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April 17, 2023

Senator Wlnsvey Campos, Co-Chair
Representative Andrea Valderrama, Co-Chair
Joint Ways and Means Human Services Sub-Committee
900 Court Street NE
State Capitol
Salem, OR 97301

Dear Co-Chairs and Committee Members:

Please find below information requested by members of the Joint Ways and Means Human Services Sub-Committee at the April 3 meeting related to Key Performance Measures (KPMs) and to new investments in the proposed OHA budget.

1. Who defines quality of life and defines premature death in the context of disabilities?

The KPMs discussed in the subcommittee meeting – *Quality of Life-Poor Physical Health* and *Quality of Life-Poor Mental Health* – are *not* related to Quality-Adjusted Life Years (QALY).

Quality of life (QOL) measures are broad constructs which aim to capture the well-being, whether of a group or individual, regarding both the positive and negative experiences of their health. For example, these frequently show up in research showing a person's reported quality of life before and after receiving a medical service. They are based on standardized surveys filled out by individuals with a particular condition about their ability to perform important life functions such as being able to work, perform household tasks and participate in social activities. If the post-treatment survey responses indicate improvement in these areas, the treatment is considered effective in improving QOL. QOL is often an important health outcome used in evaluating services, especially for people with disabilities. It can also be an important reason to cover supportive services, medical equipment and palliative services.

The two recommended KPMs will measure QOL by asking individuals to self-report the number of physically or mentally unhealthy days they have experienced in the past 30 days. These KPMs will include disparity categories, including disability, to allow for better identification of health inequities and thus inform efforts to improve the health of populations reporting worse quality of life. This would likely lead to more focus and resources for such populations. Furthermore, OHA's Equity & Inclusion Division will consult with experts in the field of disability and Quality of Life to ensure that these KPMs do not perpetuate bias by measuring quality of life based on the experiences of non-disabled people.

For comparison, Quality-Adjusted Life Year (QALY) is an econometric tool used in comparative-effectiveness research that aims to compare improvements in health across different interventions for a particular condition or population. QALYs can be calculated to compare benefits across different treatments within the same patient population, or across different populations. Potential for discriminatory impact occurs when the QALY is used to compare treatments across different populations, introducing a measurement bias that favors a return to what is considered "full health." Again, QALY are *not* a part of OHA's proposed KPMs.

2. **Please explain why OHA would drop illicit drugs from KPMs with the issues Oregon is facing, but keep tobacco measures?**

   OHA proposes deleting three KPMS: *30 Day Alcohol Use Among 6th Graders*, *30 Day Illicit Drug Use Among 11th Graders*, and *30 Day Alcohol Use Among 11th Graders*. OHA recommends keeping KPMs on *30 Day Illicit Drug Use Among 8th Graders* and *30 Day Alcohol Use Among 8th Graders*, so substance use by youth will remain in focus.

   For all these KPMs, the current rates are lower (better) than the target goal. Also, the rates are very similar to each other and do not change significantly over time. In such circumstances, having multiple KPMs measuring nearly the same thing is of limited benefit. Like the other KPMs proposed to be deleted, OHA will continue to track each measure for use by individual OHA programs.

   OHA proposes to add a KPM on *Tobacco Use-Teens*, which includes use of nicotine products such as vaping devices. Cigarette smoking is the most common cause of preventable death and disease. After years of declining, overall use rates among teens increased in recent years due to introduction of e-cigarettes and other synthetic nicotine products. Most people who use tobacco and nicotine products start when they are teenagers (or sometimes younger). A critical public health goal is to prevent the initiation of use in youth, which if successful will likely lead to the individual not using these products as an adult.

   There is already a KPM on *Rate Of Tobacco Use (Population)*, which measures use by adults. A key goal for adults is to promote quitting use of these products, more so than preventing initiation of use. Also, efforts to reduce tobacco and nicotine use usually employ very different messages, media, and activities for teens as compared to for adults. Therefore, there is benefit in measuring and tracking usage by teens and by adults separately.

3. **Please provide information on other states that currently have programs like Healthier Oregon.**

   The best summary on this topic is a Kaiser Family Foundation article about Healthier Oregon-like programs, available here: https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-and-care-of-immigrants/. The most directly applicable portion is toward the end of the article, in a section titled *State Funded Coverage for Immigrants*. The key paragraph is:

A few states have also expanded fully state-funded coverage to adult immigrants. Through its longstanding locally funded Healthcare Alliance program, the District of Columbia provides health coverage to low-income residents regardless of immigration status. In January 2020, California extended state-funded Medicaid coverage to young adults ages 19-26 regardless of immigration status, and adults ages 50 and older became eligible on May 1, 2022. The state will further extend coverage to income-eligible adults ages 26 to 49, regardless of immigration status, no sooner than January 1, 2024. In December 2020, Illinois extended state-funded coverage to low-income individuals ages 65 and older who were not eligible for Medicaid due to their immigration status. As of July 2022, coverage was also extended to low-income immigrants ages 42 to 64, regardless of status, and proposed legislation would further expand this coverage to all adults ages 19 and older. In Oregon, the Cover All People Act extended state-funded coverage to all low-income adults who are not eligible due to immigration status, subject to available funding. As of July 1, 2022, coverage was available to those ages 19-25 or 55 and older. New York plans to extend state-funded Medicaid coverage to individuals ages 65 and older regardless of immigration status beginning in 2023. Some additional states cover some income-eligible adults who are not otherwise eligible due to immigration status using state-only funds, but limit coverage to specific groups, such as lawfully present immigrants who are in the five-year waiting period for Medicaid coverage, or provide more limited benefits.

4. **What is the utilization of health services by the Healthier Oregon population versus the general Oregon Health Plan population?**

   OHA recently reviewed preliminary 2022 data and found that Healthier Oregon (HOP) member utilization was substantially lower than for comparable Medicaid members. Some of this underutilization was already priced into Healthier Oregon capitation rates, but not to the extent we are seeing at this point in time.

   These 2022 data are not ready to publish. The “ramp-up” effect of Healthier Oregon members navigating new coverage and accessing new services significantly complicates data. The gap with Medicaid spending is expected to close over time. Furthermore, the preliminary data are not complete due to lag time in medical billing.

   Likewise, the Cover All Kids population has had a history of lower utilization, ranging from approximately 60% to 85% of levels expected for Medicaid children. While there could be underlying differences in health between populations, much of the difference may be due to barriers to care, including challenges accessing culturally and linguistically appropriate care. For example, dental and primary care spending for Cover All Kids/Healthier Oregon children tend to be close to Medicaid levels, but specialist and behavioral health care spending tend to be markedly lower. In light of this experience and other benchmarks, OHA reflected an 85% of Medicaid utilization factor in many components of Healthier Oregon adult capitation rates.

Because Healthier Oregon underutilization relative to Medicaid is likely to be significantly driven by health inequities (as opposed to better health status), OHA has been cautious about further reducing capitation rates. OHA continues to review HOP utilization, in order to discern and remediate its causes, but that will be a multi-year effort.

To ensure that OHA is not overpaying CCOs, risk corridors are established that reconcile CCOs' HOP expenditures against HOP revenues and apply a settlement that recovers most of the impact of underutilization. We anticipate significant recoveries for CY22, and that may continue into CY23.

5. Are all Healthier Oregon members in CCOs or are there any Fee-For-Service?

When Healthier Oregon expansion occurred on July 1, 2022, age-eligible individuals who were enrolled in CWM automatically moved to full OHP, and the vast majority of them were enrolled in a CCO. Similar to other OHP members, most Healthier Oregon members are enrolled in CCOs. OHA worked closely with CMS to enable Oregon to integrate Healthier Oregon into managed care, while continuing to claim federal match. We are the first state in the country to successfully do so.

As of April 3, 2023, there are about 25,000 people in the Healthier Oregon population, and roughly 4% of those are on Fee-For-Service (FFS), or about 1,000. The precise number varies whenever someone is enrolled or unenrolled. Since this data comes from a point-in-time report, FFS numbers may include those in the process of transitioning to a CCO.

Included with this letter are:

- Slides with additional information on the KPMs OHA proposes to add
- The most recent KPM Annual Performance Progress Report, from September 2022
- A briefing paper on how OHA collects and uses disability data in the context of REALD

We also received a question about the regulatory history of Trillium Family Services. This information is taking longer to compile. I will send it as soon as possible.

Please do not hesitate to reach out if you have any further questions or clarifications.

Sincerely,

Dave Baden
Interim Director

Oregon Health Authority
Key Performance Measures
Additional Information on KPMs to Add

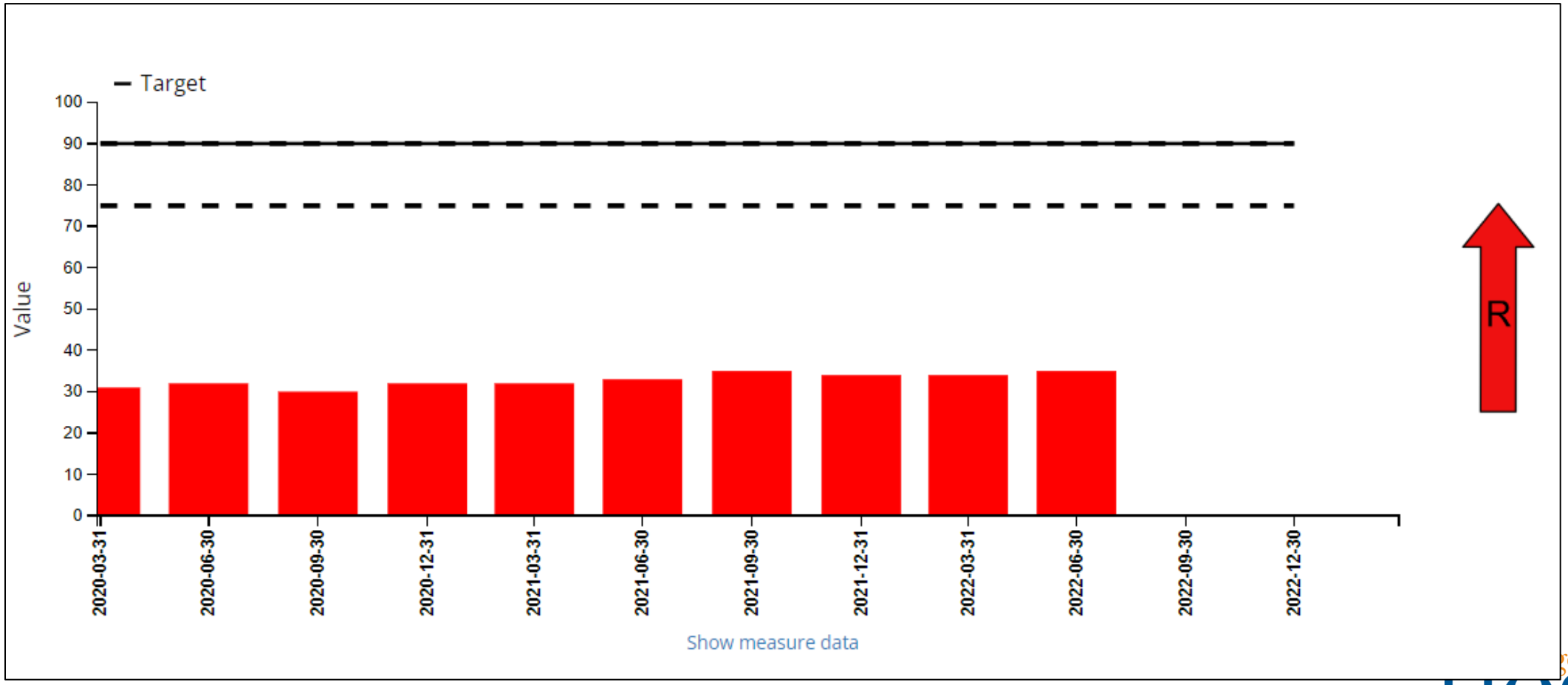
OREGON HEALTH AUTHORITY
Director's Office

Comparison of OHA Workforce to Potential Labor Market Calculation

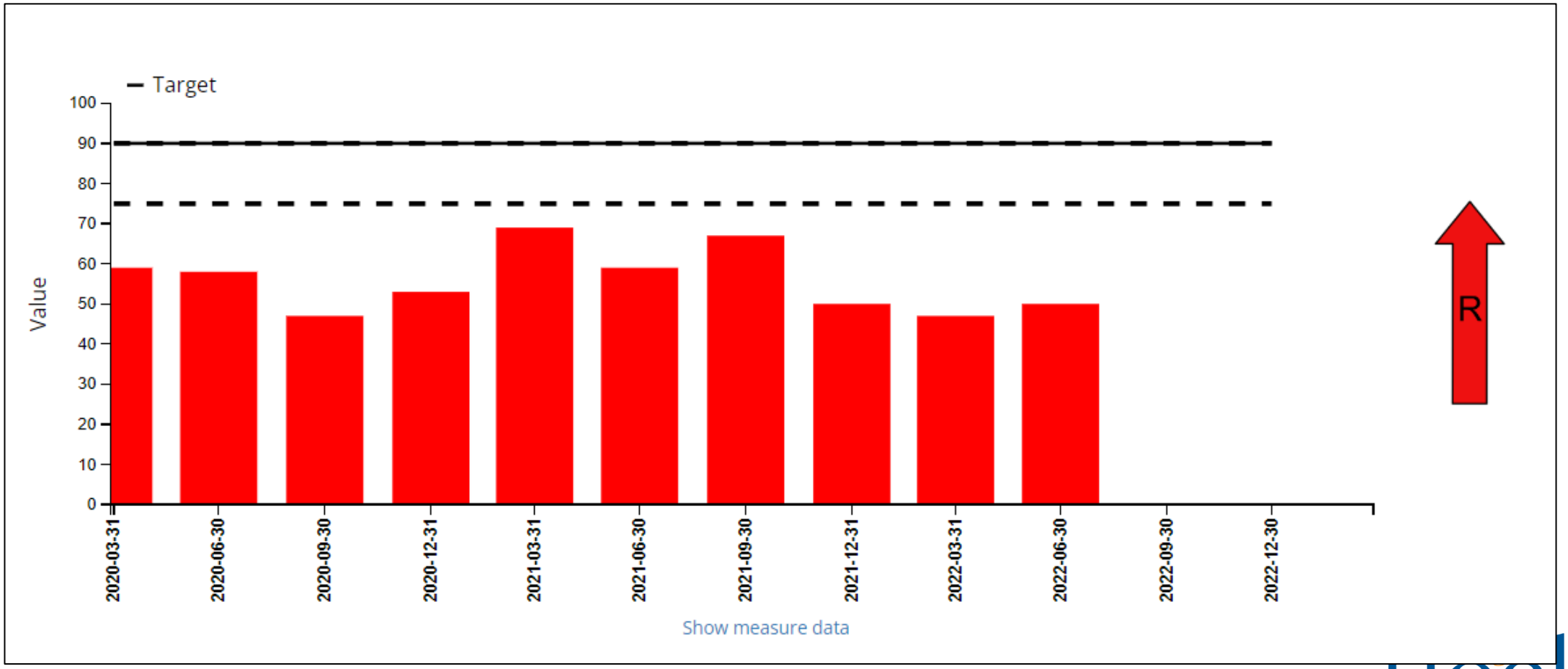
Parity is determined by the ratio of OHA's workforce (numerator) and the potential labor market (denominator). If the ratio score is less than or equal to 0.75 for Tribal communities, communities of color, people with disabilities or females, then OHA is below parity representation of that group in the OHA workforce compared to the potential labor market.

(Disparity categories: American Indian & Alaska Native, Asian, Black & African American, Hispanic & Latinx, Native Hawaiian & Pacific Islander, White/Multiracial/Other, Disability = Yes, Disability = No, Gender = Female, Gender Male) – Frequency is quarterly

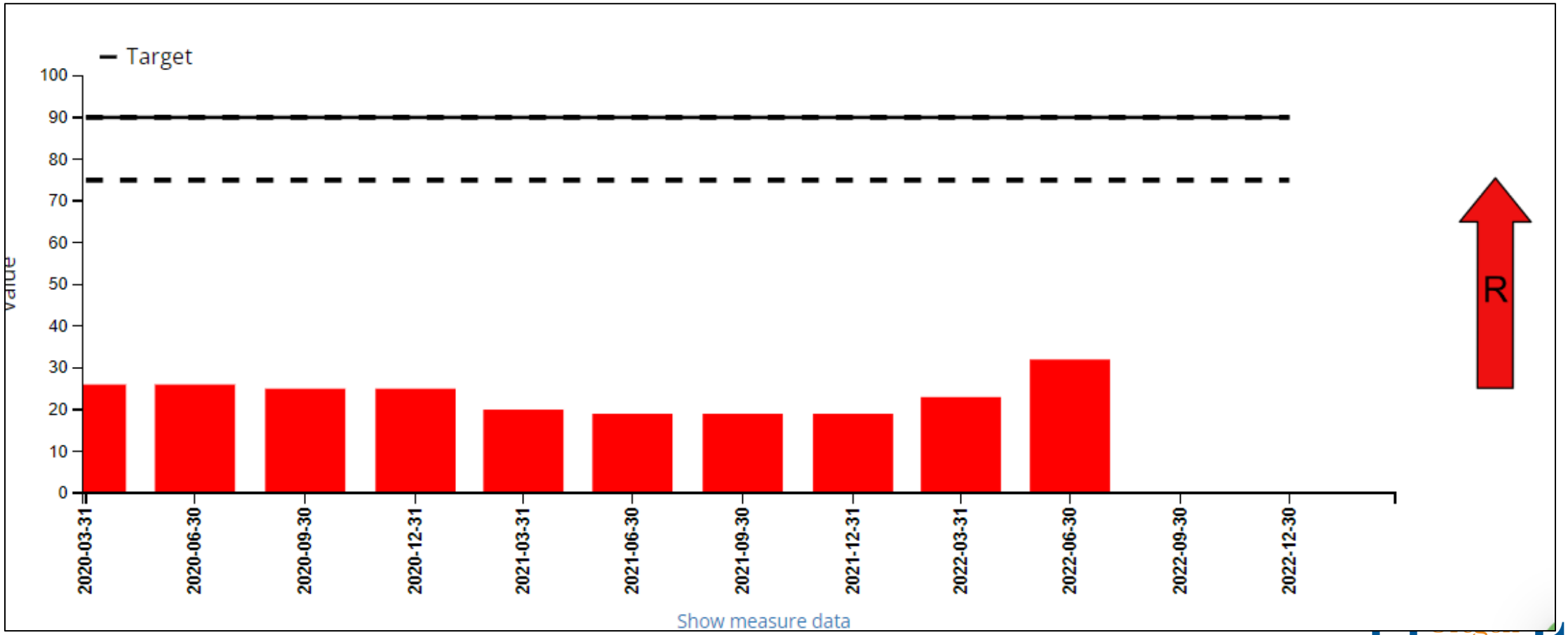
Graph – Comparison of OHA Workforce to Potential Labor Market



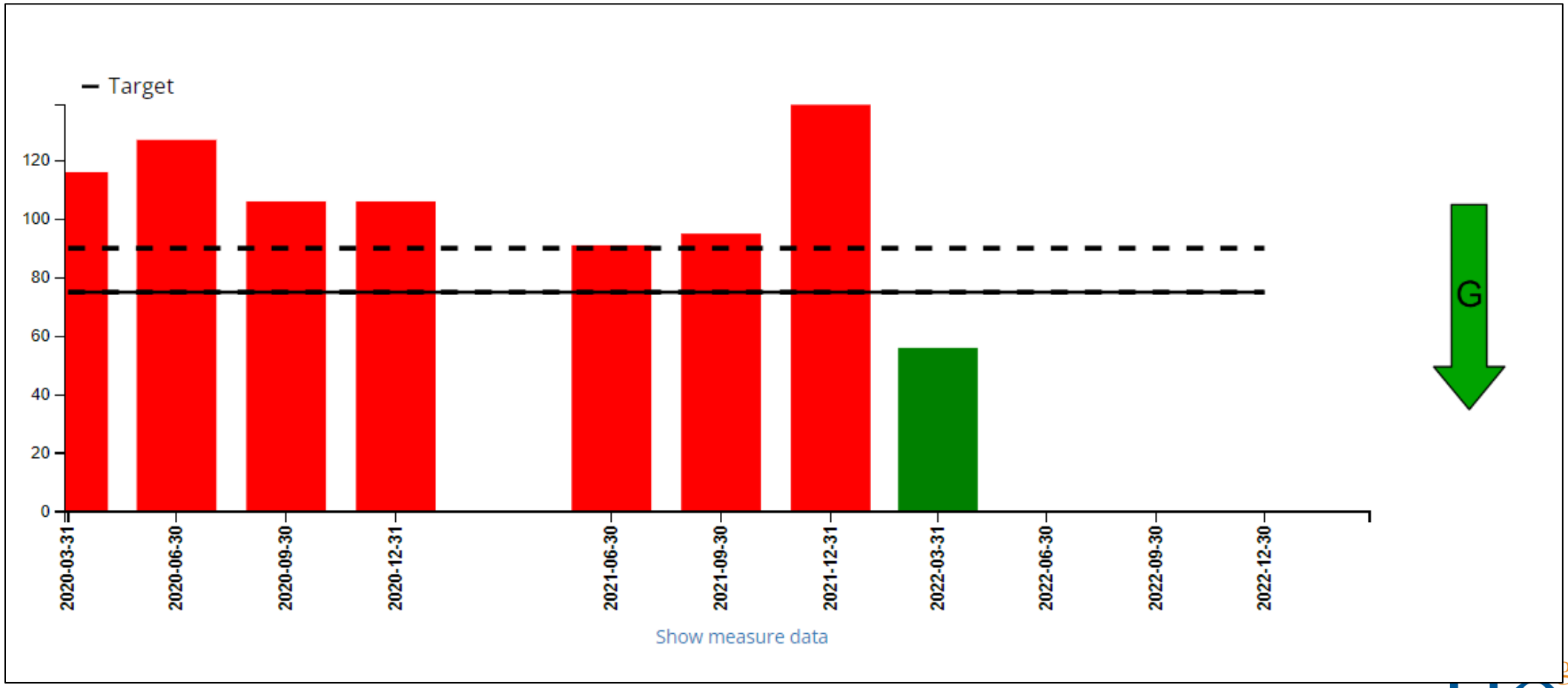
Graph – Comparison of OHA Non-Supervisory Managers Workforce to Potential Labor Market



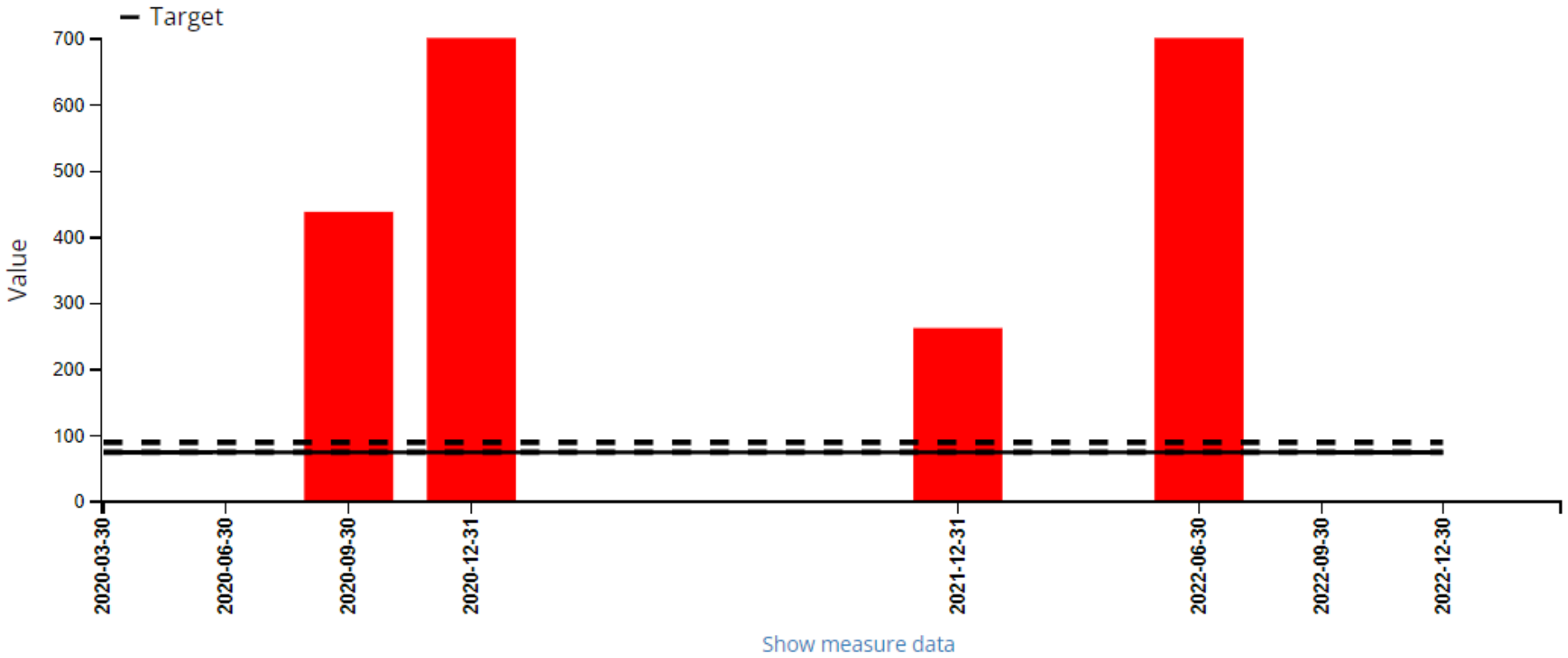
Graph – Comparison of OHA Supervisory Mangers Workforce to Potential Labor Market



