Cross Agency Health Improvement Project

Progress and Outcome Measures Update 2013-2015

September 15, 2015

CONTENTS

Executive Summary 1

Part I: Progress from CAHIP Partners

Human Resources & Shared Services 1

DHS/Aging and People with Disabilities 2

DHS/ Child Welfare 4

DHS/Developmental Disabilities/Children Residential Programs 5

DHS/Self Sufficiency/SNAP Education 6

OHA/Addictions and Mental Health 7

OHA/ Medical Assistance Programs 8

OHA/Public Health Division 9

Part II: Outcome Measures

Cigarette Smoking and Obesity by Race/Ethnicity 12

Cigarette Smoking and Obesity by Education 13

Cigarette Smoking and Obesity by Insurance Status 14

Cigarette Smoking and Obesity by Disability Status 15

Smoking During Pregnancy by Mother's Primary Race/Ethnicity 16

Quit Line Participants by Education, Race/Ethnicity, Disablity Status 17

Tobacco Use, Obesity Among DHS-OHA Employees 18

Lactation Accommodations for All State Employees 19

CAHIP Alignment with DHS-OHA Key Performance Measures 20

Cigarette Consumption: Packs Purchased Per Year 21

Appendix

Evaluation Framework: Cross Agency Health Improvement Project 22

EXECUTIVE SUMMARY

When the State of Oregon makes a decision that affects the people it serves or its workforce, it's a game-changer for all Oregonians. The Cross Agency Health Improvement Project (CAHIP) is an initiative of the Department of Human Services (DHS) and the Oregon Health Authority (OHA) to improve the health of clients, consumers and employees. Together, OHA and DHS serve 1.4 million Oregonians each year, employ over 11,000 people and have a statewide presence with facilities in every county in Oregon. As a result, CAHIP is poised to have a large statewide impact.

This report provides an overview of CAHIP and presents results on progress in achieving outcomes.

OHA and DHS addressing health equity

Tobacco use remains the top preventable cause of death and disease in Oregon; the second leading cause is obesity, with poor nutrition and physical inactivity being associated risk factors. Tobacco and obesity disproportionally affect some Oregonians more than others. Oregonians who receive state-funded services tend to experience health inequities – unfair and avoidable differences in health status. Factors that are linked with health inequity include: lower incomes, less education, minority race or ethnicity, sexual orientation, disability, mental illness and substance use disorders.

CAHIP is one way OHA and DHS are working together to address health equity by focusing on tobacco-free living, and improved nutrition and physical activity for clients, consumers and employees. CAHIP achieves outcomes through adopting policy, procedural and systems changes with DHS programs and OHA divisions.

The Cross-Agency Health Improvement Model

Collective impact: CAHIP is a unique partnership between programs and divisions across DHS and OHA, working to implement culturally and linguistically appropriate policies and programs that promote health and wellness.

Statewide reach: CAHIP's work touches DHS and OHA's numerous facilities, which are both worksites and public-facing sites for services. These strategies offer critical support to clients, consumers and employees.

Building from success: CAHIP is derived from the Tobacco Control Integration Project, a partnership from 2010 to 2012 with OHA's Tobacco Prevention and Education Program and DHS-OHA programs to reduce tobacco use and exposure among Oregonians, particularly those with fewer resources.

Leadership: CAHIP is guided by a steering committee of leaders from across DHS and OHA. CAHIP is convened by the Director of OHA's Public Health Division and is staffed by the Health Promotion and Chronic Disease Prevention Section. The steering committee adopts a work plan using data to prioritize objectives that support better health outcomes for DHS and OHA clients, consumers and employees. The work plan is implemented by DHS programs and OHA divisions with project management, technical assistance and staff support from the Public Health Division.

From 2013 to 2015, CAHIP Steering Committee members included:

- DHS Aging & People with Disabilities
- DHS Child Welfare
- DHS Developmental Disabilities
- DHS Office of Equity and Multicultural Services
- DHS Self Sufficiency
- OHA Addictions and Mental Health (as of July 2015, now part of the OHA Health Systems Division)
- OHA Medical Assistance Programs (as of July 2015, now part of the OHA Health Systems Division)
- OHA Office of Equity and Inclusion
- OHA Oregon State Hospital
- OHA Public Health Division
- OHA/DHS Human Resources & Shared Services
- Public Employees' Benefit Board
- Service Employees International Union

CAHIP VISION

All Oregonians – including OHA and DHS clients, consumers and employees – have the opportunity to take care of themselves by eating well, staying active and living tobacco-free regardless of their income, education, job title, race, ethnicity, sexual orientation, physical ability, mental health or substance use status.

Report Overview

Part I: Progress from CAHIP Partners provides a status update of key objectives, describes how each partner achieved progress in completing work plan objectives and lists barriers, if relevant.

There were several key successes in the 2013-15 partnership, highlighted below. These successes are a result of the coordinated infrastructure of the CAHIP using data, evidence-based strategies and collaboration.

- **Leadership:** Leaders have implemented evidence-based and culturally appropriate health and wellness initiatives for clients, consumers and employees.

- **Policy development and evaluation:** Shared Services supported and led the adoption of the Employee Wellness Policy which grants DHS and OHA employees two hours per month of paid work time to participate in wellness committees and develop plans. The Public Health Division evaluated implementation of the division's healthy meetings and events guidelines, demonstrating ease of implementation and broad support among meeting planners and participants.

- **Training:** Addictions and Mental Health provided technical assistance and support for optimal implementation of the Tobacco Freedom Policy in residential treatment facilities.

- **Health promotion:** Child Welfare and SNAP Education promoted culturally and linguistically appropriate tobacco cessation services to clients.

- **Data collection:** Medical Assistance Programs and the Public Health Division partnered to implement a Coordinated Care Organization cessation survey, resulting in baseline data for CCOs that will be used to inform improved tobacco cessation benefit options and the new tobacco prevalence incentive metric.

Part II: Outcome Measures are used to track health outcomes to which CAHIP activities contribute. The tables below provide an overview of CAHIP's outcome measures and alignment with DHS and OHA Key Performance Measures. CAHIP focuses on outcomes that have been prioritized in Public Health Division strategic planning and already exist within established state-level surveillance systems that track health outcomes and risk behaviors of Oregon adults.

CAHIP Outcome Measures for Target Populations		
	Tobacco	**Obesity**
Clients and consumers	Current cigarette smoking by: • Race and ethnicity • Education • Insurance status • Disability status Quit Line participants by: • Race and ethnicity • Education level	Obesity by: • Race and ethnicity • Education • Insurance status • Disability status
Employees	Current cigarette smoking by: • OHA-DHS employees • Education	Obesity by: • OHA-DHS employees • Education level Breastfeeding support: • Lactation accommodations

CAHIP Alignment with OHA-DHS Key Performance Measures (KPMs)		
OHA KPMs	Medicaid KPMs • Access to care • Member of health status • Rate of tobacco use • Rate of obesity	Population KPMs • Rate of tobacco use • Rate of obesity Cigarette consumption • Packs purchased per year
DHS KPMs	• Supplemental Nutrition Assistance Program (SNAP) utilization • Service equity	

Thousands of Oregonians have benefited from the work of CAHIP. This reports highlights CAHIP's positive contribution to the well-being of Oregon's most vulnerable populations and public employees. Significantly, CAHIP demonstrated the importance of shared and agreed upon measures and reinforcing activities to achieve improved health outcomes.

