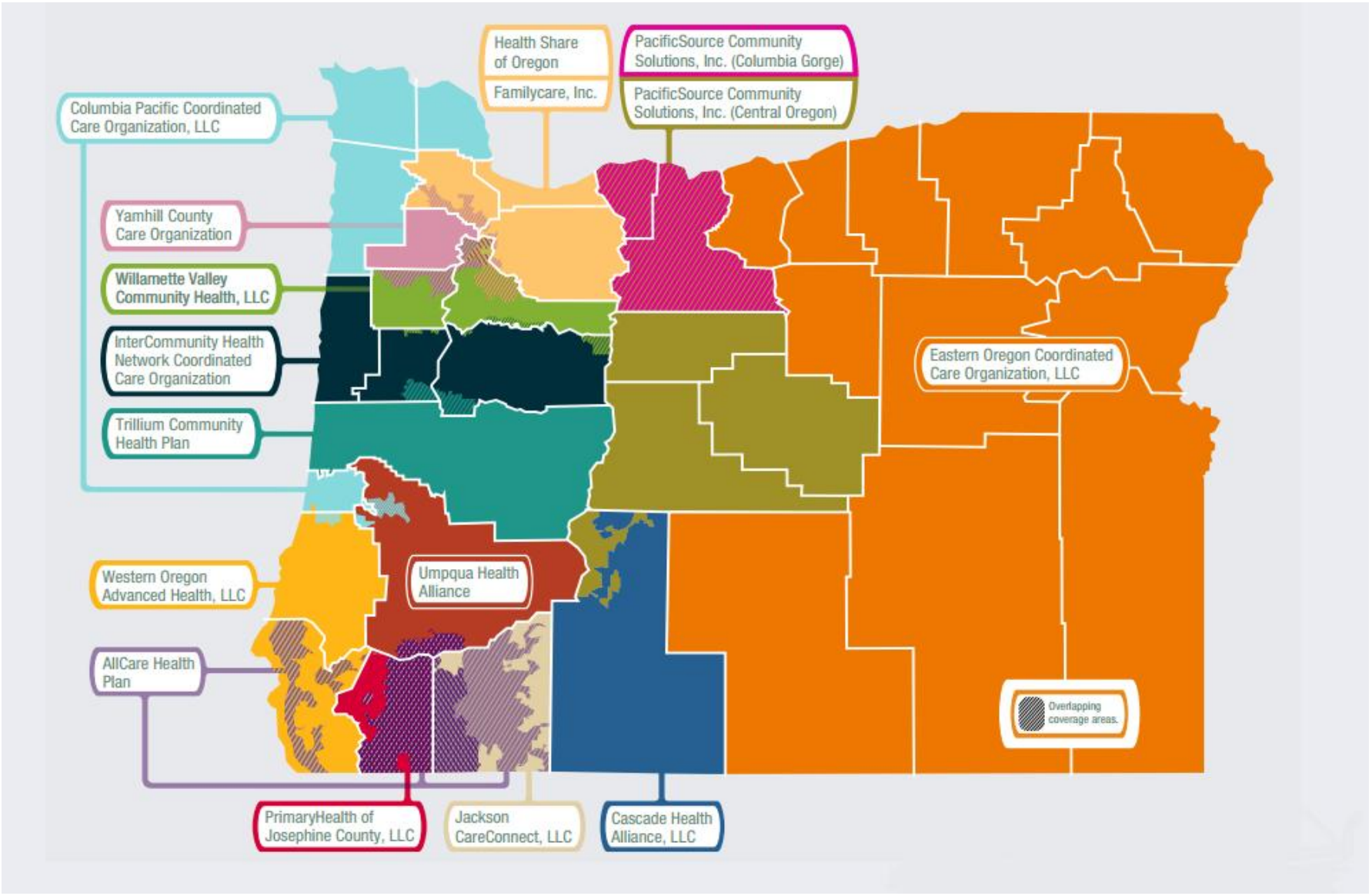
Cost data statewide (table 3 of 3)

Category	Jan - Mar 2013	Apr - Jun 2013	Jul - Sep 2013	Oct - Dec 2013	Annual 2013
Cost Per Member Per Month (PMPM)					
Inpatient -- Medical / General	$ 29.22	$ 25.15	$ 22.27	$ 24.74	$ 25.34
Inpatient -- Surgical	$ 19.98	$ 20.42	$ 20.52	$ 20.48	$ 20.35
Inpatient -- Maternity / Normal Delivery	$ 6.10	$ 6.07	$ 5.79	$ 6.29	$ 6.06
Inpatient -- Maternity / C-Section Delivery	$ 3.70	$ 3.59	$ 3.75	$ 3.47	$ 3.63
Inpatient -- Maternity / Non-Delivery	$ 0.96	$ 0.94	$ 0.82	$ 1.04	$ 0.94
Inpatient -- Newborn / Well	$ 2.32	$ 2.21	$ 1.75	$ 2.02	$ 2.07
Inpatient -- Newborn / With Complications	$ 5.86	$ 6.65	$ 7.06	$ 6.01	$ 6.40
Inpatient -- Mental Health / Psychiatric	$ 3.18	$ 3.20	$ 2.94	$ 3.02	$ 3.09
Inpatient -- Mental Health / Alcohol and Drug Abuse	$ 0.43	$ 0.48	$ 0.50	$ 0.50	$ 0.48
Inpatient -- Physician Services	$ 12.24	$ 12.65	$ 13.04	$ 12.45	$ 12.60
Outpatient -- Primary Care and Preventive Services	$ 23.95	$ 22.32	$ 22.07	$ 23.32	$ 22.91
Outpatient -- Specialty Care	$ 13.16	$ 12.70	$ 12.03	$ 11.70	$ 12.40
Outpatient -- Mental Health	$ 21.51	$ 21.10	$ 20.88	$ 19.97	$ 20.87
Outpatient -- Dental	$ 8.26	$ 8.56	$ 8.30	$ 7.98	$ 8.28
Outpatient -- Emergency Department (Professional and Technical)	$ 21.51	$ 20.53	$ 20.09	$ 18.26	$ 20.10
Outpatient -- Pharmacy Prescriptions	$ 33.76	$ 32.49	$ 34.42	$ 35.70	$ 34.09
Outpatient -- Imaging (Professional and Technical)	$ 8.54	$ 8.32	$ 8.18	$ 7.84	$ 8.22
Outpatient -- Labs (Professional and Technical)	$ 6.24	$ 6.12	$ 5.76	$ 5.61	$ 5.94
Outpatient -- Surgery (Hospital and ASC/Professional and Technica	$ 15.73	$ 16.08	$ 15.57	$ 14.59	$ 15.50
Outpatient -- Other Hospital Services	$ 7.97	$ 7.63	$ 7.52	$ 7.25	$ 7.59
Outpatient -- All Other	$ 24.55	$ 24.25	$ 25.30	$ 25.09	$ 24.80

Coordinated Care Organization Service Areas

CCO Name	Service Area by County
AllCare Health Plan	Curry, Josephine, Jackson, Douglas (partial)
Cascade Health Alliance	Klamath County (partial)
Columbia Pacific CCO	Clatsop, Columbia, Coos (partial), Douglas (partial), Tillamook
Eastern Oregon CCO	Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler
FamilyCare	Clackamas, Marion (partial), Multnomah, Washington
Health Share of Oregon	Clackamas, Multnomah, Washington
Intercommunity Health Network	Benton, Lincoln, Linn
Jackson Care Connect	Jackson
PacificSource Community Solutions - Central Oregon	Crook, Deschutes, Jefferson, Klamath (partial)
PacificSource Community Solutions - Gorge	Hood River, Wasco
PrimaryHealth of Josephine County	Douglas (partial), Jackson (partial), Josephine
Trillium Community Health Plan	Lane
Umpqua Health Alliance	Douglas (most)
Western Oregon Advanced Health	Coos, Curry
Willamette Valley Community Health	Marion, Polk (most)
Yamhill CCO	Clackamas (partial), Marion (partial), Polk (partial), Yamhill

Coordinated Care Organization Service Areas



OHA Contacts and Online Information

For questions about performance metrics, contact:

Lori Coyner
Director of Health Analytics
Oregon Health Authority
Email: lori.a.coyner@state.or.us

For questions about financial metrics, contact:

Jeff Fritsche
Finance Director
Oregon Health Authority
Email: jeffrey.p.fritsche@state.or.us

For more information about technical specifications for measures, visit:

http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

For more information about coordinated care organizations, visit:

http://www.health.oregon.gov

This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request this publication in another format or language, contact the Oregon Health Authority Director's Office at 503-947-2340 or email at OHA.DirectorsOffice@state.or.us.

Payment **REFORM** *in Oregon*

The Oregon Health Authority (OHA) has contracted the Center for Evidence-based Policy (Center) to research alternative payment methodologies (APMs) and solicit feedback on payment reform options from Oregon's health transformation stakeholders. The goal of payment reform is to incentivize value over volume and ensure providers and payers are working together to achieve the Triple Aim.

Oregon's Coordinated Care Organizations (CCOs) are statutorily required to develop APMs. The Center's findings will be available to CCOs and other organizations as they address the challenges of health care transformation.

The Center conducted an evidence review of the effectiveness of APMs as well as interviews with 18 thought leaders across Oregon. The Center is currently analyzing this data and gathering feedback from stakeholder groups, and wants your input on the following preliminary findings:

1 Evidence shows APMs can be **effective in reducing utilization, costs, and improving quality of care**

The majority of the evidence focuses on pay-for-performance and shows that these programs have been successful in improving quality indicators while reducing costs and admission rates. Studies of bundled payments and capitation also show evidence of effectiveness given certain conditions.

2 Thought leaders are **engaged and committed to implementing payment reform**

Thought leaders were informed about payment reform methodologies and generally supportive of changing health care reimbursement methods in Oregon. They see potential to improve care and reduce costs, and they are interested in moving forward in reform.

"We would like the flexibility that comes with [APM]."
— Provider

3 There is **no "one size fits all" model for payment reform**

Different models will work in different situations, such as in rural versus urban settings and, primary versus specialty care. Fitting or blending models to the situation is critical for payment reform success.

"Most of my conversations with people have been 'which model is going to work?' and I think ... it's a blend of models ... even for the big hospitals and the little hospitals."
— Hospital

4 Reform decisions need to be made **at the local level and engage all stakeholders**

Thought leaders who had successfully implemented innovative payment strategies stressed that trust among participants and communication among providers were both essential to achieving desired outcomes.

" [It's] less to do with which is the best payment model, and more to do with how you're having the conversations with constituents about the payment model." — *CCO*

5 Specialists need to be at the table

Most of the reform efforts in Oregon have focused on primary care. While primary care providers need to remain engaged it is our recommendation that specialists should also be involved in these conversations.

"One of our primary care physicians ... has 130 different metrics ... to measure." — *Health System*

6 Metrics are important

Metrics need to measure something worthwhile, and providers need control over the measured outcome. Additionally, providers are overwhelmed with current metrics and reporting requirements, and it may be beneficial to find ways to reduce this burden.

7 Reforming payment methodologies will **require other system changes**

The current system relies on fee for service encounter codes and payment reform changes will require changes to state and federal actuarial and accounting systems.

8 Sharing experiences, **best practices, success strategies, and practices to avoid are essential**

Payment reform is still nascent and there are a range of strategies and methods. Thought leaders emphasized the need to communicate successes and setbacks to help each other through this process.

Findings from the evidence review, interviews, and stakeholder feedback will be summarized in a final report to OHA. The final report will also include findings, models, tools and strategies for use in payment reform. The Center and OHA would appreciate hearing your thoughts about payment reform and invite you to contact Allison Leof at **leof@ohsu.edu**. The Center will also have an online survey to collect feedback and will provide a direct link in the next OMA newsletter. We look forward to hearing from you!

OREGON HEALTH & SCIENCE UNIVERSITY

OHSU

Oregon Health Authority

Innovative Payment Tools Project
Preliminary Findings Presentation

Innovative Payment Tools Project

Presentation Overview

- Project background
- Review of preliminary findings
- Thought leader impressions of 6 APM models

Project Background

Background

Oregon's comprehensive health care reform initiative requires that CCOs provide quality care within a defined budget and reduce the annual growth in the cost of care.

The CCOs are required by statute to adopt alternative payment methodologies (APMs) as part of their cost reduction and quality improvement strategies.

Background

The Oregon Health Authority (OHA) has contracted with the Center for Evidence-based Policy (the Center) to explore the effectiveness and feasibility of various APMs as well as identify and assist in the development of design and implementation tools for CCOs and other organizations.

Project Background – So Far

- Research staff at the Center have:
  - Completed an evidence review of APM models
  - Conducted interviews with Oregon thought leaders
  - Completed a preliminary analysis of findings
- Preliminary findings will be addressed in this presentation

Project Background – Next Steps

- Research staff at the Center will:
  - Conduct facilitated discussions statewide with diverse stakeholders
  - Synthesize all findings and report them publically
  - Identify tools to assist CCOs and other entities design and implement APMs

Preliminary Findings

Finding 1: There is Evidence for Effectiveness

Overall findings of literature review:

- APMs show promise for
  - Reducing health care utilization
  - Reducing overall costs
  - Improving quality
- Evidence is strongest for episodes of care and pay-for-performance

Finding 1: There is Evidence for Effectiveness

However

- Study quality is uneven
- Most studies have insufficient information to determine key implementation features
- Many APMs are new, and have not been fully assessed
- Effects in some cases may be due to shifting of care or patient selection biases

Finding 2: Oregon Leaders Support Exploring APMs

Overall, Oregon thought leaders were:

- Experienced and knowledgeable about APMs
- Willing to explore implementing new payment models.

Respondents shared implementation concerns for each model and APMs in general

No one model was clearly preferred over the others

Finding 3: No "One size fits all" Model

We presented six basic APM models and solicited feedback.

Majority of respondents stated that:

- Success of any given APM will depend on 'set and setting'
- Flexibility in blending models and/or implementing several models will likely be needed

Specific Models – Episodes of Care (EOC)

- Overall, support for EOC
  - Has been used successfully in obstetrics care, cardiac and orthopedic procedures
- Works best for
  - Elective or planned procedures or events with clear boundaries
  - Procedures and practices where there is sufficient volume to minimize risk
- Advantages
  - Incentivizes efficiency and high quality care to minimize adverse events
  - Offers predictability for the purchaser

Specific Models – Episodes of Care

- Challenges
  - Accounting and payment systems aren't set up to pay through episodes
  - Does not reduce administrative burden – there is still a need to record encounters
  - Risk of creating patient selection bias
  - Defining what is included in the EOC is challenge
  - Determining a proper payment rate and negotiating whether there are modifiers for high risk patients/co-morbid conditions can be challenging

Specific Models: Bundled Payments

Episodes of care were viewed more favorably than bundled payments due to the following challenges:

- How do you determine who is accountable and who manages the bundled payment?
- The need for the accountable party to subcontract services and assume risk
- How do you align efficiency and quality incentives across multiple providers?

Bundled payments seen as more likely to work in integrated systems.

Specific Models – Shared Savings & Risk

- Majority of respondents felt model needed both reward and risk
- Providers must be able to “control” or affect the outcomes for which they are at risk
- Successful models require trust and cooperation between providers and excellent communication

Specific Models – Shared Savings & Risk

Concerns include:

- Defining population to be included (By practice? Geographic are? Diagnosis?)
- Deciding how to share savings/risk across providers
- Preventing denials of care or underutilization
- Gains are likely to be realized in initial years and by less efficient and effective providers at baseline

Specific Models – Shared Savings & Risk

Suggested targets:

- Top utilizers – identify team to manage patients and improve health outcomes/reduce inappropriate utilization
- Identify DRGs that exceed defined cost threshold, work with providers to manage care and processes to reduce costs

Specific Models – Pay-for-Performance

Respondents were supportive of P4P with the following caveats:

- Many rewards are for "process pay" and may not lead to cost reductions
- Issues with metrics
  - Must actually measure significant outcomes
  - In need of standardization
  - In need of consistency over time
- Lag time on claims data weakens provider behavior change

Specific Models – Pay-for-Performance

Suggested model:

- Focus on primary care, reward providers for keeping patients out of the hospital or ED department

Specific Models – Payment Penalties

Respondents supportive of withholds or payment denials for “never events”

Otherwise, there was general discomfort with the concept

Specific Models – Capitation

The Center did not present full capitation as a model for a discussion, but a significant number of respondents discussed it

Advantages –

- Allows for flexibility and creativity in delivering care
- Puts providers at risk for overutilization

Challenges –

- Under-treatment
- Risk shifting

Specific Models – Capitation

Suggested models:

- Capitate primary care but use different mechanisms for specialty care
- Sub-capitate with payer managing risk pool. Mix with shared savings and risk

Finding 4: Local Control and Engagement

- Decisions on APMs should be made at the local level
- Providers need to participate in APM design decisions
- Develop communication, trust and commitment among APM participants

Finding 5: Specialists Needed

- Health care transformation in Oregon has focused on primary care so far
- Future efforts need to involve specialists
- All stakeholders including specialists and PCPs need to work together in APMs and transformation in general

Finding 6: Metrics are Important

Many concerns about current metrics

- Do they measure important outcomes?
- Are they within the provider's control?
- Too many!

Finding 7: APMs Require System Changes

- Reimbursement still tied to fee for service accounting model ('counting widgets')
  - Creates administrative burden
  - Creates barriers to innovative care models (e.g., alternative providers, alternative models of delivery, additional services w/o CPT codes)
- Need to examine and modify accounting and actuarial systems
- Need better, faster data and more transparency

Finding 8: Share Experiences

- APM development shouldn't take place in a silo
- We need to share:
  - Best practices
  - Success stories
  - Failures and how to avoid them

Questions?