Graph – Comparison of OHA Voluntary Separations to All Agency Separations



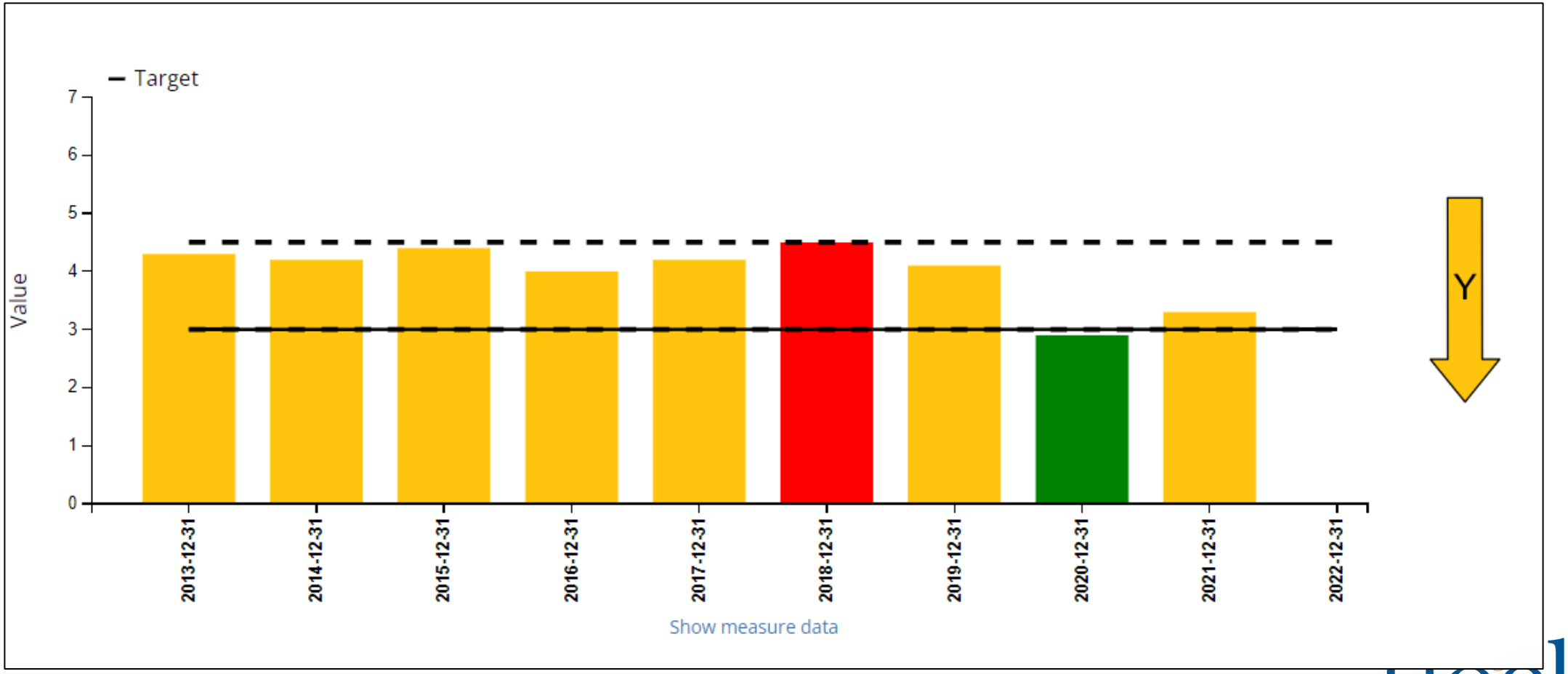
Graph – Comparison of OHA Involuntary Separations to All Agency Separations



Quality of Life – Poor Physical Health

- Calculation: Average number of physically unhealthy days in the past 30 among adults
- Frequency: Yearly
- Measure Impact: Measuring health-related quality of life helps build understanding around people's lived experience with disabilities and chronic diseases across the population. Self-report of days when physical health was not good is a reliable estimate of recent health status.
- Disparity categories: American Indian & Alaskan Native, Asian, Black or African American, Latino, Native Hawaiian/Pacific Islander, White – Non-Latino, Disability, No Disability

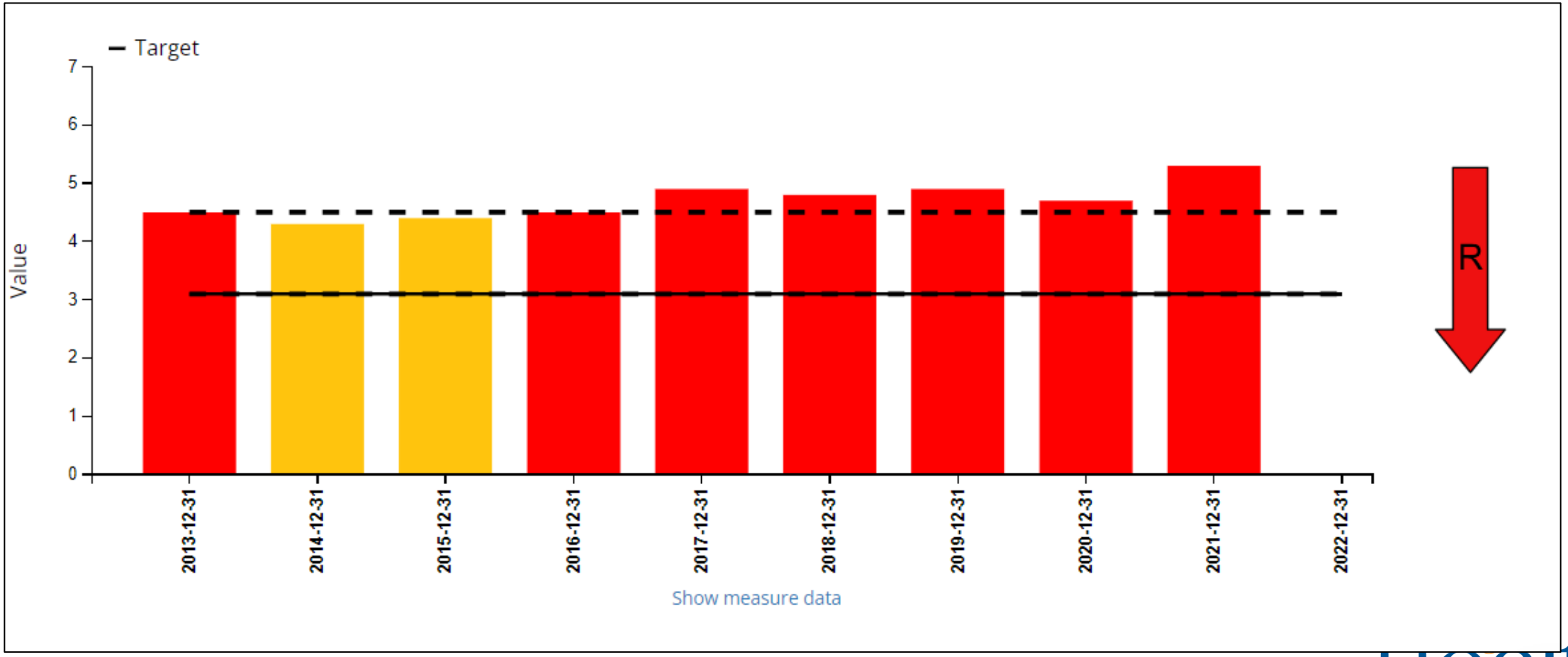
Graph – Quality of Life – Poor Physical Health



Quality of life – Poor Mental Health

- Calculation: Average number of mentally unhealthy days in the past 30 days (age 18+)
- Frequency: Yearly
- Measure Impact: Measuring health-related quality of life helps build understanding around people's lived experience with disabilities and chronic diseases across the population. Self-report of days when mental health was not good is a reliable estimate of recent health status.
- Disparity categories: American Indian & Alaskan Native, Asian, Black or African American, Latino, Native Hawaiian/Pacific Islander, White – Non-Latino, Disability, No Disability

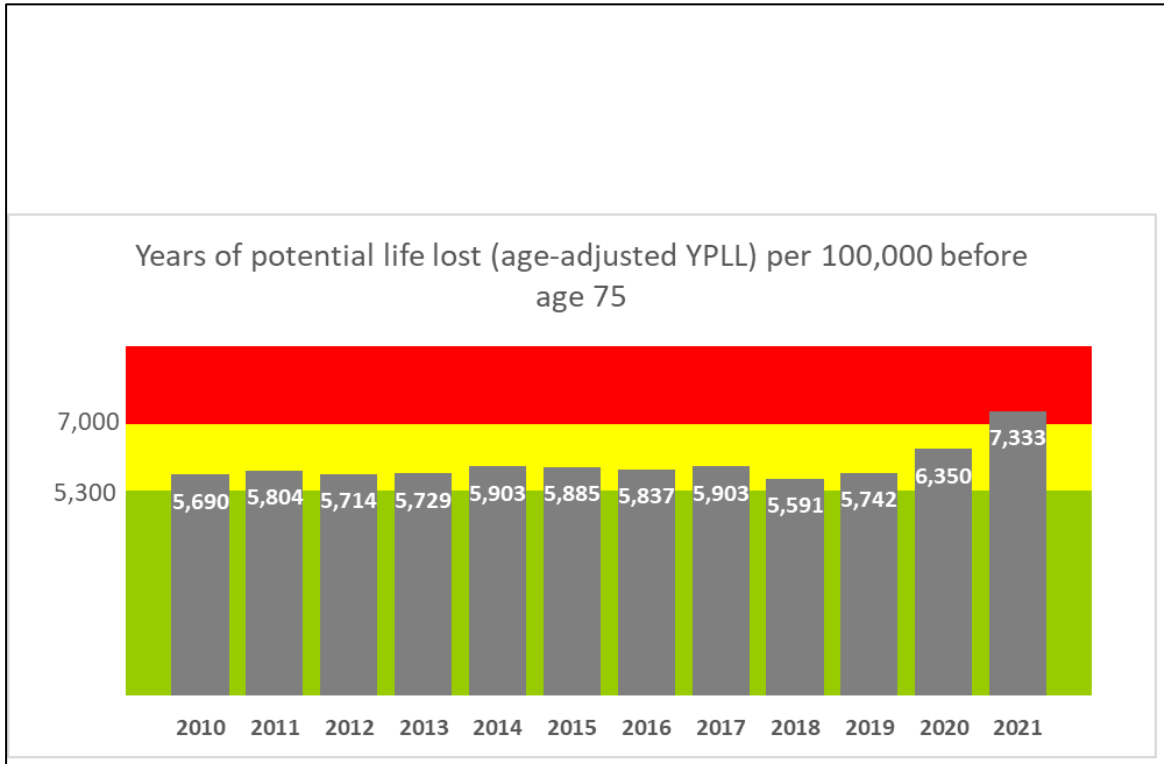
Graph – Quality of life – Poor Mental Health

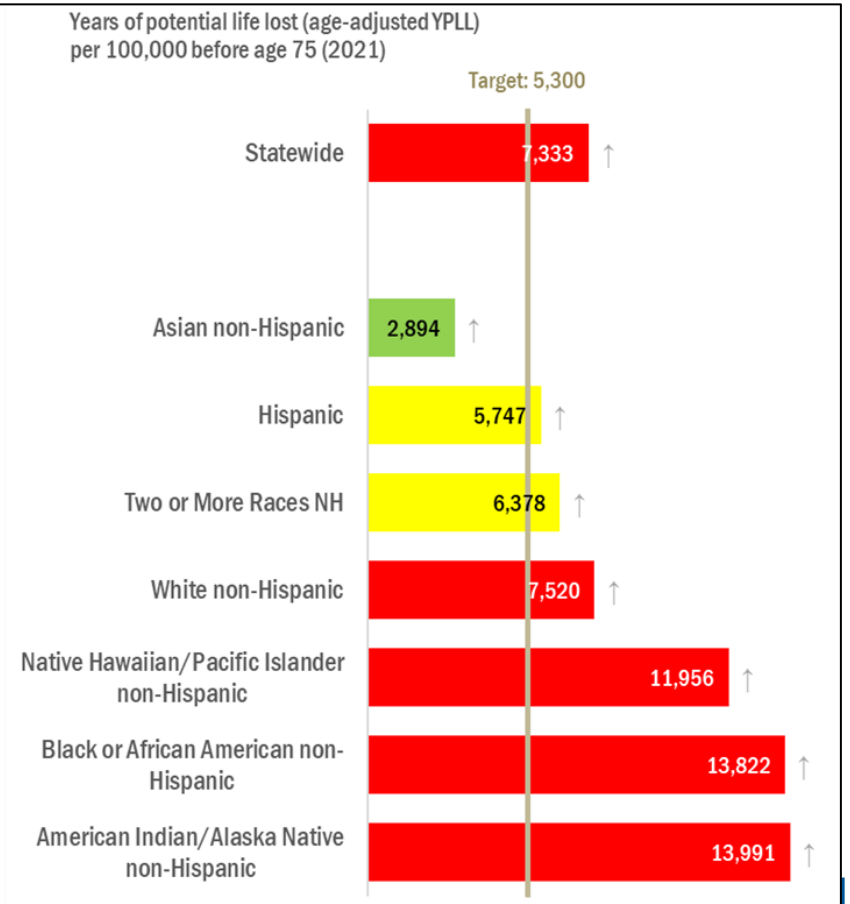


Premature Death

- Calculation: # of years of potential life lost (YPLL) per 100,000 before age 75
- Frequency: Yearly
- Measure Impact: Premature death is measured by summing the years between age at death and age 75 across all people who died before reaching that age. It's a way of quantifying the societal impact of early deaths in a population. Causes of death that are more likely to affect younger people – such as congenital anomalies and accidental injuries – contribute to higher rates of premature death.
- Disparity categories: American Indian/Alaska Native – Non-Hispanic, Asian – Non-Hispanic, Black or African American – Non Hispanic, Hispanic, Multiple Races – Non-Hispanic, Native Hawaiian/Pacific Islander – Non-Hispanic, White Non-Hispanic

Graph – Premature Death





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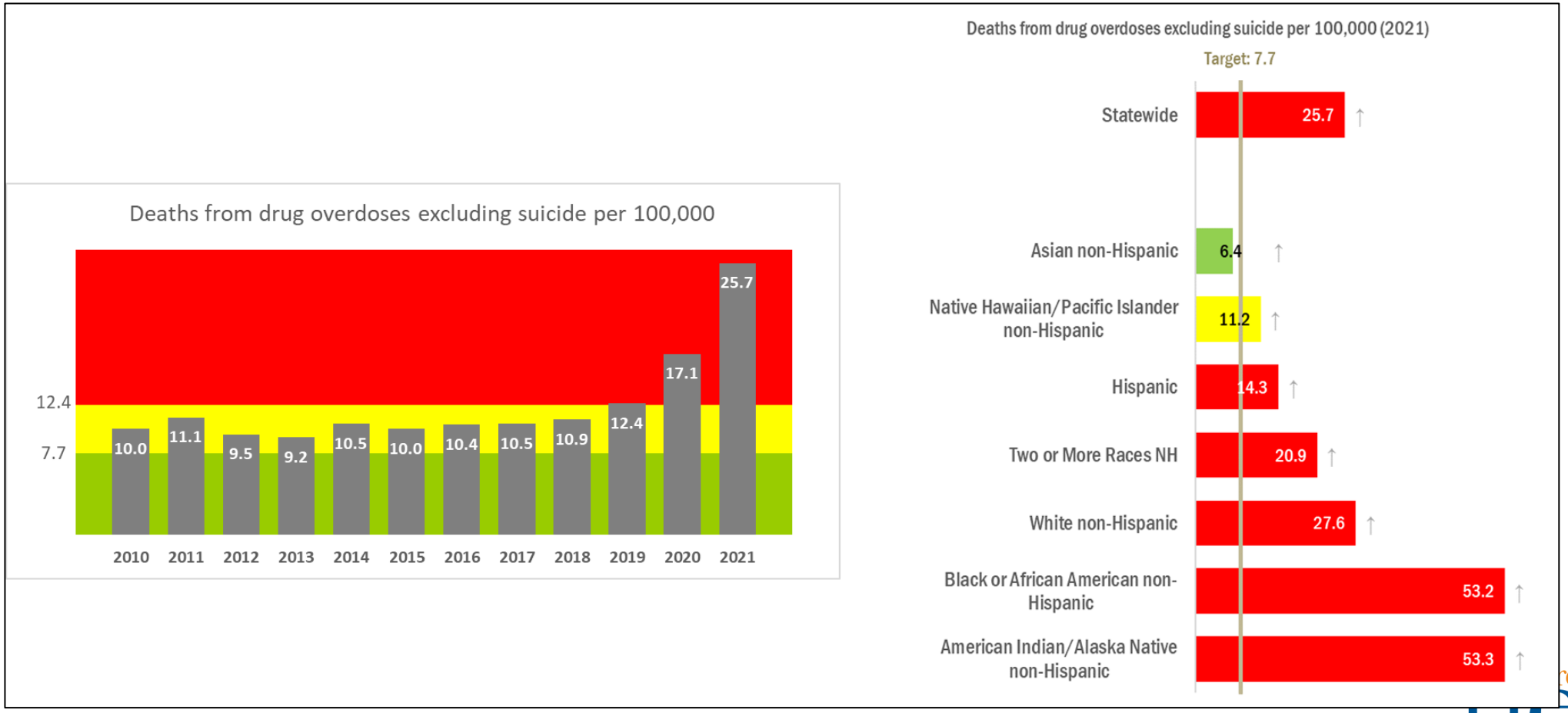
Mortality from Drug Overdose

- Calculation: # deaths per 100,000 from drug overdoses excluding suicide
- Frequency: Yearly
- Measure Impact: Drug overdose deaths account for a major proportion of all premature deaths and are largely preventable.
- Disparity categories: American Indian/Alaska Native – Non-Hispanic, Asian – Non-Hispanic, Black or African American – Non Hispanic, Hispanic, Multiple Races – Non-Hispanic, Native Hawaiian/Pacific Islander – Non-Hispanic, White Non-Hispanic
- Target: 7.7 per 100,000

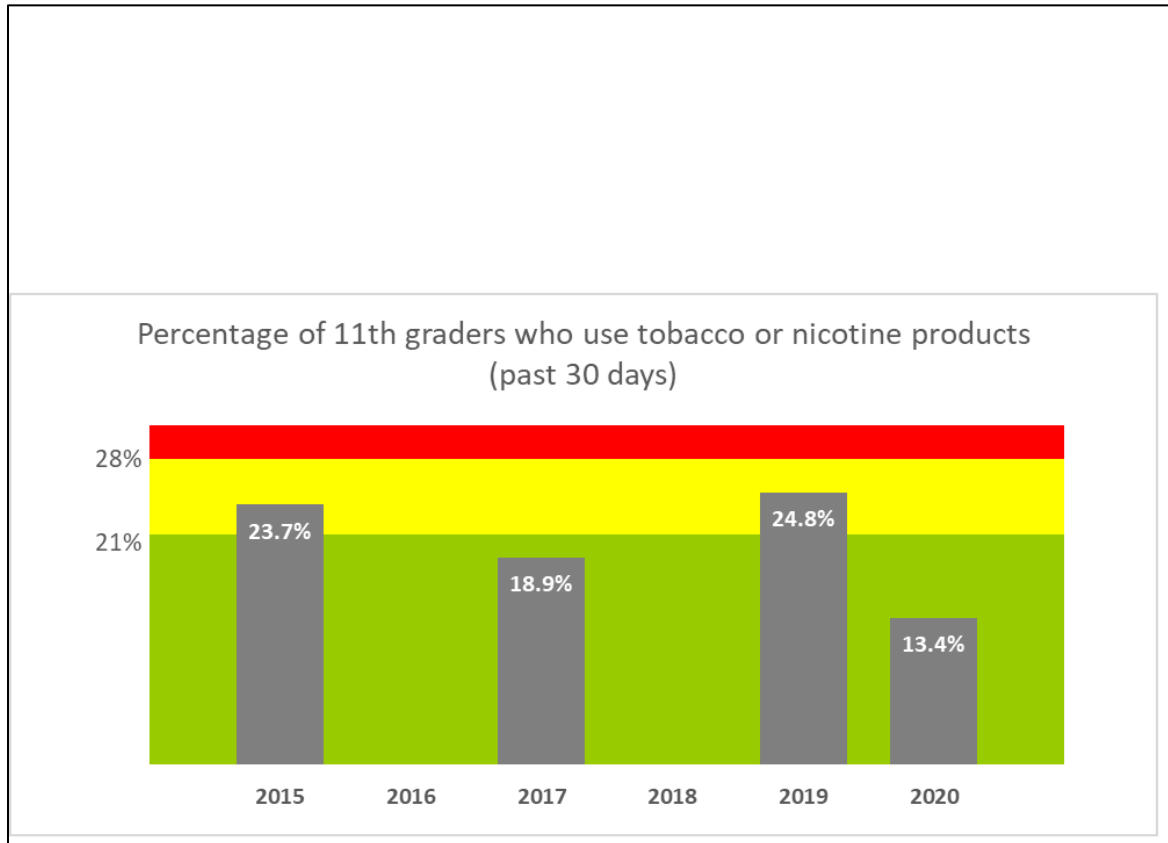
Graph – Mortality from Drug Overdose

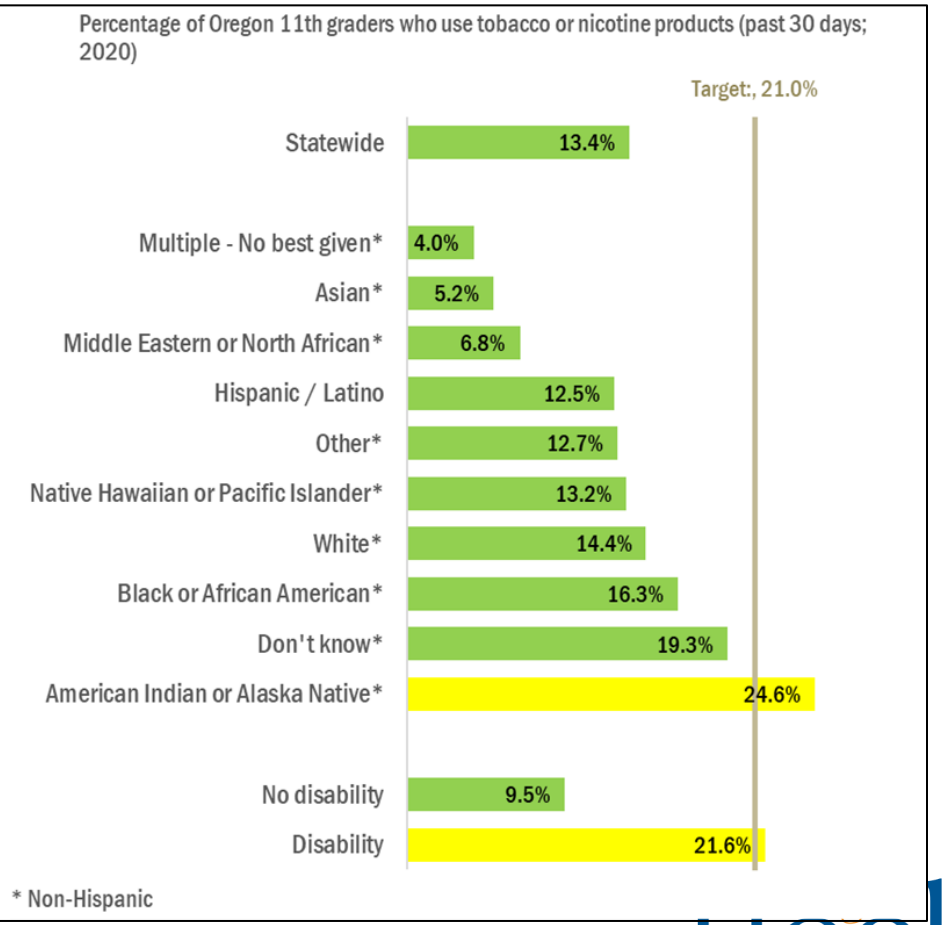


Tobacco Use – Teens

- Calculation: % of 11th graders who use tobacco or nicotine (past 30 days)
- Frequency: 2 Years
- Measure Impact: Cigarette smoking is the most common cause of preventable death and disease. It is identified as a cause of various cancers, cardiovascular disease, and respiratory conditions, as well as low birthweight and other adverse health outcomes. Many teen smokers become adult smokers. Measuring the prevalence of tobacco use in the youth population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for prevention programs or the effectiveness of existing programs.

Graph – Tobacco Use Teens

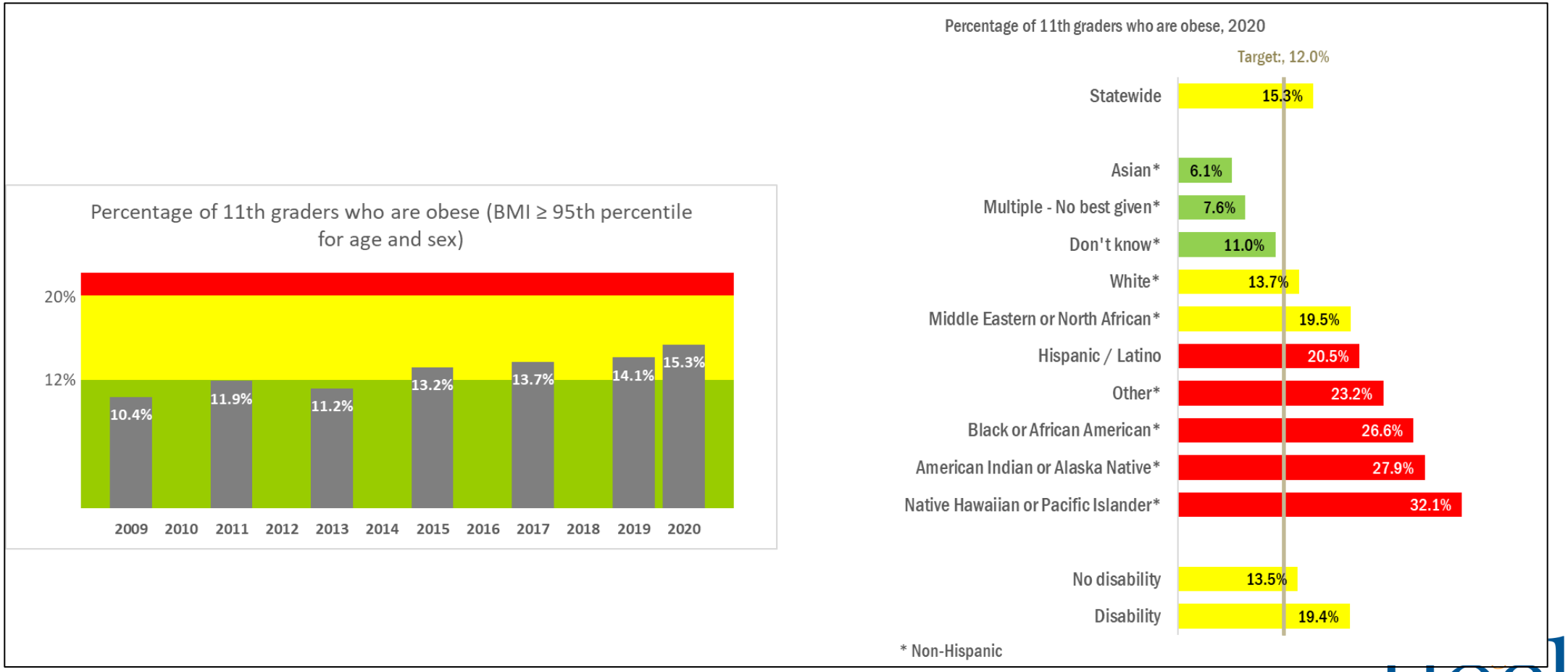




Obesity Teens

- Calculation: % of 11th graders who are obese (BMI >= 95th percentile for age/sex)
- Frequency: 2 Years
- Measure Impact: Obesity is the second leading cause of preventable death in Oregon. It is a major risk factor for high blood pressure, high cholesterol, diabetes, heart disease, and cancer. Obese teens are at an increased risk of becoming obese adults.