Contact Information:

Kirsten Aird, MPH
Chronic Disease Programs Manager
OHA – Public Health Division
Email: kirsten.g.aird@state.or.us

Beth Sanders, MPH
Health Equity Systems Coordinator
OHA – Public Health Division
Email: elizabeth.c.sanders@state.or.us

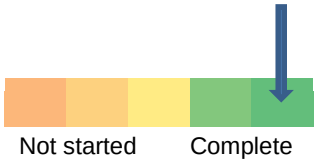
Part I:

Progress from CAHIP Partners

Human Resources & Shared Services

Key Partners: Jeremy Emerson, Jeff Akin, Tracy Garcia, Robert Salinas
CAHIP Staff: Beth Sanders, Kirsten Aird, Rebecca Pawlak

Tobacco & Obesity (Objective 1): *Pilot the Employee Wellness Policy at the Cherry Avenue building (Office of Payment Accuracy and Recovery, Background Check Unit, and Licensing & Regulatory Oversight) and at one DHS field service center.*



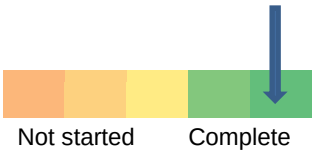
✓**Objective met:** In Summer 2014, the Policy, which allows employees to participate in worksite wellness committees during work time, was successfully piloted at the Cherry Avenue building in Salem. In Fall 2014, Shared Services and CAHIP staff presented results from the pilot project and a set supportive materials for optimal policy implementation to the Joint Policy Committee as well as the DHS OHA Operations Executive Committees. In March 2015, the Policy was announced by DHS and OHA executive leadership.

Work Plan Outputs

- Employee Wellness Policy launched by DHS and OHA
- One (1) intranet site available for employees to access resources that support implementation of wellness committees
- One (1) online registration and tracking system for wellness committees operating in DHS and OHA

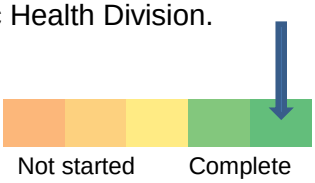
DHS/Aging and People with Disabilities

Key Partners: Donald Erickson, Nakeshia Knight-Coyle, Jennifer Mead
CAHIP Staff: Beth Sanders, Kirsten Aird



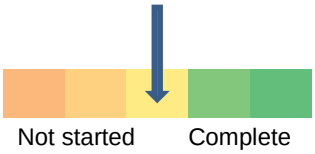
Self-Management (Objective 1a): *Partner with the State Unit on Aging (SUA) to promote use of evidence-based self-management programs by Oregon's 17 Area Agencies on Aging (AAAs), and to list available programs on the Aging and Disability Resource Connection (ADRC) of Oregon website.*

✓**Objective met:** The Public Health Division's Health Promotion and Chronic Disease Prevention Section (HPCDP) and the SUA continued to partner on a federal Administration for Community Living grant supporting chronic disease self-management education that ends in Fall 2015. Four of the five Sustainable Relationships for Community Health grants have AAAs as part of the consortium working to deliver *Living Well with Chronic Conditions* Programs. The Oregon Legislature has allocated funding for Oregon's AAAs to support evidence-based health promotion programs for older adults; many of the programs being offered by AAAs are also programs supported by the Public Health Division.



Self-Management (Objective 1b): *Ensure ongoing communication between the Public Health Division and SUA to continue to identify ways to increase self-management outreach to older adults and people with disabilities.*

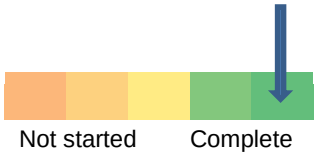
✓**Objective met:** The Public Health Division added an objective addressing healthy aging to its strategic plan to improve the quality of life and increase years of healthy life for all Oregonians. HPDCP also received funding to coordinate planning efforts around healthy aging and brain health through September 2015. The SUA continues a long-standing partnership with HPCDP in co-housing a SUA staff member within HPCDP.



Obesity (Objective 2): *Identify opportunities for systems and policy approaches to improve federal and state funded older adult nutrition programs in Oregon.*

✓**Objective not met:** The SUA does not currently have a dedicated staff person to address older adult nutrition programs PHD and SUA continue to consider opportunities to collaborate on healthy eating for older adult programs and settings.

Tobacco (Objective 3): *By July 1, 2015, culturally and linguistically appropriate tobacco cessation resources and access such as the Oregon Quit Line will be available to older adults and people with disabilities.*



✓**Objective met:** The Quit Line is listed as a resource on the statewide ADRC website. This is linked to culturally and linguistically appropriate services available for older adults and people with disabilities.

Work Plan Outputs

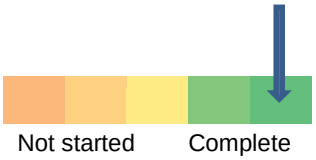
- 150 community organizations across Oregon offer *Living Well with Chronic Conditions* and *Walk with Ease* programs to older adults and people with disabilities
- One (1) partnership between SUA and HPCDP to support chronic disease self-management education and other evidence-based self-management programs
- One (1) partnership between the SUA, PHD, and the Alzheimer's Association to communicate the link between heart and brain health
- One (1) statewide ADRC website, which features culturally and linguistically appropriate Quit Line information

DHS/ Child Welfare

Key Partners: Jason Walling
CAHIP Staff: Beth Sanders, Jennifer Young, Kirsten Aird

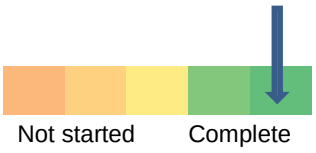
Work Plan Progress

Tobacco (Objective 1): *By July 1, 2015, culturally and linguistically appropriate Oregon Quit Line materials will be readily available at stand-alone Child Welfare offices.*



✓**Objective met:** In February 2014, CAHIP and Child Welfare/Self Sufficiency Operations staff worked together to disseminate a memo to Children and Families (CAF) district offices introducing local staff to local public health partners in their area who can share Quit Line materials and support tobacco-free initiatives. By September 2014, 70% of local public health partners indicated in a survey that they had contacted CAF district offices to offer Quit Line materials. There is still work to be done to ensure that Quit Line materials are available in youth shelters.

Tobacco (Objective 2): *Starting June 30, 2013, investigate including contract language for smoke-free housing in those instances where Child Welfare has housing inclusive contracts.*



✓**Objective met:** All housing is already tobacco-free, but contracts do not necessarily include tobacco-free language.