If you have questions about this project, please contact:

Allison Leof
Center for Evidence-based Policy
Oregon Health & Sciences University
leof@ohsu.edu
(503) 494-3805

Thank You!

We look forward to hearing your thoughts on payment reform models during our upcoming conversation.

By working together, we can achieve Oregon's goals of high quality care in an efficient and cost effective system.

Appendix 4
Regional Health Equity Coalitions
Summary of Site Visit Findings: June 2014

After conducting site visits with all the Regional Health Equity Coalitions (RHECs), themes began to emerge from each of the four component areas. When asking about coalitions' regional focus, specifically, how populations of focus were identified:

- RHECs with identified populations of focus: used existing data and reports to guide the selection of communities to include. Some RHECs also used informal interviews with stakeholders to get feedback on what communities to include. Other coalitions also considered their capacity when choosing their population and geographic area of focus.
- Transportation is an issue due to geographic spread of RHEC areas, not just for community members accessing health services, but for engaging geographically diverse communities to participate in coalition activities.

When asked what the benefits are of approaching work as a regional vs. county model, grantees said:

- Counties often create artificial boundaries where there are none-community members may be accessing services or migrating between multiple counties, but having a regional focus allows the inclusion of areas where community members are living or spending their time. Also, living situations can be very different among counties, so reasons for health disparities, availability of resources, and access to transportation and services can all look very different. Having a regional approach also provides an awareness of other health equity efforts. Regional approach allows for inclusivity.

With regard to the health issues component, when asked if CCOs been engaged, RHECs said that:

- Most RHECs have been able to connect in some way with their local CCOs whether it's been through connecting with Transformation Center Innovator agents, attending Community Advisory Committee (CAC) meetings or being CAC members, or having CCO staff as RHEC members or RHEC steering committee members. Where these relationships exist there was mention of mutual learning benefits.

When asked if coalitions had seen positive changes in the way CCOs work with/for the community RHECs mentioned:

- That many CCOs are still catching their breath and building their capacity to meet expansion challenges, but that overall, RHECs anticipate positive changes over the next few years.
- Wanting to explore more opportunities to connect their regional communities to CCOs more in the future. It was often mentioned that there's a need for more community voice in CAC membership and leadership.

Grantees were asked how coalitions prioritized issues to advance equity given the number of disparities affecting their region, coalitions said:

- Existing data was utilized to guide those decisions.
- RHECs evaluated whether they had the existing capacity to take on each priority.
- It is important to go back to the communities impacted by specific health disparities to ask if addressing certain issues are a priority for the community partners.
- Utilizing strategic plans as a living document rather than a one-time deliverable was noted as being helpful in guiding priorities over time.

With regard to the most commonly experienced challenges or barriers around coalition-building responses included:

- Scheduling issues and getting all coalition members into a room is challenging since people are so busy.
- Most coalitions experienced capacity challenges in comparison to the level of disparity existing in their communities, which makes priority setting activities important but also challenging because RHECs have to prioritize what's feasible.

When asked what the key ingredients are for the accomplishments coalitions have achieved, grantees said:

- Building relationships in regions of focus, and making connections with organizations in the community.
- Being mindful of how you ask for people's time, and using that time wisely.
- Having a willingness to share knowledge, information and resources.
- Having the right mix of people on the RHECs that have the knowledge and expertise needed to address and move forward priorities. It was also mentioned that it is especially important to have respected and trusted community leaders who can ensure authentic community engagement over time.

Appendix 5
DELTA Program Session 4: Effective Community Engagement Facilitators: Carol Cheney and Charniece Tisdale

Quantitative Responses, N=16

Below are the average scores for the following assessments.
Scale (1- Strongly Disagree, 2-Disagree, 3-Agree, 4-Strongly Agree)

	Average
I took responsibility for being fully present and engaged in this training	**3.6**
This training session held my interest:	
Lecture	**3.8**
Exercises (worksheets, quizzes, games, etc.)	**3.8**
Group discussion	**3.6**
Movement	**3.3**
Visual media	**3.5**
The facilitation style of the trainer contributed to my learning experience	**3.8**
The trainer effectively led challenging or difficult conversations	**3.8**
The information in this training is relevant and applicable to my work	**4.0**
The handouts/materials support the training/learning in this session	**3.8**

Participants were asked to circle the appropriate rating of themselves before the training and now (after the training). Below are the average scores:
Scale (1- Little or no understanding, 2-Basic understanding but cannot demonstrate it, 3-Understand and can demonstrate with assistance, 4-Can demonstrate without assistance, 5-Can demonstrate and teach others to do it)

Average Before		**Average After**
3.0	**a) I recognize the different levels of community engagement and the utility/limitations of each level.**	**4.1**
Comments: • Hearing the experiences shared by others provided new ideas that I plan to implement • Guidelines are very helpful and processing case study and coalition builders helped to identify and reinforce.		
2.8	**b) I am familiar with the guidelines for effective community engagement.**	**4.1**
Comments:		

• I now know and realize that the community succeeds when they drive the discussions		
3.0	**c) I understand how my organizations can move along a community engagement continuum.**	**4.1**
Comments: • State government= bureaucratic red tape. Depends on the agenda, program, policies, stakeholders and end results. Community resource coordinators exist—just not effective those roles are.		
2.8	**d) I understand best practices for community engagement.**	**4.1**
Comments: • Wonderful group discussion today. Thank you. Break out group, speed dating, panel discussion was very effective. • Case studies, guide and listening to how the speakers created community engagement. Thank you very much. • I have a long way to go and this has really helped me point me in that direction.		

Qualitative Responses: Learning Application, N=12

How do you anticipate using the knowledge and skills you gained from this training when you go back to your work setting?

- Immediately—information gained today will help inform and improve my input into a UW collaborative effort
- Reach out to my community to see what their needs are regarding their language
- I believe I can use cohort members and presenters as resources for health professions students of color to become community engagement champions
- Education for staff. More in-depth education for key staff.
- I really like the community engagement scale—it is a practical tool. I also really liked the storytelling kit.
- Community engagement is extremely important to CCOs. It is one of our primary focus issues. I will be using a great deal of this information in my work.
- I plan to start community engagement activities by indentifying venues to develop relationships.
- I appreciate receiving the community engagement continuum because I can track our work against this measure and use to help move the work along the continuum
- Knowledge and skills will be shared with work staff in pursuit of health equity return from community engagement
- Sharing guidelines with all units and worksheets from hope. Incorporating guidelines into our charter.
- I plan to take the information learned today and determine how and where they can be implemented and infused within the work I do.
- I would like to create some agency standards and expectations on how we do community engagement work…

What actionable best or promising practices have you identified from this training? Please list:

- Community engagement continuum and story-telling toolkit
- Seeing the community as a partner and learn from them
- Have a community capacitating component built into any process
- Multicultural storytelling and identifying levels of engagement
- Story telling; community-led initiatives
- The "Levels of Community Engagement" will be a very helpful model for my work in the organization.
- Multicultural storytelling; community readiness
- Revise project aim to explicitly state community groups will be involved in the shaping of the intervention
- Community engagement learning has been incredibly promising in that I learned tons from the panel of speakers who shared their experiences
- Ask people to speak; listen to people speak. Ask them [community]/individuals how we can put things into action

- Collaboration with non-profits and community organizations to open doors for serving clients holistically. Example—Zan said Cover Oregon's website has application assisters listed statewide; now DHS can direct clients directly.
- I am very interested in the power/use of visual storytelling

What outcomes are you hoping to achieve as a result of your efforts?

- Integrate principles into community engagement plan for collaborative effort. Integrate principles into organizational community engagement.
- Better relationship with community members
- Assist/support health professions students of color in becoming champions of community engagement
- Increasing organizations knowledge of engaging (alumni) communities
- Better community/agency collaboration
- Greater power for our OHP members and a bigger voice for the community in the governance of our CCO
- Better service to underserved people
- Project activities that have been initiated by our community partners
- Increase and improve community engagement within communities of color
- Developing collaborations with coalitions throughout Oregon
- Better service, all inclusive. Awareness of local resources that can be shared with clients. Equitable ability to apply/receive services. Community empowerment.
- Move the needle on my agency's community engagement efforts

What barriers or challenges do you anticipate that might prevent you from applying what you learned?

- Get my leadership engaged and see the importance of this
- Current legislative priorities target non-professional health workers of color and cultural competence of majority member health professionals
- Identifying specific steps to move forward
- None for now
- It is work that is very transformational, and it is hard to get our systems to change. There will be a lot of hard work needed to make change.
- We have very few people of color on staff
- Resources—financial and staffing
- Organizational structural angst towards change. Knowledge and skills learned will have to be adopted to involve community group culture.
- Time to develop, support to develop, and incorporating into communications, policies and contracts.
- Time and resources, but I plan to push forward regardless. Information sharing is empowering and I have the privilege of being in a role that can share info.
- Lack of time and capacity to infuse these skills

What might help to overcome these barriers?

- Share learned experiences/ideas with small group. Partner with current community outreach programs.
- Don't know yet, but learning more about partners involved in setting legislative health policy priorities
- Will require time to really think through and map out
- Greater education of the management of the organization. Consistent focus on this issue. Working as a part of a bigger system of community change.
- Community engagement ☺
- Management support, return on investment (ROI)
- Sharing these wonderful resources and valuable tools
- Agreement of bridge building with all communities
- Connecting with advocates, networking with partners and seek common goals. Survey the community to create awareness.
- Maybe this program (DELTA) can form partnerships with foundations that would fund participating agencies with capacity assistance funds (to DELTA cohort graduates) to fund a portion of their FTE to implement some of these equity tools…

Do you have any additional feedback about the training session and logistics (facility, timing, etc.)?

- Great presenters! Smart participants!
- Felt like we could have gone deeper with challenging conversations; that's what I value about DELTA
- A little unstructured time at the halfway point during sessions for networking
- The 3 panelists were great, however there was too much time dedicated to this section; a panel discussion would have sufficed minus the break out group. A couple of the panelist really didn't allow for dialogue/questions—it was more of a lecture. More time for the group (DELTA) to story tell and have time to support each other.
- This was a lovely facility. Thank you Care Oregon! Great food.
- Great. I'm so glad I have the opportunity to do this. Maybe more movement during the day.
- It was great! Phenomenal presenters and panelists.
- Excellent!
- NA—all's good! Thank you for a great session and yummy food ☺

DELTA Program Session 5: Transformational Communication: Tools for Cross-Cultural Understanding and Inclusion

Facilitators: Nanci Luna Jiménez

Quantitative Responses, N=14

Below are the average scores for the following assessments.
Scale (1- Strongly Disagree, 2-Disagree, 3-Agree, 4-Strongly Agree)

	Average
I took responsibility for being fully present and engaged in this training	**3.8**
This training session held my interest:	
Lecture	**3.9**
Exercises (worksheets, quizzes, games, etc.)	**3.9**
Group discussion	**3.8**
Movement	**3.8**
Visual media	**3.8**
The facilitation style of the trainer contributed to my learning experience	**3.8**
The trainer effectively led challenging or difficult conversations	**3.9**
The information in this training is relevant and applicable to my work	**3.9**
The handouts/materials support the training/learning in this session	**3.9**

Participants were asked to circle the appropriate rating of themselves before the training and now (after the training). Below are the average scores:
Scale (1- Little or no understanding, 2-Basic understanding but cannot demonstrate it, 3-Understand and can demonstrate with assistance, 4-Can demonstrate without assistance, 5-Can demonstrate and teach others to do it)

Average Before		**Average After**
2.2	**a) I am familiar with the guidelines of Constructivist Listening and how it plays out in my personal and professional life.**	**4.0**
Comments:		
3.0	**b) I recognize the dynamics of oppression and how they are perpetuated at a personal level, as well as within my organizational/institutional culture.**	**4.2**
Comments:		

2.9	**c) I know how to improve communication with diverse groups and recognize the importance of allyship in achieving health equity.**	**3.9**
Comments:		

Qualitative Responses: Learning Application, N=10

How do you anticipate using the knowledge and skills you gained from this training when you go back to your work setting?

- Distribute amongst my organization and peers
- Integrate learning into organizational self-assessment for racial equity
- First do internal work
- Do paper, rock, scissors activity
- Start with more internal reflection and build relationships
- I'll practice constructivist listening
- Integrate relaxation
- Share exercises and maybe try to start a circle of shame
- I have to sit with it for a while, but I know I will
- Work with self, family and moving it to work—will use constructivist listening with Advisory Group

What actionable best or promising practices have you identified from this training? Please list:

- Listening; culture from oppression
- Function of oppression->patterns->adopted by groups
- Differing between culture and oppression
- Healing from past hurt
- Adultism
- Seeing the good in people
- Culture vs. Oppression
- Do internal work as the best strategy to address oppression
- Deeper understanding
- Helping people connect in their humanness; doing more delf-reflection on my own triggers and restimulation
- Constructive listening

What outcomes are you hoping to achieve as a result of your efforts?

- Continue equity work
- Increased self awareness; better leadership
- Wholeness
- I become more patient and tolerant
- More freedom in my life so I can communicate it to others
- To let go and discharge more hurts and be happier in this next phase of my life
- Social cohesion; peerness
- Better parenting; more intentionality in the workplace of encouraging all of us to do our own internal work
- Various exercises; Nature of Human Being Model; recognizing my own Adultism and early experiences with it

- Better relationships; more people feel heard

What barriers or challenges do you anticipate that might prevent you from applying what you learned?

- None—disseminate information; workshop on info learned
- Busy life; ease of resorting to old patterns
- Fear
- Bringing these ideas to the leadership
- Naps= not allowed
- Being attacked on a regular basis by people in my organization and community, and not knowing how to stay open
- Ugh, my own work—need to process and trust my brain to the process
- Taking time for self reflection
- Push back and being forced to do as much as we can

What might help to overcome these barriers?

- Activity
- Intentional commitment to use concepts/ideas/strategies regularly
- Support and love
- Communicate this to like-minded fellow coworkers
- Be around and practice with more people
- More time with DELTA and Nanci
- Scheduling time in for the work
- Set boundaries

Do you have any additional feedback about the training session and logistics (facility, timing, etc.)?

- Thank you!
- Nanci should do multiple sessions
- End too rushed, but great overall
- Amazing
- Want more of this kind of training! Best in the series—brought to the next level.

Appendix 6
Clinical Innovators Announcement

Dear Transformation Center staff and Innovator Agents:

The following message will be shared today with CCO CEOs, the Governor's office, OHA leadership, CCO learning collaborative participants and Clinical Innovation Fellows.

Dear CCO and OHA leaders:

The OHA Transformation Center and Council of Clinical Innovators Steering Committee is excited to announce our first cohort of Clinical Innovation Fellows.

The selection committee was impressed by the quality of applications and was encouraged by the innovative projects going forward throughout the state. We strongly believe in the potential of this chosen cohort to be leaders in Oregon's health system transformation, and we are excited to help support their work.

Through participation in a year-long learning experience with emphasis on health system transformation projects in their local communities, this select group of Clinical Innovation Fellows will develop and refine skills in leadership, quality improvement, implementation and dissemination science that creates a network of expertise supporting the Oregon coordinated care model.

Here are the 13 fellows and their supporting organizations, local CCOs and project topics.

- **Allison Elliott, MSW**: South Lane Mental Health; Trillium CCO; Behavioral health integration
- **Honora Englander, MD**: OHSU, Health Share of Oregon/FamilyCare; Transitions of care
- **Jessica Flynn, MD**: OHSU Family Medicine; Health Share of Oregon/FamilyCare/Columbia Pacific CCO; Transitional care
- **Sarah Fronza, MS**: Silverton Health; Willamette Valley Community Health; Regional care management
- **Emily Hitchcock, MD**: Providence St. Vincent Internal Medicine Residency Program; Health Share of Oregon/FamilyCare; Health literacy/provider-patient communication
- **Kathryn Lueken, MD, MMM**: WVP Health Authority; Willamette Valley Community Health; Interventional emergency department team
- **Jim Rickards, MD**: Yamhill Community Care Organization; Tele-dermatology
- **Ericka Rickman, RN**: Our House of Portland; Health Share/FamilyCare; Therapeutic gardening with HIV+ residents
- **Mary Rumbaugh, BSN**: Clackamas Behavioral Health Division; Health Share of Oregon/FamilyCare; Regional clinic redesign of mental health services
- **Reba Smith, MS**: Addictions Recovery Center; Jackson Care Connect/AllCare Health Plan; Trauma-informed care
- **Mindy Stadtlander, MPH**: CareOregon; Columbia Pacific CCO; Alternative payment model for primary care

- **Caroline Suiter, BA, CADC**: Center for Family Development; Trillium Community Health Plan; Behavioral health integration
- **Judy Sundquist, MPH, RDN**: Benton County Health Services; Intercommunity Health Network CCO; Childhood obesity prevention with Latino youth

We are still recruiting one Oral Health Clinical Innovation Fellow to join the program (call for applications is attached).

Sincerely,

Ron Stock
on behalf of the
Council of Clinical Innovators Steering Committee

Community Advisory Council Summit: Communities in Action

May 29-30, 2014
Hilton Eugene, 66 E. 6th Ave., Eugene, OR 97477

May 29, 2014

11:00 a.m. **Registration and Lunch**
Lobby

12:00 p.m. **Welcome Address from Leadership**
Williams/ O'Neill

- Chris DeMars, Director of Systems Innovation, OHA Transformation Center
- Leah Edelman, CAC Steering Committee Chair, Lane County CAC, Trillium Community Health Plan
- Terry Coplin, CEO, Trillium Community Health Plan

Transformation Updates from Leadership
Leaders from the Oregon Health Authority and Northwest Health Foundation share updates and thoughts about health system transformation activities in Oregon.