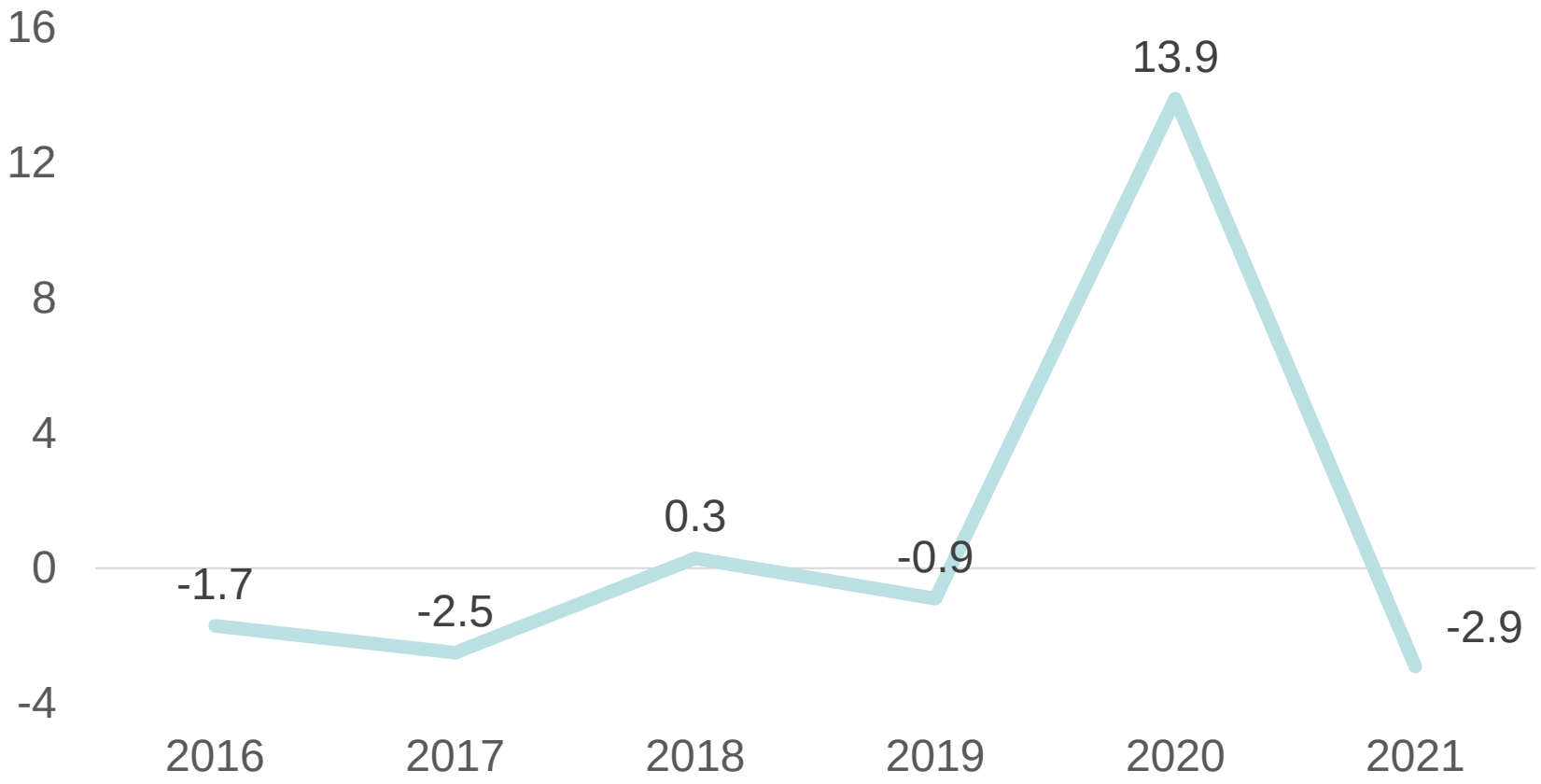
Graph – Obesity Teens



Statewide Sustainable Cost of Care

- Calculation: Use the data collected from health care payers (CCOs and insurance companies) as part of the Oregon Sustainable Health Care Cost Growth Target program. These data use a total cost of care methodology to show per person health care costs. The data are always submitted for two sequential years, which allows OHA to calculate the per person cost growth as a percent. Calculation: For year 1, sum all costs across all payers and divide by the number of member months. For year 2, sum all costs across all payers and divide by the number of member months. Divided year 2 total per member per month cost by year 1 total per member per month cost, and then subtract 1 to obtain a percent of growth. Obtain data about the growth in per capita wage from the Oregon Office of Economic Analysis. Subtract the previously calculated per member per month cost growth percentage from the per capita wage growth percentage. Success occurs when the difference is positive because we want health care cost growth not to exceed wage growth.
- Frequency: Yearly
- Measure Impact: To create an indicator of Oregon health care costs and whether or not they are being contained to a sustainable rate of growth relative to the growth of Oregon residents' wages (i.e. lower statewide health care costs).

Graph – Statewide Sustainable Cost of Care



Data from 2020 is anomalous because health care consumption dropped 6% due to the pandemic, while income grew 8% in Oregon, resulting in a difference of nearly **14 percentage points**

OHA Sustainable Cost Of Care

- Calculation: Difference between real personal income and health care inflation
- Frequency: Yearly

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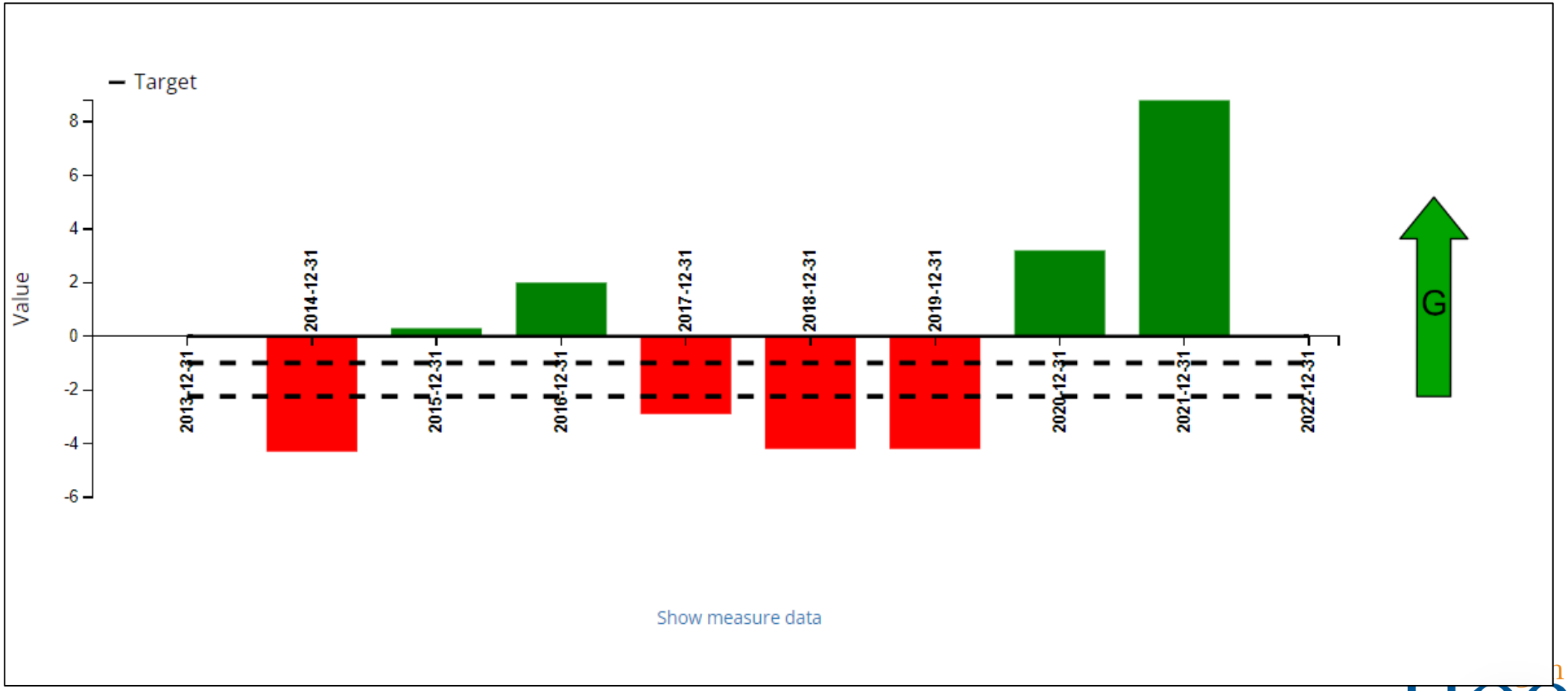
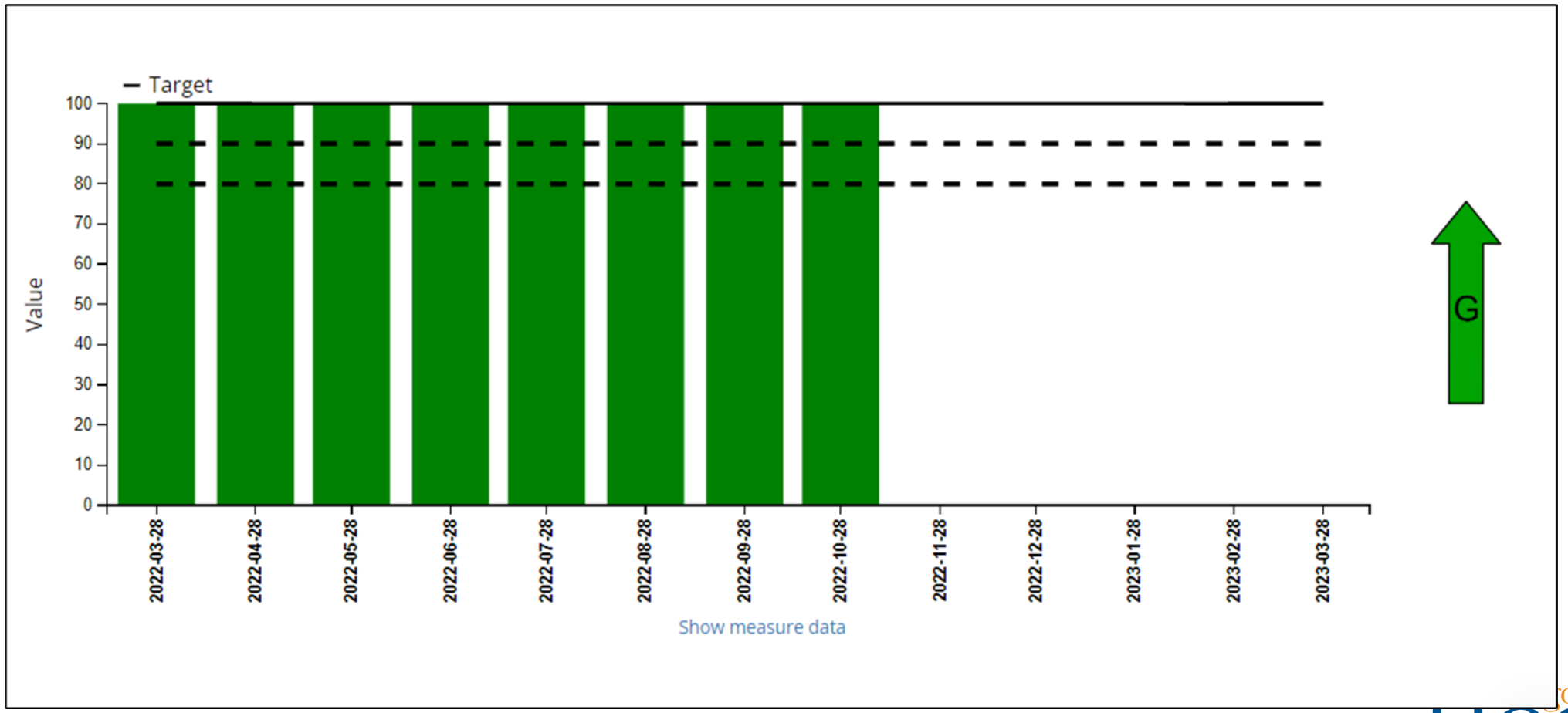
Graph – OHA Sustainable Cost of Care



Critical Events Meeting the 14-Calendar Day Timeline to Provide Correspondence to Tribal Leaders

- Calculation: % of critical events meeting the timeline. Total number of critical events meeting the timeline/total number of identified critical events.
- Frequency: Monthly
- Measure Impact: To track compliance with the OHA Tribal Consultation Policy timelines

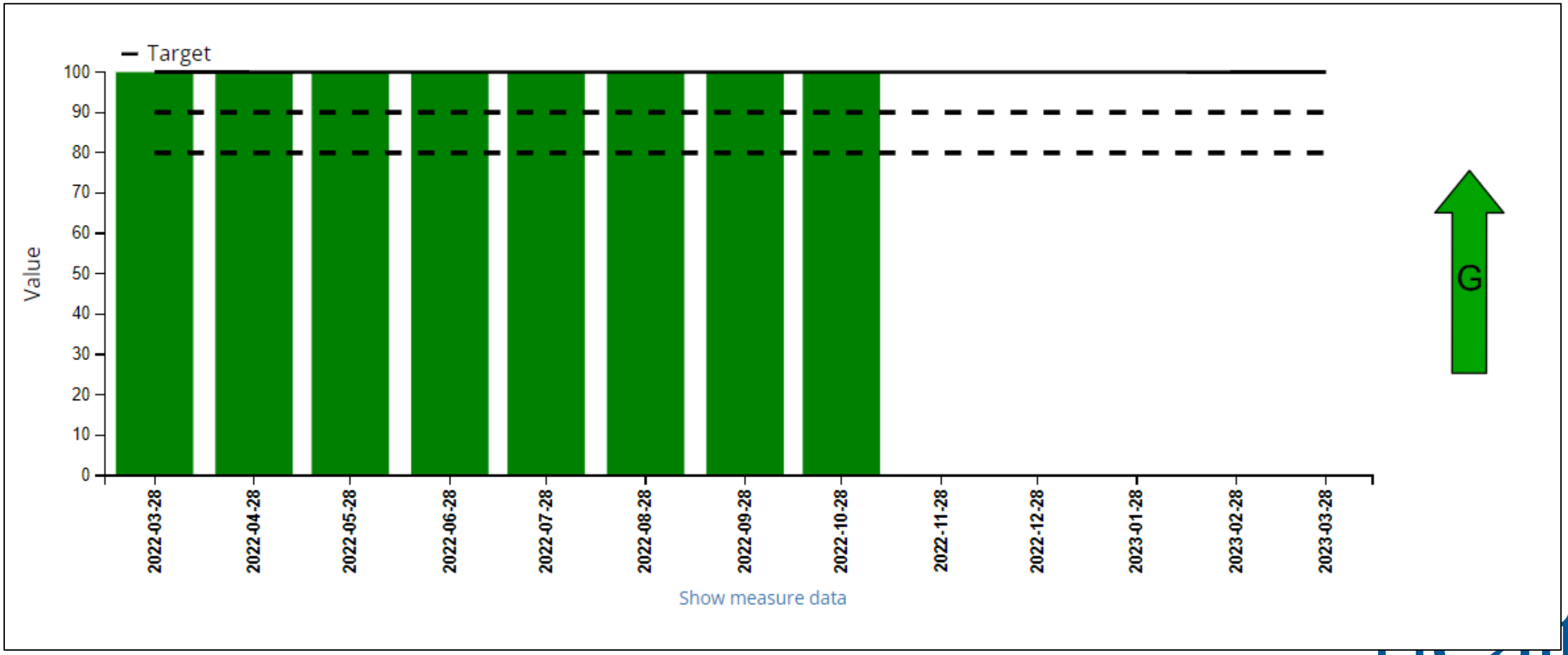
Graph – Critical Events Meeting the 14-Calendar Day Timeline to Provide Correspondence to Tribal Leaders



Tribal Consultations Meeting the 30-Calendar Day Timeline for Reporting of Outcome of Consultation

- Calculation: % of consultations meeting the timeline. Total number of consultations meeting the scheduling timeline/total number of consultations.
- Frequency: Monthly

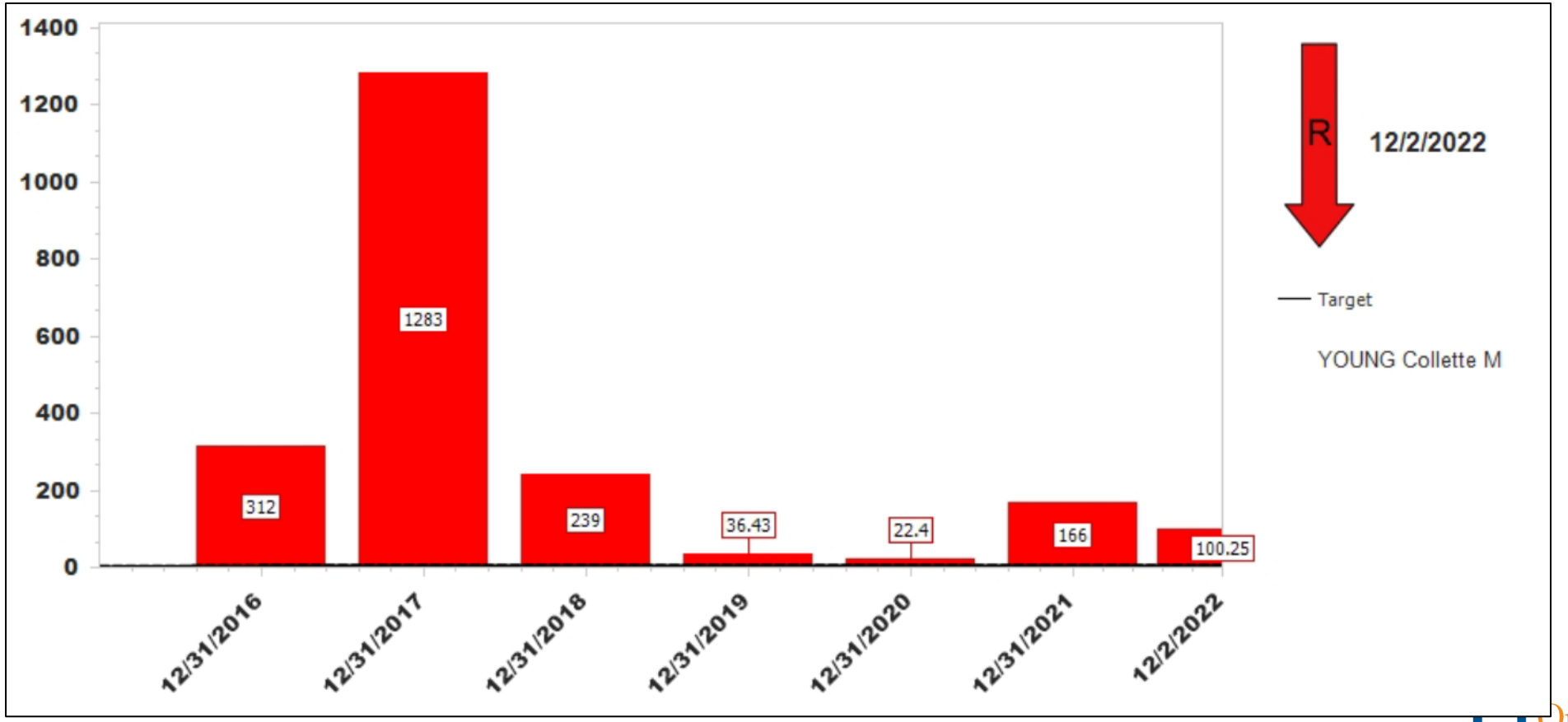
Graph – Tribal Consultations Meeting the 30-Calendar Day Timeline for Reporting of Outcome of Consultation



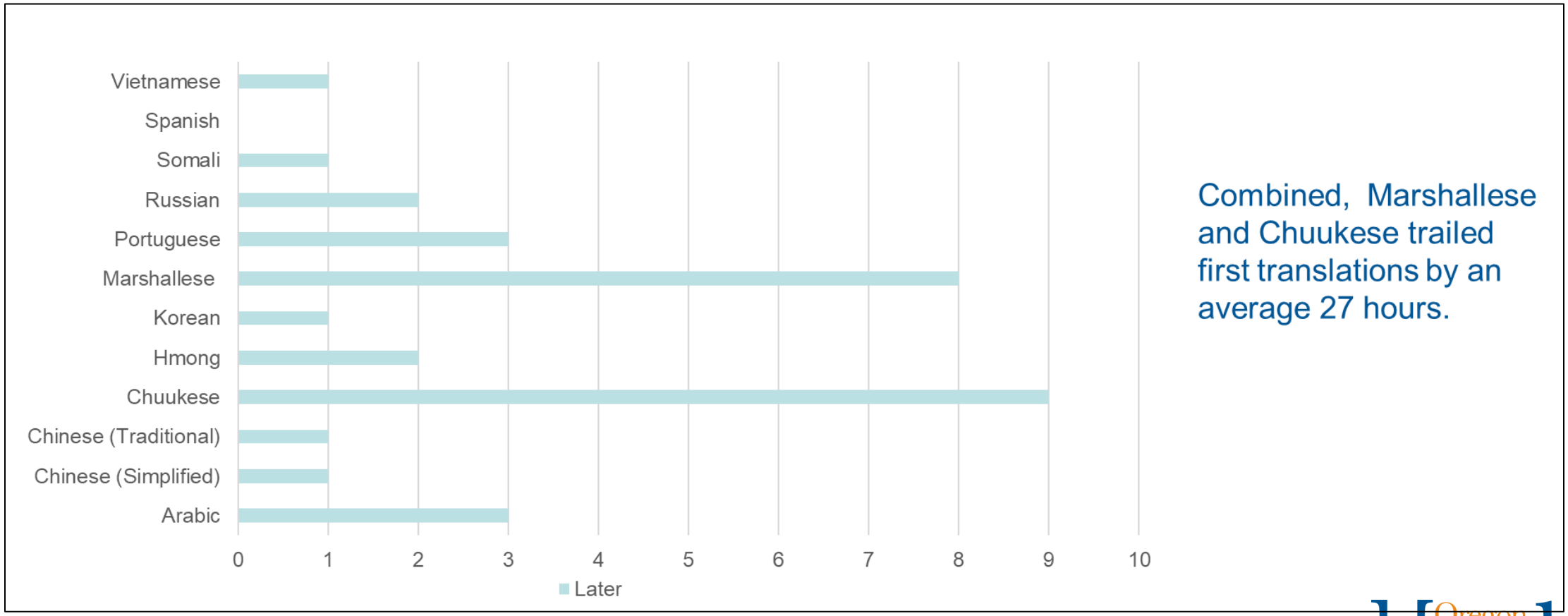
Timeliness of Translations During Emerging Public Health Events

- During emerging public health events, OHA relays public health information to communities that, when delivered in a timely fashion, will help individuals make informed decisions to protect their health.

Graph – Timeliness of Translations During Emerging Public Health Events



Language Graph – Timeliness of Translations During Emerging Public Health Events



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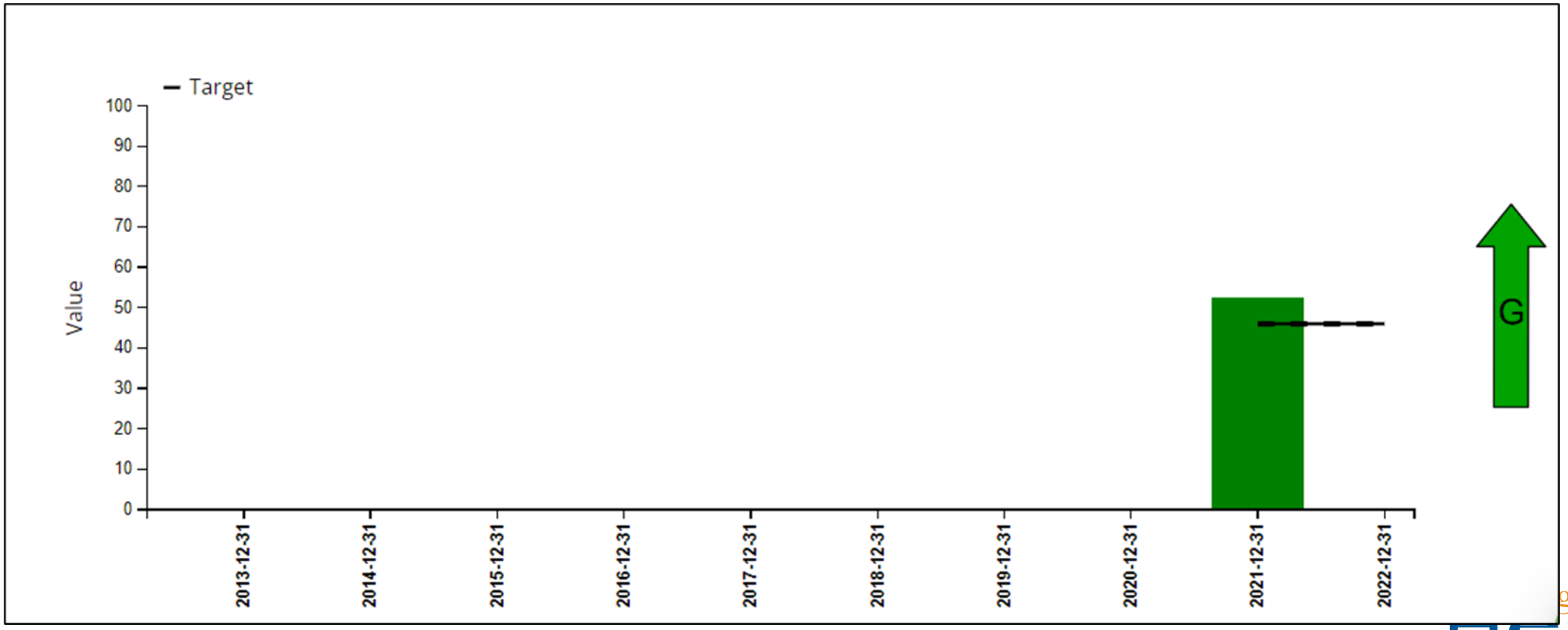
Health Equity Measure: Meaningful Language Access to Culturally Responsive Health Care Services for CCO Members – Component 1

- Measure Goal
- Achieve meaningful access to health care services for all CCO members through quality communication and language access services, and the delivery of culturally responsive care.