Work Plan Outputs

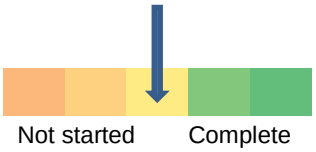
- One (1) survey distributed to local public health partners to check on the status of contact with CAF district offices
- 70% of CAF district offices and local public health partners developed a relationship to provide Quit Line resources to Child Welfare clients

DHS/Developmental Disabilities/Children Residential Programs__

Key Partners: Debbi Kraus-Dorn
CAHIP Staff: Beth Sanders, Kirsten Aird, Jennifer Young

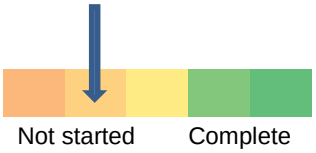
Work Plan Progress

Tobacco (Objective 1): *By July 1, 2015, place a culturally and linguistically appropriate hyperlink for the Oregon Quit Line on the website of all the ODDS children's group home agencies.*



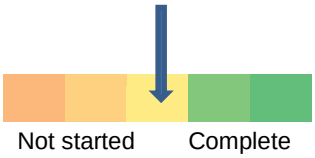
✓**Objective partially met:** A survey inquiring about the status of promoting the Quit Line and healthy eating opportunities was disseminated to ten children's developmental disability group home agencies. Half (5) of the agencies responded to the survey. Of the five, one agency had placed a Quit Line hyperlink on their website. Respondents provided feedback that an e-mail with instructions on how to place a hyperlink on the website would help them meet this goal.

Tobacco (Objective 2): *By July 1, 2015, include a culturally and linguistically appropriate web link to the Oregon Quit Line on staff newsletters.*



✓**Objective not met:** A web link to the Quit Line was not added to staff newsletters because the agencies needed a template. To overcome this barrier, a brief narrative on the Quit Line will be written by CAHIP staff that will be shared with all agencies.

Obesity (Objective 3): *By July 1, 2015, establish a protocol to include physical activity opportunities and healthy foods for both children and staff at all state licensed ODDS children group homes.*



✓**Objective partially met:** Physical activity and nutrition are typically addressed in individual treatment plans. The survey results indicate that there is a broad array of nutrition and physical education opportunities in which group home staff and residents participate. These include: gym memberships, community gardens, safety and wellness committees, and play equipment on site.

Work Plan Outputs

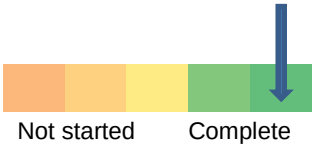
- One (1) survey disseminated to children group home providers to assess nutrition practices
- One (1) presentation delivered to children group home providers on survey results and information on CAHIP
- One (1) Quit Line link placed on a Developmental Disabilities agency website

DHS/Self Sufficiency/SNAP Education

Key Partners: Belit Burke, Heather Miles (Self Sufficiency) and Sally Bowman (SNAP-Education)
CAHIP Staff: Beth Sanders, Jennifer Young, Kirsten Aird

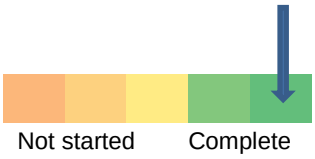
Work Plan Progress

Tobacco (Objective 1): *By July 1, 2015, establish a protocol whereby the SNAP Education Program promotes the Oregon Tobacco Quit Line.*



✓**Objective met:** A protocol was developed where local public health partners and SNAP Education coordinators work together to promote the Oregon Tobacco Quit Line to SNAP clients. 70% of local public health partners had connected with SNAP Education coordinators to promote the Quit Line. Quit Line materials have been placed at OSU Extension and DHS Self Sufficiency offices for clients.

Obesity (Objective 2): *By July 1, 2015, include culturally and linguistically appropriate SNAP Education Program information in the resources provided to CCOs to assist them in being successful in addressing their target areas related to decreasing obesity among Oregon Health Plan members.*



✓**Objective met:** Self Sufficiency staff placed information about a Childhood Food Insecurity course and the *Food Hero* social marketing campaign in the November 2013 Quality Health Outcomes Committee (QHOC) newsletter. Materials in languages other than English that are culturally appropriate have been distributed to health care settings. Agencies may provide this information to CCOs.

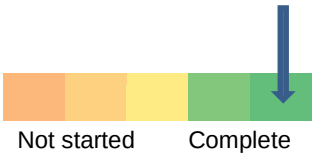
Work Plan Outputs

- One (1) survey distributed to local public health partners to check on the status of contact with local SNAP Education coordinators.
- 70% of Local SNAP Education coordinators and local public health partners developed a relationship to provide Quit Line resources to SNAP clients.
- Information on food insecurity was included in one (1) QHOC newsletter in 2013

OHA/Addictions and Mental Health

Key Partners: Karen Wheeler, Justin Hopkins, Barrett Crosby
CAHIP Staff: Beth Sanders, Kirsten Aird, Scott Montegna

Work Plan Progress



Tobacco (Objective 1): *By July 1, 2013, all licensed and funded AMH residential treatment facilities will have implemented the Tobacco Freedom policy in their campus.*

✓**Objective met:** In Summer of 2014, AMH and CAHIP staff partnered to disseminate a survey to evaluate implementation of the Tobacco Freedom Policy, which prohibits tobacco use in all residential treatment facilities.

- In Spring 2015, PHD and AMH collaborated to offer trainings to residential facility providers on tobacco-free policy fundamentals and techniques to incorporate tobacco cessation into treatment practices.
- PHD's Health Promotion and Chronic Disease Prevention Section and AMH are continuing to explore possibilities of bulk shipments of Nicotine Replacement Therapy (NRT) directly to AMH residential facilities.
- 70% of local public health partners have connected with their local residential treatment facilities to support implementation of the Tobacco Freedom Policy. They have provided technical assistance, delivered presentations to behavioral health stakeholders, provided tobacco-free campus signage, and shared information about tobacco dependence treatment and the Quit Line.

Work Plan Outputs

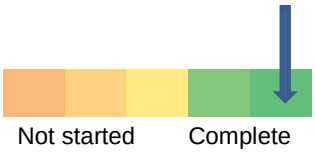
- One (1) survey disseminated to residential treatment facilities to evaluate implementation of the Tobacco Freedom Policy
- One (1) report created discussing survey results and implications for future work
- Four (4) tobacco policy and cessation trainings to residential treatment facility providers

OHA/ Medical Assistance Programs

Key Partners: Rhonda Busek
CAHIP Staff: Beth Sanders, Kirsten Aird, Scott Montegna

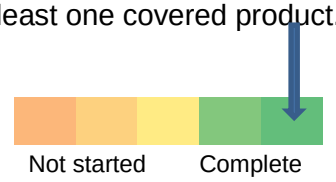
2013-2015 Work Plan Progress:

Tobacco (Objective 1): *By July 1, 2015, promote culturally appropriate best practices to reduce tobacco use among the OHP population within CCOs.*



✓**Objective met:** In 2014, in partnership with OHA's Medical Assistance Programs (MAP) and the Transformation Center, the Public Health Division (PHD) conducted an assessment of culturally relevant best-practices and tobacco cessation benefits offered by CCOs. The survey found that tobacco cessation benefits vary by CCO: 14 of 16 CCOs cover all three types of counseling- telephone, individual and group; nine of 16 CCOs provide coverage for all seven FDA-approved tobacco cessation medications; and all CCOs currently require a prior authorization for at least one covered product.