- Chris DeMars, Director of Systems Innovation, OHA Transformation Center
- Lillian Shirley, Director, OHA Public Health Division
- Maria Elena Castro, Rural and Migrant Health Coordinator, OHA Office of Equity and Inclusion
- Nichole June Maher, President, Northwest Health Foundation

1:00 p.m. **Across the State with CACs**
Williams/ O'Neill

CAC representatives share highlights of their work.

Facilitated by Liz Baxter, Executive Director, Oregon Public Health Institute
Panelists:

- George Adams, Jackson Care Connect CAC
- Jolene DeLilys, PrimaryHealth of Josephine County CAC
- Susan Lowe, Pacific Source Community Solutions Columbia Gorge CAC
- Arturo Vargas, Willamette Valley Community Health CAC

2:00 p.m. **Break**

2:15 p.m. **Breakout Sessions**

Wilder Rm
- **Building & Maintaining a High Performing CAC**
  Vanessa Becker, V Consulting & Associates Inc.

Hellman Rm
- **Working Together for Successful Communication**
  Liz Baxter, Executive Director, Oregon Public Health Institute

Williams/ O'Neill
- **Let's Get Engaged: Creating & Sustaining Partnerships for Community Health**
  Mary Minniti, Institute for Patient- and Family-Centered Care

3:30 p.m. **Break**

3:45 p.m. **Community Health Assessment and Community Health Improvement Plan Sharing**
Williams/ O'Neill

CAC representatives share their CHA/CHIP experiences and outcomes.

Facilitated by Katrina Hedberg, MD, OHA Public Health Division
Panelists:

- John Adams, Lake County CAC, Eastern Oregon CCO
- Rebekah Fowler, PhD, Intercommunity Health Network CAC Coordinator with Cascade West Council of Governments
- Rick Kincade, MD, Lane County CAC, Trillium Community Health Plan
- Commissioner Chris Labhart, Regional CAC, Eastern Oregon CCO
- Mike Volpe, Intercommunity Health Network CAC

4:45 p.m. **Dinner Celebration**

Lobby

6:00 p.m. **Optional Evening Sessions**

Wilder Rm
- **Roundtable discussions for CCO CAC Coordinators**

Hellman Rm
- **Roundtable discussion for CAC Chairs and Co-Chairs**

Williams/ O'Neill
- **Viewing of *Unnatural Causes* hosted by Lane County CAC, Trillium Community Health Plan**

May 30, 2014

7:30 a.m. **Breakfast**

Lobby

8:30 a.m. **Welcome Back**

Williams/ O'Neill
- Chris DeMars, Director of Systems Innovation, OHA Transformation Center
- Leah Edelman, CAC Steering Committee Chair, Lane County CAC, Trillium Community Health Plan

8:45 a.m. **Funding Opportunities**

Williams/ O'Neill

Foundation staff share possible funding opportunities to support CAC work.

Facilitated by Chris DeMars, Director of Systems Innovation, OHA Transformation Center
Panelists:
- Melissa Durham Freeman, The Oregon Community Foundation
- Steve Lesky, Cambia Health Foundation
- Jen Matheson, Northwest Health Foundation

9:45 a.m. **Break**

10:00 a.m. **Breakout Sessions**

Wilder Rm
- **Promoting Health Equity**
  Carol Cheney and Maria Elena Castro, OHA Office of Equity and Inclusion

Hellman Rm
- **Patient-centered Communication for CCOs: Transformation through Health Literacy**
  Cliff Coleman, MD, Oregon Health & Science University

Williams/ O'Neill
- **CHIP Implementation**
  Facilitated by Cara Biddlecom, OHA Public Health Division
  Panelists:
  - Tara DaVee, Lane County CAC, Trillium Community Health Plan
  - Muriel DeLaVergne-Brown, Crook County Health Department

- Ellen Larsen, Hood River County Health Department
- Jeff Luck, PhD, Oregon State University

11:15 a.m. **Pick up lunch boxes**

Lobby

11:45 a.m. **Moving Forward**

Williams/ O'Neill

Share plans and hopes for CAC work in the year ahead.
Liz Baxter, Executive Director, Oregon Public Health Institute

1:00 p.m. **Closing Remarks**

Williams/ O'Neill

- Tom Cogswell, OHA Transformation Center
- MaiKia Moua, OHA Transformation Center

Thank you for attending.

Appendix 8

Oregon Complex Care Collaborative Meeting

Holiday Inn Eugene/Springfield, 919 Kruse Way, Springfield, OR 97477
Tuesday, April 29, 2014, 7:30 a.m. – 4:30 p.m.

Meeting Objectives:

- Improve health outcomes for Oregon Health Plan members who require complex care.
- Support the spread of innovative complex care models throughout Oregon.
- Promote information sharing and networking.

Registration with continental breakfast 7:30 a.m. – 8:30 a.m.

Agenda

1. **Welcome and introductions** *(30 minutes)* 8:30 a.m. – 9:00 a.m.
   Ron Stock and Emilee Coulter-Thompson

2. **Opening address: Sustaining the work** *(45 minutes)* 9:00 a.m. – 9:45 a.m.
   Fabiana Wallis, PhD, Clinical Psychologist, Trauma Specialist and Consultant

   Fabiana Wallis, PhD, received her doctoral degree in clinical psychology from University of Massachusetts Boston and completed her clinical training at Harvard Medical School and MIT. She has been working with men and women affected by psychological trauma since 1997. She is a Trauma Recovery and Empowerment Model (TREM) Facilitator and Trainer, Eye Movement Desensitization and Reprocessing (EMDR) therapist, co-author of a cultural adaptation of a trauma intervention, and Co-Founder of the Center for Trauma Recovery in Portland, Oregon. She provides clinical services, consultation, supervision, mentorship and training in the areas of trauma, diversity and Latino mental health.

3. **Opioids/pain management presentations & discussions** *(105 minutes)* 9:45 a.m. – 11:30 a.m.

   Each session will include the following format:

   - **Presentations** *(30-40 minutes total for two to three topic panelists)*
   - **Question and answer** with panelists *(10-15 minutes)*
   - **Roundtable discussions** *(30 minutes)*
   - **Reflections** *(10 minutes)* 1-2 pre-assigned spokespeople share key reflections/synthesis.

Session 1:
Jim Shames, Jackson County Health and Human Services
Bob Isler, Providence Persistent Pain Project
Rachel Solotaroff, Central City Concern

Lunch networking session *(75 minutes)* 11:30 a.m. – 12:45 p.m.

Optional round table discussions will meet from 11:45 a.m. – 12:15 p.m. at tables indicated below:

- **Alternative Payment Methodologies,** Tracy Muday, Table 1
- **Behavioral Health Integration,** Jeff Emrick, Table 3
- **Care Coordinators Affinity Group,** Jennifer Johnstun, Table 7
- **Community Based Models for Complex Care,** Anne Alftine, Table 10
- **Community Health Workers Affinity Group,** Kristen Powers, Table 8
- **Early Learning,** Joell Archibald, Table 12
- **Financial Sustainability/The Business Case for Complex Care,** Kate Wells, Table 4
- **Health information technology,** Susan Otter, Table 18
- **Trauma-informed care/Adverse Childhood Experiences,** Fabiana Wallis, Table 14
- **Workforce development, recruitment and provider well-being,** Laurie Lockert, Table 16

4. **Behavioral health presentations and discussions** 12:45 p.m. – 2:15 p.m.
(90 minutes)

Session 2:
Jill Archer, Clackamas County
Daren Ford, OHSU Richmond Clinic
Chris Siegner, Symmetry Care Inc.

Break *(15 minutes)* 2:15 p.m. – 2:30 p.m.

5. **Maternal health presentations and discussions** *(90 minutes)* 2:30 p.m. – 4:00 p.m.

Session 3:
Jennifer Johnstun, Josephine County Maternal Medical Home
Kathryn Lueken, Willamette Valley Community Health
Maggi Machala, Deschutes County Health Services

6. **Next steps** *(20 minutes)* 4:00 p.m. – 4:20 p.m.
Ron Stock and Emilee Coulter-Thompson

7. **Closing comments** *(10 minutes)* 4:20 p.m. – 4:30 p.m.
Ron Stock and Emilee Coulter-Thompson

Institute for Healthcare Improvement

Oregon Health Authority TRANSFORMATION CENTER

Appendix 9

OHA ISIA Agenda At-a-Glance
April 30th to May 2nd, 2014

Time	Wednesday, 30 April	Thursday, 1 May	Friday, 2 May
6:30 AM		Morning Run/Walk (5K) *(optional; meet in lobby)*	Morning Run/Walk (5K) *(optional; meet in lobby)*
7:15-8:00 AM	Breakfast and Registration *(O'Neill-Williams)*	Breakfast *(O'Neill-Williams)*	Breakfast *(O'Neill-Williams)*
8:00 AM Start	Intro, Welcome, Overview *(O'Neill-Williams)*	Opener and Review/Questions *(O'Neill-Williams)*	Opener *(O'Neill-Williams)*
		Run charts	The Third Question: Getting Great Ideas for Change: Change Concepts- Application to Project
	Overview of Science of Improvement Application to Project	Strength Deployment Inventory Teams 1-10: *(O'Neill-Williams)* Teams 11-20: *(Breakout Room: Hellman)*	
	Model for Improvement		Reliability Science and Your Project- Application to Project
	6 Essential Skills for Improvement		Testing Changes
Lunch	11:45 AM – 12:45 PM	12:15 PM – 1:15 PM	11:30 AM – 12:30 AM
	The First Question (Aim, Charter, Driver Diagram, MUSIQ, Charter assessment) Application to Project	Strength Deployment Inventory Teams 1-10: *(O'Neill-Williams)* Teams 11-20: *(Breakout Room: Hellman)*	Accelerating Testing Application to Project
		Teamwork Skills Teams 1-10: *(O'Neill-Williams)* Teams 11-20: *(Breakout Room: Hellman)*	
	The Second Question (Measurement, Family of Measures, Outcome, Process, Balancing) Application to Project	The Third Question: Getting Great Ideas for Change (Logical methods, use of data, Flow Charts, Fishbone, Affinity, Force Field Analysis *(O'Neill-Williams)*	Understanding Variation (Pareto, Histograms, Scatter and Intro to Shewhart charts)
			Graphical Excellence
		Generating Ideas: Creativity Methods	
Close 5:45	Clarification of Next Day and Homework Assignments	Clarification of Next Day and Homework Assignments	Clarification Upcoming Calls and Assignments - End 4:00 PM
5:45 pm – 7:00 PM	Reception and Office Hours (Team Consultations) *(O'Neill-Williams)*	Office Hours (Team Consultations) *(O'Neill-Williams)*	
7:00 PM		Guided Dinners in Eugene *(optional; sign up at registration before 12 PM, meet in lobby)*	

Oregon's Healthy Future

September 2013

A Plan for Empowering Communities

Oregon Health Authority

Welcome to Oregon's Healthy Future!

This statewide community health improvement plan is a collaboration between the public, public health stakeholders and key leaders. It builds on work started in 2010 with the Oregon Health Improvement Plan Committee. In 2010, that committee completed the Oregon Health Improvement Plan, which acknowledged chronic diseases as the major driver of health care costs and outlined strategies for the prevention and management of chronic diseases.

The 2012 Oregon's Healthy Future Advisory Group consisted of representatives from a variety of sectors and groups, including populations experiencing health inequities, and public health officials from county and state levels (see page 3 for list of advisory group members). The advisory group reviewed the results of community engagement processes from 2010 and 2012 and Oregon's Community Health Assessment and deliberated to recommend health priorities based on need and strategic advantage. Additional representatives served as subject matter experts in advisory groups for each priority area, developing strategies to help us meet our goals.

This plan outlines strategies for our communities to work together to improve health. Oregon's Healthy Future is a living document. While the priorities are clear, the methods for addressing each of them will evolve and grow over time. Groups are coalescing to better understand and outline ways to achieve health equity and to support lifelong health.

We envision an Oregon where every community is empowered to improve the lifelong health of all people in Oregon. Oregon's Healthy Future incorporates strategies for taking the most timely and critical steps to realizing that vision.

Acknowledgements

Members from private and public sector groups worked together on the Oregon's Healthy Future plan. Their time, dedication and efforts are greatly appreciated.

Oregon's Healthy Future Advisory Group members

- Paul Bellatty, Research Manager, Oregon Department of Corrections
- Janne Boone-Heinonen, Assistant Professor, Department of Public Health and Preventive Medicine, Oregon Health & Science University
- Morgan Cowling, Executive Director, Oregon Coalition of Local Health Officials
- Ben Duncan, Oregon Environmental Justice Task Force
- Molly Emmons, Policy and Title V Coordinator, Oregon Health Authority Public Health Division
- Karen Girard, Health Promotion Manager, Oregon Health Authority Public Health Division
- Tia Henderson, Research Manager, Upstream Public Health
- Paula Hester, Executive Director, Oregon School-Based Health Care Network
- Ellen Larsen, Director, Hood River County Health Department
- Kerri Lopez, Director, Northwest Tribal Cancer Control Project, NW Portland Area Indian Health Board
- Alberto Moreno, Executive Director, Oregon Latino Health Coalition
- Joseph Santos-Lyons, Development and Policy Director, Asian Pacific American Network of Oregon
- Elizabeth Sazie, Chief Medical Officer, Coffee Creek Correctional Facility, Oregon Department of Corrections
- Jim Shames, Medical Director, Jackson County Health and Human Services
- Gail Shibley, Former Senior Advisor for Environmental Health and Administrator, Oregon Health Authority Public Health Division
- Michael Skeels, Interim Administrator, Oregon Health Authority Public Health Division

Acknowledgements

Oregon's Healthy Future Health Equity Advisory Group members

- Ben Duncan, Oregon Environmental Justice Task Force
- Molly Emmons, Oregon Health Authority Public Health Division
- Rachel Gilmer, Oregon Health Authority Office of Equity and Inclusion
- Karen Girard, Oregon Health Authority Public Health Division
- Brett Hamilton, Tobacco-Free Coalition of Oregon, Inc.
- Kerri Lopez, NW Portland Area Indian Health Board
- Scott Montegna, Upstream Public Health
- Andrew Riley, Hope Coalition

Oregon's Healthy Future Behavioral Health and Substance Abuse Advisory Group members

- Lesa Dixon-Gray, Oregon Health Authority Public Health Division
- Molly Emmons, Oregon Health Authority Public Health Division
- Rusha Grinstead, Oregon Health Authority Addictions and Mental Health
- Michael Mahoney, Oregon Department of Education
- Alberto Moreno, Oregon Latino Health Coalition
- Cinzia Romoli, Oregon Health Authority Public Health Division
- Jim Shames, Jackson County Health and Human Service
- Lucrecia Suarez, Conexiones
- Elizabeth Thorne, Oregon Health Authority Public Health Division
- Kerryann Woomer, Oregon Health Authority Addictions and Mental Health

CONTENTS

Executive summary

Oregon has a tradition of healthy communities built around abundant natural resources, hard work, caring for our neighbors and a spirit of innovation. We are proud that Oregon ranks 14th among U.S. states for overall health (America's Health Rankings, 2011). Yet, we realize that more must be done to improve the health of all people in Oregon.

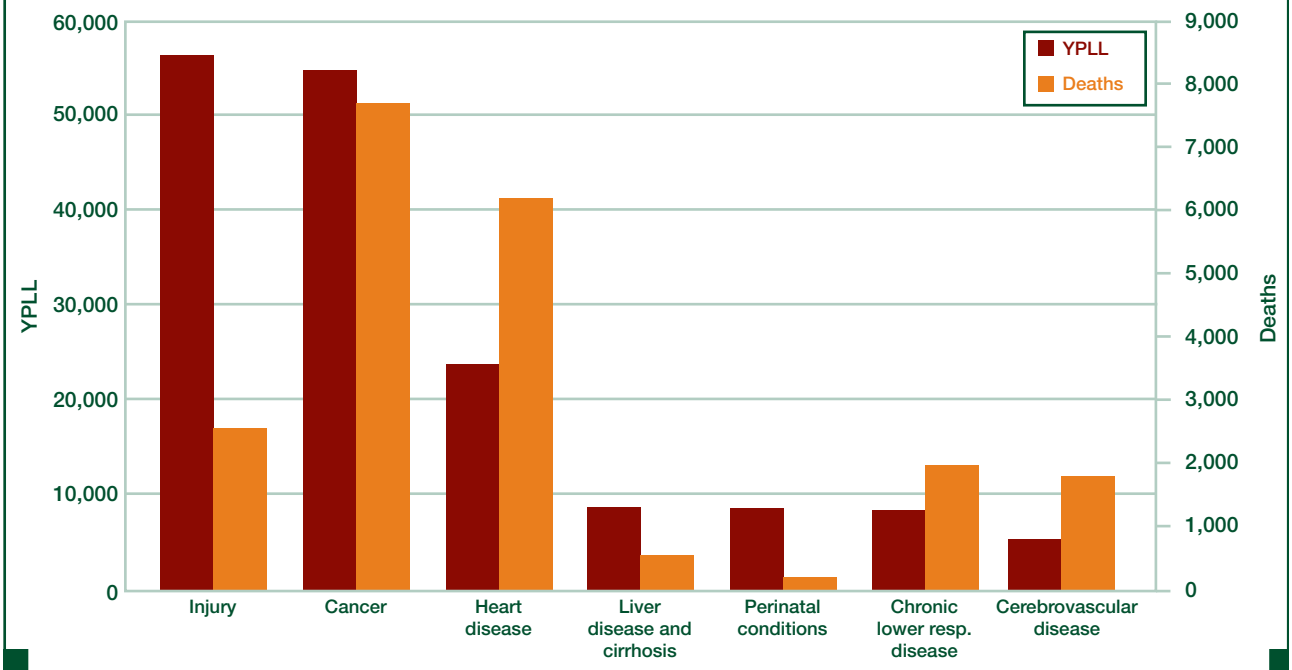
Oregon's low smoking rates notwithstanding, tobacco-use continues to be the leading preventable cause of death and disease in the state; rates of obesity and diabetes affect many of us; and oral health outcomes among Oregon's children are some of the worst in the nation. Additionally, health inequities persist for communities of color, low-income populations, sexual minorities and incarcerated people. These are complex challenges. Addressing them successfully requires resources, effort, innovation and participation from everyone.