- What is meaningful access? Access that is not significantly restricted, delayed or inferior as compared to programs or activities provided to English proficient individuals (Department of Justice, 2012).

- Language access to culturally responsive health care services for CCO members
- The total points for the survey are 89 and some questions in each domain are “must pass”.
- Each CCO must score a minimum of 52%, 63%, and 87% on their self-assessments in years 1, 2 and 3 respectively to pass this component of the measure in respective years.

Graph – Health Equity Measure: Meaningful Language Access to Culturally Responsive Health Care Services for CCO Members – Component 1



Health Equity Measure: Meaningful Language Access to Culturally Responsive Health Care Services for CCO Members – Component 2

Component 2 is based on the reporting of quarterly utilization data on interpreter services and designed to measure quality of interpreter services. Quality interpreter service is defined as services provided by OHA credentialed qualified or certified HCIs and measured as the proportion of interpreter needs by CCO members which are provided by OHA qualified or certified HCIs.

The following calculation is utilized: Total number of visits with interpreter services provided by OHA certified or qualified interpreters / Total number of visits from members in the eligible population. Eligible population: CCO members who have indicated a need for spoken or sign language interpretation services for their health care visits.

Interpreter need: Is defined as CCO members with “needs interpreter” indicated in the 834-eligibility file in the Medicaid Management Information System (MMIS), including additional members identified during CCO or provider intake process as needing interpreter services. Data elements of required denominator: Total number of member visits during the measurement period from the eligible population (members who identified as needing interpreter services), regardless of whether interpreter services were provided.

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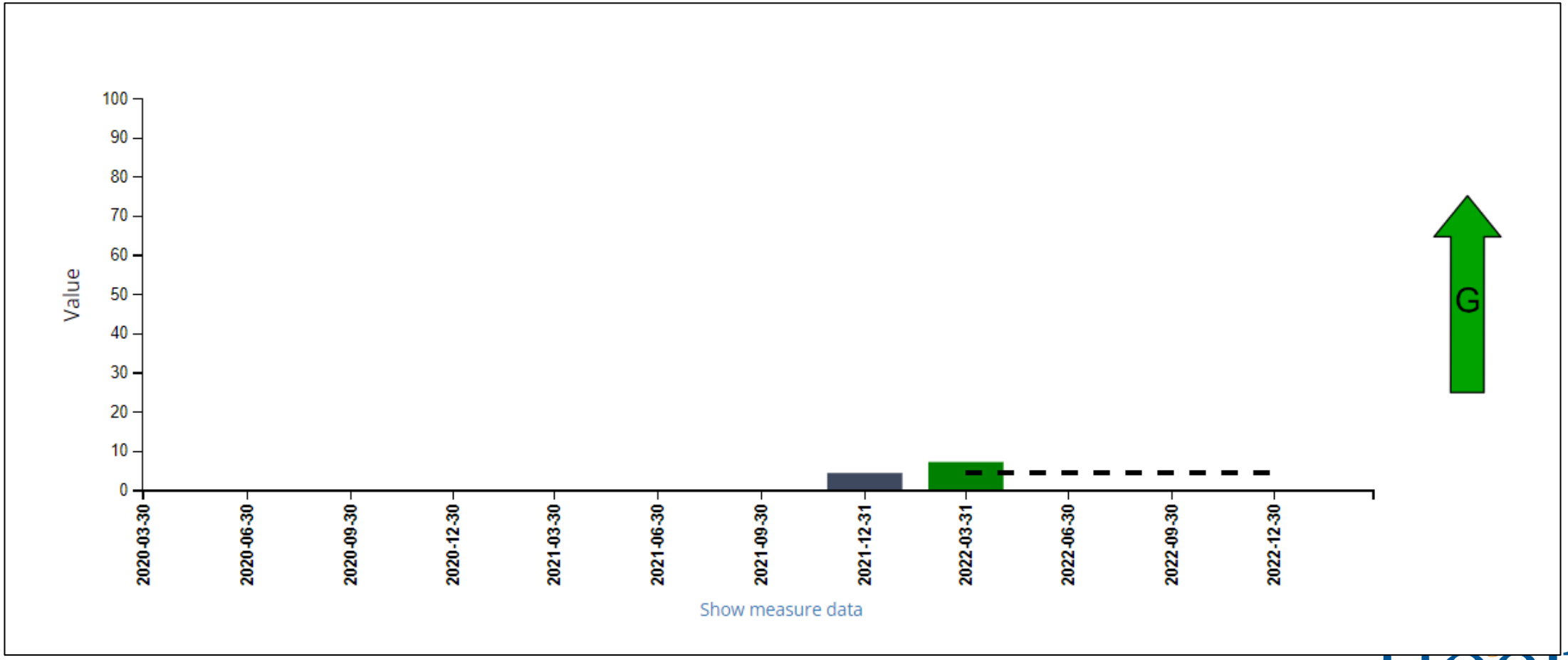
Graph – Health Equity Measure: Meaningful Language Access to Culturally Responsive Health Care Services for CCO Members – Component 2



Infant Mortality Rate

- Fundamental indicator of population health
- Reflects the broader socioeconomic, structural and environmental factors that influence health and access to health care
- The inputs needed to decrease IMR inequities are the same ones needed overall to achieve health equity by 2030
- All social determinants of health and associated family supports
- Advancements in policy and funding mechanisms for health care access including culturally sensitive health care supports and navigation

Infant Mortality Rate Definition

- Data is from Vital Statistics: population-based

$$\frac{\text{Number of infant deaths}}{\text{Number of live births}} \times 1000$$

- Using a 5 year rolling average allows for disaggregation by race/ethnicity

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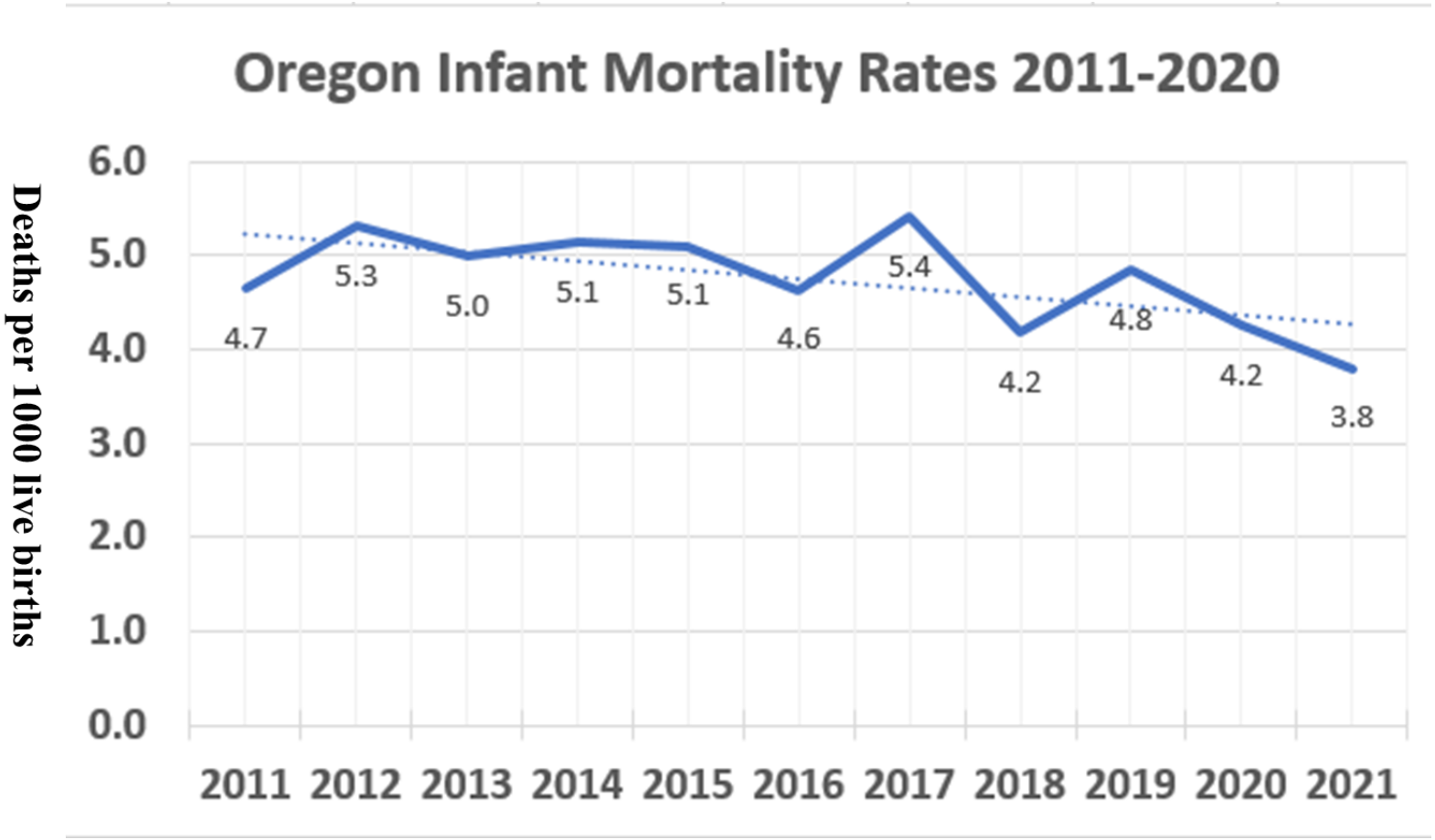
Graph – Infant Mortality Rate



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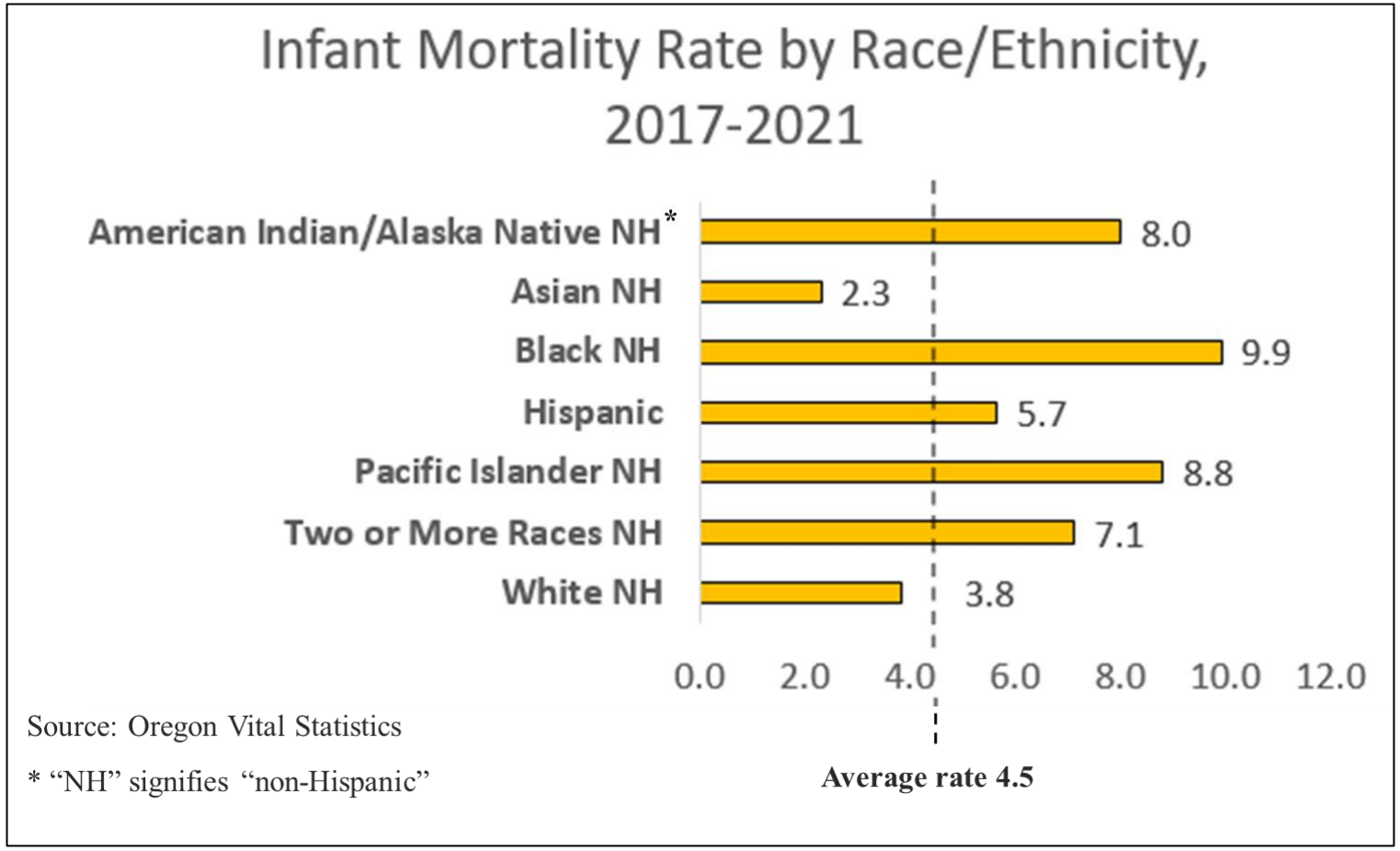
Graph – Infant Mortality Rate
Racial/ethnic Inequity



Reduction of Severe Maternal Morbidity

- In progress – expected completion by July 2023

Oregon Health Authority

Annual Performance Progress Report

Reporting Year 2022

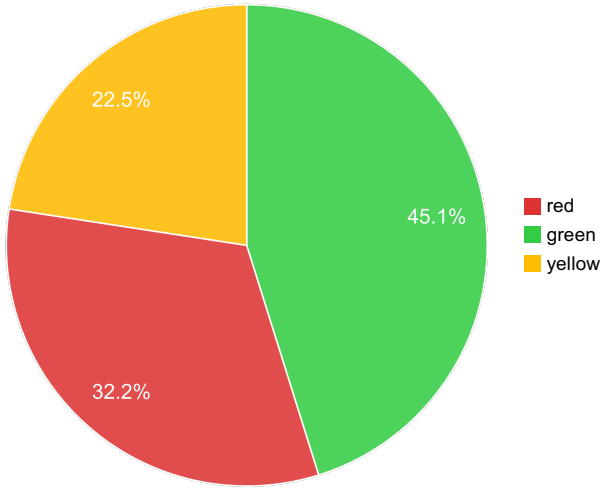
Published: 9/26/2022 2:04:50 PM

KPM #	Approved Key Performance Measures (KPMs)
1	INITIATION OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received initiation of AOD treatment within 14 days of diagnosis.
2	ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received two or more services within 30 days of initiation visit.
3	FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS - Percentage of enrollees 6 years of age and older who were hospitalized for treatment of mental health disorders and who were seen on an outpatient basis or were in intermediate treatment within seven days of discharge.
4	MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY - Percentage of children in DHS custody who receive a mental, physical, and dental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with DHS (foster care).
5	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (INITIATION) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
6	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (CONTINUATION AND MAINTENANCE) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
8	30 DAY ALCOHOL USE AMONG 6TH GRADERS - Percentage of 6th graders who have used alcohol in the past 30 days.
9	30 DAY ILLICIT DRUG USE AMONG 8TH GRADERS - Percentage of 8th graders who have used illicit drugs in the past 30 days.
10	30 DAY ALCOHOL USE AMONG 8TH GRADERS - Percentage of 8th graders who have used alcohol in the past 30 days.
11	30 DAY ILLICIT DRUG USE AMONG 11TH GRADERS - Percentage of 11th graders who have used illicit drugs in the past 30 days.
12	30 DAY ALCOHOL USE AMONG 11TH GRADERS - Percentage of 11th graders who have used alcohol in the past 30 days.
13	PRENATAL CARE (POPULATION) - Percentage of women who initiated prenatal care in the first 3 months of pregnancy.
14	PRENATAL CARE (MEDICAID) - Percentage of women who initiated prenatal care within 42 days of enrollment.
15	PATIENT CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT - Number of members enrolled in patient-centered primary care homes by tier.
16	PQI 01: Diabetes Short-Term Complication Admission Rate -
17	PQI 05: COPD or Asthma in Older Adults Admission Rate -
18	PQI 08: Congestive Heart Failure Admission Rate -
19	PQI 15: Asthma in Younger Adults Admission Rate -
20	ACCESS TO CARE - Percentage of members who responded "always" or "usually" to getting care quickly.
21	MEMBER SATISFACTION OF CARE - Composite measurement: how well doctors communicate; health plan information and customer service (Medicaid population).
22	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good, or good).
23	RATE OF TOBACCO USE (POPULATION) - Rate of tobacco use among adults.
24	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.
25	RATE OF OBESITY (POPULATION) - Percentage of adults who are obese among Oregonians.
26	EFFECTIVE CONTRACEPTIVE USE (POPULATION) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
27	EFFECTIVE CONTRACEPTIVE USE (MEDICAID) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
28	FLU SHOTS (POPULATION) - Percentage of adults ages 50-64 who receive a flu vaccine.
29	CHILD IMMUNIZATION RATES (POPULATION) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
30	CHILD IMMUNIZATION RATES (MEDICAID) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
31	PLAN ALL CAUSE READMISSIONS - Percentage of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years and older.
32	ELIGIBILITY PROCESSING TIME - Median number of days processing time from date of request to eligibility determination.
33	OHP MEMBERS IN CCOs - Percent of Oregon Health Plan members enrolled in Coordinated Care Organizations.
34	CUSTOMER SERVICE - Percentage of OHA customers rating their satisfaction with the agency's customer service as "good" or "excellent" overall, timeliness, accuracy, helpfulness, expertise, availability of information.

Proposal	Proposed Key Performance Measures (KPMs)

Proposal	Proposed Key Performance Measures (KPMs)
Delete	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (INITIATION) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
Delete	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (CONTINUATION AND MAINTENANCE) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
Delete	30 DAY ALCOHOL USE AMONG 6TH GRADERS - Percentage of 6th graders who have used alcohol in the past 30 days.
Delete	30 DAY ILLICIT DRUG USE AMONG 11TH GRADERS - Percentage of 11th graders who have used illicit drugs in the past 30 days.
Delete	30 DAY ALCOHOL USE AMONG 11TH GRADERS - Percentage of 11th graders who have used alcohol in the past 30 days.
Delete	PRENATAL CARE (POPULATION) - Percentage of women who initiated prenatal care in the first 3 months of pregnancy.
Delete	PRENATAL CARE (MEDICAID) - Percentage of women who initiated prenatal care within 42 days of enrollment.
Delete	PATIENT CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT - Number of members enrolled in patient-centered primary care homes by tier.
Delete	PQI 01: Diabetes Short-Term Complication Admission Rate -
Delete	PQI 05: COPD or Asthma in Older Adults Admission Rate -
Delete	PQI 08: Congestive Heart Failure Admission Rate -
Delete	PQI 15: Asthma in Younger Adults Admission Rate -
Delete	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good, or good).
Delete	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.
Delete	EFFECTIVE CONTRACEPTIVE USE (POPULATION) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
Delete	EFFECTIVE CONTRACEPTIVE USE (MEDICAID) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
Delete	FLU SHOTS (POPULATION) - Percentage of adults ages 50-64 who receive a flu vaccine.
Delete	CHILD IMMUNIZATION RATES (POPULATION) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
Delete	CHILD IMMUNIZATION RATES (MEDICAID) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
Delete	PLAN ALL CAUSE READMISSIONS - Percentage of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years and older.
Delete	ELIGIBILITY PROCESSING TIME - Median number of days processing time from date of request to eligibility determination.
Delete	OHP MEMBERS IN CCOs - Percent of Oregon Health Plan members enrolled in Coordinated Care Organizations.
New	Health Equity Measure – component #1: Meaningful language access to culturally responsive health care services for CCO members - Component 1 is based on an annual language access self-assessment survey and designed to evaluate the development of structures and workflow processes to provide quality and consistent interpreter services.
New	Health Equity Measure – component #2: Meaningful language access to culturally responsive health care services for CCO members - Component 2 is based on the reporting of quarterly utilization data on interpreter services and designed to measure quality of interpreter services.
New	Infant Mortality Rate - Rate of infants who die in the first year of life. Numerator: # of deaths of infants <365 days of age in specified time period. Denominator: 100,000 live births in specified time period. Rate = (Num/Denom)*100,000
New	Reduction of Severe Maternal Morbidity - TBD
New	Comparison of OHA Workforce to Potential Labor Market - Comparisons of the OHA workforce to the potential labor market provide a measurement of parity, defined as: achieving comparable representation of Tribal communities, communities of color, people with disabilities and females (binary gender for now) in OHA's workforce to the same proportion in the potential labor market.
New	Comparison of OHA Non-Supervisory Managers to Potential Labor Market - Comparisons of OHA non-supervisory managers to the potential labor market provide a measurement of parity, defined as: achieving comparable representation of Tribal communities, communities of color, people with disabilities and females (binary gender for now) who are OHA non-supervisory managers to the same proportion in the potential labor market.
New	Comparison of OHA Supervisory Managers to Potential Labor Market - Comparisons of OHA supervisory managers to the potential labor market provide a measurement of parity, defined as: achieving comparable representation of Tribal communities, communities of color, people with disabilities and females (binary gender for now) who are OHA supervisory managers to the same proportion in the potential labor market.
New	Comparison of OHA Voluntary Separations to All Agency Separations - OHA defines parity as achieving comparable representation of Tribal communities, communities of color, people with disabilities and females (binary gender for now) in OHA's workforce to the same proportion to OHA's potential labor market.
New	Comparison of OHA Involuntary Separations to All Agency Separations - Parity is determined by a ratio of OHA involuntary separations—dismissal, dismissal during trial service or layoff—(numerator) and all agency separations (denominator). If the ratio score is greater than or equal to 0.90 for Tribal communities, communities of color, people with disabilities or females, then there is a relatively high representation of that group in involuntary separations from the agency. Excludes deaths and unknown separations.

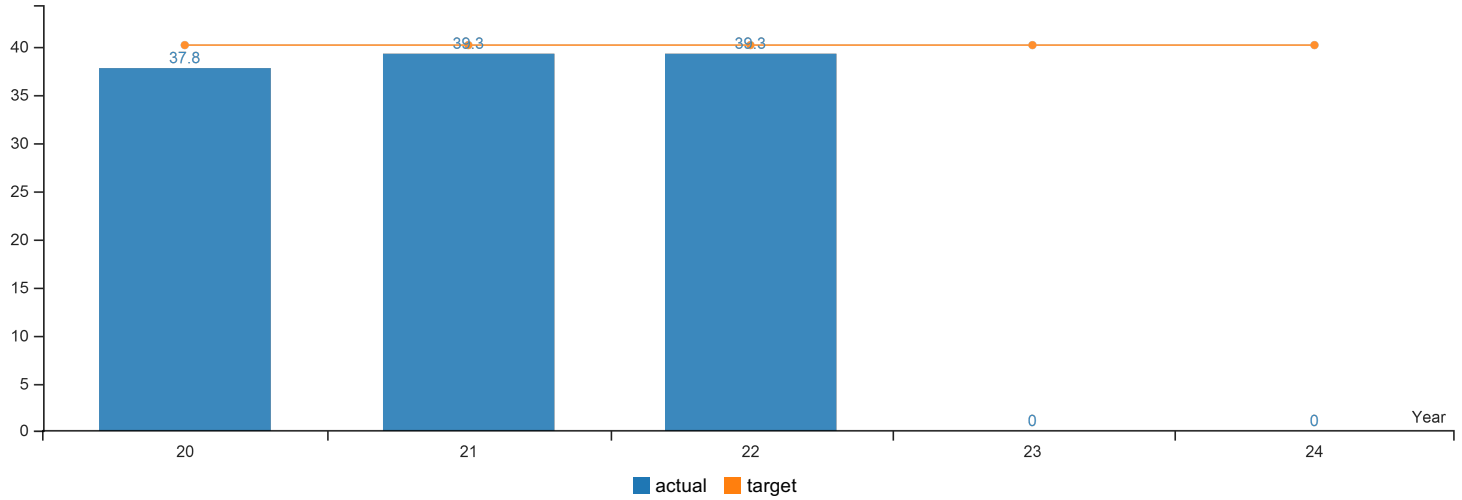
Proposal	Proposed Key Performance Measures (KPMs)
New	Quality of Life - Poor Physical Health - Average number of physically unhealthy days in the past 30 among adults. Measuring health-related quality of life helps build understanding around people's lived experience with disabilities and chronic diseases across the population. Self-report of days when physical health was not good is a reliable estimate of recent health status.
New	Quality of Life - Poor Mental Health - Average number of mentally unhealthy days in the past 30 days (age 18+). Measuring health-related quality of life helps build understanding around people's lived experience with disabilities and chronic diseases across the population. Self-report of days when mental health was not good is a reliable estimate of recent health status.
New	Premature Death - Number of years of potential life lost (YPLL) per 100,000 before age 75. Premature death is measured by summing the years between age at death and age 75 across all people who died before reaching that age. It's a way of quantifying the societal impact of early deaths in a population. Causes of death that are more likely to affect younger people – such as congenital anomalies and accidental injuries – contribute to higher rates of premature death.
New	Mortality from Drug Overdose - Number of deaths per 100,000 from drug overdoses excluding suicide. Drug overdose deaths account for a major proportion of all premature deaths and are largely preventable.
New	Tobacco Use - Teens - Percent of 11th graders who use tobacco (past 30 days). Cigarette smoking is the most common cause of preventable death and disease. It is identified as a cause of various cancers, cardiovascular disease, and respiratory conditions, as well as low birthweight and other adverse health outcomes. Many teen smokers become adult smokers. Measuring the prevalence of tobacco use in the youth population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for prevention programs or the effectiveness of existing programs.
New	Obesity - Teens - Percent of 11th graders who are obese (BMI >= 95th percentile for age/sex). Obesity is the second leading cause of preventable death in Oregon. It is a major risk factor for high blood pressure, high cholesterol, diabetes, heart disease, and cancer. Obese teens are at an increased risk of becoming obese adults.
New	Statewide Sustainable Cost of Care - Comparison of health care cost changes to personal income changes
New	OHA Sustainable Cost of Care - Difference between real personal income and health care inflation
New	Critical events meeting the 14-calendar day timeline to provide correspondence to Tribal Leaders - To track compliance with the OHA Tribal Consultation Policy timelines, % of critical events meeting the timeline. Total number of critical events meeting the timeline/total number of identified critical events.
New	Tribal consultations meeting the 30-calendar day timeline for reporting of outcome of consultation - To track compliance with the OHA Tribal Consultation Policy timelines, % of consultations reporting outcome within 30 calendar days. Total number of consultations meeting reporting timeline/total number of consultations
New	Timeliness of Translations During Emerging Public Health Events - To allow for equitable access to important public health information during public health events. Meet Federal and state legal obligations to provide information in alternative languages and formats, including Title VI of the Civil Rights Act. Compliance with agency policies, including DHS|OHA-010-013 Alternate Formats and Language Access Services. Number of hours from Incident Manager approval of an important (expedited) public information document for an identified public health event to the return of translated documents to the incident's Joint Information Center.