Obesity (Objective 2): *By July 1, 2015, promote culturally appropriate best practices to improve nutrition and increase physical activity of OHP clients within CCOs.*



✓**Objective met:** MAP collaborated with PHD on the Innovations in Childhood Obesity Learning Collaborative supported by Center for Healthcare Strategies and Kaiser Permanente Community Benefit.

Work Plan Outputs

Tobacco:

- One (1) tobacco cessation benefits survey distributed to all CCOs
- One (1) tobacco cessation benefits report developed and published on OHA website
- One (1) presentation delivered to QHOC committee in February 2015 that presented the report and discussed strategies CCOs can take with contracted providers to reduce tobacco use
- Five (5) CCO community health improvement plans included goals around addressing tobacco use

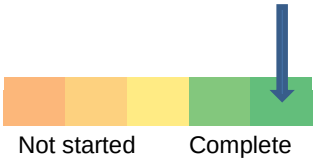
Obesity:

- One (1) survey conducted to assess CCO nutrition-related interventions with members
- Eight (8) CCO community health improvement plans included goals around addressing obesity and nutrition

OHA/Public Health Division

Key Partners: Jennifer Woodward, Health Statistics; Tawana Nichols, Medical Marijuana; Cate Wilcox, Lari Peterson, Fran Goodrich, MCH; Veda Latin-Green, HIV, STD & TB; Sue Woodbury, WIC
CAHIP Staff: Beth Sanders, Kirsten Aird, Rebecca Pawlak

Work Plan Progress

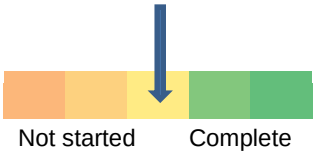


Tobacco (Objective 1): *By July 1, 2015, promote the Oregon Quit Line and integrate the Quit Line fax referral process into established systems, protocols and procedures at clients' point of service areas for the following programs: Babies First, HIV, STD &TB, Maternity Case Management, Medical Marijuana, Oral Health, Vital Records, and WIC.*

✓**Objective met:** All of the above programs meet on an ongoing basis to identify opportunities for PHD programs to support tobacco-free living.

Tobacco related protocols include:

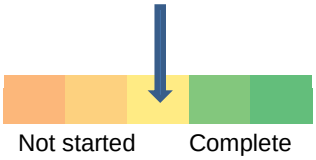
- Vital Records has Quit Line brochures in its lobby.
- The CAREAssist program's 6-month eligibility form includes a question on interest in tobacco cessation. If a client replies "yes", they were reached with information by 30 days. Clients can go to a pharmacy to get Nicotine Replacement Therapy funded by CAREAssist.
- Babies First! has a protocol to refer clients to the Quit Line with some education and outreach on tobacco use. Work is underway with tribal clinics to systematize fax referrals to the Quit Line.
- Home Visiting programs include questions on tobacco use.
- Oregon Mother'sCare program has screening and referral (5A's) embedded in their services.
- Medical Marijuana program included Quit Line fliers in re-enrollment mailers.
- WIC embedded screening questions for tobacco use and secondhand smoke and Quit Line referral prompts into standard intake forms.



Tobacco (Objective 2): *By July 1, 2015, leadership (Director, Section Managers, PSM, etc.) for the Center for Prevention and Health Promotion will consider adoption of guidelines that allow vendors and contractors doing business with the Center to received bonus points for having a tobacco-free campus for their employees.*

✓**Objective not met:** An assessment of PHD contracts from 2011-2015 found that only HPCDP RFPs and contracts included language that directs contractors to support and maintain tobacco-free facilities and promote cessation benefits for employees. As a next step, CAHIP staff plan to partner with the Office of Contracts and Procurement (OC&P) to identify strategies for OC&P staff to routinely ensure that PHD programs include tobacco-free language in Requests for Proposals and contracts.

Obesity (Objective 3): *By July 1, 2015, the PHD's Healthy Meetings and Events guidelines will be revised to include provisions for ensuring lactation accommodation at PHD-sponsored meetings*



✓**Objective partially met:** Staff from WIC, Maternal and Child Health (MCH) and the Health Promotion and Chronic Disease Prevention Section collaborated to develop and implement strategies that support lactation accommodations throughout OHA and DHS. Shared Services is the lead for revising the DHS-OHA's lactation policy. The goal is to update the policy and revise intranet guidance by December 2015.

Work Plan Outputs

- One (1) ongoing collaboration among PHD programs to promote tobacco-free living and lactation accommodations for clients and employees
- Four thousand (4,000) Quit Line flyers were disseminated to Medical Marijuana program clients in re-enrollment packets
- Five hundred (500) Quit Line brochures were available for members of the public visiting the PSOB 2nd floor lobby
- MCH disseminated QR codes for clients to access one (1) pregnancy and newborn resource guide that features Quit Line information

Part II:

Outcome Measures

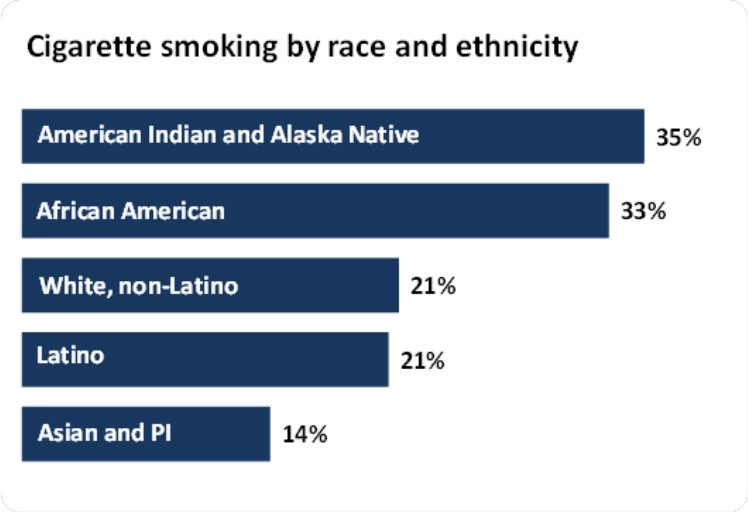
Outcome Measures for Clients and Consumers

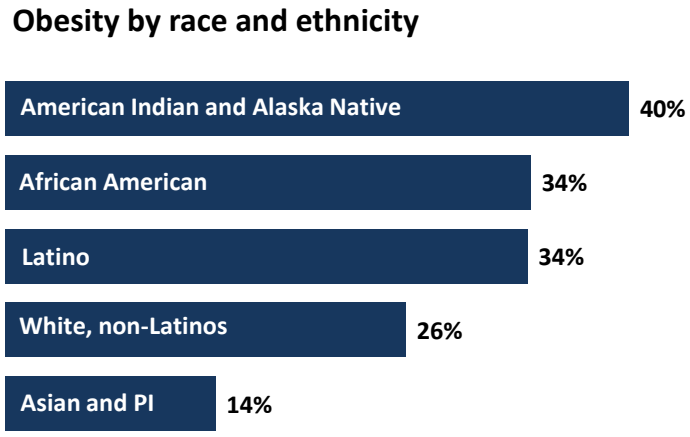
CAHIP's efforts target tobacco and obesity prevention strategies toward clients and consumers of OHA and DHS. The following measures look at cigarette smoking and obesity by race and ethnicity, education, insurance status and disability status.