Leading causes of death and social impact of premature death in Oregon

Because leading causes of death vary by age, mortality rates by underlying cause alone do not reflect the full social impact of premature death. Estimating years of potential life lost (YPLL) is a way of quantifying the cost of early death by measuring the number of years between age at death and a specific standard age. For instance, if the standard is set at 75 years, a death at age 21 results in 54 years of potential life lost.

The figure below compares causes of death by YPLL before age 75 years with the number of deaths.

Leading causes of death and years of potential life lost (YPLL) before age 75, Oregon residents, 2010



DATA SOURCE: OREGON DEATH CERTIFICATE DATA

In order to create a healthier Oregon, stakeholders and key organizations collaborated to review critical health indicators and strategic issues. *Oregon's Healthy Future* identifies five priority objectives for improving health and quality of life in Oregon over the next five years:

- Improve health equity
- Prevent and reduce tobacco use
- Slow the increase of obesity
- Improve oral health
- Reduce substance abuse and other untreated behavioral health issues

These priorities were chosen based on which accomplishments would offer the greatest improvements in lifelong health, advance health equity, and promote equal access to conditions in which people can be healthy.

Based upon the strength of collective impact, this plan outlines improvement strategies that will address each of these priorities and allow us to advance toward our vision.

Vision statement

Communities are empowered to improve the lifelong health of all people in Oregon.

Introduction and background

During this time of unprecedented change with national health reform and Oregon's health system transformation, Oregon needs a bold vision for improving the health of its residents. Oregon's Healthy Future is a plan for ensuring the lifelong health for all people of Oregon, regardless of where they live, no matter their income, education, race or ethnicity.

Most of a person's health is determined by social and economic factors rather than by the health care he or she receives. According to the World Health Organization (1948), "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The underlying determinants of health include our health behaviors, environments in which we live, health care settings, educational attainment and social support systems around us.

Oregon's Healthy Future focuses on helping communities and individuals make policy, systems and environmental improvements that put healthy options and health-promoting services within reach for everyone in Oregon. The health priorities and improvement strategies in Oregon's Healthy Future are the foundation and scaffold for improving health in Oregon over the next five years. These outcomes will be achieved by forming strong community connections and being part of a transformed health system.

Health in Oregon: Challenges and opportunities

While Oregon is the ninth largest U.S. state geographically, its 3.8 million residents make it the 29th most populous state. About two-thirds of the state's population lives west of the Cascade Mountains in the Willamette Valley — the rest of the state is more rural. Traditionally, Oregon has been a state of farmers, loggers, ranchers and fishermen. While we are proud of our heritage, some aspects of Oregon's demography, geography and economy present challenges to achieving optimum health for the majority of our population. The rural nature of vast areas of the state requires some Oregonians to travel long distances to health care appointments. Others face similar challenges to maintaining good health due to unemployment, inadequate income and food insecurity. These factors adversely affect a disproportionate number of children. Like many other states, Oregon is dealing with shifting causes of disease, rising burden of chronic diseases, and changes in the way we access and pay for health care. Never before has Oregon faced such significant risks to its health budget and at the same time had such promising opportunities to improve health and lower costs through the prevention of the leading causes of death, disease and injury in the state.

Challenges

Changing demographics

Oregon's population is growing, aging and becoming more diverse. The total population grew by 12% between 2000 and 2010; in contrast, the national average for the same period was 9.7%. In 2010, approximately 14% of Oregon's population was over 65 years; by 2020, this is projected to increase to 20%. In 1990, Oregon's population was 90% white non-Hispanic, and in 2010 it was less than 80% white non-Hispanic. In 2010, 11.7% of the population was Hispanic; 3.7% Asian; 1.8% African American; 1.4% American Indian; and 3.8% more than one race. As Oregon's population becomes increasingly diverse, we must develop a health system that effectively meets the needs of Oregon's diverse populations.

Shifting causes of disease

In the last century, the causes of morbidity and mortality have shifted from infectious diseases to chronic disease and injuries. Tobacco, obesity and heart disease/stroke are the three leading causes of premature death in Oregon, and injury is the single leading cause of death in people under the age of 40. Oregon has made significant progress in reducing tobacco use and promoting healthy environments. However, more than 7,000 Oregonians die each year as the result of tobacco use, and more than 80 cents of every health care dollar is still spent on treating chronic diseases. Each biennium, smoking costs Oregon $4.8 billion, including $748 million from the Oregon Health Plan. Obesity accounts for one-third of the recent increase in Oregon's medical costs. The U.S. Centers for Disease Control and Prevention estimate that annual medical costs for individuals with obesity are $1,429 higher than for non-obese people.

Among children, dental decay is the most common chronic condition — five times more common than asthma. Children with poor oral health often have poor academic performance and are three times more likely to miss school. Preventing decay in childhood increases the likelihood that an individual can avoid dental disease and other health-related consequences throughout adulthood.

Furthermore, mental illness and substance abuse have significant negative effects on individual and family health and the broader social and economic environment, including public safety and worker productivity. Suicide is the eighth leading cause of death for Oregonians overall. The number of Oregon eighth graders who have had a drink in the past 30 days is twice the national average, and Oregon has one of the highest rates of prescription drug misuse in the nation. This proves that in addition to preventing chronic diseases and reducing injury, Oregon must focus on successful strategies to improve mental well-being, prevent suicides, and address alcohol and drug addictions. Only by addressing all of these health issues, while also continuing to control infectious diseases, can we improve the overall population's health and reduce future health care costs.

Health disparities

These health issues have significant disproportionate effects on communities based on population characteristics such as race/ethnicity, geography, income, educational attainment, language spoken, sexual orientation, disability status and other characteristics. For example, adult obesity rates are higher for communities of color compared to non-Latino whites, and Oregon's African American diabetes and stroke mortality rates are among the highest in the nation. Eliminating health disparities and promoting health equity — attaining the highest level of health for all people — is essential to truly improve the lifelong health of everyone in Oregon.

Opportunities

Health system transformation in Oregon

To address these challenges, federal health reform in the United States has recently motivated an unprecedented investment in prevention and wellness activities. This movement is also reflected in Oregon's pioneering health reform efforts. Governor Kitzhaber played a key role in the creation of the Oregon Health Plan in 1994 and now has made Oregon's health system transformation one of his top two priorities. This reform upholds Oregon's proud tradition of improving health through innovation and ingenuity with a focus on the Triple Aim:

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

With the support of the Oregon Legislature and under the direction of Governor Kitzhaber and the Oregon Health Policy Board, the Oregon Health Authority has led the formation of regional coordinated care organizations (CCOs). As of November 2012, CCOs served an estimated 90% of Oregon's Medicaid population. CCOs aim to bend the cost curve on health care by integrating physical, mental and oral health care, public health, and community level health improvement efforts. The goal is to achieve a high standard of overall health for all Oregonians, regardless of income, race, ethnicity or geographic location.

Education reform in Oregon

Optimal health is critical for addressing Governor Kitzhaber's other top priority: education reform. Oregon's four-year high school graduation rate (67% in 2011) is the 46th worst in the United States. Younger students are increasingly dropping out of school, and youth of color and youth from low-income families drop out at higher rates than their white and higher-income counterparts. Health is positively associated with regular school attendance, academic achievement and increased likelihood of high school graduation. Health system transformation is essential to meeting Oregon's 40/40/20 goal to improve the number of adults who graduate from high school and complete post-secondary education.

10-Year Plan for Oregon

In August 2011, Governor Kitzhaber created the 10-Year Plan for Oregon initiative. Health and education are two of the five cross-cutting priority areas identified. The Healthy People objective for the state seeks to ensure that Oregonians are healthy and have the best possible quality of life at all ages. Health is also an important prerequisite for the Education objective in the plan. The combined emergence of health system transformation, education reform, and the Governor's 10-Year Plan for Oregon provide a window of opportunity to achieve sustainable and measurable improvements in the state population's health.

Oregon's Statewide Community Health Improvement Plan

In order to improve the lifelong health of all people in Oregon and support education and health system transformation priorities, the public health community must identify and address health priorities, including persistent disparities in health outcomes and the social, economic, educational and environmental inequities that contribute to them. Oregon's Healthy Future is Oregon's plan for ensuring the lifelong health for all people of Oregon, regardless of where they live, and no matter their income, education, race or ethnicity. The plan focuses on helping communities and individuals, in collaboration with local public health departments and other community partners, make policy, systems and environmental improvements that put healthy options and health-promoting services within reach for everyone in Oregon.

> "Health does not occur in the doctor's office or hospitals alone ... It also occurs where we work, where we learn, where we play."
>
> Dr. Regina Benjamin, U.S.Surgeon General

This plan builds upon the work of prior state health improvement plans — most notably the Oregon Health Improvement Plan (December 2010), which was legislatively directed to focus on the prevention and management of chronic diseases. In 2012 the Oregon's Healthy Future Advisory Group, a multi-sector group of representatives from populations experiencing health inequities and local and state public health officials, sought additional community feedback from over 300 participants; reviewed the full spectrum of public health issues, including data from Oregon's State Health Profile of key health indicators; and synthesized the findings to create this five-year statewide community health improvement plan.

Leadership and implementation

Statewide and community-level leadership is essential to achieving this vision of lifelong health for all people in Oregon. Full achievement of the goals and progress on the priorities in this health improvement plan can only be achieved through partnership with state, local and tribal public health departments, coordinated care organizations, health care organizations, government agencies, educational institutions, employers, nonprofit and community-based organizations, faith communities, the private sector, community members, and many others. This plan is also intended to guide and support the work of the Oregon public health system. Oregon needs a strong public health system to achieve better health outcomes at lower costs and to transform health care delivery.

Oregon public health system

The Oregon public health system works daily to prevent disease and injury and promote and protect health. Oregon's system is comprised of state, local and tribal public health departments and public and private partnerships. Some key public health activities and programs are administered by the state component of the system, the Oregon Health Authority Public Health Division. Others are delivered in collaboration with 34 local health departments, which have statutory authority to protect the public's health in their counties. The public health system serves three main functions: 1) assessment of the public's health in Oregon through data collection and investigations of disease; 2) the development of policies and programs that support improved health outcomes; and 3) the assurance that those policies and programs are achieving the intended purpose. Public health programs reduce costs by promoting healthy options, creating safe and healthy communities, and preventing the need for acute medical care.

National public health accreditation

In September 2011, the Public Health Accreditation Board officially launched national public health accreditation. Accreditation provides public health departments an opportunity to measure their performance under a set of standards. Accreditation prerequisites include a community health assessment, community health improvement plan and agency strategic plan. As Oregon's Statewide Community Health Improvement Plan, Oregon's Healthy Future is a resource to inform the development of local community health improvement plans and the Oregon Health Authority Public Health Division Strategic Plan.

Priority areas

Oregon's Healthy Future identifies five priority objectives for improving health and quality of life in Oregon. These priorities were chosen based on which accomplishments would offer the greatest improvements in lifelong health, to advance health equity and achieve more equal access to conditions in which people can be healthy.

The selection of priorities was influenced by more than 300 planning participants around the state and shaped by knowledgeable teams based on trends affecting population health.

Priority areas:

- Improve health equity
- Prevent and reduce tobacco use
- Slow the increase of obesity
- Improve oral health
- Reduce substance abuse and other untreated behavioral health issues

> "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."
>
> World Health Organization

Improvement strategies

Oregon's Health Future Advisory Group and subgroups collaborated to develop specific improvement strategies for each of the five priority objectives. These groups of experts and stakeholders carefully selected strategies based on evidence of potential for effect, political feasibility, timing and opportunity for change, and potential to reduce health disparities.

The health priorities and improvement strategies in Oregon's Healthy Future are the foundation and scaffold for improving health in Oregon over the next five years.

OREGON HEALTH PRIORITIES

Health priorities

These five priority objectives are offered to focus the attention and work of policy makers and organizations, including state, local and tribal government agencies, educational institutions, employers, health care organizations, nonprofit and community-based organizations, faith communities, and others:

- Improve health equity;
- Prevent and reduce tobacco use;
- Slow the increase of obesity;
- Improve oral health;
- Reduce substance abuse and other untreated behavioral health issues.

IMPROVE HEALTH EQUITY

Background

The vision for Oregon's Healthy Future is that "Communities are empowered to improve the lifelong health of all people in Oregon." A key principle in this vision is that all people have the opportunity to attain their full health potential. The values of fairness and justice should spur action to ensure that the community conditions to improve health are available across the state.

Health disparities are population-specific differences in health outcomes. Examples of health disparities are when a specific population (defined by race/ethnicity, income, education or other factors) has an increased likelihood of using tobacco, having heart disease or dying prematurely. Some health disparities cannot be eliminated, for example, older adults are more likely to have heart disease than younger adults.

Health inequities are the unfair, avoidable and unjust social and community conditions that lead to disparities in health outcomes. Examples of health inequities include neighborhoods with less access to healthy food options, areas with higher air pollution, communities with lower-achieving schools, and populations that have less access to appropriate health care.

Achieving health equity requires structural, social and political changes to equalize the conditions that promote health for all people, especially populations that have experienced historical injustices or face socioeconomic disadvantages.

The first and most important health priority in Oregon's Healthy Future is improving health equity. Populations experiencing health inequities can be defined by a number of characteristics, including but not limited to race/ethnicity, income, educational attainment, occupation, geography (e.g., rural or urban), mental and physical disability status, language spoken, country of origin, immigration status, sexual orientation, and gender identity.

According to the most recent U.S. Census, Oregon's population is becoming more racially and ethnically diverse. From 2000 to 2010, the total population of Oregon increased 12%, while the population of Oregon's communities of color increased 46%, almost four times as fast. Communities of color now comprise 22% of the total state population, up from 16% in 2000. This trend is likely to continue, as 34% of Oregon youth under 18 years old are members of communities of color. Among the population receiving services from the Oregon Health Plan (Medicaid), 40% are from communities of color.

Effects of health inequities

Health inequities result in unnecessary loss of life and also increase the costs of the health care system. A national study by Johns Hopkins University and University of Maryland researchers found that almost one-third of the medical care expenditures for African Americans, Asians and Hispanics were excess costs due to health inequities.[1]

Data from Oregon's State Health Profile show the extent of some current health disparities. For example, adult obesity rates are higher for Latinos (31%), American Indian/Alaska Native (30%), and African Americans (29%) compared to non-Latino whites (24%). The prevalence of asthma is twice as high for economically disadvantaged adults (defined by educational attainment and household income) compared to non-economically disadvantaged adults. Compared to the overall adult smoking prevalence of 20%, the smoking prevalence is higher for adults who are economically disadvantaged (33%), American Indian/Alaska Native (38%), and African American (30%).

Factors that influence health equity

There are many causes for the adverse health outcomes experienced by certain communities. Populations experiencing health disparities may be less likely to live in neighborhoods with easy access to fresh produce, less likely to be tobacco-free, less likely to have health insurance, and less likely to receive the appropriate care when seeing a health care provider. Equity must be considered in all health issues, spanning from preconception to the end of life.

[1]LaVeist TA, Gaskin DJ, Richard P. The Economic Burden of Health Inequalities in the United States. 2009. www.jointcenter.org/hpi/sites/all/files/Burden_Of_Health_FINAL_0.pdf

Health outcomes are also strongly influenced by factors that are not always seen as directly related to health. Such factors include housing, transportation, economic development and educational opportunities. It is critical to address equity in all the areas that affect a person's health. And, it should be recognized that health affects a person's ability to succeed in other areas. For example, a healthy youth is more likely to do well academically, and a healthy adult can be a more productive worker.

Equity lens

An equity lens process is a method for identifying and addressing health inequities. The equity lens is used to assess policies and programs for disproportionate effects on specific populations. Then, necessary modifications can be made that would improve health equity. The equity lens process is an intentional method for making more informed decisions and moving toward the goal of achieving health equity. An equity lens can be applied to any policy or program that affects health.

For example, the equity lens was used to review the improvement strategies for the four other health priorities in this plan relating to tobacco, obesity, oral health and substance abuse/behavioral health. Among the improvement strategies developed for these four health priorities, the following strategies have the greatest potential to promote health equity, although they are not strategies that have been adopted into the identified health equity priority strategies.

Priority: Prevent and Reduce Tobacco Use

Strategy: Increase the price of cigarettes by a $1/pack excise tax (and a proportionate amount on other tobacco products), and dedicate 10% ($40 million) to comprehensive and effective efforts at the state and local levels to reduce tobacco use and exposure in adults and children, especially in populations experiencing disparities, including implementation of best and emerging practice interventions by counties, regions, tribes, schools, coalitions and community-based organizations.

Increasing the price of tobacco and funding comprehensive tobacco control efforts lead to reduced tobacco use. It is important to dedicate funding to community-based organizations representing populations that are currently experiencing a disproportionate share of the tobacco-use burden and ensure that these communities have lead roles in the decisions about how resources are allocated to reduce tobacco-related disparities. Diverse communities must be engaged throughout the planning, implementation and evaluation processes in order to most effectively eliminate health inequities.