Performance Summary	Green	Yellow	Red
	= Target to -5%	= Target -5% to -15%	= Target > -15%
Summary Stats:	45.16%	22.58%	32.26%

KPM #1	INITIATION OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received initiation of AOD treatment within 14 days of diagnosis.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Initiation of alcohol and other drug dependence treatment					
Actual	37.80%	39.30%	39.30%		
Target	40.20%	40.20%	40.20%	40.20%	40.20%

How Are We Doing

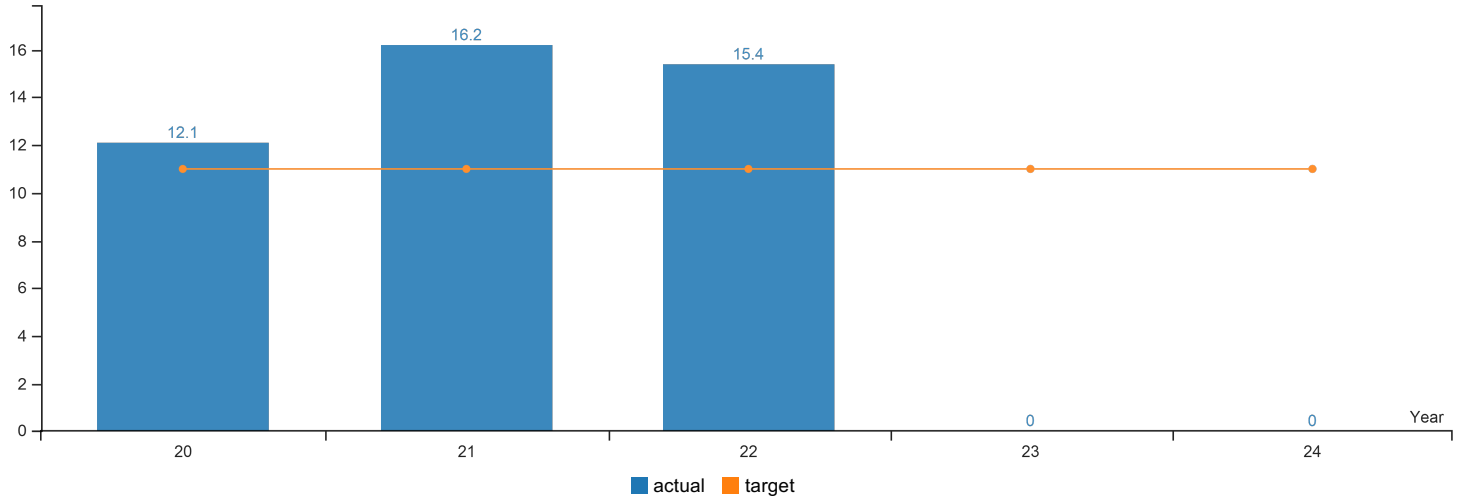
The percentage of members ages 13 and older newly diagnosed with alcohol or other drug dependencies who initiated treatment within 14 days stayed the same at 39.3% from 2020 to 2021. Data prior to 2020 are not directly comparable to 2020 and 2021 data due to a methodology change.

Factors Affecting Results

It is possible that the increased statewide emphasis on alcohol and drug use screening (SBIRT) due to the CCO incentive measure in 2020 resulted in an increase in initiation of alcohol and drug treatment, as more individuals with risky or problematic substance use are identified and referred to treatment services.

KPM #2	ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received two or more services within 30 days of initiation visit.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Engagement of alcohol and other drug dependence treatment					
Actual	12.10%	16.20%	15.40%		
Target	11%	11%	11%	11%	11%

How Are We Doing

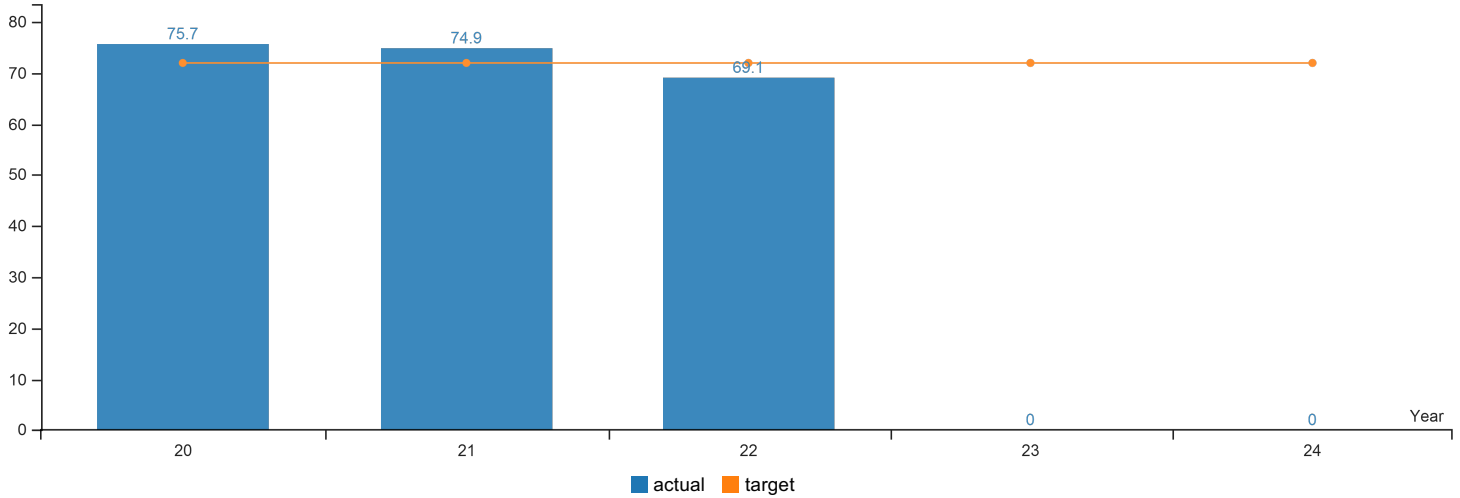
The percentage of members who continued their treatment decreased from 16.2% in 2020 to 15.4% in 2021. However, Data prior to 2020 is not directly comparable to 2020 and 2021 data due to a methodology change.

Factors Affecting Results

This was selected to be an incentive measure beginning in 2020, which possibly brought increased focus on this measure. However, the COVID-19 pandemic may have impacted initial gains.

KPM #3	FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS - Percentage of enrollees 6 years of age and older who were hospitalized for treatment of mental health disorders and who were seen on an outpatient basis or were in intermediate treatment within seven days of discharge.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Follow-up after hospitalization for mental illness					
Actual	75.70%	74.90%	69.10%		
Target	72%	72%	72%	72%	72%

How Are We Doing

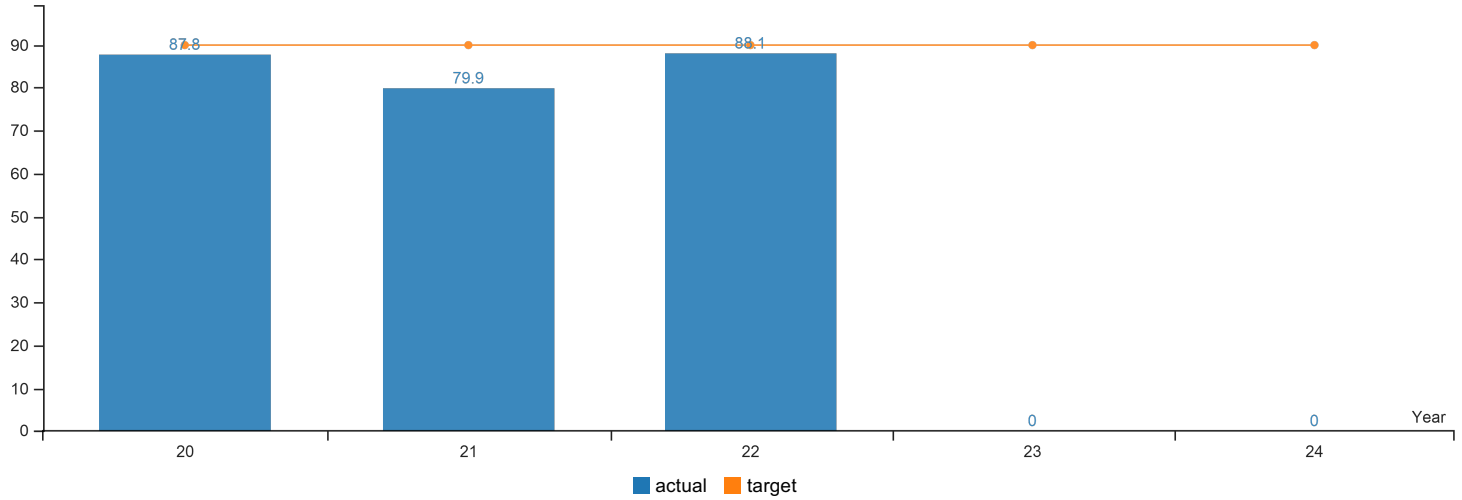
Performance on this measure continued to decline from 2020 to 2021. This is the fourth year in which performance has declined.

Factors Affecting Results

After rising steadily while included in the CCO Quality Incentive Program, performance on this measure has continued to decline since it was retired from the program in 2018. The decline continued through the COVID-19 pandemic.

KPM #4	MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY - Percentage of children in DHS custody who receive a mental, physical, and dental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with DHS (foster care).
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY					
Actual	87.80%	79.90%	88.10%		
Target	90%	90%	90%	90%	90%

How Are We Doing

The percentage of children in foster care who received mental, physical, and dental health assessments increased from 79.9% in 2020 to 88.1% in 2021. Previously, 2020 was the first year in which this measure decreased since 2014. The 2021 rate of 88.1% marks a return back to the year over year increases seen in 2014 - 2019.

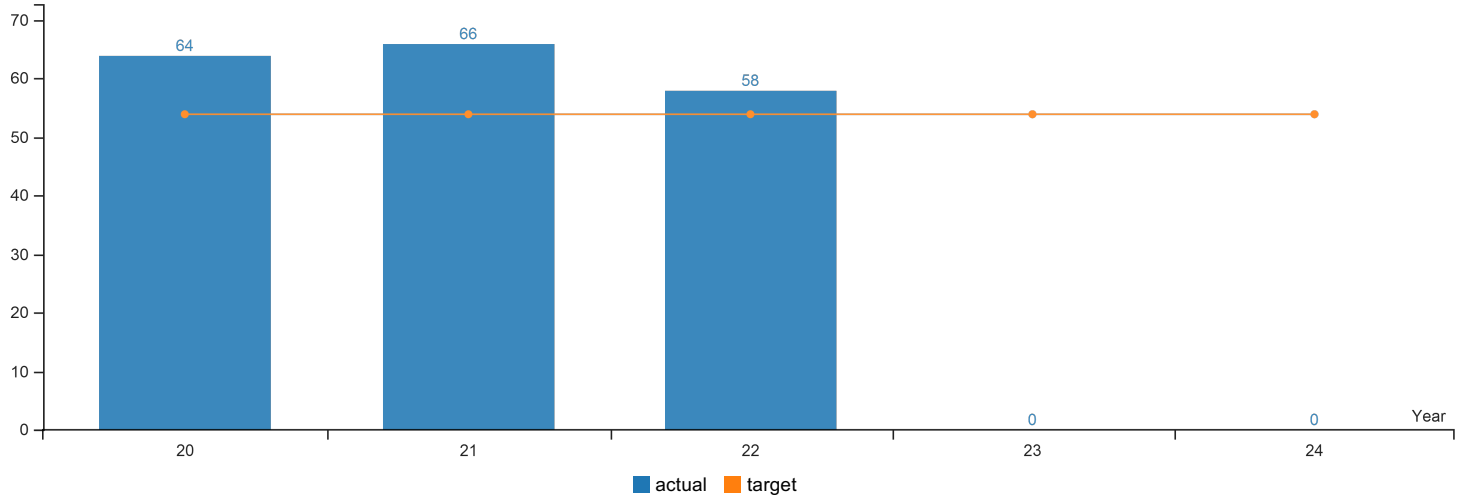
Factors Affecting Results

The COVID-19 pandemic negatively impacted this measure in 2020.

NOTE: 2013 not comparable to later years due to methodology change. In addition, dental assessments added in 2014.

KPM #5	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (INITIATION) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Follow-up care for children prescribed with ADHD medication (initiation)					
Actual	64%	66%	58%		
Target	54%	54%	54%	54%	54%

How Are We Doing

The rate of children ages 6-12 who had at least one follow-up visit with a health care provider during the 30 days after receiving a new prescription for ADHD medication improved through 2018 (65.9%), declined in 2019 (64.0%), and improved to slightly above the 2018 rate in 2020 (66.0%). In 2021, the rate dropped to 58.0%, which is the lowest performance since 2014. NOTE: This measure was included in the CCO Quality Incentive Program, for which CCOs can earn incentive payments based upon performance improvements, in 2013 and 2014.

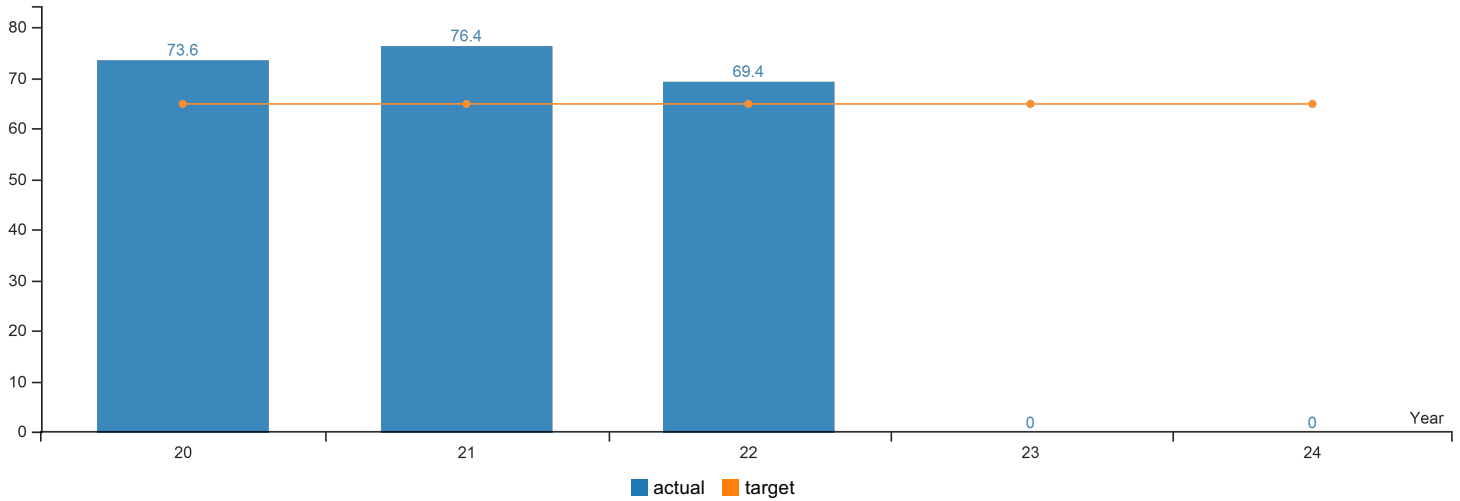
Factors Affecting Results

We have heard from providers that limiting the follow up visit to within the first 30 days is not well aligned with some of the current ADHD medications, which may require a 45 day initial prescription. Children with these longer initial prescriptions would fall outside of the 30 day window for this measure. The COVID-19 pandemic may have affected most recent performance.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #6	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (CONTINUATION AND MAINTENANCE) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Follow-up care for children prescribed with ADHD medication (continuation and maintenance)					
Actual	73.60%	76.40%	69.40%		
Target	65%	65%	65%	65%	65%

How Are We Doing

Calendar year 2011 is the baseline for this measure. In 2011, 61.0% of children who remained on ADHD medication for 210 days after receiving a new prescription also had at least two follow up visits with a provider. This rate remained fairly steady in 2013 and 2014, and increased notably in 2015, with 68.9% of children receiving continued follow-up with a provider. The rate declined from 2018 (74.4%) to 2019 (73.6%). In 2020 the rate increased to 76.4%. The rate dropped in 2021 to 69.4%.

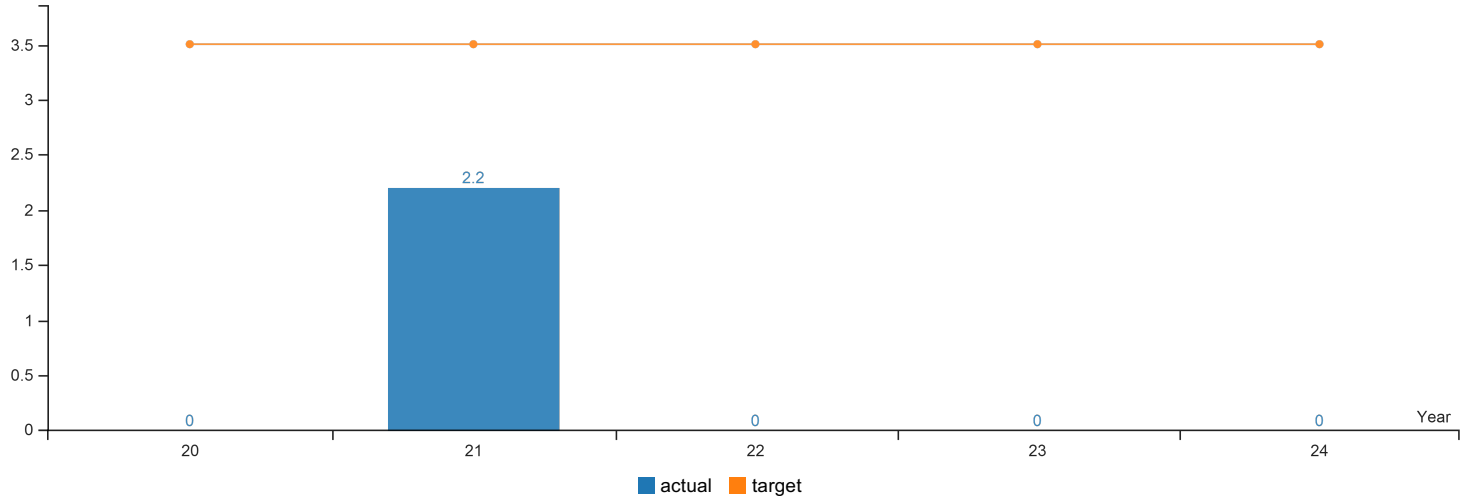
Factors Affecting Results

A number of CCO incentive measures as well as initiatives including the patient-centered primary care home model put greater emphasis on preventive care and well child visits. These efforts may result in children being more likely to engage with their primary care providers, leading to greater follow-up care for children prescribed medications for their ADHD. This measure is also notable for small denominators across the CCOs (with some having fewer than 30 children that meet these criteria); data shifts are more likely given these small numbers. The COVID-19 pandemic may have affected most recent performance.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #8	30 DAY ALCOHOL USE AMONG 6TH GRADERS - Percentage of 6th graders who have used alcohol in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
30 day alcohol use among 6th graders					
Actual		2.20%			
Target	3.50%	3.50%	3.50%	3.50%	3.50%

How Are We Doing

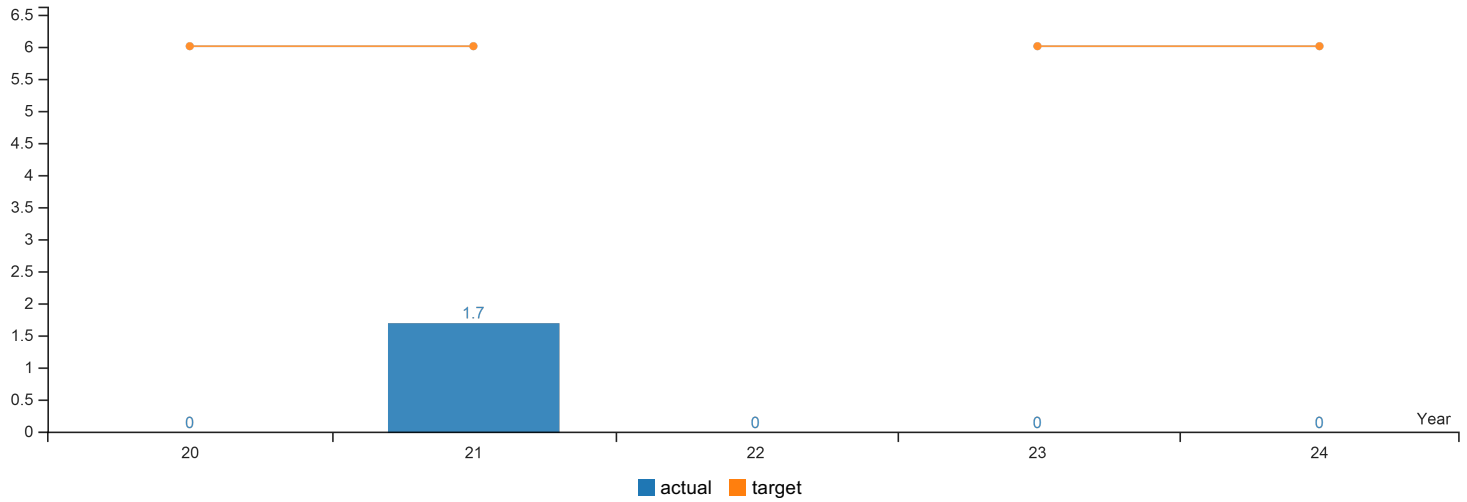
Data only collected in even numbered years. No update available.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #9	30 DAY ILLICIT DRUG USE AMONG 8TH GRADERS - Percentage of 8th graders who have used illicit drugs in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
30 day illicit drug use among 8th graders					
Actual		1.70%			
Target	6%	6%		6%	6%

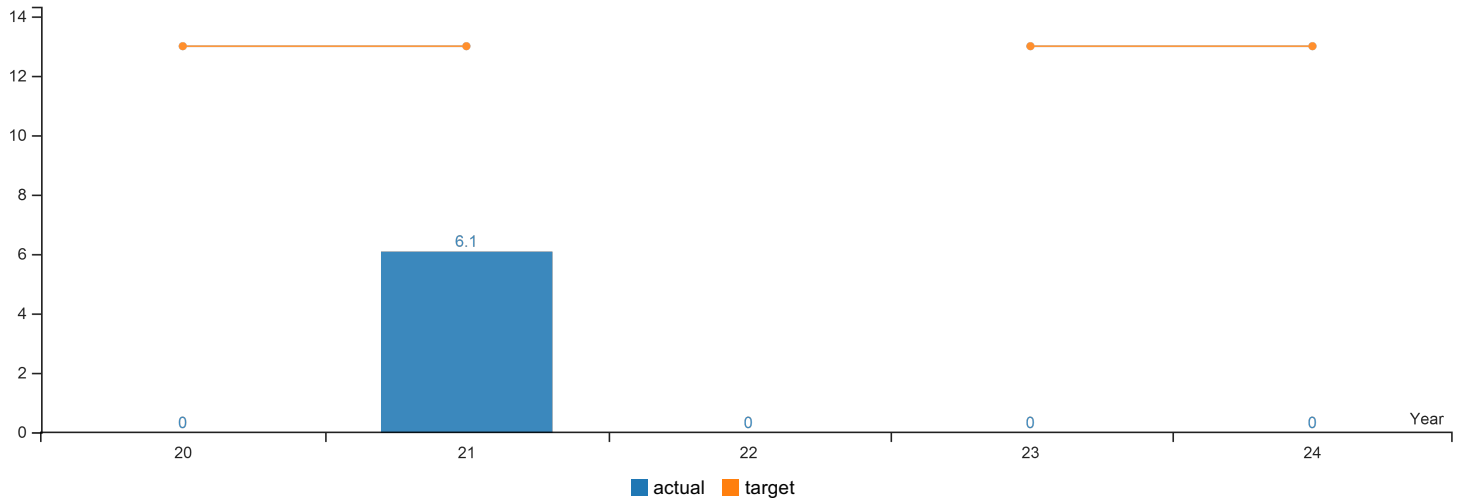
How Are We Doing

Data currently being collected in even numbered years and reported in odd numbered years. No update available.