Cigarette smoking and obesity by race and ethnicity

Source: 2010-2011 BRFSS Race Oversample. Estimates are age-adjusted.
Note: No current data is currently available for comparison over time.

Compared to White non-Latino Oregonians, **American Indians and Alaska Natives** and **African Americans** have a higher obesity and cigarette smoking prevalence, while **Latinos** have a higher prevalence of obesity. **Asians and Pacific Islanders** may experience lower smoking and obesity rates compared to white non-Latinos. Cigarette smoking and obesity among American Indians and Alaska Natives are 67% and 54% higher than White, non-Latinos, respectively.

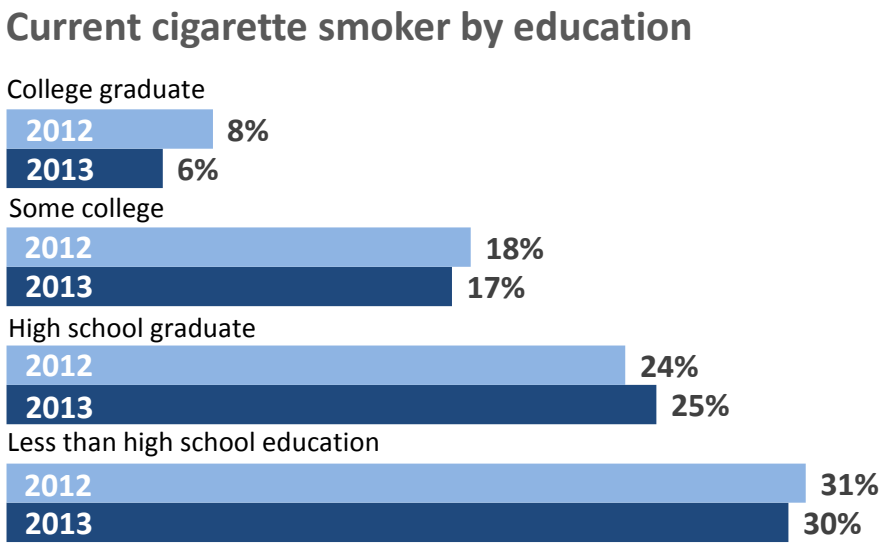


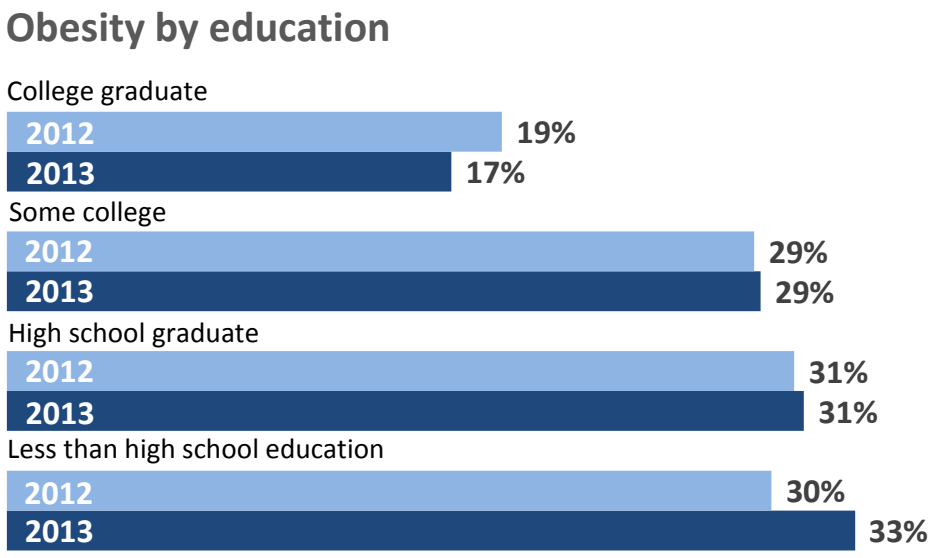


Cigarette smoking and obesity by education

Source: 2012 and 2013 BRFSS. Estimates are age-adjusted.
Note: 2014 data is not yet available for comparison.

Compared to college graduates, the cigarette smoking prevalence among adults with a high school degree is three times higher; and nearly four times higher for adults with less than a high school education.



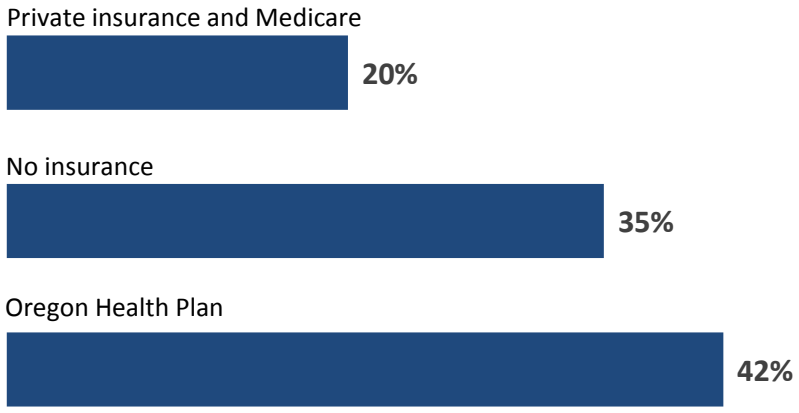


Cigarette smoking and obesity by insurance status

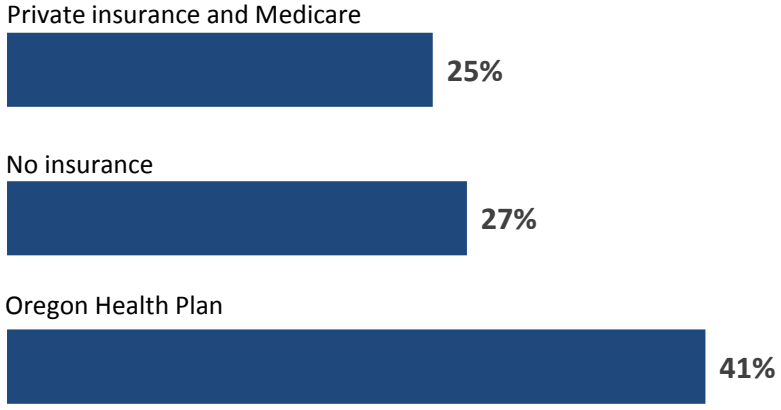
Source: 2012 BRFSS. Estimates are age-adjusted.
Note: 2013 and 2014 data are not yet available for comparison.

Obesity and tobacco use among OHP members is higher compared to Oregonians with private insurance or no insurance at all. Tobacco use among OHP members is more than double that of Oregon adults with private insurance; and obesity is 64% higher.