Priority: Slow the Increase of Obesity

Strategy: Adopt and implement nutrition standards for foods and beverages sold in cafeterias, stores and vending machines in state agencies, schools and universities, including eliminating the sale of sugar-sweetened beverages.

Strategy: Support legislative efforts to fund the Farm to School and School Garden, and the Farm to Institution programs through Oregon State Lottery funds.

Access to healthy foods, especially for youth, can improve nutrition and build lifelong good eating habits. Many youth with limited access to nutritious foods, such as those from low-income families, eat many of their meals at school. To ensure the effectiveness of nutrition programs, diverse community members need to be engaged so that foods offered through such programs are both desirable and healthy for all populations. Farmers and food processors that benefit economically from these programs should represent the socioeconomic and racial/ethnic diversity of Oregon, and maintain growing and labor practices that promote health.

Priority: Improve Oral Health

Strategy: Encourage public water districts to fluoridate water based on CDC recommendations to reduce tooth decay.

Optimally fluoridated water is the most effective method for reaching all populations to improve oral health. Implementation of water fluoridation will improve the oral health of populations experiencing oral health disparities. This does not eliminate the need to increase access to oral health services, such as every child having an oral health screening or preventive dental visit by age 1.

Priority: Reduce Substance Abuse and Other Untreated Behavioral Health Issues

Strategy: Collect and analyze baseline data on the availability of culturally and language-competent behavioral health providers.

The availability of culturally and language-competent behavioral health providers is essential to assure that diverse populations in Oregon can access effective services. Conducting an assessment of the current behavioral health providers is just the first step to assuring access to these important services.

Cross-cutting objectives and strategies for health equity

The table on pages 22 and 23 includes a cross-cutting set of measurable objectives and strategies that outline the equity lens process and are applicable to any health issue. Diverse community perspectives are necessary for the equity lens process to be effective. The strategies throughout Oregon's Healthy Future are not meant to override a particular community's plans or priorities for improving health. Community-driven initiatives are critical to improving health equity, and the equity lens is designed to help identify and support these initiatives.

The measurable objectives in the table were chosen because disparities in these areas are the result of multiple inequities. For example, whether a child graduates from high school can be influenced by factors ranging from environmental asthma triggers to smoking status to the quality of the neighborhood school.

The available data for some objectives also shows some of the current difficulties in monitoring disparities. For example, data on incarceration rates are available for only three racial/ethnic groups, and the most recent data are for 2005. Additionally, appropriate analysis is also difficult when data for certain ethnic or cultural populations are combined into one group, which can hide significant differences among subpopulations. For example, while Asian and Pacific Islander (API) communities share some cultural similarities, there are important historical, social, educational and economic differences among the various ethnic groups; more than100 languages are spoken by people of API descent in Oregon. While API groups typically have very low smoking rates, smoking rates among Vietnamese-American and Korean-American men can be much higher than smoking rates among both the general population and other API groups. Care should be taken in the collection and analysis of data so that institutions and policymakers can develop, implement and evaluate appropriate solutions for the health issues facing diverse communities.

Performance measures for the health equity strategies can be specifically designed within any health priority. Here's an illustration using Health Equity Strategy 7: Ensure that health information systems include specific data on race/ethnicity and other characteristics necessary to monitor health equity. Looking at the health priority of reducing tobacco use, studies have shown that people who identify as lesbian/gay/bisexual/transgendered (LGBT) are more likely to use tobacco. Therefore, this strategy could have a performance measure: the number of tobacco use surveys that include questions on sexual orientation and gender identity. The responsible parties for implementing a health equity strategy will include the groups responsible for working on the underlying health priority (reducing tobacco use, in this example).

Achieving health equity

The time frame is five years for implementing Oregon's Healthy Future strategies; its goal is to significantly improve health equity in that time period. However, the struggle to achieve full health equity will continue. We need to take the steps that could improve the health of someone today, such as ensuring that the tobacco quit line has services tailored to specific communities. Also, we need to continue the efforts that have longer timelines, such as diversifying the health work force. Through all this, we must focus on the goal of eliminating the poor health outcomes and premature deaths that unnecessarily occur in communities confronted by health inequities. We must continue to empower communities to improve the lifelong health of all people in Oregon, ensuring that all people have the opportunity to attain their full health potential.

Health Priority 1: Improving Health Equity

Health outcomes

Age adjusted death rates by race/ethnicity

Measurable objectives

High school graduation rates by race/ethnicity – baseline data (2010)

- African American ----------49.8%
- American Indian/Alaska Native----------59.3%
- Asian/Pacific Islander ----------76.1%
- Hispanic----------55.2%
- White----------69.9%

Percentage of babies with low birth weight by race/ethnicity – baseline data (2010)

- African American ----------10.9%
- American Indian/Alaska Native---------- 7.4%
- Asian ---------- 7.8%
- Hawaiian/Pacific Islander ----------11.1%
- Hispanic---------- 6.1%
- White---------- 6.0%

Incarceration rates per 100,000 by race/ethnicity – baseline data (2005)

- African American ---------- 2,930
- Hispanic---------- 573
- White---------- 502

1 Strategy

Create and disseminate a health equity lens tool that can help assess policies and programs for disproportionate impacts on specific populations and recommend modifications that would improve health equity.

Performance measures	Target	Responsible parties
The creation of a health equity lens tool and the number of organizations that have adopted its use	Health equity lens tool created (2014).	• Health Equity Policy Review Committee • Oregon Health Authority • Regional equity coalitions • Coordinated care organizations and community advisory councils • Culturally diverse community-based organizations • Health advocates • Policy makers • Elected officials

2 Strategy	Provide resources to increase the capacity of Oregon's diverse populations to improve community health.
3 Strategy	Meaningfully engage diverse communities to ensure that the effects on health equity are considered when developing, implementing and evaluating policies and programs.
4 Strategy	Collaborate with K-12 and higher educational institutions and employers to diversify the health work force and ensure that workers from diverse background have the educational and employment opportunities to move up the career ladder.
5 Strategy	Increase the cultural competency of the health work force to more effectively work with diverse populations.
6 Strategy	When determining priorities for improving health, set measurable goals for reducing health disparities.
7 Strategy	Ensure that health information systems include detailed data on race, ethnicity, language, and other characteristics necessary to monitor health equity.
8 Strategy	Disseminate lessons learned from initiatives to improve health equity in order to help replicate successful efforts.

Performance measures	Target	Responsible parties
For each health area, performance measures should be defined for these health equity strategies.	Targets defined for each health area's health equity strategies (2017).	All people and organizations working on the underlying health area

PREVENT AND REDUCE TOBACCO USE

Background

Tobacco use remains the number-one cause of preventable death in Oregon and nationally. Tobacco use kills approximately 7,000 Oregonians each year, and secondhand smoke causes an additional 650 deaths. Oregon's public health system has made powerful inroads into addressing the harm caused by tobacco use, but much remains to be done.

In 2011 in Oregon:

- 20% of adults smoked cigarettes.
- 12% of 11th graders smoked cigarettes.
- 7% of eighth graders smoked cigarettes.
- 4% of adults used smokeless tobacco.
- 12% of 11th-grade boys used smokeless tobacco.

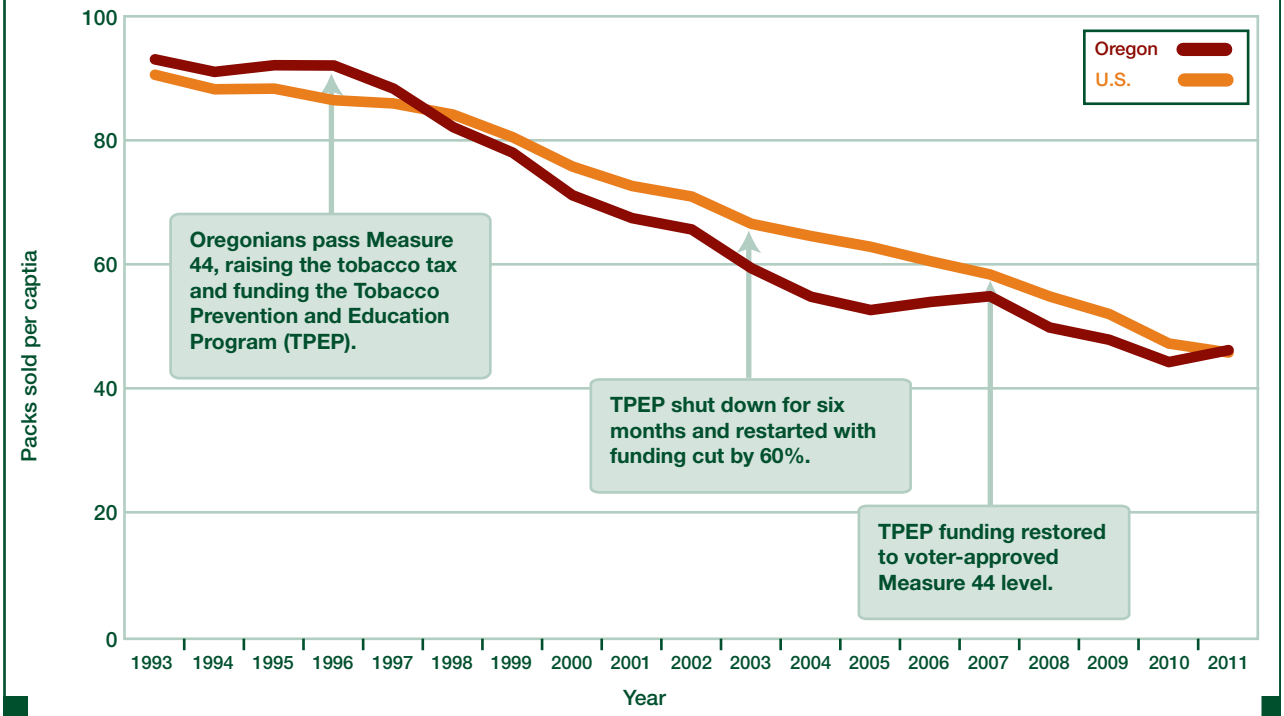
Smoking costs Oregon more than $2.5 billion annually in direct medical expenditures and indirect costs due to premature death. Treating smoking-related disease costs Oregon Medicaid $374 million per year. In 2011, Oregon smokers paid an average of $5.41 per pack, in contrast with the true cost to society of $13.94 per pack (Oregon Tobacco Facts & Laws, 2011).

Tobacco use causes or worsens almost every chronic disease. Chronic diseases account for approximately 85 cents of every $1 spent on health care costs. For Oregon to achieve success with health system transformation and the Triple Aim of better health and better health care at lower cost, Oregon must reduce tobacco use and exposure to secondhand smoke.

To reduce tobacco use, Oregon must take a comprehensive approach, addressing tobacco use from every angle. Implementing hard-hitting messages and warnings, providing advice and assistance to quit, increasing the price of tobacco products, improving access to and affordability of cessation services, enacting restrictions on where tobacco can be used, and restricting how tobacco can be promoted are all necessary components of an effective and comprehensive tobacco control strategy.

Oregonians voted in 1996 for Measure 44, which raised cigarette taxes and funded the Tobacco Prevention and Education Program. As shown in the chart below, cigarette consumption has declined in Oregon during the past 15 years.

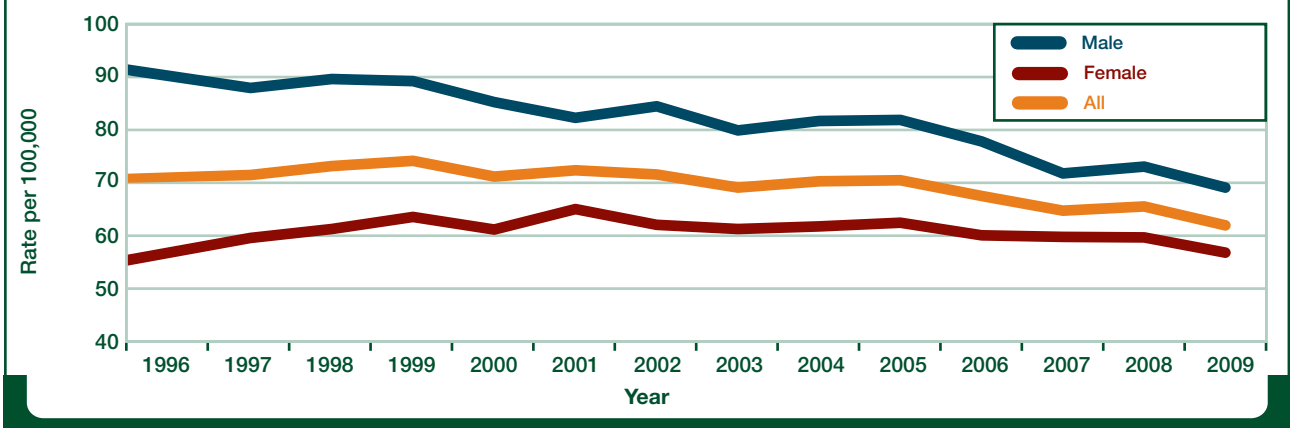
Cigarette packs sold per capita, Oregon vs. United States, 1993–2011



RESEARCH TRIANGLE INSTITUTE (1993–1998); ORZECHOWSKI AND WALKER (1999–2009) POPULATION – U.S. CENSUS BUREAU

Lung cancer is the third most common cancer and the number-one leading cause of cancer deaths in Oregon; almost 90% of lung cancers are related to smoking. Lung cancer diagnosis rates among men have dropped markedly during the past decade due to decreases in smoking. Rates among women are slightly lower than rates among men but have remained relatively flat. Lung cancers among men and women can be expected to decline if smoking rates fall further.

Age-adjusted rate of invasive lung and bronchial cancer diagnoses per 100,000 Oregonians, 1996–2009



SOURCE: OREGON STATE CANCER REGISTRY

Tracking and monitoring policy, systems and environmental change

Several of the performance measures recommended in the table below will be assessed by a policy database developed by the Oregon Health Authority Public Health Division's Health Promotion and Chronic Disease Prevention Section. Oregon's public health system routinely collects and analyzes data on the prevalence of diseases and risk factors across the population and among sub-populations, and monitors state and local policies that prevent disease and support healthy living. To capture local and state policies, the Health Promotion and Chronic Disease Prevention Section established a policy database to track local and state policies to prevent tobacco use, obesity and related chronic diseases and promote tobacco-free living, healthy eating and active living. Components of the database include, but are not limited to:

- Type of policy;
- Date policy adopted and implemented;
- Population-reach;
- Jurisdiction;
- Contact information.

Health Priority 2: Prevent and Reduce Tobacco Use

Health outcomes

Reduce the prevalence of asthma attacks, arthritis, cancer, diabetes, heart disease and stroke among children and adults.

Measurable objectives

Reduce the percentage of adults who smoke to 15% or less (2011: 20%).

- This decline would result in 148,000 fewer adult smokers and a cumulative savings of $2.2 billion in future health costs.

Smoking prevalence will be reduced among:

- 11th graders to 7.5% or less (2011: 12%);
- 8th graders to 5% or less (2011: 7%).

Reduce the number of packs of cigarettes sold per capita each year to less than 22 (2009: 48).

1 Strategy

Increase the price of cigarettes by a $1/pack excise tax (and a proportionate amount on other tobacco products).

Dedicate 10% ($40 million) to comprehensive and effective efforts at the state and local levels to reduce tobacco use and exposure.

Note 1: Efforts are geared to adults and children, especially in populations experiencing disparities.

Note 2: Strategies include implementation of best and emerging practice interventions by counties, regions, tribes, schools, coalitions and community-based organizations.

Note 3: This was identified by the Health Equity Advisory Group as the tobacco prevention and reduction strategy that provides the greatest opportunity to affect health equity.

Performance measures	Baseline	Target	Responsible parties
The amount of state tax on a pack of cigarettes	$1.18 (2012)	$2.18 tax/pack (2017)	Tobacco control advocacy partners: • American Heart Association • American Cancer Society • American Lung Association • Campaign for Tobacco-Free Kids
Secured allocations to the Tobacco Use Reduction Account	$12.5 million (2009–2011 biennium)	Approximately $20 million annually allocated to the Tobacco Use and Reduction Account (2017)	

2 Strategy

Ban free sampling of tobacco products, tobacco coupon redemption, and other tobacco price reduction strategies.

Performance measures	Baseline	Target	Responsible parties
Number of laws passed at the local and statewide levels banning tobacco sampling Note: Policy database is being developed to monitor this measure.	Not available	Tobacco sampling banned in five additional jurisdictions (2017).	Tobacco-Free Coalition of Oregon (to be confirmed)

3 Strategy

Increase the number of environments where tobacco use is prohibited including:

- Publicly owned multi-unit housing;
- City, County, tribally owned or operated campuses, parks and outdoor recreational spaces;
- Schools;
- Community colleges;
- Universities;
- Coordinated Care Organizations and hospitals.

Performance measures	Baseline	Target	Responsible parties
Number of environments where tobacco use is prohibited Note: Policy database is being developed to monitor this measure.	• Counties, 8% (2012); • tribes, 0% (2012); • community colleges, 29% (2012); • public universities, 29% (2012); • public housing authorities, 91% (2012)	Number of environments where tobacco use prohibited increased by 100% (2017).	• OHA Public Health Division • Tribal health organizations • County health department's tobacco control programs

4 Strategy Adopt and implement tobacco-free campus policies in all state agencies, hospitals and addictions and mental health facilities contracting with OHA.