Factors Affecting Results

KPM #10	30 DAY ALCOHOL USE AMONG 8TH GRADERS - Percentage of 8th graders who have used alcohol in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
30 day alcohol use among 8th graders					
Actual		6.10%			
Target	13%	13%		13%	13%

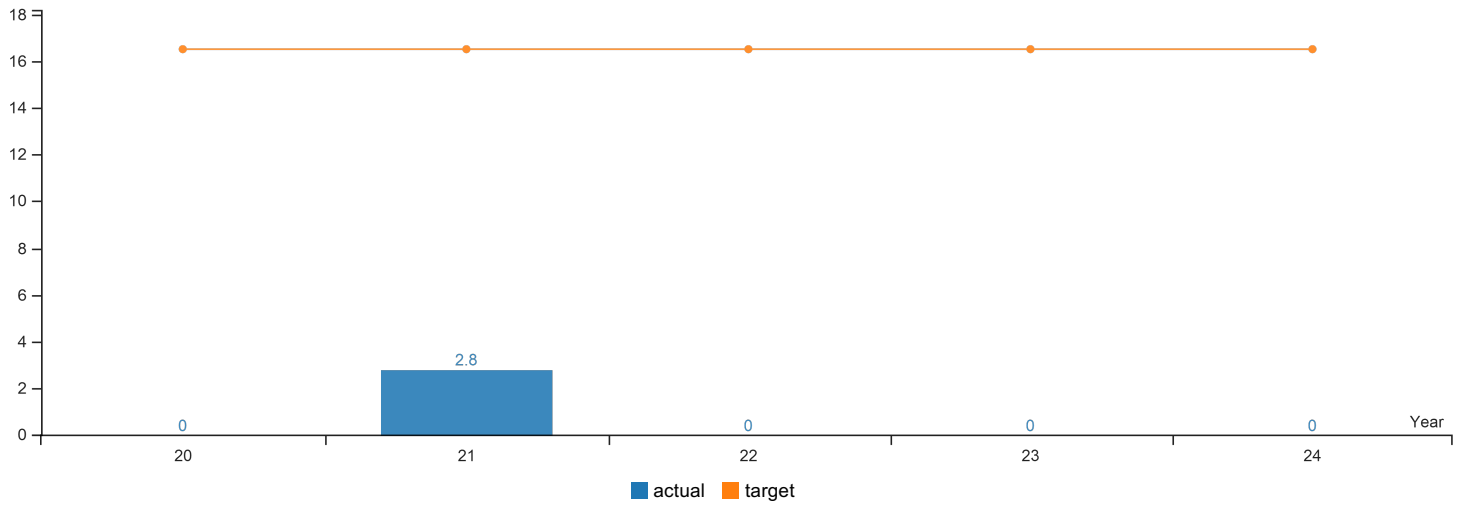
How Are We Doing

Data currently being collected in even numbered years and reported in odd numbered years. No update available.

Factors Affecting Results

KPM #11	30 DAY ILLICIT DRUG USE AMONG 11TH GRADERS - Percentage of 11th graders who have used illicit drugs in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
30 day illicit drug use among 11th graders					
Actual		2.80%			
Target	16.50%	16.50%	16.50%	16.50%	16.50%

How Are We Doing

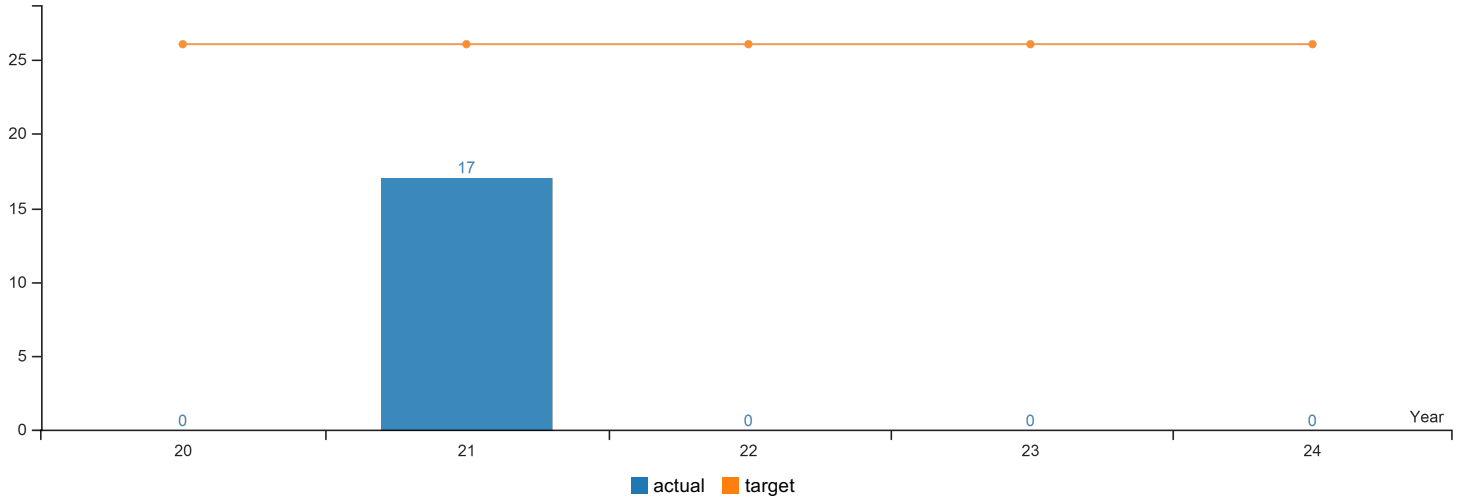
Data only collected in even numbered years. No update available.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #12	30 DAY ALCOHOL USE AMONG 11TH GRADERS - Percentage of 11th graders who have used alcohol in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
30 day alcohol use among 11th graders					
Actual		17%			
Target	26%	26%	26%	26%	26%

How Are We Doing

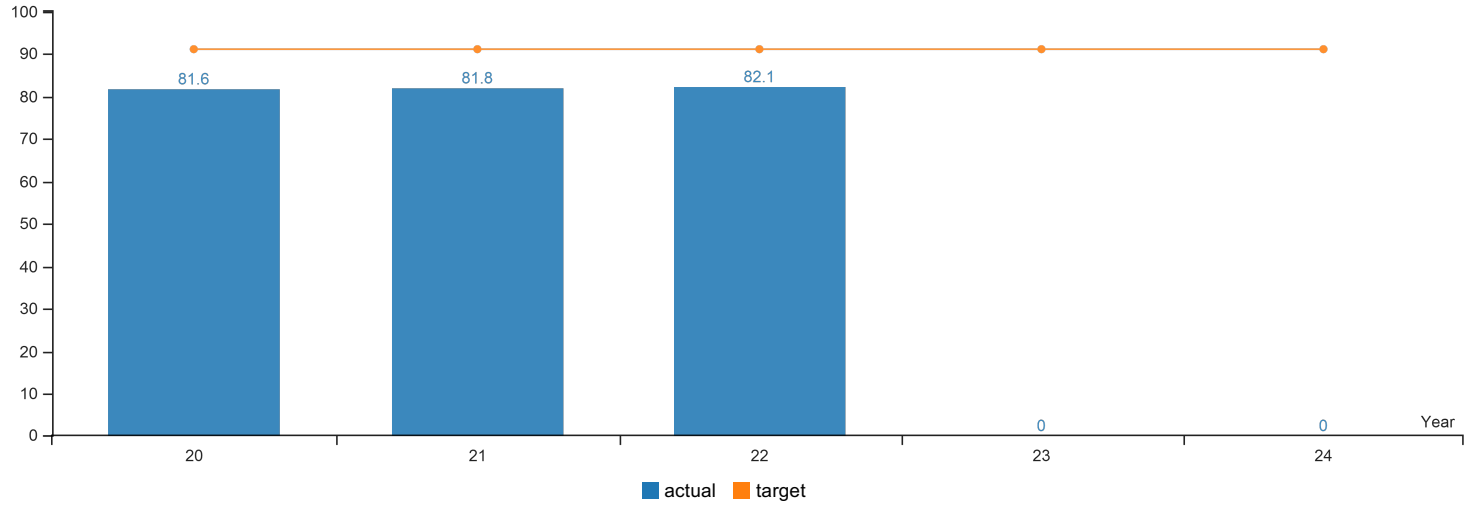
Data only collected in even numbered years. No update available.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #13	PRENATAL CARE (POPULATION) - Percentage of women who initiated prenatal care in the first 3 months of pregnancy.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Prenatal care - population					
Actual	81.60%	81.80%	82.10%		
Target	91%	91%	91%	91%	91%

How Are We Doing

The percentage of women initiating prenatal care during the first trimester is a marker for access to maternal health care services. This percentage has been slowly but steadily increasing in Oregon from 2015 to 2021. Early prenatal care is important to identify and treat babies or mothers at risk for health conditions that can affect the pregnancy, such as hypertension and diabetes. It is also important because health care providers can educate and assist mothers with health issues related to pregnancy including nutrition, alcohol use, smoking, exercise, and preparing for childbirth and infant care. Prenatal care is an important screening point for behavioral and social risks such as perinatal depression, intimate partner violence, and food insecurity. Babies born to women who receive prenatal care early and throughout the pregnancy are less likely to have low birth weight or to be born prematurely. Psychosocial, financial, logistical, health care provider, and many other issues can create barriers for women in obtaining early prenatal care. This indicator is used by states and at the national level, as the data is from vital statistics (birth certificates), therefore making it widely available and representative of the population. While this indicator has been traditionally used, and is widely understood, it is also valuable to examine the Adequacy of Prenatal Care Utilization Index (https://www.mchlibrary.org/databases/HSNRCPDFs/Overview_APCUIndex.pdf), which examines the number of prenatal care visits a woman has received throughout pregnancy in addition to the timing of initiation. This allows for a more thorough examination of woman's access to care. It is worth noting that the data for prenatal care used in both indicators is only available for live births, and therefore does not include information on the prenatal care of women who had a miscarriage or a still birth. The data on first trimester initiation of prenatal care is publicly released by the Oregon Center for Health Statistics in their Annual Vital Statistic Report. These reports can be found at https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/VITALSTATISTICS/ANNUALREPORTS/VOLUME1/Pages/index.aspx. Data entered is preliminary for 2021.

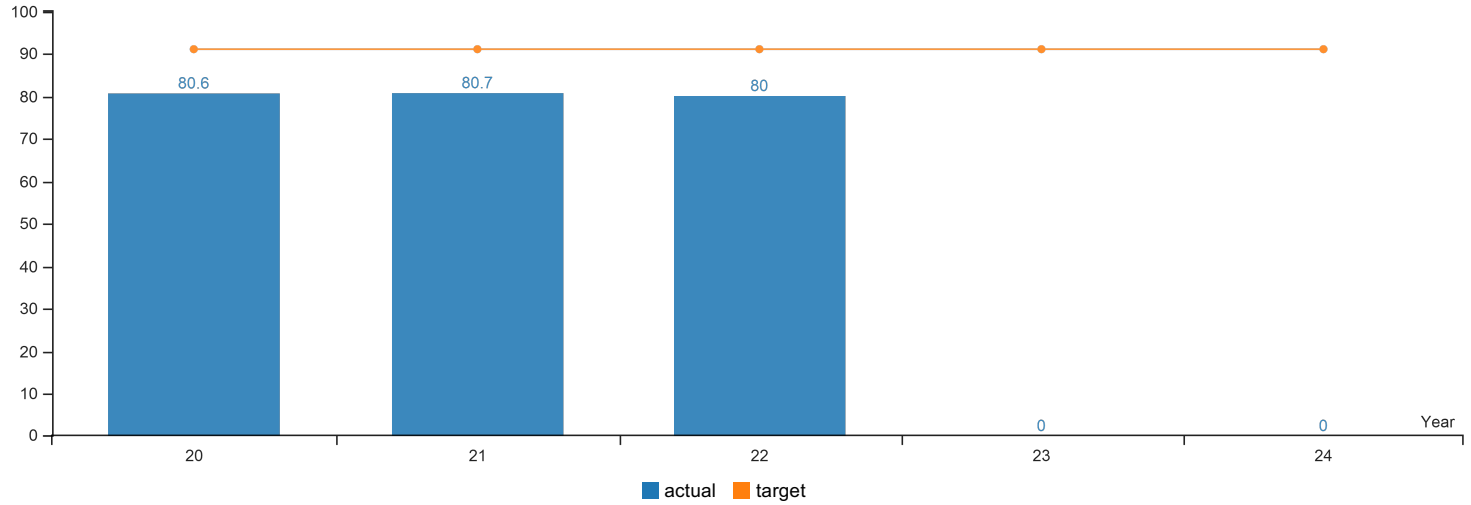
Factors Affecting Results

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

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #14	PRENATAL CARE (MEDICAID) - Percentage of women who initiated prenatal care within 42 days of enrollment.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Prenatal care - Medicaid					
Actual	80.60%	80.70%	80%		
Target	91%	91%	91%	91%	91%

How Are We Doing

Performance on timeliness of prenatal care slightly decreased from 80.7% in 2020 to 80.0% in 2021.

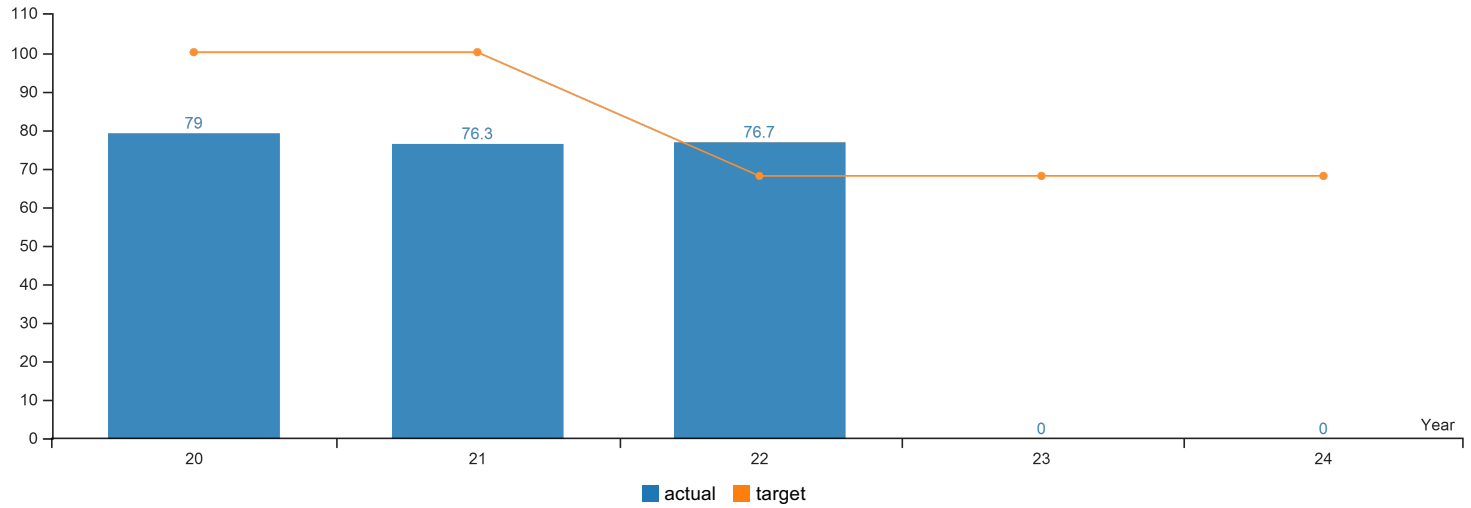
Factors Affecting Results

This measure was an incentive measure through 2018, but not incentivized for 2019 onwards. NOTE: Results prior to 2014 are not directly comparable to later years due to change in methodology.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #15	PATIENT CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT - Number of members enrolled in patient-centered primary care homes by tier.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Patient centered primary care home (PCPCH) enrollment					
Actual	79%	76.30%	76.70%		
Target	100%	100%	68%	68%	68%

How Are We Doing

This measure uses a weighted methodology to ensure members are not just enrolled in a Patient-Centered Primary Care Home (PCPCH), but are enrolled in the higher PCPCH tiers. Statewide in 2019, 96 percent of CCO members were enrolled in a PCPCH, resulting in a weighted score of 79. This weighted score dropped in 2020 to 76.3, with 92 percent of CCO members enrolled in a PCPCH. The weighed score increased slightly in 2021 to 76.7. Beginning in 2017, the PCPCH program launched 5 STAR recognition. This new level of recognition was incorporated into the weighting formula for PCPCH score. Thus, scores are not comparable to previous years.

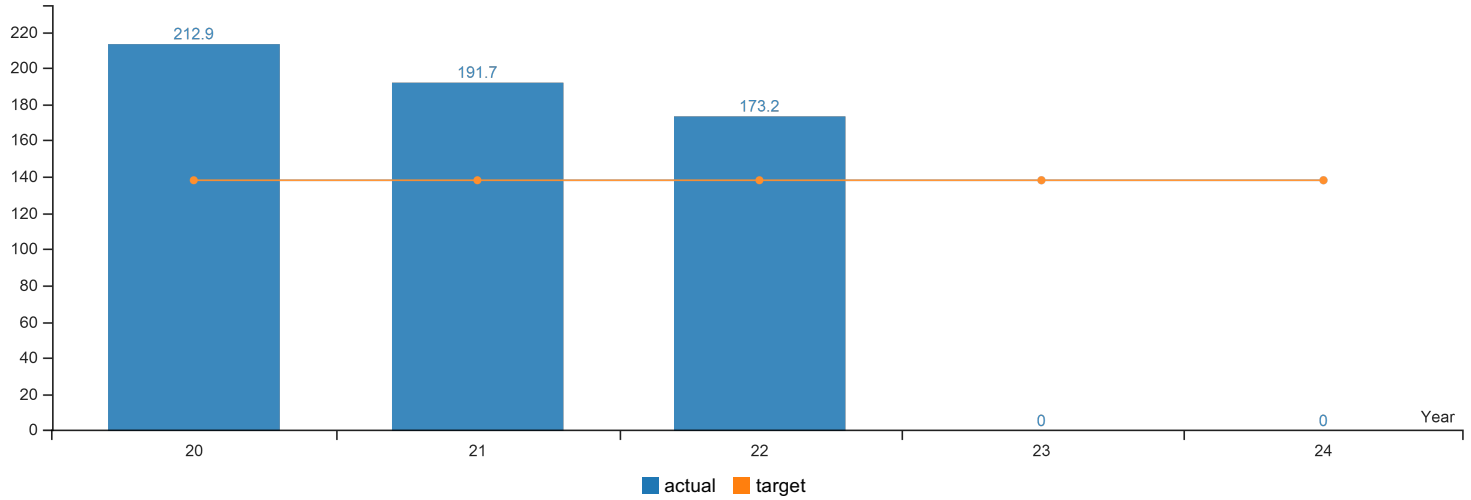
Factors Affecting Results

Coordinated care organizations are driving improvement on this measure through two main efforts: (1) working with contracted providers to go through the PCPCH recognition process, and (2) preferentially assigning members to certified PCPCHs.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #16	PQI 01: Diabetes Short-Term Complication Admission Rate -
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
PQI 01: Diabetes Short-Term Complication Admission Rate					
Actual	212.90	191.70	173.20		
Target	138	138	138	138	138

How Are We Doing

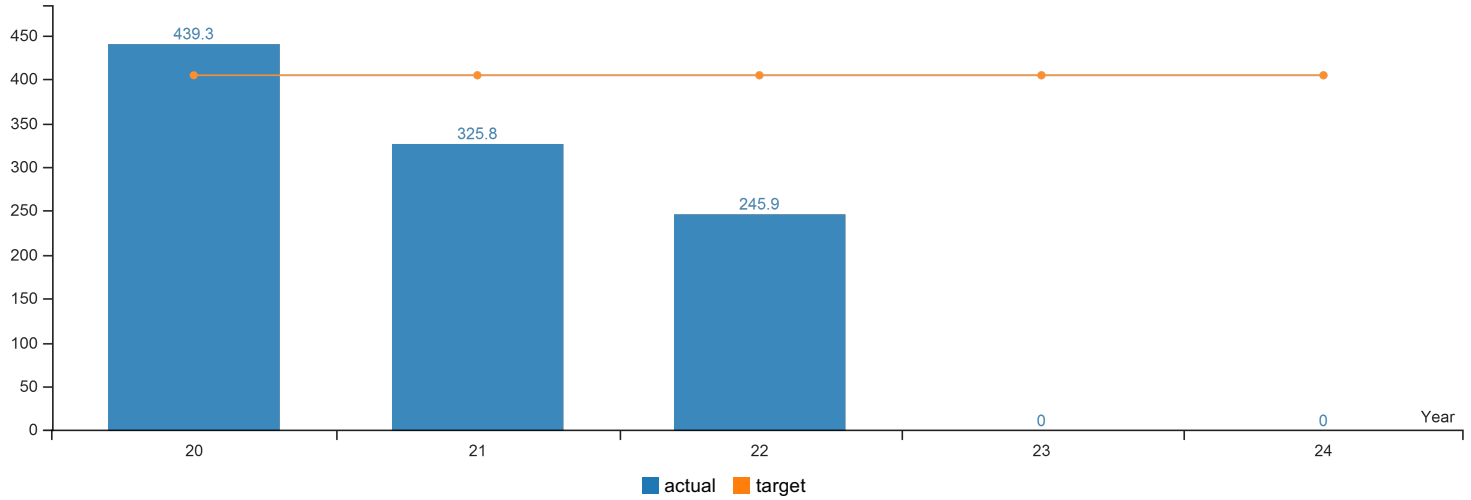
The rate of adult members with diabetes who had a hospital stay because of a short-term problem from their disease improved from 191.7 in 2020 to 173.2 in 2021. Lower is better on this measure. This measure is calculated using proprietary software from AHRQ, which was updated in 2018. Because of the changes that AHRQ made to the way this measure is calculated, data prior to 2018 are not directly comparable to later years.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #17	PQI 05: COPD or Asthma in Older Adults Admission Rate -
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
PQI 05: COPD or Asthma in Older Adults Admission Rate					
Actual	439.30	325.80	245.90		
Target	404	404	404	404	404

How Are We Doing

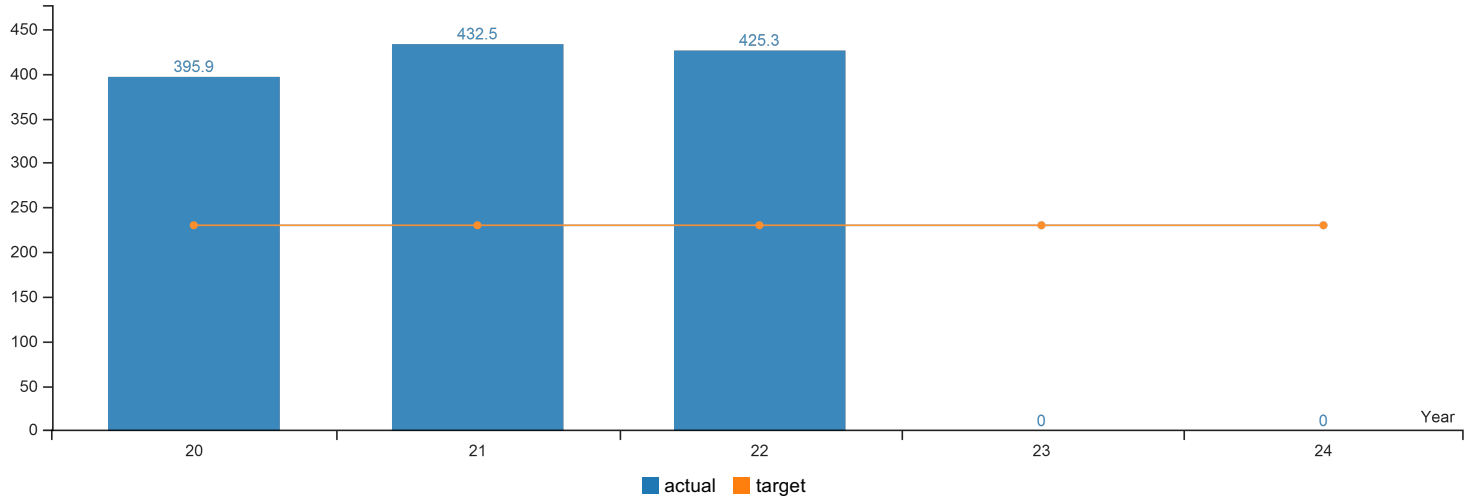
The rate of adult members (ages 40 and older) who had a hospital stay because of chronic obstructive respiratory disease or asthma improved from 325.8 in 2020 to 245.9 in 2021. Lower is better on this measure. This measure is calculated using proprietary software from AHRQ, which was updated in 2018. Because of the changes that AHRQ made to the way this measure is calculated, data prior to 2018 are not directly comparable to later years.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #18	PQI 08: Congestive Heart Failure Admission Rate -
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
PQI 08: Congestive Heart Failure Admission Rate					
Actual	395.90	432.50	425.30		
Target	230	230	230	230	230

How Are We Doing

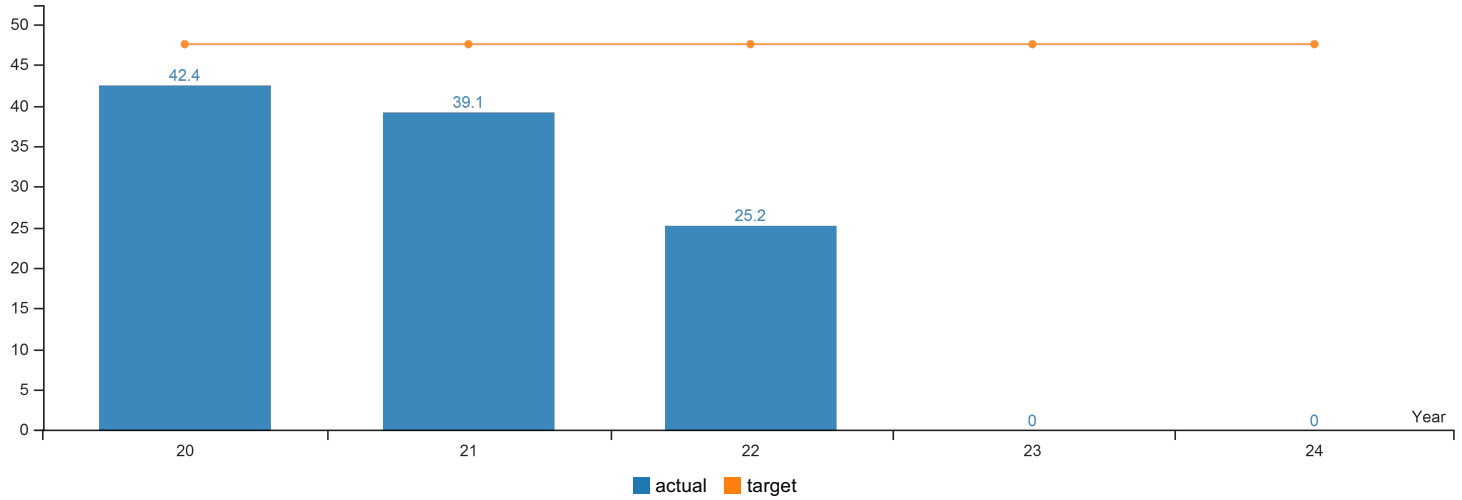
The rate of adult members who had a hospital stay because of congestive heart failure improved from 432.5 in 2020 to 425.3 in 2021. Lower is better on this measure. This measure is calculated using proprietary software from AHRQ, which was updated in 2018. Because of the changes that AHRQ made to the way this measure is calculated, data prior to 2018 are not directly comparable to later years.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #19	PQI 15: Asthma in Younger Adults Admission Rate -
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
PQI 15: Asthma in Younger Adults Admission Rate					
Actual	42.40	39.10	25.20		
Target	47.50	47.50	47.50	47.50	47.50