Current cigarette smoking by insurance status in 2012



Obesity by insurance status in 2012

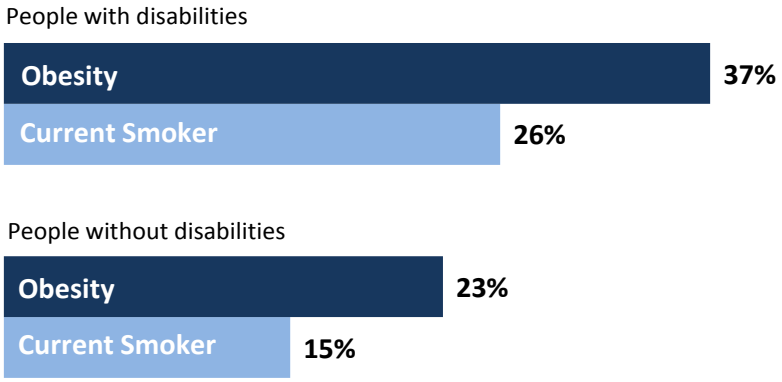


Cigarette smoking and obesity by disability status

Source: 2012 and 2013 BRFSS. Estimates are age-adjusted.
Note: 2014 data is not yet available for comparison.

Oregon **adults with disabilities** have a higher prevalence of obesity and cigarette smoking compared to adults without disabilities. Over 1 in 3 adults with disabilities are obese and 1 in 4 smoke cigarettes. People with a disability state that they are either limited in any way in any activity because of a physical, mental or emotional condition or currently have any health condition that requires use a special equipment.

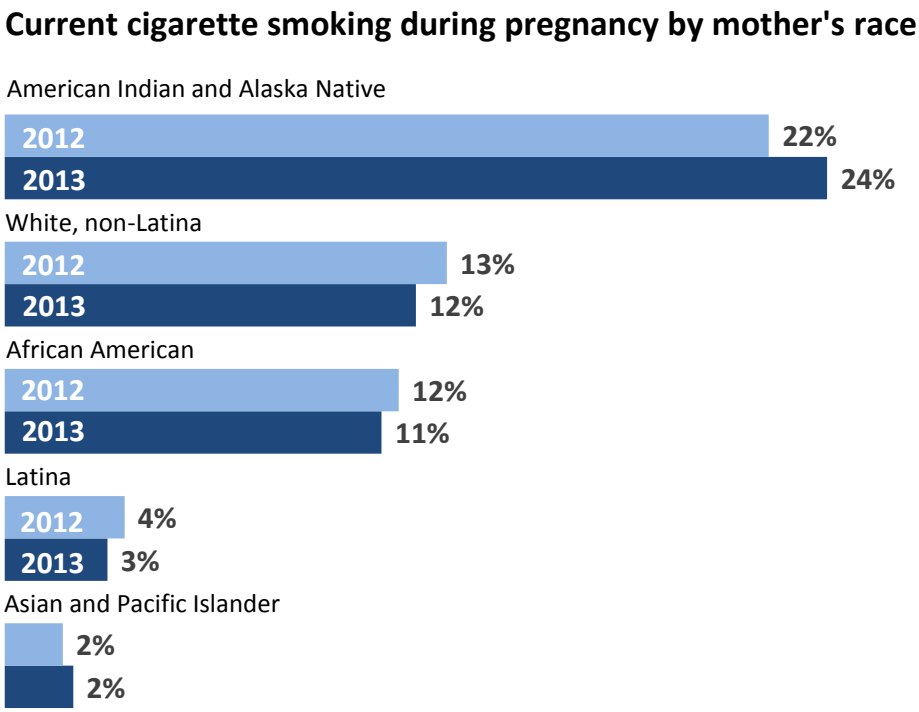
Obesity and current smoking among people with and without disabilities



Smoking during pregnancy by mother's primary race/ethnicity

Source: 2012 and 2013 Oregon birth certificates
Note: 2014 data is not yet available for comparison.

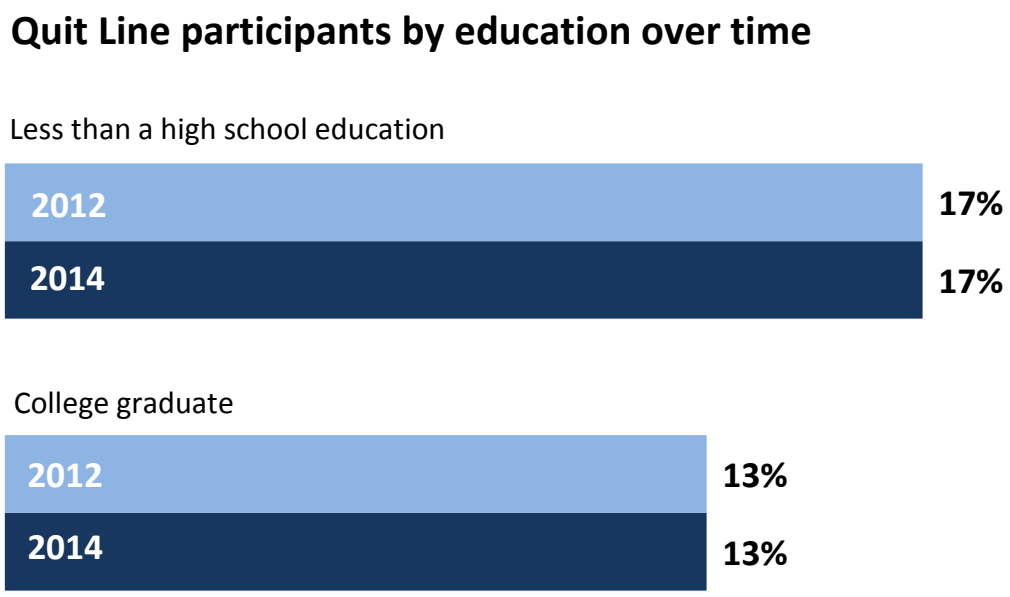
Compared to White non-Latina mothers who smoke during pregnancy, American Indians and Alaska Natives have a 73 percent higher prevalence; African Americans have an 11 percent lower prevalence; Latinas have a 73 percent lower prevalence; and Asian and Pacific Islanders may have an 87 percent lower prevalence.



Quit Line participants by education, race and ethnicity, disability status

Source: 2012 & 2014 Oregon Tobacco Quit Line data

Between 2012 and 2014, the proportion of Quit Line participants who had **less than a high school education** as well as those with a college degree remained relatively unchanged. In 2014, 37 percent of Quit Line callers reported having a **physical limitation**. From 2012 to 2014, the **racial and ethnic** composition of Quit Line callers remained relatively unchanged. In 2014, 88 percent of Quit Line callers identified as white, non-Latino.