Performance measures	Baseline	Target	Responsible parties
Number of agencies and organizations that have adopted tobacco-free campus policies	2% (2012)	Rules adopted and policy implementation guidance issued in 100% of organizations (2017).	• OHA Public Health Division • County health department's tobacco control grantee programs

5 Strategy Ensure that evidence-based,comprehensive tobacco cessation benefits are available and promoted to Oregonians.

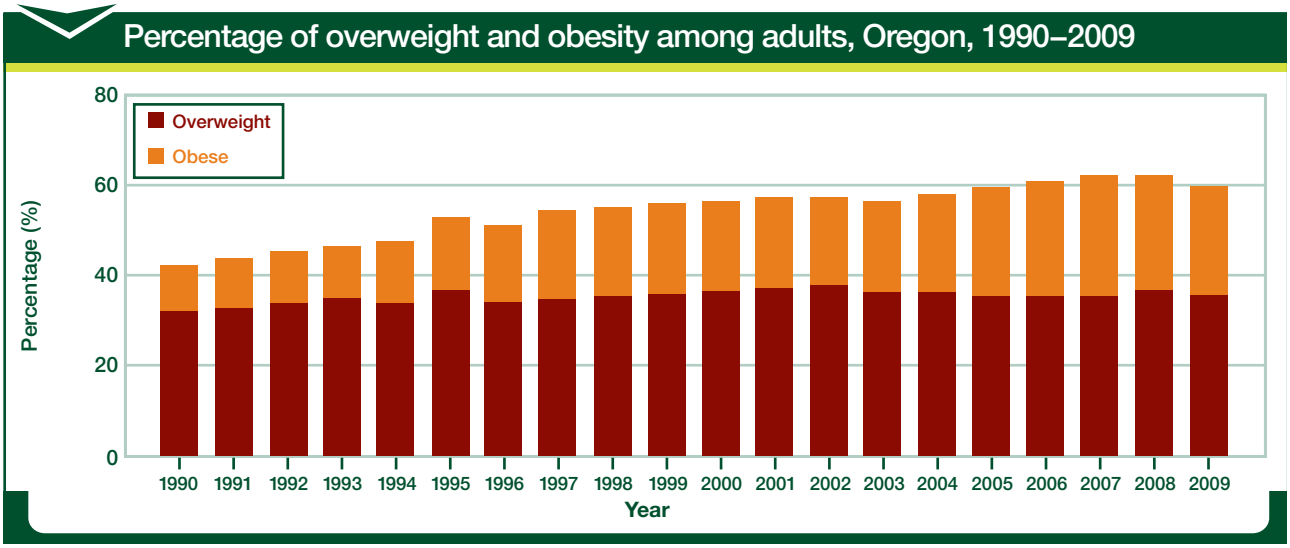
Performance measures	Baseline	Target	Responsible parties
Essential benefit package tobacco cessation coverage for the Oregon Health Insurance Exchange Note: These measure benefit availability, not promotion. The promotion of benefits cannot be measured with current data systems.	Not available	The essential benefit package for the Oregon Health Insurance Exchange includes evidence-based, comprehensive tobacco cessation (2017).	OHA Medical Assistance Programs
	Not available	100% of coordinated care organizations provide evidence-based tobacco cessation benefits to their members (2017).	
	Not available	75% of insured adult smokers in Oregon report their health insurance coverage pays for the cost of any smoking cessation assistance (2017).	

SLOW THE INCREASE OF OBESITY

Background

Obesity is the number-two cause of preventable death both in Oregon and nationally, second only to tobacco use. Obesity-related illnesses annually account for approximately 1,500 deaths in Oregon. Between 2001 and 2009, the percentage of Oregon students who were obese increased 53% for eighth-graders and 55% for 11thgraders. Since 1990, Oregon's adult obesity rate has increased 121% (Oregon Overweight, Obesity, Physical Activity and Nutrition Facts, 2012).

Preventing obesity among Oregonians lowers the risk of diabetes, heart disease, stroke, high blood pressure, stress and depression. Children and adolescents who are obese are at increased risk for becoming obese as adults and face a lifetime of health consequences.

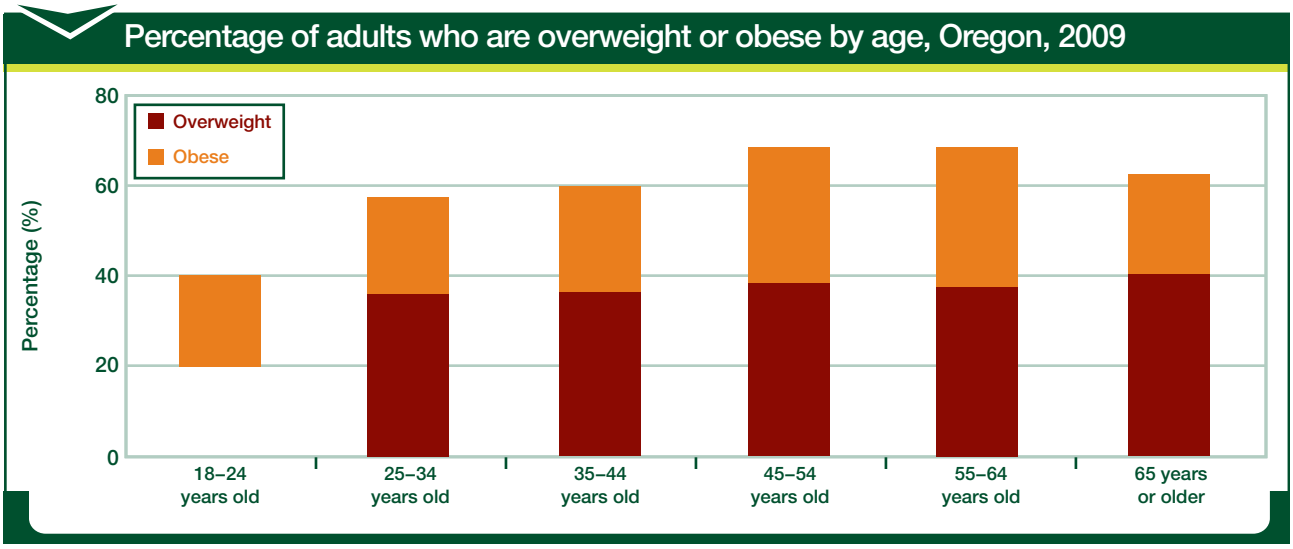


SOURCE: OREGON BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM

In Oregon in 2009:

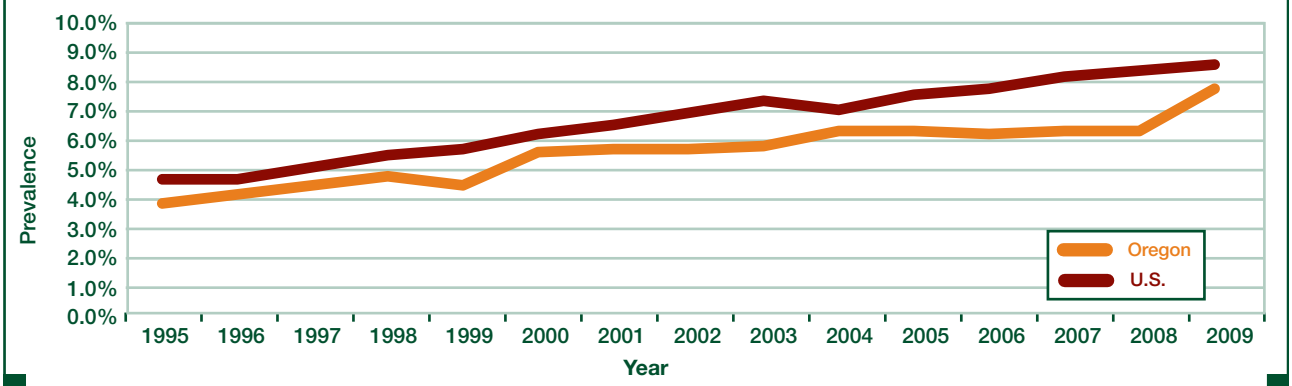
- 60% of adult Oregonians were overweight or obese.
  - ➤ 26% of adults met recommendations for fruit and vegetable consumption.
  - ➤ 57% of adults met minimum recommendations for physical activity.
  - ➤ 73% of adults with a history of heart attack were overweight or obese.
- 27% of eighth-graders were overweight or obese.
  - ➤ 21% of eighth-graders drank seven or more soft drinks a week.
  - ➤ 27% of eighth-graders played video games, computer games or used the Internet for non-schoolwork for three or more hours in an average school day.
- 24% of 11th-graders were overweight or obese.
  - ➤ 19% of 11th-graders drank seven or more soft drinks a week.
  - ➤ 12% of 11th-graders participated in daily physical education.

(Oregon Overweight, Obesity, Physical Activity and Nutrition Facts, 2012)



SOURCE: OREGON BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM

Age-adjusted diabetes prevalence, Oregon and United states, 1995–2009



SOURCE: OREGON AND U.S. BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEMS

Each year, Oregon spends approximately $1.6 billion ($339 million paid by Medicaid) in medical expenses for obesity-related chronic diseases, such as diabetes and heart disease. Annual medical costs of persons who are obese are estimated to be $1,429 higher per person than those of people who are not obese (Oregon Overweight, Obesity, Physical Activity and Nutrition Facts, 2012).

To slow the increase in obesity, Oregon must take a comprehensive approach. The same framework for addressing tobacco use also applies to obesity. Monitoring obesity, obesity-related diseases, and healthy eating and active living policies; promoting healthy eating and active living; raising the price of unhealthful foods and lowering the price of healthful foods; and offering support for people to manage their weight are all necessary components of an effective obesity prevention strategy.

Chronic diseases account for approximately 85 cents of every $1 spent on health care costs. For Oregon to achieve success with health system transformation and the Triple Aim of better health and better health care at lower costs, Oregon must reduce and prevent obesity.

Health Priority 3: Slow the Increase of Obesity

Health outcomes

Reduce the prevalence of asthma attacks, arthritis, cancer, diabetes, heart disease and stroke among children and adults.

Measurable objectives

Obesity prevalence will be maintained or reduced among:

- Adults to 30% or less (2010: 28%);
- 11th graders to 10% or less (2009: 10%);
- 8th graders to 11% or less (2009: 11%).

1 Strategy

Adopt and implement nutrition standards for foods and beverages sold in cafeterias, stores and vending machines in state agencies, schools and universities. This includes eliminating the sale of sugar-sweetened beverages.

Note: This was identified by the Health Equity Advisory Group as the obesity reduction strategy that provides the greatest opportunity to affect health equity.

Performance measures	Baseline	Target	Responsible parties
Percentage of state agencies, schools and universities with written nutrition standards adopted or improved	State agencies, 0% (2012)	• 100% of state agencies and universities have adopted nutrition standards for food sold or served (2017). • Schools improve their nutrition standard policies to include sports drinks and juices at school events (2017).	Oregon Nutrition Policy Alliance

2 Strategy

Reduce consumption of sugar-sweetened beverages by raising the price through a $0.005 per ounce excise tax (going to $0.01 per ounce).

Dedicate a portion of proceeds to reach recommended funding ($22 million) for comprehensive efforts to reduce obesity and chronic diseases in adults and children, especially in populations experiencing disparities.

Note: Strategies include media campaigns and implementation of best and promising practice interventions by counties, regions, tribes, schools, coalitions and community-based organizations.

Performance measures	Baseline	Target	Responsible parties
The amount of state tax on sugar-sweetened beverages	Not available	• Sugar-sweetened beverages taxed (2017). • Funding allocated to obesity prevention (2017).	Oregon Nutrition Policy Alliance

3 Strategy

Secure dedicated funds to support active transportation projects, such as public transit, inter-city rail, and bicycle and pedestrian projects.

Performance measures	Baseline	Target	Responsible parties
Secure $50 million each biennium in dedicated funds to support active transportation projects outside of the road right of way, such as public transit, inter-city rail, and bicycle and pedestrian projects.	Not available	$50 million (in state budget) dedicated annually (2017).	• Oregon Department of Transportation Safe Routes to Schools program • Oregon chapters of the American Planning Association, American Institute of Architects and American Society of Landscape Architects • Sustainable Communities (HUD, EPA, USDOT) and Smart Growth Organizations • Local and statewide planning departments

4 Strategy

Promote and support physical activity throughout the work and school day for employees and students including accessible stairs, breaks for stretching, walking meetings, recess, physical education and after-school play time.

Performance measures	Baseline	Target	Responsible parties
Note: Policy database is being developed to monitor this measure.	Not available	Number of institutions with policies promoting physical activity throughout the day increased by 100%.	To be determined

5 Strategy

Support efforts to fund the Farm to School, Farm to Institution and School Gardens Nutrition Programs through State Lottery funds.

Note: This was identified by the Health Equity Advisory Group as the obesity reduction strategy that provides the greatest opportunity to affect health equity.

Performance measures	Baseline	Target	Responsible parties
Amount of significant and/or sustaining legislation passed	Not available	• Farm to School funding legislation renewed (2017). • Farm to Institution legislation developed.	Upstream Public Health

IMPROVE ORAL HEALTH

Background

Oral health affects overall health and can have a significant effect on the quality of life. Oral diseases can affect our ability to eat well, our appearance, how we communicate, and our productivity at work and school. Oral diseases, which can range from cavities to oral cancer, cause needless pain and disability.

Evidence shows that oral health complications lead to or worsen many general health conditions. Recent studies have linked infections in the mouth with heart disease, diabetes and autoimmune disorders. Among pregnant women, oral infections can increase the risks for premature delivery and low birth weight babies.

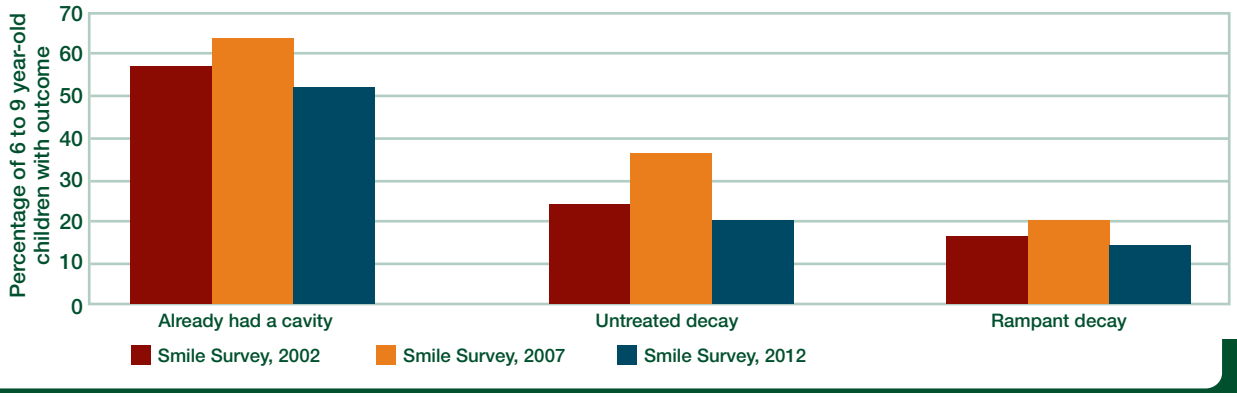
Healthy mouths are very important to child development. Poor oral health among young children affects speech, nutrition, growth, social development and quality of life. Dental decay is the most prevalent chronic condition among children — five times more common than asthma. Children with poor oral health have worse academic performance and are nearly three times more likely to miss school. Nationally, more than 51 million school hours are lost each year due to dental illness.

In Oregon:

- 58% of third graders had dental decay.[1]
  - ➤ 20% had untreated decay.
  - ➤ 10% had decay in permanent teeth.
  - ➤ 14% had decay in seven or more teeth.
- 76% of 11th graders had dental decay.[2]
  - ➤ 28% did not visit a dental provider in the previous year.
- 37% of adults had permanent tooth loss.[3]
  - ➤ 31% did not have a dental visit the previous year.[4]
  - ➤ 14% of those over age 65 had no teeth.
- 51% of women did not have a dental visit during pregnancy.[4]
  - ➤ 52% did not receive information about oral health during their pregnancy.
- 78% of toddlers (1 to 3 years of age) did not have a dental visit in the previous year.[4]
  - ➤ 60% did not receive fluoride.
  - ➤ 27% used bottles filled with something other than water

Most recent data available from:
[1]2012
[2]2011
[3]2010
[4]2007

Oral health status, *6 to 9 year-old children, Oregon 2002–2012 Smile Surveys



SOURCE: OREGON SMILE SURVEY, 2002, 2007 AND 2012

Timely access to preventive dental care can reduce health care costs, while lack of care can lead to costly hospital emergency care. The number of dental-related emergency visits by Oregon's Medicaid enrollees was 31% higher in 2010 than in 2008. Research shows that hospital care for a Medicaid enrollee costs nearly 10 times more than preventive care in a regular dental office (Pew Center on the States, 2012).

Oral health diseases are largely preventable. Effective behavioral interventions, such as good dental hygiene and regular visits to a dentist, and policy interventions, such as policies that increase access to fluoridated water, can help reduce the suffering and costs of oral diseases.

Early behavioral interventions include:

- Scheduling a child's first dental visit by 12 months of age;
- Receiving oral health and nutrition education based on the child's developmental needs (also known as anticipatory guidance), beginning prenatally;
- Reducing at-will consumption of liquids, beverages and foods containing fermentable carbohydrates (e.g., juice drinks, soft drinks, milk and starches), including no sugary liquids while a child is in bed and infrequent use of a training cup;
- Implementing proper oral hygiene as soon as the first tooth erupts;
- Checking the child's teeth for white spots (evidence of beginning cavities);

- Ensuring access to fluoridated water and preventive dental sealants.