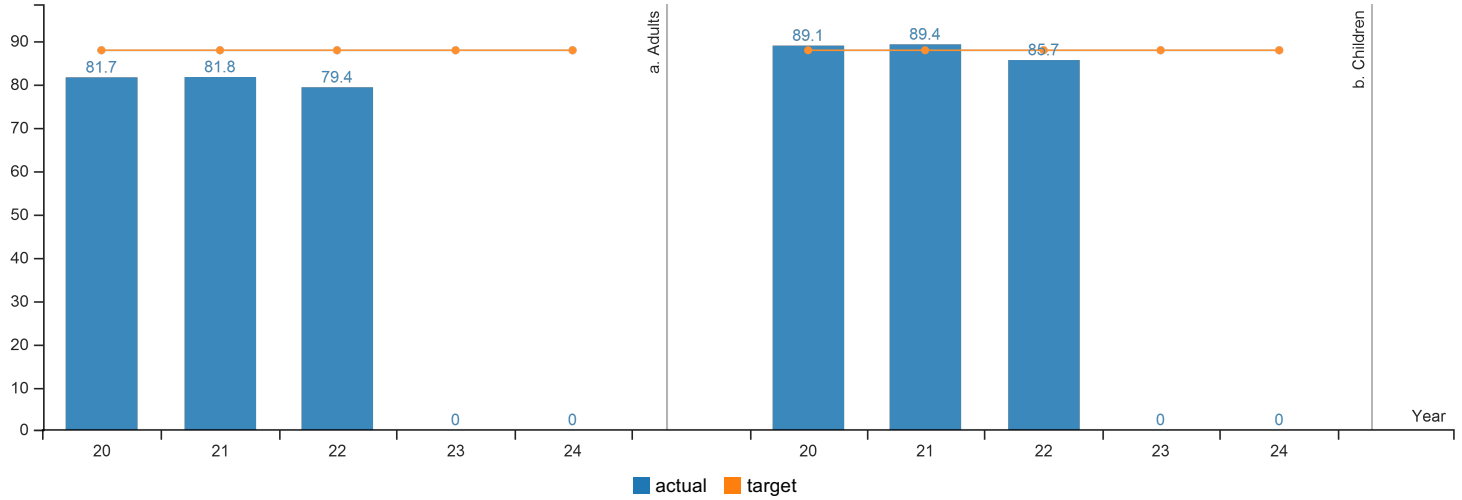
How Are We Doing

The rate of younger adult members (ages 18-39) who had a hospital stay because of asthma improved from 39.1 in 2020 to 25.2 in 2021. Lower is better on this measure. This measure is calculated using proprietary software from AHRQ, which was updated in 2018. Because of the changes that AHRQ made to the way this measure is calculated, data prior to 2018 are not directly comparable to later years.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #20	ACCESS TO CARE - Percentage of members who responded "always" or "usually" to getting care quickly.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2020	2021	2022	2023	2024
a. Adults					
Actual	81.70%	81.80%	79.40%		
Target	88%	88%	88%	88%	88%
b. Children					
Actual	89.10%	89.40%	85.70%		
Target	88%	88%	88%	88%	88%

How Are We Doing

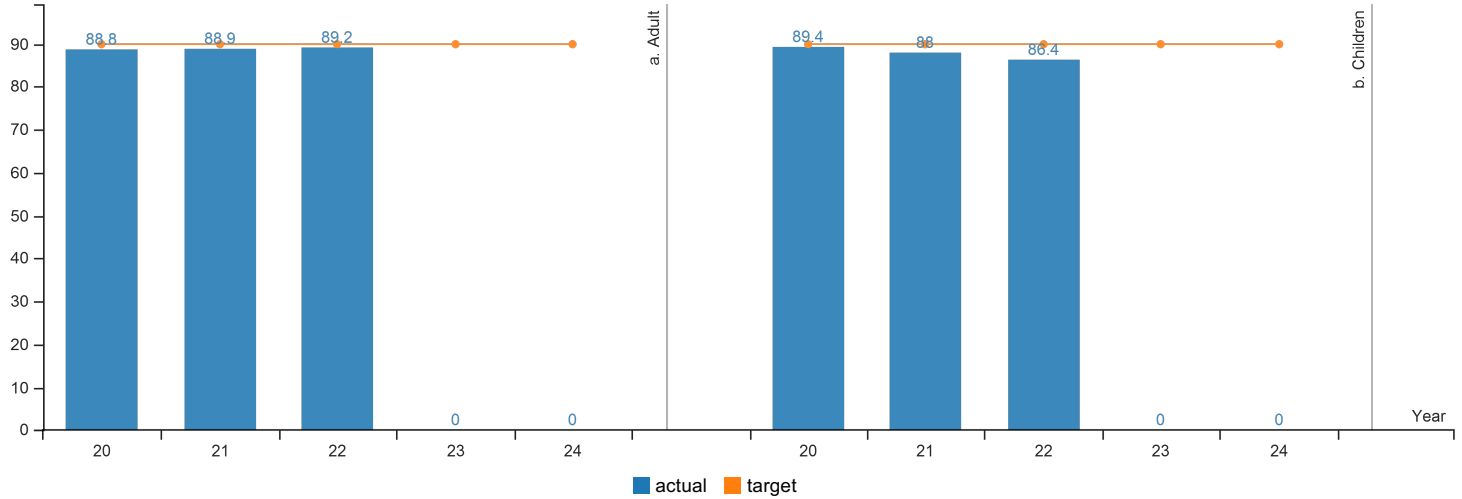
The percentage of adult members who thought they received appointments and care when needed was 79.4%. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. OHA added an oversample of race/ethnicity groups to the 2021, making them not directly comparable to previous years.

The percentage of child members who received appointments and care when needed was 85.7% in 2021. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. OHA added an oversample of race/ethnicity groups to 2021, making them not directly comparable to previous years.

Factors Affecting Results

The COVID-19 pandemic may have affected most recent performance. This measure is included in the state's Medicaid demonstration agreement with CMS.

KPM #21	MEMBER SATISFACTION OF CARE - Composite measurement: how well doctors communicate; health plan information and customer service (Medicaid population).
	Data Collection Period: Jan 01 - Dec 31



Report Year	2020	2021	2022	2023	2024
a. Adult					
Actual	88.80%	88.90%	89.20%		
Target	90%	90%	90%	90%	90%
b. Children					
Actual	89.40%	88%	86.40%		
Target	90%	90%	90%	90%	90%

How Are We Doing

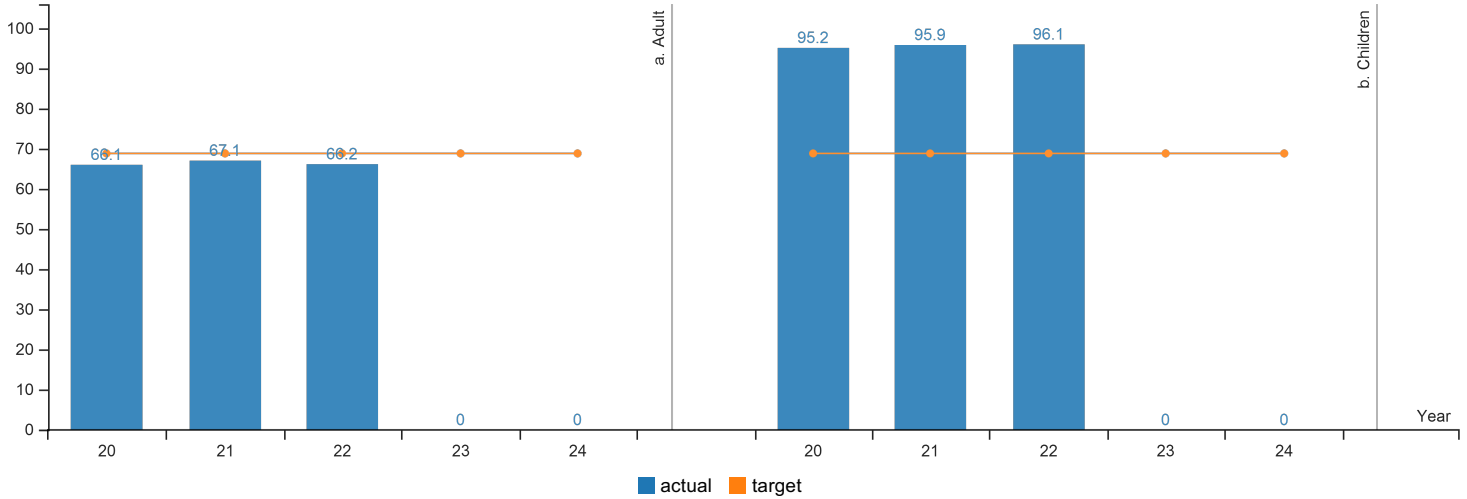
The rate of adults who were satisfied with their experience of care was 89.2% in 2021. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. OHA added an oversample of race/ethnicity groups to 2021 results, making them not directly comparable to previous years.

The percentage of adults who were satisfied with their child's experience of care was 86.4% in 2021. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. OHA added an oversample of race/ethnicity groups to 2021 results, making them not directly comparable to prior years.

Factors Affecting Results

NOTE: This was retired from the incentive measure set in 2017.

KPM #22	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good, or good).
	Data Collection Period: Jan 01 - Dec 31



Report Year	2020	2021	2022	2023	2024
a. Adult					
Actual	66.10%	67.10%	66.20%		
Target	68.90%	68.90%	68.90%	68.90%	68.90%
b. Children					
Actual	95.20%	95.90%	96.10%		
Target	68.90%	68.90%	68.90%	68.90%	68.90%

How Are We Doing

The percentage of adult members who rated their overall health as good, very good, or excellent was 66.2% in 2021. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. The 2021 rate is not directly comparable to previous years due to adding an oversample of race/ethnicity groups.

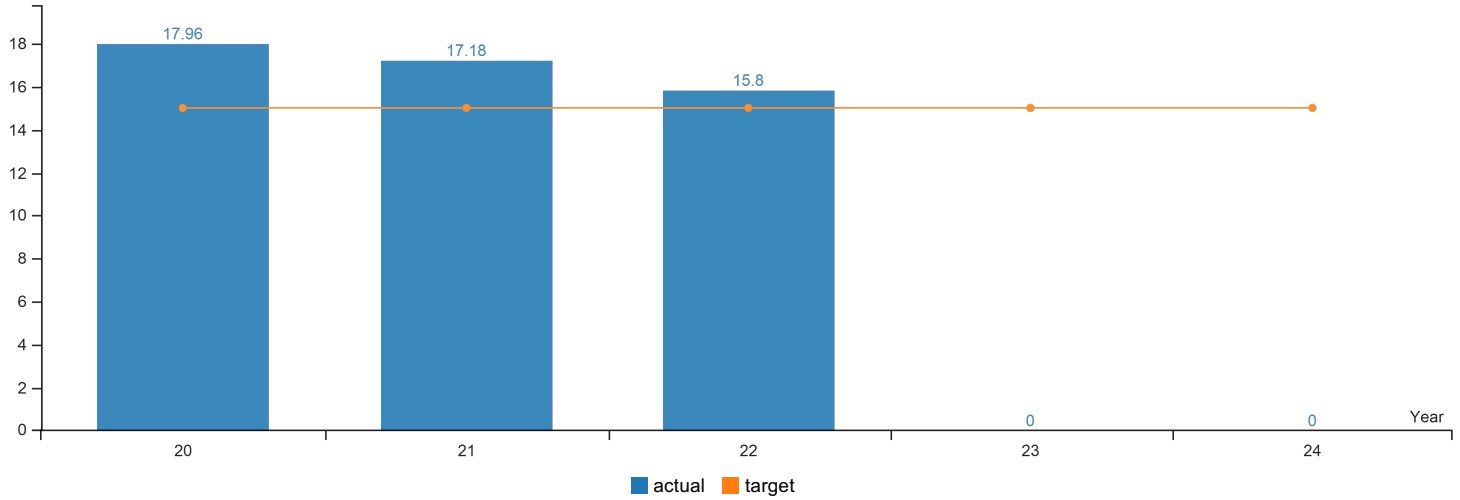
The percentage of children whose parents rated their overall health as good, very good, or excellent was 96.1% in 2021. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. OHA added an oversample of race/ethnicity groups to the 2021 results, meaning that the rate is not directly comparable to previous years.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #23	RATE OF TOBACCO USE (POPULATION) - Rate of tobacco use among adults.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
Rate of tobacco use - adult population					
Actual	17.96%	17.18%	15.80%		
Target	15%	15%	15%	15%	15%

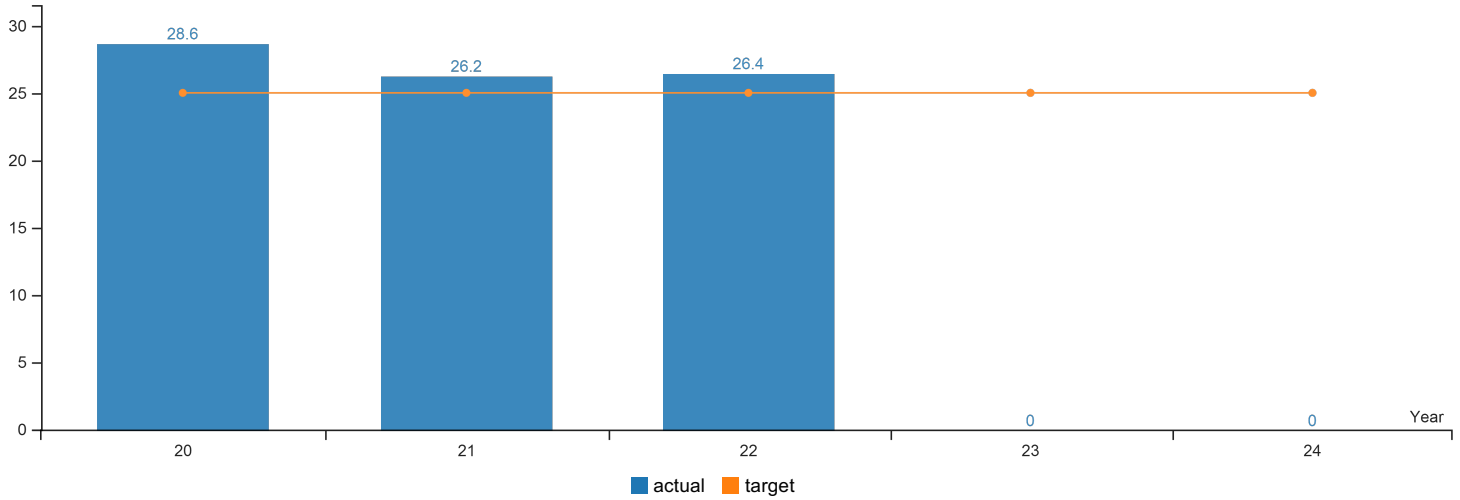
How Are We Doing

Oregon has reached less than 16% of Oregon adults using tobacco (cigarette and smokeless tobacco).

Factors Affecting Results

KPM #24	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
Rate of tobacco use - Medicaid population					
Actual	28.60%	26.20%	26.40%		
Target	25%	25%	25%	25%	25%

How Are We Doing

The percentage of members who self-reported smoking cigarettes or using tobacco every day or some days was 26.4% in 2021. Lower is better on this measure. Results in 2021 are not directly comparable to previous years due to adding an oversample of race/ethnicity groups.

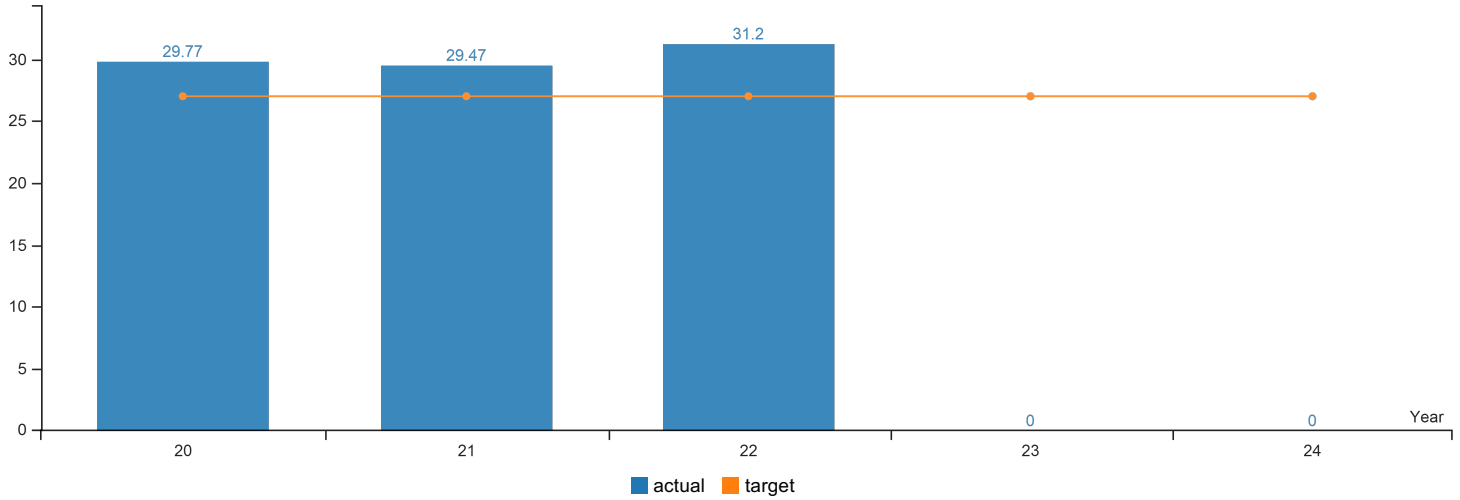
Factors Affecting Results

Note: This self-reported, survey-based measure was included in our previous CMS waiver, but was not included as a metric in the current 2017-2022 waiver; instead the current Medicaid waiver includes a different measure focused specifically on cigarette smoking prevalence, and sourced from electronic health records.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #25	RATE OF OBESITY (POPULATION) - Percentage of adults who are obese among Oregonians.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
Rate of obesity - adult population					
Actual	29.77%	29.47%	31.20%		
Target	27%	27%	27%	27%	27%

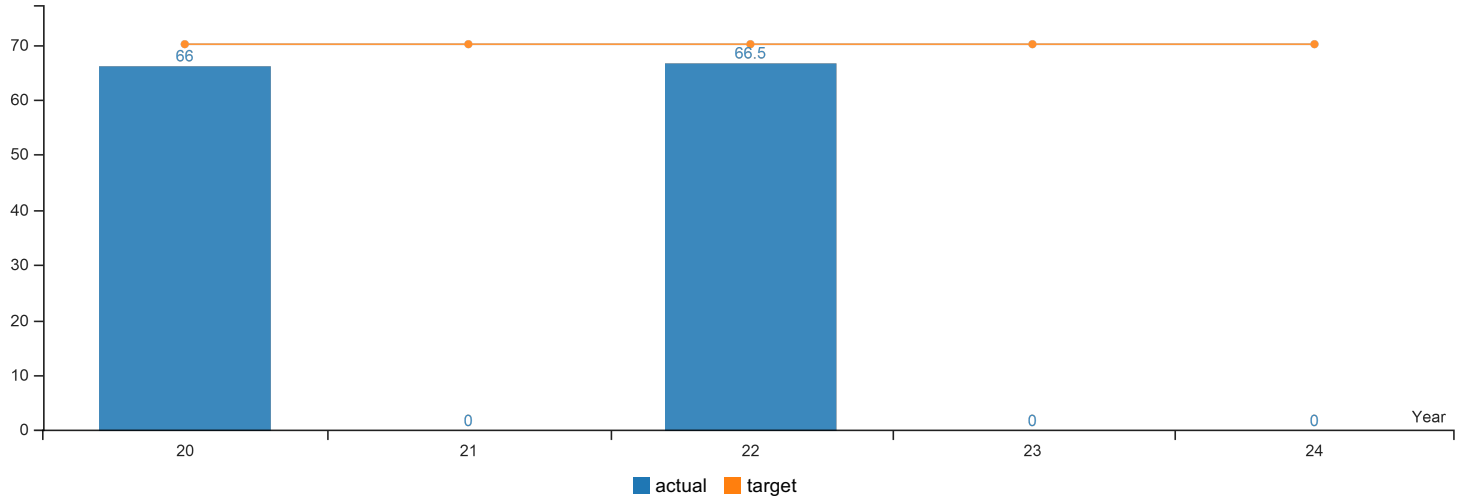
How Are We Doing

The obesity rate continues to increase (worsen) in Oregon. The main factor affecting Oregonian's results is limited funds for statewide initiatives that promote healthy environments where access to physical activity is improved and barriers to nutrition security are reduced.

Factors Affecting Results

KPM #26	EFFECTIVE CONTRACEPTIVE USE (POPULATION) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Effective contraceptive use - population					
Actual	66%		66.50%		
Target	70%	70%	70%	70%	70%

How Are We Doing

The 2020 data was not available to report on in 2021 due to delays caused by COVID19. The data collection cadence has changed on this metric as well, such that the survey is only being completed in even numbered years. As such, there is no 2021 survey data for us to report on in 2022. The 2020 data is available now and are reporting that number - 66.5%. The proportion of women at risk of unintended pregnancy who are using effective contraceptive methods has remained steady for the past several years.

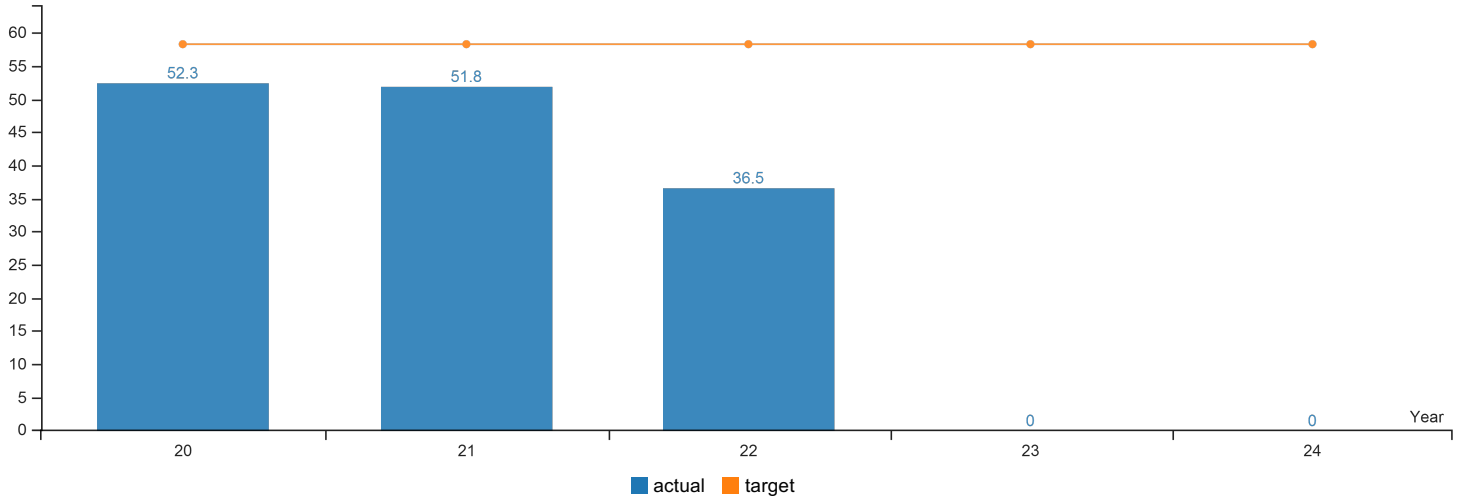
Factors Affecting Results

Access to contraception services was greatly impacted during the acute phase of the COVID-19 pandemic. Family planning clinics demonstrated innovations in service delivery to maintain access during this time.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #27	EFFECTIVE CONTRACEPTIVE USE (MEDICAID) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Effective contraceptive use - Medicaid population					
Actual	52.30%	51.80%	36.50%		
Target	58.20%	58.20%	58.20%	58.20%	58.20%

How Are We Doing

The rate of effective contraceptive use increased since while the measure was included in the CCO Quality Incentive Program from 2015-2019; this means CCOs could earn incentive payments for improving performance during this time period. The Metrics & Scoring Committee retired this measure from the incentive program in 2020 due to equity concerns about the measure. Subsequently, the rate decreased from 52.3% in 2019 to 51.8% in 2020. The rate continued to decrease in 2021 to 36.5%.