Outcome Measures for OHA-DHS Employees

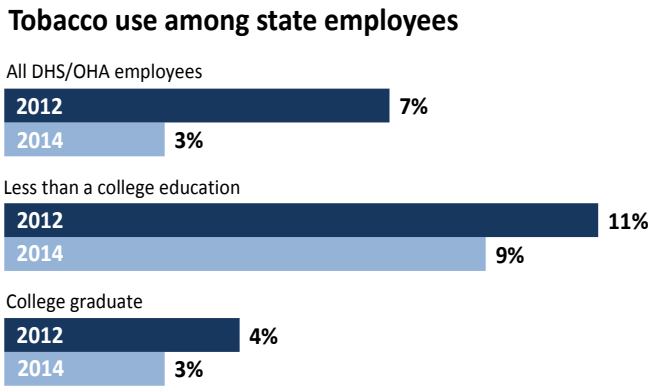
CAHIP's efforts target tobacco and obesity prevention strategies toward employees of OHA and DHS. The following measures look at cigarette smoking and obesity by race and ethnicity, education, insurance status and disability status.

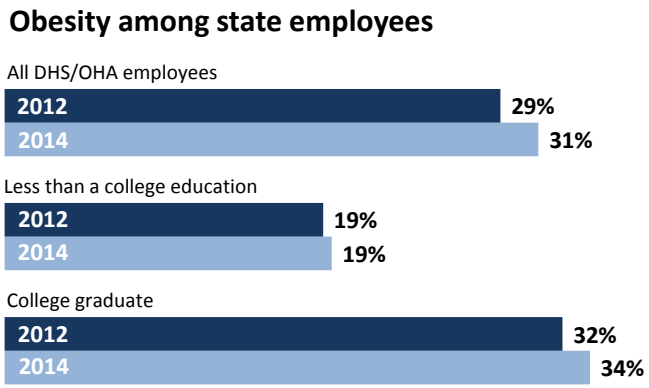
Cigarette smoking, obesity among OHA-DHS employees

Source: 2012 & 2014 BRFSS Survey of State Employees. Estimates are age-adjusted.
Notes: These numbers may be statistically unreliable and should be interpreted with caution. Data includes cigarettes and chew only.

Between 2012 and 2014, tobacco use more than doubled and obesity decreased by seven percent among state employees who work for OHA and DHS. In general, there are large health disparities within the state employee population based on education level. In 2012, tobacco use among adults with less than a college education was three times higher than adults who graduated college. In addition, obesity prevalence among adults with less than a college education was 79% higher than adults who are college graduates. These disparities in tobacco use and obesity were also observed in 2014, where tobacco use among adults with less than a college education was two-and-a-half times higher than college graduates, and obesity was 75% higher.

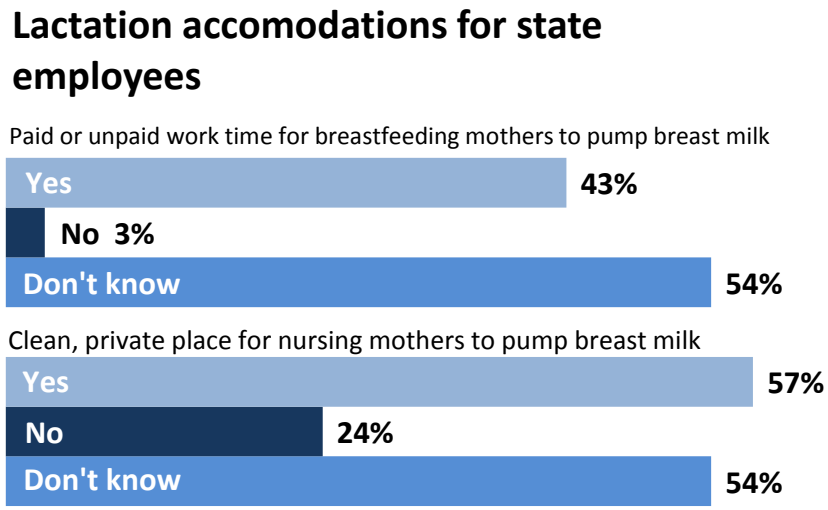
In 2014, fifty seven percent of all state employees reported that nursing mothers have a clean, private place to pump breast milk. Forty seven percent reported that nursing mothers have paid or unpaid work time for breastfeeding mothers to pump breast milk. Of note, a little more than half (54%) of state employees did not know if their worksite offered nursing mothers a clean, private place to pump breast milk or provided paid or unpaid work time to pump breast milk.





Lactation Accommodations (All state agency employees)

Note: This data was first collected in 2014, so there is no available 2012 data for comparison.



CAHIP alignment with OHA-DHS Key Performance Measures (KPMs)

The following data table includes Key Performance Measures (KPMs) developed by the Oregon Health Authority and the Department of Human Services (DHS). Performance measures are used to track program success over time. The KPMs below relate to long-term outcomes identified in the Evaluation Framework for the Cross Agency Health Improvement Project (see appendix), which are projected to be realized in 2019. The tables below highlight KPM data for the years 2011 through 2013; the 2011 data provide a baseline for the KPMs and represent health outcomes of interest prior to the implementation of CAHIP, while data for years 2012 and 2013 depict health outcomes of interest during CAHIP implementation. When interpreting the data below, it is important to consider the relatively short period of time in which the CAHIP work plan has been in effect. Due to this relatively short time frame, attribution of changes in KPMs to CAHIP activities should be made with caution. In the interim, it is more appropriate to measure CAHIP successes based on short term process outcomes listed for each partner in Section I.

Selected KPMs for the Oregon Health Authority & the Department of Human Services

KPM #	Description	2011	2012	2013
17	Access to care (Medicaid)	83%	-	83.6%
19	Member health status (Medicaid)	23%	-	29%
20	Rate of tobacco use (population)	22%	22%	-
21	Rate of tobacco use (Medicaid)	31%	-	34.1%
22	Rate of obesity (population)	27%	27%	-
23	Rate of obesity (Medicaid)	37%	41%	-
4	SNAP utilization	92.5%	96.4%	-
18	Service equity*			

*This placeholder measure will show whether clients of each reported race group is over-represented or under-represented compared to all clients served by DHS.

Tobacco use

Between 2011 and 2012, there was no change in the rate of tobacco use (OHA KPM #20) among the general adult population (#22); from 2011 to 2013, tobacco use among CCO enrollees increased by 10 percent (OHA KPM #21).

Obesity and nutrition

Between 2011 and 2012, there was no change in the rate of obesity among the general adult population (#22), yet there was an 11 percent increase in obesity prevalence among CCO enrollees (OHA KPM #23). Between 2011 and 2012, there was a four percent increase in the proportion of Oregonians eligible for Supplemental Nutrition Assistance Program (SNAP) who are accessing the program (DHS KPM #17).