Effective interventions that do not rely on behavioral changes include:

- Public water fluoridation:
  Fluoridation produces a median decrease in caries[2] of 29.1% to 50.7% among children ages 4 to 17 years. In 2010, only 23% of Oregon's water supplies were fluoridated to optimum levels.
- School-based dental sealant programs:
  School-based dental sealant programs produce a median 81% decrease in cavities in children (The Guide to Community Preventive Services, 2013). Dental sealant programs currently service approximately 69% of the eligible schools in Oregon.

[2]Early childhood caries is defined as the presence of one or more decayed, missing (due to caries) or filled tooth surfaces in any primary tooth in a preschool-age child between birth and 71 months of age. The American Dental Association (ADA) recognizes that "early childhood caries is a significant public health problem in selected populations and is also found throughout the general population" (ADA, 2013).

Health Priority 4: Improve Oral Health

Health outcomes

Reduce the prevalence of decay in permanent teeth among third graders.

Reduce the prevalence of older adults who have lost all their natural teeth.

Measurable objectives

- Reduce the percentage first-grade through third-grade children with untreated tooth decay to 30% (2007: 36%).
- Increase the percentage of adults with any dental visit in the past year to 75% (2010: 70%).

1 Strategy

Expand school-based dental sealant programs to reach more children.

Performance measures	Baseline	Target	Responsible parties
Percentage of eligible schools with a dental sealant program Note: Eligible schools have at least 50% of students receiving free or low-cost school meals.	61% (2011)	75% of eligible schools have a dental sealant program (2017).	• Schools • Local organizations • OHA Public Health Division Oral Health Unit

2 Strategy

Encourage public water districts to optimally fluoridate water to reduce tooth decay.

Note: This was identified by the Health Equity Advisory Group as the oral health improvement strategy that provides the greatest opportunity to affect health equity.

Performance measures	Baseline	Target	Responsible parties
Percentage of population residing in optimally fluoridated communities	22.6% (2010)	30% of the population reside in optimally fluoridated communities (2017).	• Local municipalities • Local water districts • General public • County health departments

3 Strategy

Ensure that children have a preventive dental visit by age 1.

Performance measures	Baseline	Target	Responsible parties
Percentage of children under 4 years old with a fluoride varnish application by a medical provider	1.6% (2009)	10% have a fluoride varnish application (2017).	• Family medical providers • Dental care organizations • Dentists • Caregivers
Percentage of children under 4 years old receiving preventive oral health services by a dental provider	17.6% (2009)	25% receive preventive oral health services (2017).	

4 Strategy

Increase public knowledge about oral health by promoting accurate and consistent messages, including the link between oral health and overall health.

Performance measures	Baseline	Target	Responsible parties
Percentage of women who received information on dental care during pregnancy	55.4% (2010)	60% of women will receive information on dental care during pregnancy (2017).	• Dental health providers • Oregon Dental Association • OHA Public Health Division Oral Health Unit
Percentage of women who received advice on preventing child tooth decay	33.5% (2010)	50% of women receive advice on preventing child tooth decay (2017).	
Data developed for performance measure related to knowledge among the general population			

5 Strategy

Enhance oral health services provided through Federally Qualified Health Centers and School-Based Health Centers.

Performance measures	Baseline	Target	Responsible parties
Percentage of Federally Qualified Health Centers with onsite dental services	Not available	Data to come.	• Federally Qualified Health Centers • School-Based Health Centers
Percentage of School-Based Health Centers with a dental provider (dentist or dental hygienist)	4.7% (2010)	15% of School-Based Health Centers have a dental provider (2017).	

6 Strategy

Within health systems, promote the inclusion of oral health in chronic disease prevention and management models.

Performance measures	Baseline	Target	Responsible parties
Percentage of overweight children with untreated decay	Not available	Oregon Smiles & Healthy Growth Survey data available (December 2012).	• Health systems • Health care providers
Percentage of adults with diabetes who visited the dentist, dental hygienist or dental clinic within the past year	65.6% (2008)	70% visited the dentist, dental hygienist or dental clinic within the past year (2017).	

REDUCE SUBSTANCE ABUSE AND OTHER UNTREATED BEHAVIORAL HEALTH ISSUES

Background

According to the Substance Abuse Mental Health Services Administration (SAMHSA), behavioral health issues, including substance abuse and mental illness, substantially contribute to disease and premature death in Oregon. Behavioral health is a general term that encompasses the promotion of emotional health; the prevention of substance abuse and mental illness. The Oregon State Health Profile shows that Oregon's death rates are higher than those of the overall U.S. death rates for liver disease (28% higher) and suicide (36% higher). Suicide kills more people in Oregon than motor vehicle crashes. The majority of Oregon suicide victims had a diagnosed mental disorder, alcohol and /or substance use problems, or depressed mood at time of death. Efforts to treat behavioral health and reduce the abuse of alcohol, opioids (painkillers) and other drugs, will decrease deaths from liver disease and suicide and improve Oregonians' overall health.

Alcohol use

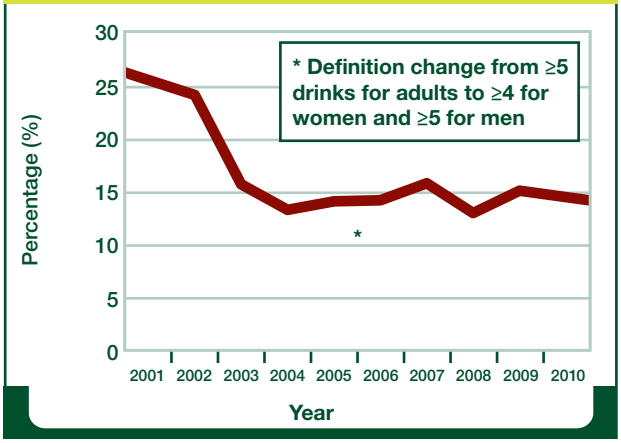
Age of first use of alcohol and alcohol dependency are closely related. Supporting youth to delay first use could yield immediate and long-term health benefits. Research shows that approximately four in 10 youth who first used alcohol by age 14 were diagnosed with alcohol dependency at some time in their lives. Only one in 10 people who first use alcohol at age 21 had that same risk.

Alcohol use during pregnancy increases the risk of fetal alcohol spectrum disorder (FASD), the leading preventable cause of mental retardation. In Oregon, 51.7% of new mothers reported drinking alcohol before they knew they were pregnant and 8.7% consumed alcoholic beverages during their last trimester (Oregon Pregnancy Risk Assessment and Monitoring System, 2007). Pregnant women were advised to abstain from any alcohol use.

Binge drinking

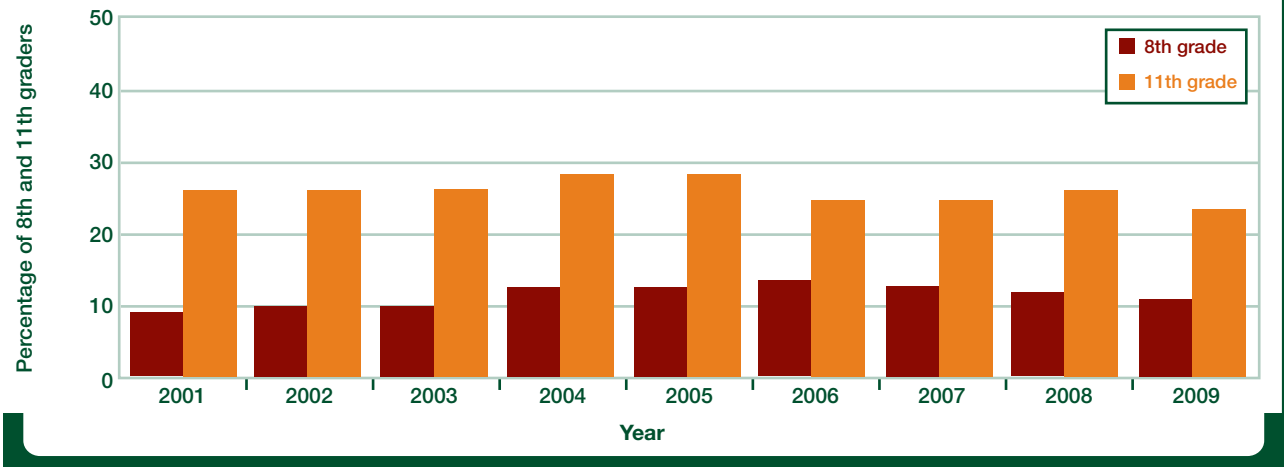
Binge drinking is a significant risk factor for injury, violence and chronic substance abuse. During 2010, 14.4% of adults reported binge drinking on at least one occasion during the past 30 days. Self-reported binge drinking declined from 2001 to 2004 but has not changed appreciably since that time. Males, in general, report binge drinking more frequently than women. Male binge drinking peaked (29.5%) in the 25–34-year age group; female binge drinking peaked (18.1%) in the 18–24-year age group.

Percentage of adults reporting binge drinking, Oregon 2001–2010



SOURCE: OREGON BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM

8th- and 11th-graders reporting binge drinking, Oregon 2001–2009

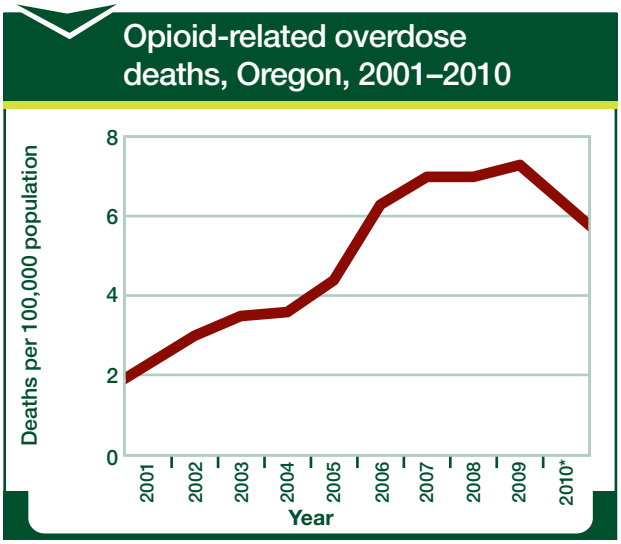


SOURCE: OREGON HEALTHY TEENS SURVEY

Among youth in 2009, 10.7% of Oregon eighth-graders and 23.4% of Oregon 11th-graders reported binge drinking in the past 30 days. Levels of binge drinking were similar among boys and girls (Oregon State Health Profile, 2012).

Opioid-related overdose

Unintentional opioid-related overdose is one of the leading causes of injury mortality in Oregon, and has increased three- to four-fold during the past decade (from 69 total deaths during 2001 to 225 during 2010). The numbers of Oregonians killed in motor vehicle crashes have declined substantially during the past decade, but the numbers dying from opioid overdoses have been steadily increasing. Efforts targeted at patients who use opioids as well as clinicians who prescribe them are needed to address this emerging public health problem.



SOURCE: OREGON DEATH CERTIFICATE DATA
VOTE: 2010 DATA ARE PROVISIONAL

Untreated mental illnesses cost the United States at least $105 billion in lost productivity annually, including 35 million lost workdays each year, according to Harvard University Medical School research. In 2010 alone, 678 Oregonians died by suicide; the estimate of total lifetime cost of suicidal deaths was nearly $680 million. Annual health care expenditures associated with fetal alcohol spectrum disorder totaled $78 million (Oregon Department of Human Services, 2009).

Effective approaches to promote positive behavioral health include primary care screenings of substance use and mental health issues; culturally appropriate mental health care; population-based surveillance such as Oregon's Prescription Drug Monitoring Program; and policy interventions, including increased alcohol taxes and enhanced enforcement of laws prohibiting sales to minors.

Health Priority 5: Reduce Substance Abuse and Other Untreated Behavioral Health Issues

Health outcomes

Reduce the prevalence injuries, suicide deaths, opioid overdose deaths and alcohol-induced diseases.

Measurable objectives

- **Alcohol-induced diseases** — Baseline: 14 per 100,000 (2012). Targets to be determined.
- **Reduction in underage binge drinking** — Baseline: 23% 11th Grade (2009), 11% 9th Grade (2009), 17.9% 18-24 (2010), targets to be determined
- **Alcohol-related motor vehicle transportation injuries** — Baseline: 44% of all MVT injuries (2004). Targets to be determined.
- **More behavioral health providers with language and cultural competency skills** — Baseline: 26.0% of Oregon physicians speak more than one language (2009); 93.2% of substance abuse treatment services provide counseling in Spanish, 8.1% in American Indian/Alaska Native languages and 16.2% in other languages. Targets to be determined.
- **Reduce opioid overdose mortality** — Baseline: 6 per 100,000 (2010). Targets to be determined.
- **Any reported alcohol use during pregnancy** — Baseline: 53.6% first trimester, 6.9% third trimester (2010). Targets to be determined.

1 Strategy

Start a formal, cross-sectoral (including representatives from behavioral health, public health, education and youth groups) planning process to develop a unified policy/systems change agenda for alcohol abuse prevention with emphasis on:

- Adolescents (aged 10 to 24) and young adults (ages 18 and older);
- Alcohol prevention in pregnant women;
- Community-school climate.

Performance measures	Baseline	Target	Responsible parties
Diverse and representative group of key stakeholders (including clients and survivors) convened to develop the action plan. Actionable plan developed.	Not available	Plan complete (June 2013).	• OHA Public Health Division • OHA Addictions and Mental Health • Oregon Department of Education • Oregon Health & Science University • Oregon Research Institute

2 Strategy

Conduct political feasibility assessments to determine the overall political feasibility of increasing beer and wine taxes with funding for law enforcement, treatment and prevention.

Performance measures	Baseline	Target	Responsible parties
Completed study	Not available	Study complete (December 2014).	Drug and alcohol prevention partners

3 Strategy

Collect and analyze baseline data on the availability of culturally and language-competent behavioral health providers.

Note: This was identified by the Health Equity Advisory Group as the substance abuse and untreated behavioral health issues reduction strategy that provides the greatest opportunity to affect health equity.

Performance measures	Baseline	Target	Responsible parties
Completed study	January 2015	Not available	OHA Addictions and Mental Health

4 Strategy

Support CCOs in maximally integrating substance abuse, behavioral health and physical health; screening and brief intervention at the primary care level; provider training on resources and education.

Performance measures	Baseline	Target	Responsible parties
Percentage of members over 12 years of age with routine visits screened and referred as necessary	Not available	10% increase (2014).	• OHA Addictions and Mental Health • OHA Transformation Center • Coordinated care organizations • OHA Medical Assistance Programs

5 Strategy

Establish and promote statewide best practices for the treatment of chronic non-cancer pain; promote wellness activities for health and wellness.

Performance measures	Baseline	Target	Responsible parties
Establishment of best practices	Not available	Decrease in number of opioids prescribed (2014).	• Oregon Prescription Drug Monitoring Program • Oregon Medical Association • Lines for Life • Board of Medical Examiners

Conclusion and special thanks

CONCLUSION

This plan outlines strategies for our communities to work together to improve health. Oregon's Healthy Future is a living document. While the priorities are clear, the methods for addressing each of them will evolve over time. Groups recognize this potential collective effort as a powerful means to improve critical health indicators. Across the state, diverse stakeholders are working together to better understand and outline ways to achieve health equity and to support lifelong health.

As the numbers of those engaged in this effort grow, we envision a future where *every* community is empowered to improve the lifelong health of all people in Oregon.

SPECIAL THANKS

A special thank you goes to Mosbaek Consulting and Agnew::Beck, which provided consultation and direction to the Oregon's Healthy Future plan. The Oregon Health Authority and Rede Group appreciate and value the collaborative effort it took to create this plan.

AGNEW ::BECK

Engage Plan Implement

REDE GROUP

STRATEGY | HEALTH | POLICY

Appendix

APPENDIX 1: Planning process

The process for developing Oregon's Healthy Future was built upon the work of recent planning processes, most importantly the 2010 Oregon Health Improvement Plan. The Oregon Health Policy Board convened a 26-member Oregon Health Improvement Plan Committee (OHIPC) in January 2010 and charged it with developing a 10-year overarching plan to improve Oregonians' health through reducing chronic disease. OHIPC members represented schools, tribes, academia, government agencies, businesses and communities throughout the state. they were legislatively directed to focus on the prevention and management of chronic disease. The committee conducted a large-scale community feedback and engagement process, a detailed review of Oregon's public health data, and a rigorous review of the literature around evidence-based practices for improving population health.

Overview of 2010 Oregon Health Improvement Plan planning process

- Committee appointments (January 2010);
- 10 committee meetings (from March 30 to Oct. 8, 2010);
- Eight community listening sessions (summer 2010);
- Website Community Input Survey for those not able to attend a listening session (summer 2010);
- Public input through a website for review of final draft (fall 2010);
- Presentation to Oregon Health Policy Board (Nov. 9, 2010);
- Final report (December 2010).

The 2010 Oregon Health Improvement Plan Committee used a set of guiding principles to direct its work throughout the development of the plan:

- Focusing on prevention;
- Using evidence and data;
- Advancing health equity;
- Addressing social, economic and environmental factors;
- Respecting cultures and traditions;
- Empowering local communities;
- Creating short- and long-term policy actions.

As a result, the plan focused on chronic disease prevention and outlined a broad spectrum of policies and interventions to improve lifelong health (available at http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/OregonHealthImprovementPlan/Pages/index.aspx).

Overview of 2012 Oregon's Healthy Future planning process

In developing the 2012 Oregon's Healthy Future plan, The Oregon Health Authority Public Health Division and the planning advisory group sought to:

- Seek additional community feedback to ensure timeliness of information;
- Review the full spectrum of public health issues and problems; and
- Create a five-year Statewide Community Health Improvement Plan.