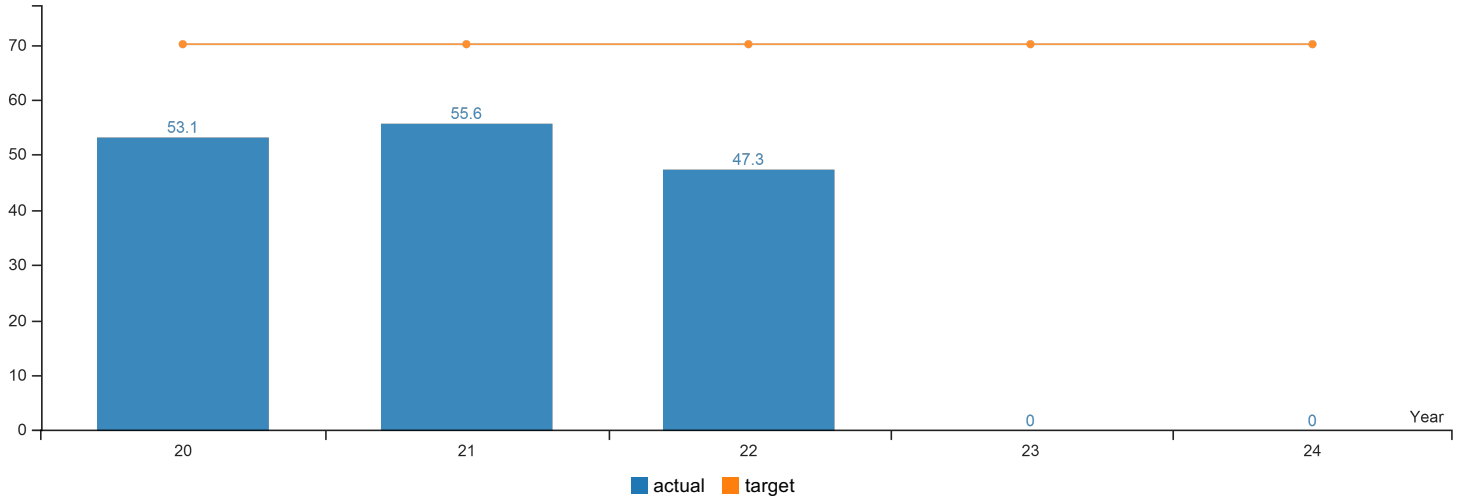
Factors Affecting Results

This was a CCO incentive measure from 2015 - 2019 (the incentive measure also included young women ages 15-17 in 2018 & 2019). The 2020 rate of 51.8% includes women ages 18-50, while the 2021 rate includes women ages 15-50, which may have affected the decreased rate. Due to the change in ages included in this measure, 2021 results are not directly comparable to 2020.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #28	FLU SHOTS (POPULATION) - Percentage of adults ages 50-64 who receive a flu vaccine.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Flu shots - population					
Actual	53.10%	55.60%	47.30%		
Target	70%	70%	70%	70%	70%

How Are We Doing

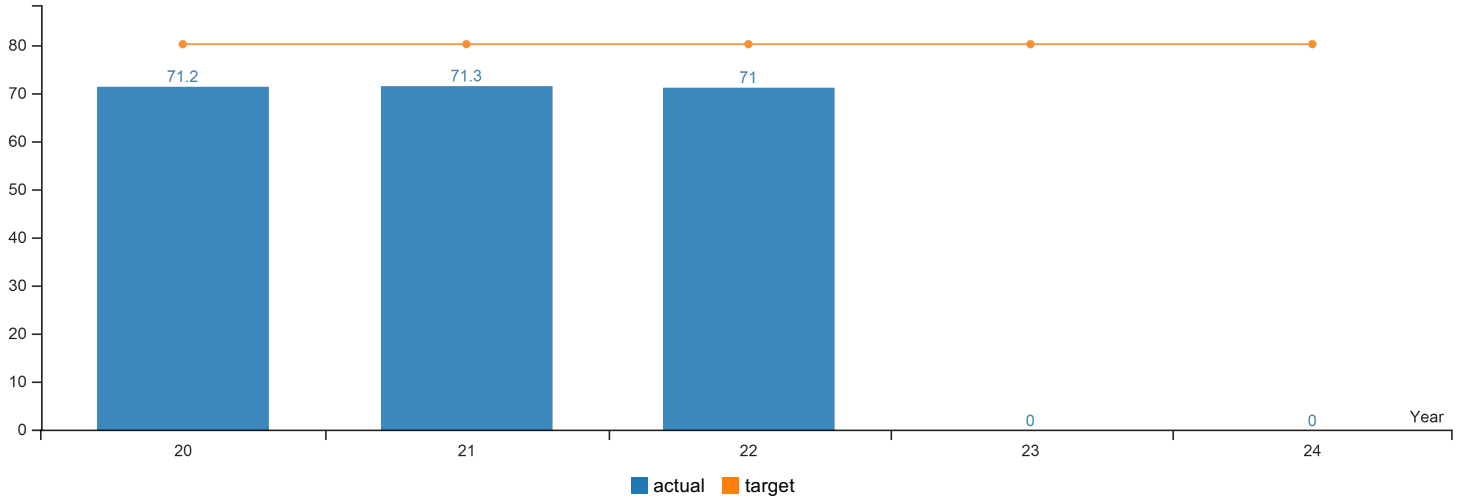
Adult influenza immunization in the Fall of 2021 was reduced to the overlap in time with the recommendation for COVID-19 booster doses.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #29	CHILD IMMUNIZATION RATES (POPULATION) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Child immunization rates - population					
Actual	71.20%	71.30%	71%		
Target	80%	80%	80%	80%	80%

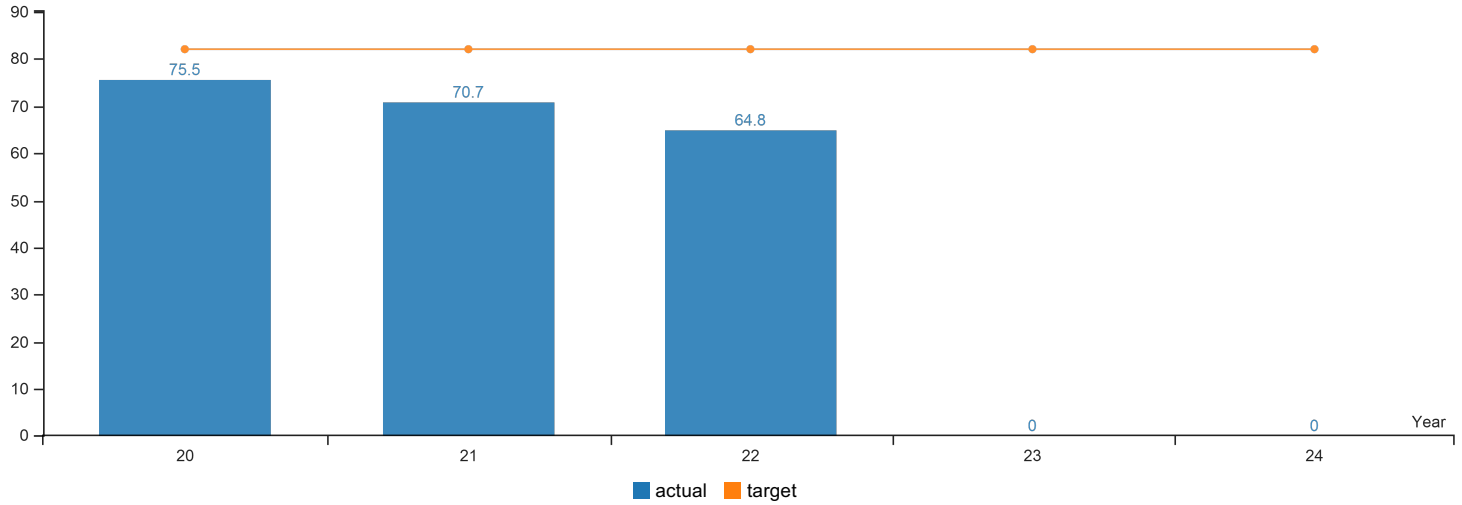
How Are We Doing

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #30	CHILD IMMUNIZATION RATES (MEDICAID) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Child immunization rates - Medicaid population					
Actual	75.50%	70.70%	64.80%		
Target	82%	82%	82%	82%	82%

How Are We Doing

In 2015, 68.2% of CCO members received recommended vaccines before their second birthday. This increased to 73.2% in 2017, and continued to increase to 74.5% in 2018 and 75.5% in 2019. In 2020 this measure decreased to 70.7%. The measure continued to decrease to 64.8% in 2021.

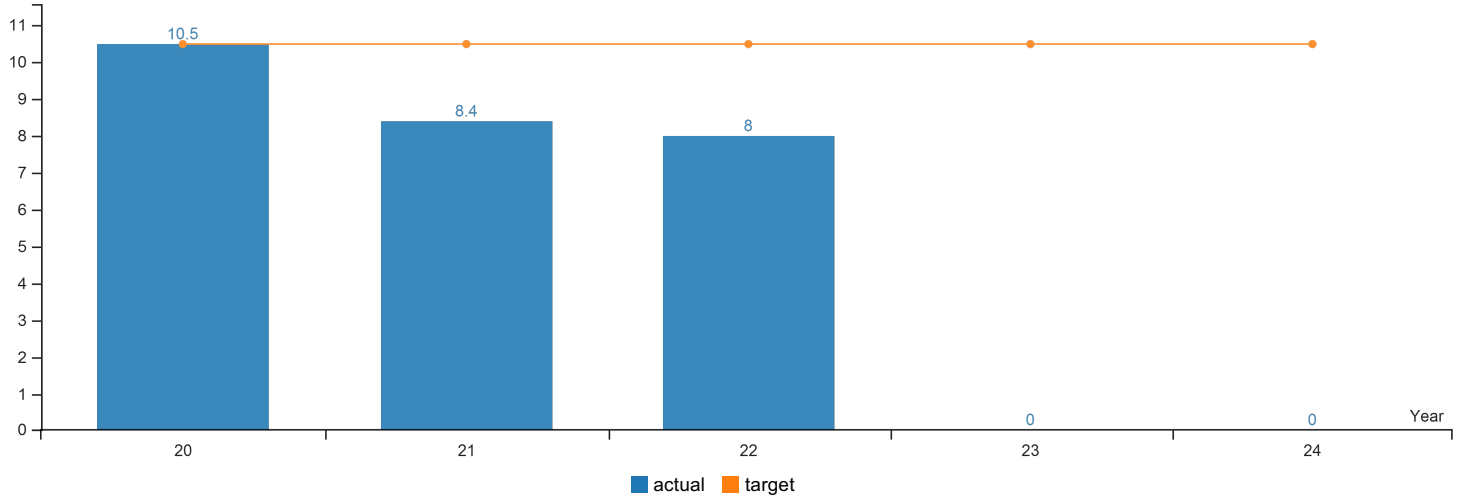
Factors Affecting Results

The COVID-19 pandemic negatively impacted this measure in recent years. Beginning 2016, childhood immunization status was added to the Quality Incentive Program, which means CCOs could earn incentives for improving performance, and which likely drove improved outreach and workflows. This measure is limited to children who turn two during the measurement year and who have been continuously enrolled in an Oregon Health Plan CCO for at least the 12 months preceding their second birthday, and may not be comparable to immunization rates for the general population.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #31	PLAN ALL CAUSE READMISSIONS - Percentage of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years and older.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
Plan all cause readmissions					
Actual	10.50%	8.40%	8%		
Target	10.50%	10.50%	10.50%	10.50%	10.50%

How Are We Doing

Hospital readmissions continue to decline in Oregon (lower is better), decreasing from 8.4% in 2020 to 8.0% in 2021. However, 2020 and 2021 data for this measure are not directly comparable to previous years due to a methodology change.

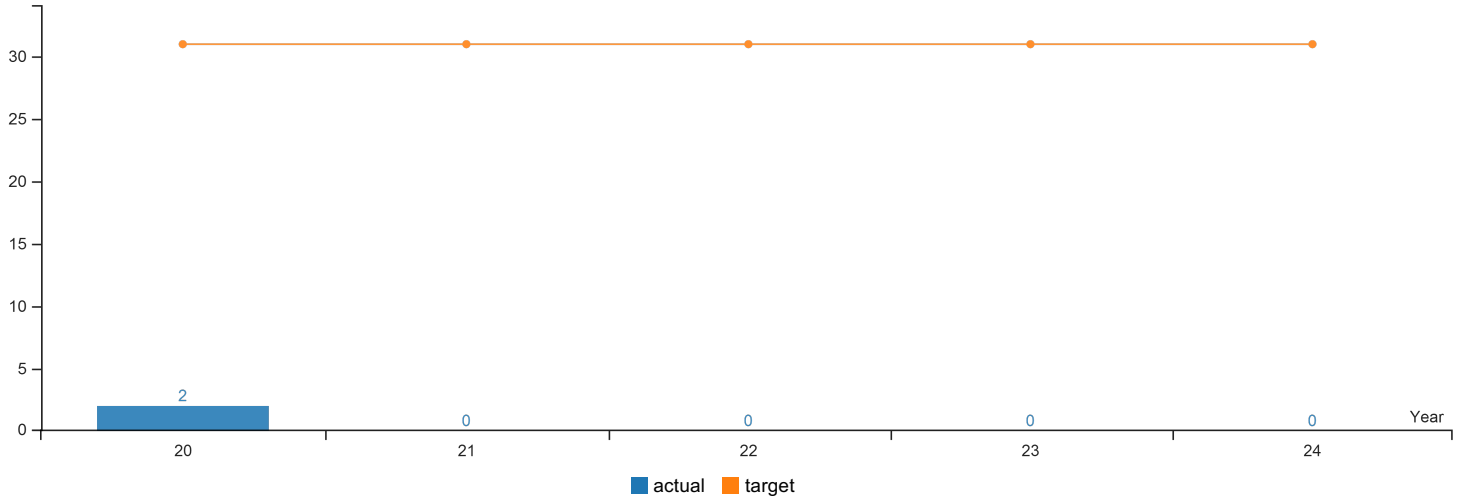
Factors Affecting Results

As CCOs continue to focus on ensuring their members receive the appropriate care at the appropriate time in the appropriate place, many performance indicators are affected. As providers continue to emphasize the importance of coordinated, preventive care, post-discharge care is likely to be more appropriately addressed, resulting in a reduction in this readmission rate.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #32	ELIGIBILITY PROCESSING TIME - Median number of days processing time from date of request to eligibility determination.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
ELIGIBILITY PROCESSING TIME					
Actual	2	0	0		
Target	31	31	31	31	31

How Are We Doing

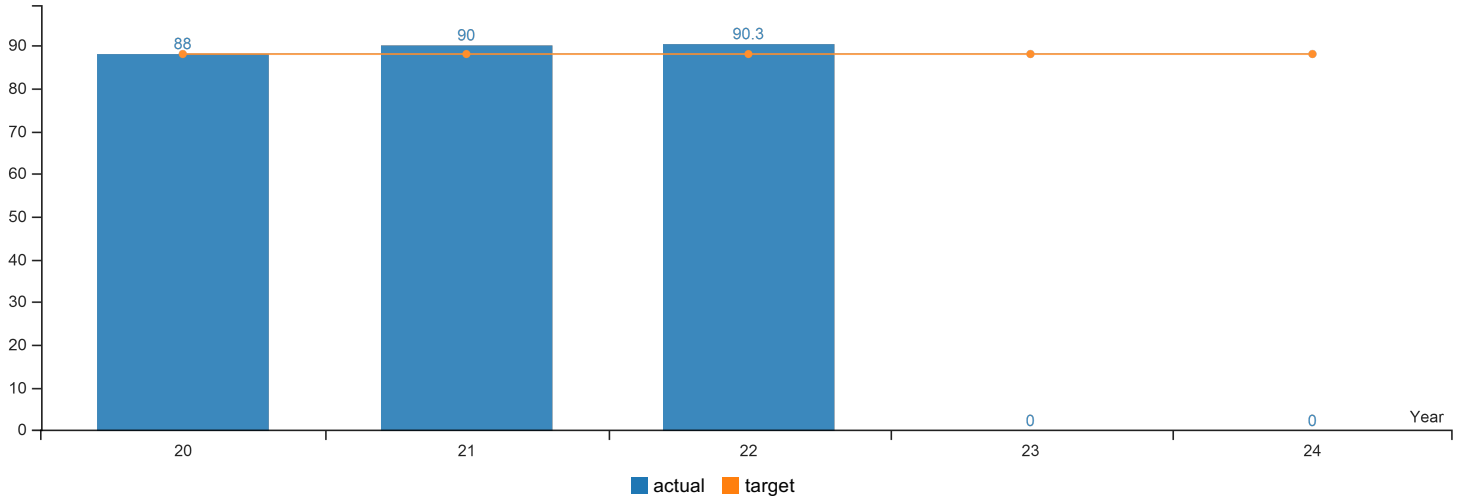
The processing time remains low because Oregon uses an automated eligibility process.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #33	OHP MEMBERS IN CCOs - Percent of Oregon Health Plan members enrolled in Coordinated Care Organizations.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
OHP MEMBERS IN CCOs					
Actual	88%	90%	90.30%		
Target	88%	88%	88%	88%	88%

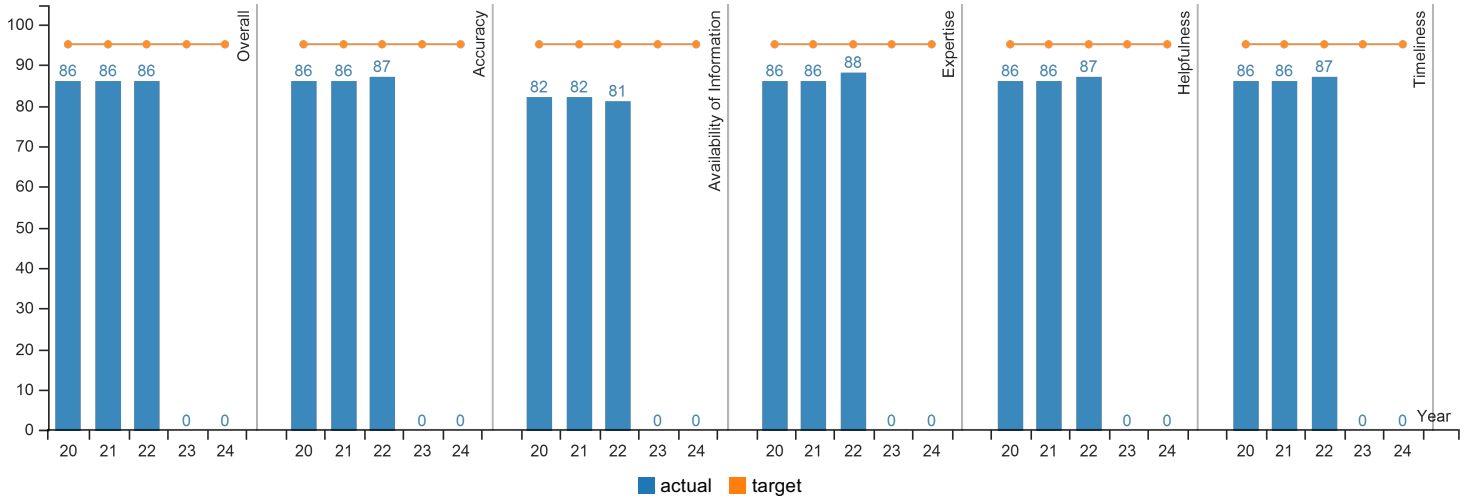
How Are We Doing

In 2021, OHA continued automatic re-enrollment of members into their current CCO. OHA also continued the automatic enrollment of dual eligible members into CCOs for their physical health care. These processes make enrollment in CCOs easier and quicker. As a result, 2021 has the highest rate of CCO enrollment ever.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #34	CUSTOMER SERVICE - Percentage of OHA customers rating their satisfaction with the agency's customer service as "good" or "excellent" overall, timeliness, accuracy, helpfulness, expertise, availability of information.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2020	2021	2022	2023	2024
Overall					
Actual	86%	86%	86%		
Target	95%	95%	95%	95%	95%
Accuracy					
Actual	86%	86%	87%		
Target	95%	95%	95%	95%	95%
Availability of Information					
Actual	82%	82%	81%		
Target	95%	95%	95%	95%	95%
Expertise					
Actual	86%	86%	88%		
Target	95%	95%	95%	95%	95%
Helpfulness					
Actual	86%	86%	87%		
Target	95%	95%	95%	95%	95%
Timeliness					
Actual	86%	86%	87%		
Target	95%	95%	95%	95%	95%

How Are We Doing

Overall: Results are about the same as we continue to provide services fully remote. Percent of members rating quality of service excellent increased quite a bit since last reporting period.

Accuracy: Excellent - 51.86% Good - 35.01%; Results have improved even with continuing to provide services in a fully remote work environment. More members have reported service accuracy as excellent than in the prior reporting period.

Availability of information: Excellent -46.30% Good - 35.03%; Staff continue to work fully remote. We just starting implementing some new communication strategies that should reflect with improved results in the upcoming year. Members who rated availability of information as excellent increased from the last year.

Expertise: Excellent - 54.62% Good - 33.69%; Results have improved since the last reporting period. Especially those rating staff expertise as excellent.

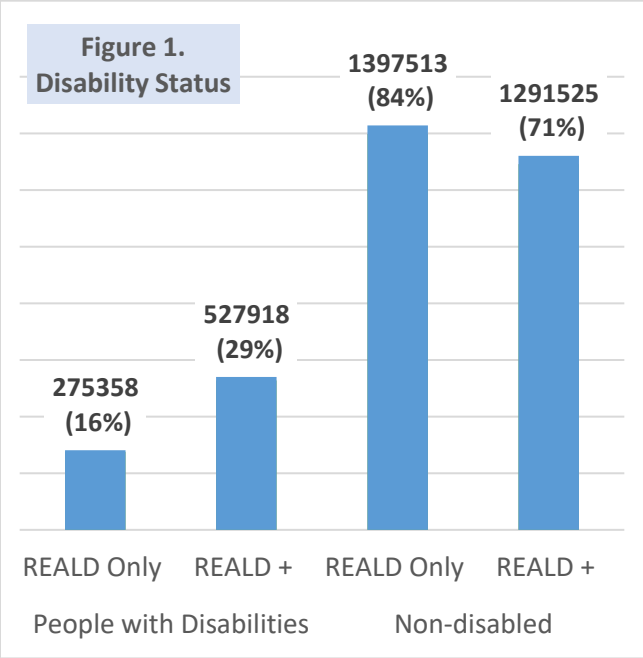
Helpfulness: Excellent - 55.86% Good - 31.42%; More members rated staff helpfulness as excellent over the last reporting period, while overall results stayed about the same.

Timeliness: Excellent - 50.34% Good - 36.98% Overall timeliness results have improved as well as the percent rating it excellent.

Factors Affecting Results

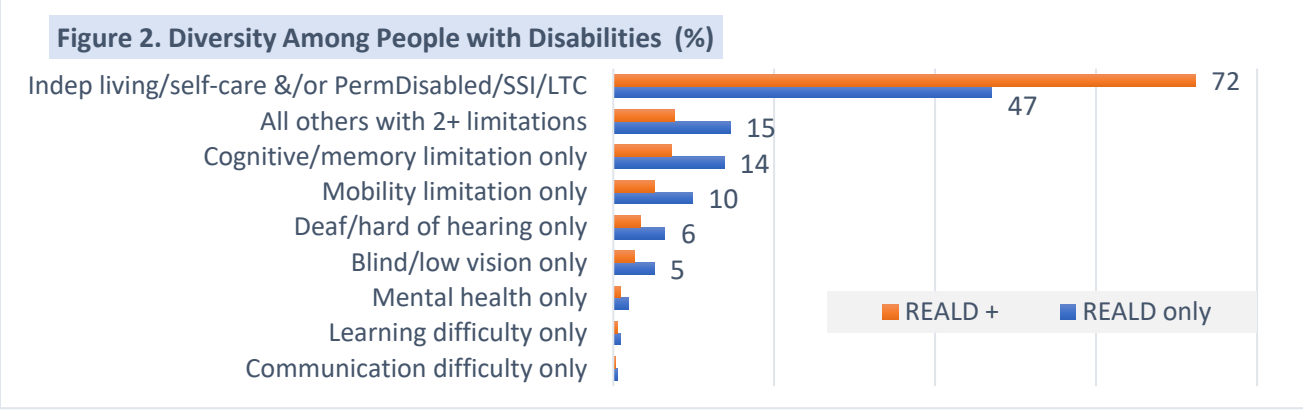
REALD Disability Questions, Data Quality & Usages within OHA

The disability questions[1] in REALD (race/ethnicity, language, and disability) are based on functional limitations which are better suited to identity people with disabilities. Six of the nine disability questions are used by the Census, and two are derived from the UN Washington Group. The ninth question, about mental health, was developed in collaboration with local and national known experts on disability research in 2020. Each disability question has a follow-up question asking about age when the condition began. These questions allow us to discern differences in potential social, educational and health inequities among people with disabilities by when the disability or limitation was first acquired.



OHA is committed to improving data collection and data quality. We have improved data quality by utilizing other related disability information[2] (denoted by "REALD +" in the figures below), and by developing the Initial Repository in the Equity & Inclusion Division. The Repository is designed to maximize data completeness and accuracy for all REALD & SOGI data elements. Currently the Repository leverages REALD & SOGI data collected from case investigators and providers who ordered COVID-19 testing for their patients (per HB 4212), as well as the REALD and gender identity data in the ONE system.

Figure 2 (below) reveals the diversity among people with disabilities.[3] Over time, a combination of responses to these newer questions may help us to better identify people with intellectual and developmental disabilities, and those with severe and persistent mental health disabilities.



[1] See here for an at-a-glance view of the disability questions (page 2).

[2] Affirmative responses to three additional questions are used to impute if REALD disability questions are incomplete; these include a question about permanent disability, receiving Social Security Insurance, and receiving Long Term Care services.

[3] Note that the numbers for three of the disability questions are likely smaller (learning, communication, mental health) as these were added in 2020 in several Public Health data systems, and in April 2022 in the ONE system.

For examples of how OHA reports disability data, and the relevance to policy, see:

- Healthier Oregon Report. Jan 2023. https://tinyurl.com/HealthierOregonReport
- Mpox Dashboard (Demographics). https://tinyurl.com/OHAMpoxDashboard

There are plans to incorporate disability in the CCO Performance Metrics dashboard this year as well.

On April 4th, the REALD & SOGI Unit in OHA's Equity & Inclusion Division launched their first three-day REALD & SOGI Data Analytic Institute with the goal of increasing capacity among OHA & ODHS analyst to better use REALD & SOGI data to identity and address inequities.

Together with training and technical assistance on implementation internally and with providers, development of enterprise-standards for REALD & SOGI, and a focus on building internal capacity, we aim to support data equity so that communities can do data justice. For more information about REALD & SOGI, please OHA's REALD & SOGI Website at https://www.oregon.gov/oha/EI/Pages/Demographics.aspx.