Access to healthcare and overall health (Medicaid)

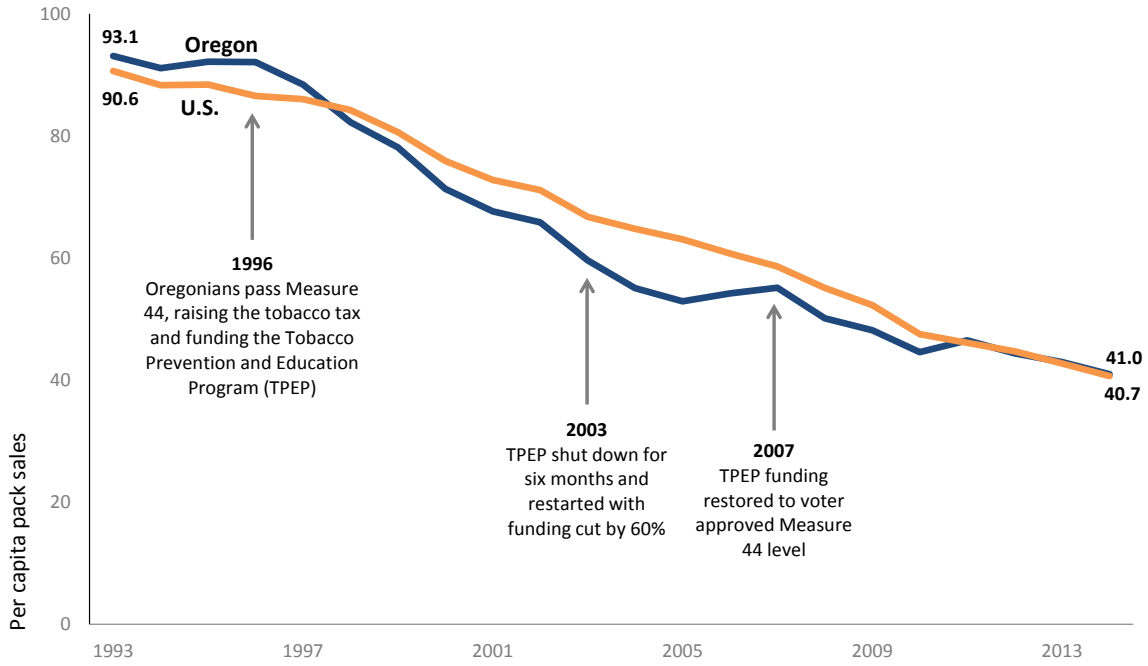
Between 2011 and 2013, less than one percent more Oregon Health Plan members said that they are getting care quickly (OHA KPM #17); and 26 percent more CAHPS survey respondents had a positive self-reported rating of overall health (OHA KPM #19).

Cigarette Consumption – Packs Purchased Per Year

Source: Orzechowski and Walker (2014). The Tax Burden on Tobacco.

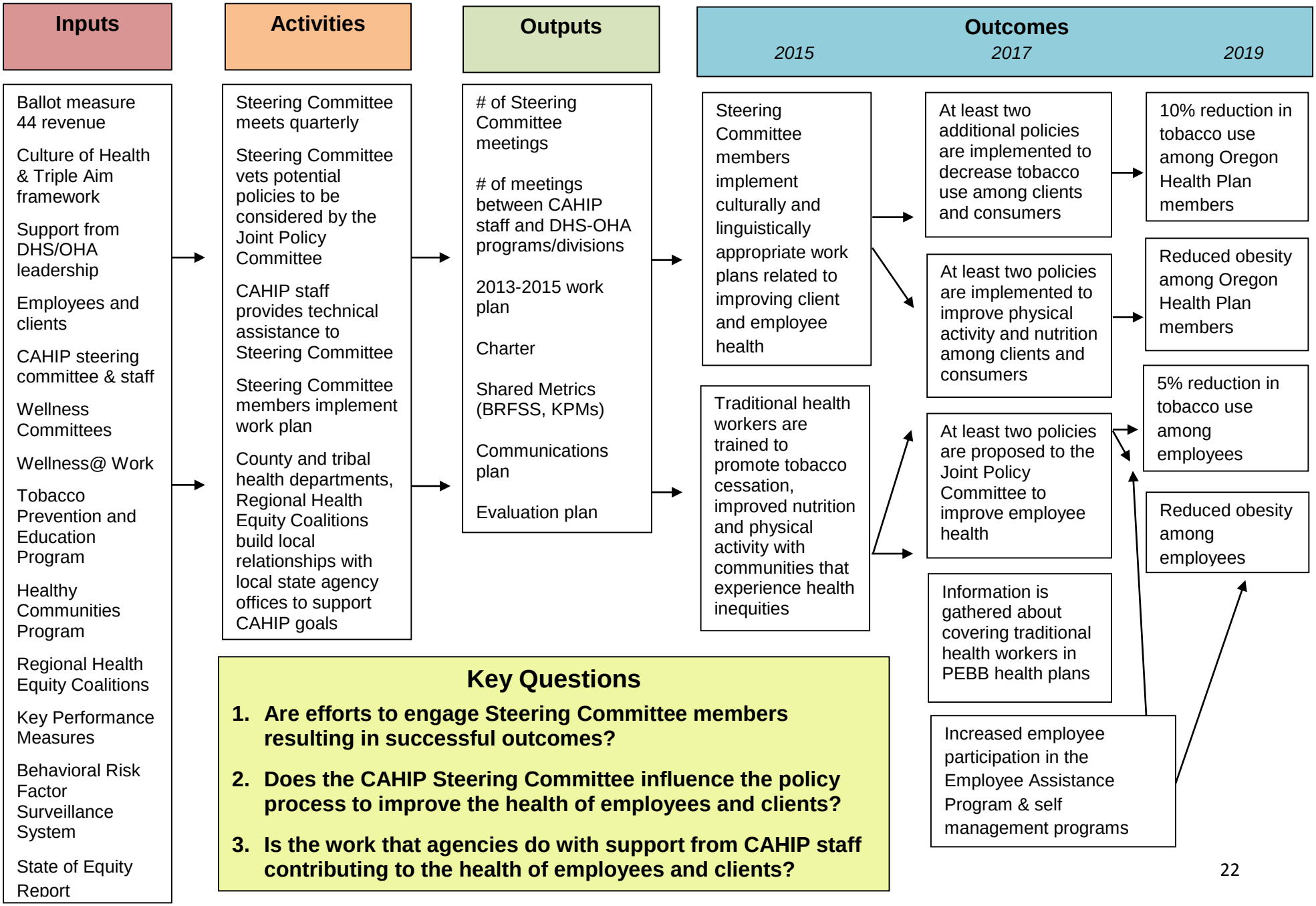
In addition to OHA and DHS Key Performance Measures, CAHIP tracks statewide cigarette consumption by packs purchased per year. Between fiscal years 2012 and 2014, population consumption of cigarettes among Oregonians decreased by eight percent. Figure 1 illustrates this outcome along with the overall decreasing trend of cigarette pack consumption since 1996 when Measure 44 passed, which raised the tobacco tax and funded the Tobacco Prevention and Education Program (TPEP). Since TPEP's inception, Oregon's population cigarette consumption has declined by 56 percent.

Figure 1: Per capita cigarette pack sales in Oregon and the United States, Fiscal Year 1993-2014



Source: Orzechowski and Walker (2014). The Tax Burden on Tobacco.

Appendix: Evaluation Framework for Cross Agency Health Improvement Project



Key Questions

1. **Are efforts to engage Steering Committee members resulting in successful outcomes?**
2. **Does the CAHIP Steering Committee influence the policy process to improve the health of employees and clients?**
3. **Is the work that agencies do with support from CAHIP staff contributing to the health of employees and clients?**