Two community listening, feedback and solutions work sessions were conducted in June and July 2012 as part of the community input process for Oregon's Healthy Future. The purpose of these work sessions — held in Portland and La Grande — was to gather community perspectives on Oregon's state of health. This outreach effort was intended to build upon the community input collected in 2010 for the Oregon Health Improvement Plan (OHIP). Approximately 300 people representing all regions of the state participated in the 2010 process through a series of statewide public meetings and an online survey; an additional 20 Oregonians took part in the 2012 work sessions.

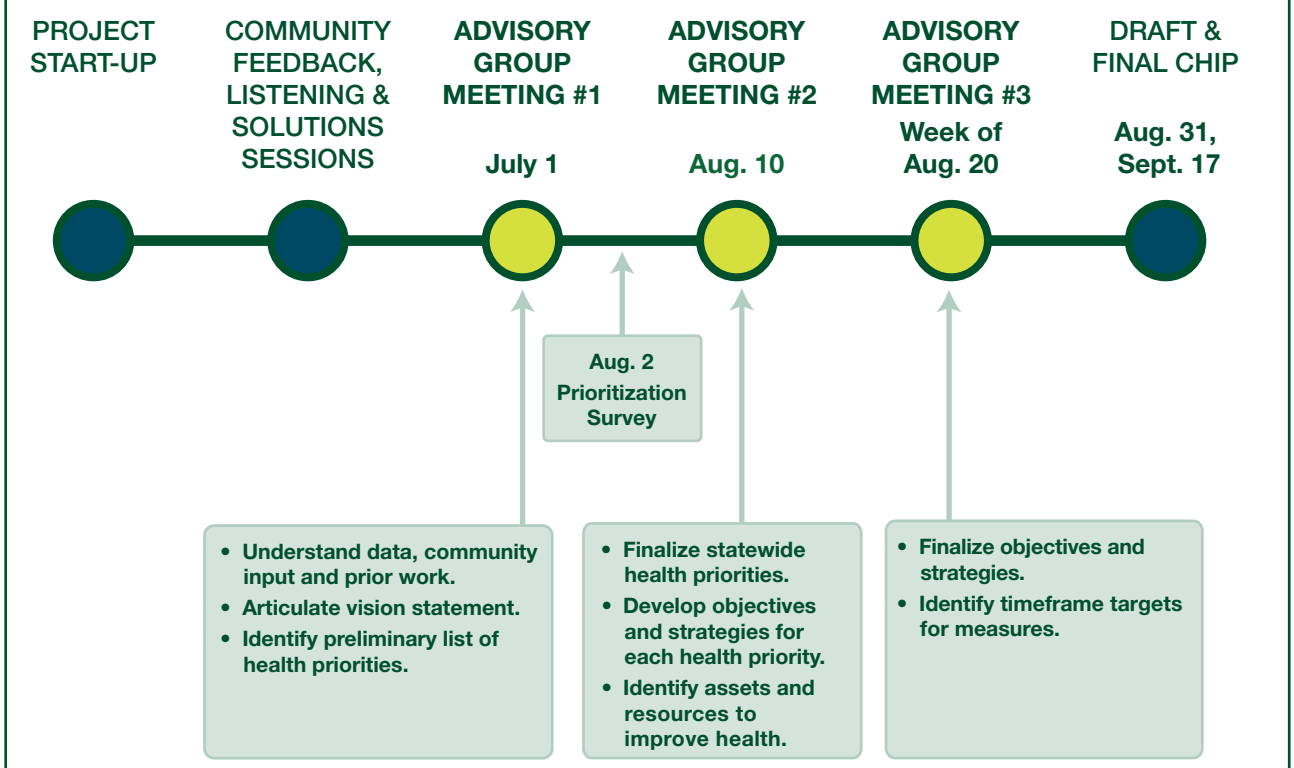
Details of the community input from these engagement processes are summarized in appendices 2 and 3. The 2012 public engagement process requested feedback from communities on Oregon's health indicators as well as on the health indicators from the World Health Organization's Healthy Cities initiative.

Together, these community engagement processes were vital to following the Mobilizing for Action through Planning and Partnership (MAPP) process, which entails including a "community themes and strengths assessment [to] provide a deep understanding of the issues that residents feel are important."

This input and state health indicators data were then summarized and shared with the advisory group. This data included a statewide community health assessment recently conducted by the Oregon Health Authority Public Health Division that included comprehensive Oregon Public Health Division System Assessment of state resources that can be mobilized to address identified health challenges; and a State Health Profile that presents information on selected health indicators and offers a snapshot of Oregonians' health status. (Both the assessment and profile are available at www.healthoregon.org/about.) The State Health Profile was a central focus of discussion and decision making.

In a series of three facilitated meetings and an in-depth online survey of advisory group members, health priority areas were identified and specific strategies and outcomes recommended.

Timeline – 2012 Oregon's Healthy Future planning process



APPENDIX 2:
Community engagement

Themes from the 2010 OHIP process

Participants in the 2010 outreach process were asked the following questions in a public meeting and online survey:

- What are the issues in your community that have the greatest impact on your health and that of others in the community?
- What is happening in your community that promotes health and supports a thriving community?
- What three to five changes in policy would make your community healthier and thrive?

From these discussions, the following main themes were identified and used to shape recommendations in the 2010 OHIP:

- Access to nutrition;
- Access to health care;
- Good transportation;
- Adequate funding and programs;
- Improved physical activity.

Additionally, poverty, joblessness and homelessness were identified as pressing underlying socio-economic issues that negatively affected health.

Themes from the 2012 community listening, feedback and solutions process

The main themes emphasized by participants in the 2012 work sessions are summarized below and illustrated in Appendix 3 and 4.

Themes repeated from 2010 included funding, access to health care, nutrition and addressing chronic diseases. New emphasis was placed on collaboration, mental health, providing for vulnerable populations, air quality, youth and teens, and promoting an overall healthy community and lifestyle.

Broad understanding of health

Participants uniformly viewed health as more than health care. In their view, health considers not only primary care and behavioral health, but also active lifestyles and access to quality foods, jobs, shelter and safety. Social equity and equal access for all people to the conditions necessary for a healthy life were especially important.

The importance of collaboration

The ability to remove barriers to collaboration was another major theme of the sessions. These barriers sometimes take the form of lack of communication or lack of knowledge sharing among programs and communities throughout the state. Participants felt that a forum for a better understanding of what other communities, providers and programs are doing would be very beneficial. But bureaucratic and funding barriers also exist. Likewise, who is responsible for what, concerns over sharing funding, and hesitancy to try new or experimental approaches to health were commonly cited as barriers to resolving pressing issues. Session participants strongly recommended identifying and removing these barriers, and involving communities in the developing solutions.

Developing compassionate communities

Participants spoke about several programs, policies and practices that would contribute to — as one participant said – developing "compassionate communities." Compassionate communities are ones in which fellow members of the community are encouraged to be concerned about, reach out to and care about one another. They are communities in which is it easy to find ways to volunteer, reach out to neighbors who are at risk and offer different levels of support.

Health is severely underfunded

Nearly every participant commented on the level of public health funding that Oregon budgets. While participants recognized that funding is a common issue in the field of public health, nationally, Oregon's funding level is particularly low. Participants felt strongly that a change in Oregon's funding levels would result in significant improvement of public health throughout the state.

Focus on youth

Session participants agreed that promoting and protecting the health of youth populations was a priority across the board, from pre-natal to infant to school-aged, teen and young adult groups. Participants discussed a number of specific programs and practices on this topic.

Address chronic diseases

In addition to the new ideas noted above, participants strongly supported continuing to address issues of chronic disease, particularly the underlying health habits that increase its incidence.

Each theme identified in the 2010 and 2012 community engagement processes is addressed through one or a combination of the identified health priorities and strategies.

APPENDIX 3:
Portland community engagement themes

Portland community feedback and solutions sessions

VISION

QUESTION:
What is important to our community?
How is quality of life perceived in our community?
What does a healthy community look like?

1. Practice smart, effective COORDINATION and COLLABORATION.

- Collaboration entails trusting, being open, giving up "turf" and focusing on solutions.
- Coordinated care organizations reach out, bring more people to the table.
- Existing resources are used wisely.
- Healthy communities are open to new methods.

2. Build COMPASSIONATE COMMUNITIES.

- People feel cared about and part of a community.
- People are empowered to watch out for each other, and to be neighborly and compassionate.
- Focus is on marginalized communities—children, teens, seniors/elders, people with mental and behavioral issues.

3. Realign INCENTIVES. Broaden view of HEALTH.

- Health funding is greatly increased.
- Health goes beyond health care.
- Collaboration effectiveness is valued and rewarded.
- Issues are addressed that disproportionally affect populations.

4. Design HEALTHY PLACES.

- There is an abundance of parks, gardens and open spaces.
- Everything is cared for and inviting.
- Environments are safe.
- There is access to healthy local foods.
- Health care is easily and equally accessed.

5. Focus on CHILDREN and TEENS.

- Social change starts by changing conditions of our youth.
- People have access to affordable child care, dental and health care, education and activities.
- Youth feel that they belong rather than feeling lost.

Statewide Community Health Improvement Plan 2012

Portland community feedback and solutions sessions

SOLUTIONS to KEY ISSUES

QUESTION:

What are our most pressing health issues?
Which issues are often overlooked?
What assests do we have to address them?
What solutions would address our issues?

- View health policy development through the lens of equity. Track and use disparities data.
- Coordinated care organizations reach out, bring more people to the table.
- Be open to new methods, and resource innovative pilot programs.

- Obesity is addressed through physical activity, nutrition, access to healthy food and education programs.
- Smoking bans and funding for tobacco prevention and control increase.

- Provide health insurance to more people.
- Coordinated care organizations (CCOs) spearhead efforts.

- Encourage sense of health ownership even in entities that aren't health organizations, e.g., reach out to business community.
- Share lists of resources, case studies of best practices.

- Mental health funding increases.
- Mentors and models act as guides for teens.
- Working parents and single parents are supported in raising their children.
- Companionship for seniors is available.

Statewide Community Health Improvement Plan 2012

APPENDIX 4:
La Grande community engagement themes

La Grande community feedback and solutions sessions

VISION

QUESTION:
What is important to our community?
How is quality of life perceived in our community?
What does a healthy community look like?

1. People are living a HEALTHY LIFESTYLE overall.

- There is great air quality, water, environmental quality, parks and safe places to live, work and play.
- Lifestyle is relatively slow-paced and stress-free.
- People are actively engaged in healthy exercise, activities and eating well.
- A strong sense of community exists.
- Parks, outdoor opportunities and walkable neighborhoods are present.
- Poverty is addressed.
- Everyone in Oregon experiences equity and social justice.

2. People UPSTREAM address issues identified by people DOWNSTREAM.

- Coalitions address common issues, coordinate programs and services.
- Coordinated care organizations reach out and bring more people to the table.
- Requirements and timelines are aligned so limited resources can be used most efficiently.

3. Program FUNDING is SUSTAINABLE.

- Funding for health is increased greatly. Health goes beyond health care.
- Programs last for long enough to have real impact on an issue.

4. CHILDREN and YOUTH are a major focus.

- Youth are in safe environments.
- Everyone is immunized and vaccinated.
- Great opportunities exist for healthy activities, good careers and quality education.

Statewide Community Health Improvement Plan 2012

La Grande community feedback and solutions sessions

SOLUTIONS TO KEY ISSUES

QUESTION:

What are our most pressing health issues?
Which issues are often overlooked?
What assests do we have to address them?
What solutions would address our issues?

1. ACCESS to CARE for ALL PEOPLE

- Area has a great hospital, but lacks specialists, telemedicine and mobile medical units. Recruitment can help.
- More people need health insurance.
- Easy access to quality primary care, vaccinations and immunizations are ensured through CCOs.
- Awareness increases of many good programs.

2. CANCER and CHRONIC DISEASE, especially OBESITY, ALCOHOL USE

- Obesity is addressed through physical activity education programs.
- People are educated and encouraged to take advantage of the region's recreational options.
- Programs are needed to teach nutrition and increase access to healthy and local foods.

3. EQUITY, SOCIAL JUSTICE, EDUCATION and HOUSING

- View health policy development with a particular focus on vulnerable populations and issues associated with poverty.
- Coordinated care organizations reach out and bring more people to the table.

4. COORDINATION and COLLABORATION

- This is a small community with a very positive attitude about working together.
- Innovation is valued. Stretching and combining resources solves problems.
- Caseworkers should be assigned to support high-impact clients.

5. AIR QUALITY and ENVIRONMENTAL EXPOSURE

- Increased controls on secondhand smoke are needed.
- The general environmental quality is perceived as good already. It should be protected.

Statewide Community Health Improvement Plan 2012

This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills.
To request this publication in another format or language, contact the OHA Public Health Division at 971-673-0984 (voice) or 971-673-0372 (TTY) or email tobacco.ohd@state.or.us

Oregon Health Authority

Appendix 11
Regional Health Equity Coalitions
Summary of Site Visit Findings: June 2014

After conducting site visits with all the Regional Health Equity Coalitions (RHECs), themes began to emerge from each of the four component areas. When asking about coalitions' regional focus, specifically, how populations of focus were identified:

- RHECs with identified populations of focus: used existing data and reports to guide the selection of communities to include. Some RHECs also used informal interviews with stakeholders to get feedback on what communities to include. Other coalitions also considered their capacity when choosing their population and geographic area of focus.
- Transportation is an issue due to geographic spread of RHEC areas, not just for community members accessing health services, but for engaging geographically diverse communities to participate in coalition activities.

When asked what the benefits are of approaching work as a regional vs. county model, grantees said:

- Counties often create artificial boundaries where there are none-community members may be accessing services or migrating between multiple counties, but having a regional focus allows the inclusion of areas where community members are living or spending their time. Also, living situations can be very different among counties, so reasons for health disparities, availability of resources, and access to transportation and services can all look very different. Having a regional approach also provides an awareness of other health equity efforts. Regional approach allows for inclusivity.

With regard to the health issues component, when asked if CCOs been engaged, RHECs said that:

- Most RHECs have been able to connect in some way with their local CCOs whether it's been through connecting with Transformation Center Innovator agents, attending Community Advisory Committee (CAC) meetings or being CAC members, or having CCO staff as RHEC members or RHEC steering committee members. Where these relationships exist there was mention of mutual learning benefits.

When asked if coalitions had seen positive changes in the way CCOs work with/for the community RHECs mentioned:

- That many CCOs are still catching their breath and building their capacity to meet expansion challenges, but that overall, RHECs anticipate positive changes over the next few years.
- Wanting to explore more opportunities to connect their regional communities to CCOs more in the future. It was often mentioned that there's a need for more community voice in CAC membership and leadership.

Grantees were asked how coalitions prioritized issues to advance equity given the number of disparities affecting their region, coalitions said:

- Existing data was utilized to guide those decisions.
- RHECs evaluated whether they had the existing capacity to take on each priority.
- It is important to go back to the communities impacted by specific health disparities to ask if addressing certain issues are a priority for the community partners.
- Utilizing strategic plans as a living document rather than a one-time deliverable was noted as being helpful in guiding priorities over time.

With regard to the most commonly experienced challenges or barriers around coalition-building responses included:

- Scheduling issues and getting all coalition members into a room is challenging since people are so busy.
- Most coalitions experienced capacity challenges in comparison to the level of disparity existing in their communities, which makes priority setting activities important but also challenging because RHECs have to prioritize what's feasible.

When asked what the key ingredients are for the accomplishments coalitions have achieved, grantees said:

- Building relationships in regions of focus, and making connections with organizations in the community.
- Being mindful of how you ask for people's time, and using that time wisely.
- Having a willingness to share knowledge, information and resources.
- Having the right mix of people on the RHECs that have the knowledge and expertise needed to address and move forward priorities. It was also mentioned that it is especially important to have respected and trusted community leaders who can ensure authentic community engagement over time.

APPENDIX 12

State of Oregon
Quarterly Report Work Breakdown Structure
April 1, 2014 -June 30, 2014

Category	Time	Description (By SIM Program Area)	Payments Received	Expenditure	
Salary	April-June	Transformation Center		$ 196,143.40	
Salary	April-June	Analytics and Evaluation		$ 36,711.47	
Salary	April-June	Equity and Inclusion (DELTA, HCI, RHEC)		$ (19,577.55)	*
Salary	April-June	Long Term Support & Services		$ 92,987.12	
Salary	April-June	Patient Centered Primary Care Home (PCPCH)		$ 7,546.95	
Salary	April-June	Health Information Technology		$ -	
Salary	April-June	Medicare/Medicaid Dually Eligible (Duals)		$ (30,742.11)	*
Salary	April-June	Population Health		$ 88,932.19	
Salary	April-June	Early Learning Council		$ -	
Salary	April-June	SIM Grant Management		$ 85,235.56	
Total Salary	April-June	All above		$ 457,237.03	
Fringe	April-June	All above	None	$ 201,523.28	
Travel	April-June	Transformation Center, Analytics and Evaluation, Equity and Inclusion, Long Term Care, PCPCH, Population Health, SIM Grant Management	None	$ 42,814.98	
Equipment	April-June	NA	None	$ -	
Supplies	April-June	Transformation Center, Long Term Support & Services	None	$ 4,509.52	
Contractual	April-June	Transformation Center, Analytics and Evaluation, Equity and Inclusion, Long Term Supports & Services, PCPCH, Health Information Technology, Population Health	None	$ 878,923.54	
Other	April-June	Transformation Center, Analytics and Evaluation, Equity and Inclusion, Long Term Supports & Services, PCPCH, Duals, Population Health, SIM Grant Management	None	$ 60,751.36	
Total Direct	April-June	NA	None	$ 1,645,759.71	
Cost Allocation	April-June	NA	None	$ 526,221.32	
Total	April-June	NA	None	**$ 2,171,981.03**	

* Reflect corrections from prior periods.