Oregon
Health
Authority

April 13, 2015

The Honorable Senator Richard Devlin, Co-Chair
The Honorable Representative Peter Buckley, Co-Chair
Joint Committee on Ways and Means
900 Court Street, NE
H-178 State Capitol
Salem, OR 97301

Re: Oregon Health Authority (OHA) update on Transformation Fund

Dear Co-Chairpersons:

NATURE OF THE REQUEST

The Oregon Health Authority (OHA) Transformation Center is responding to the HB 5030-A budget note, passed on June 28, 2013 (see Appendix A), related to the $30 million General Fund Health System Transformation Fund. This report is an update from a letter submitted January 24, 2014.

Summary:
The Health System Transformation Fund provides a strategic investment in 16 coordinated care organizations (CCOs) to engage in innovative projects that support better health, better health care and lower costs in their communities. A portion of the fund also leverages 90 percent federal funding to invest in statewide health information technology (HIT) to share and aggregate electronic health information.

CCOs have indicated that these funds are supporting innovative projects that would not have been possible otherwise. The funding has led to 120 projects that have impacted health care utilization, care integration, provider capacity and patient outcomes. Preliminary results show that projects are leading to outcomes such as decreased emergency room visits and greater access to primary care or prenatal care.

As requested in the budget note, this report includes:
- Distribution process details;
- The dollar amounts distributed, to whom, and for what purpose;
- Expected outcomes and outcome measures, with some preliminary results; and
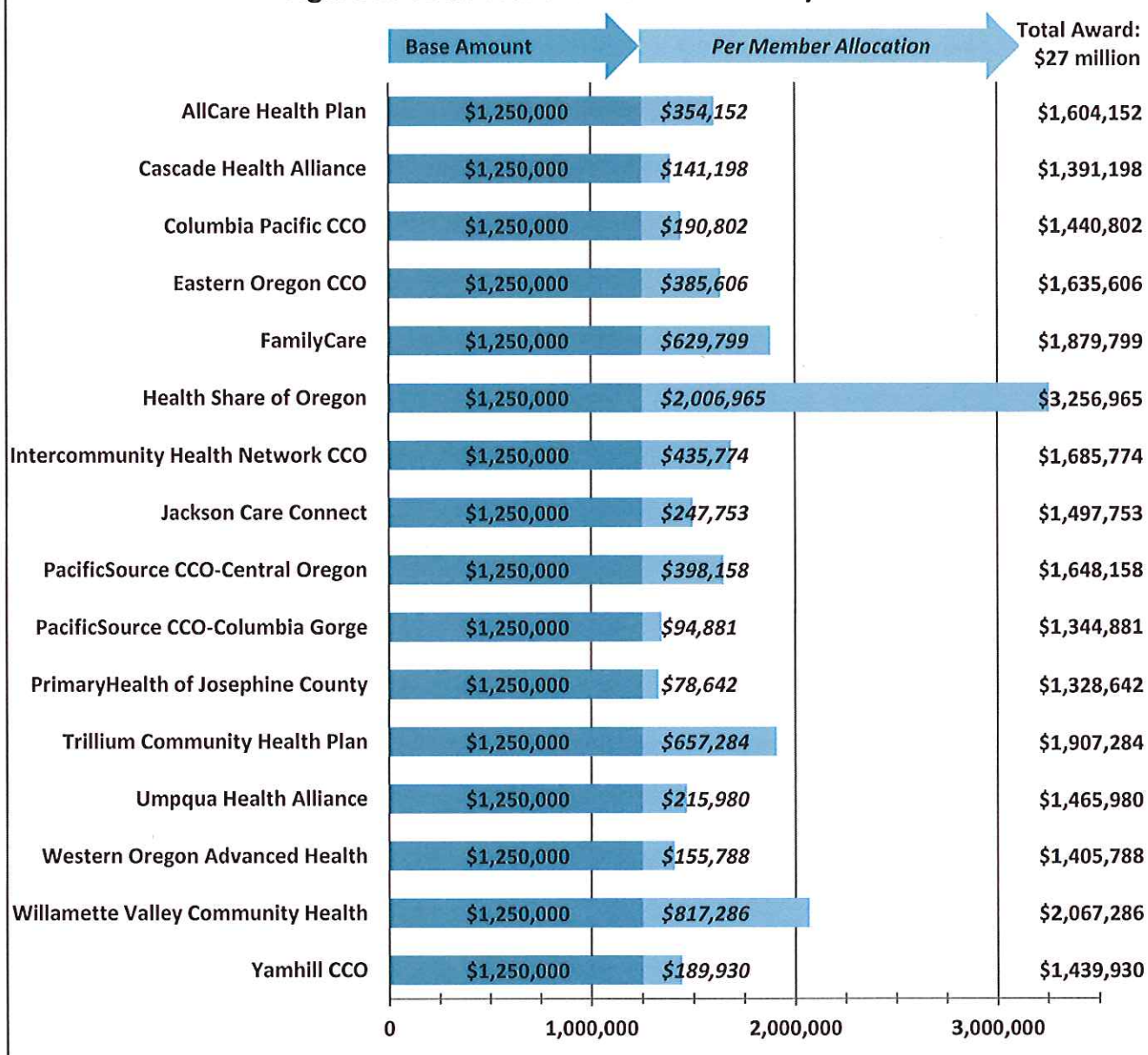- Expected next steps.

The report also includes:
- A high-level summary of Transformation Fund projects, including common project focus areas;
- OHA's role in building a culture of improvement and innovation among the CCOs;
- Challenges in Transformation Fund grant implementation;
- Information about a grant period extension for 13 CCOs that requested it; and
- An update on the HIT portion of the fund.

TRANSFORMATION FUND: AT-A-GLANCE

Health System Transformation Fund Total:	**$30,000,000**
Amount allocated for shared statewide HIT investments:	**$3,000,000**
Amount distributed to CCOs for Transformation Projects:	**$27,000,000**
Total number of CCO Transformation Fund Projects:	**120**

Figure 1: Total Transformation Funds by CCO

CCO	Base Amount	Per Member Allocation	Total Award: $27 million
AllCare Health Plan	$1,250,000	$354,152	$1,604,152
Cascade Health Alliance	$1,250,000	$141,198	$1,391,198
Columbia Pacific CCO	$1,250,000	$190,802	$1,440,802
Eastern Oregon CCO	$1,250,000	$385,606	$1,635,606
FamilyCare	$1,250,000	$629,799	$1,879,799
Health Share of Oregon	$1,250,000	$2,006,965	$3,256,965
Intercommunity Health Network CCO	$1,250,000	$435,774	$1,685,774
Jackson Care Connect	$1,250,000	$247,753	$1,497,753
PacificSource CCO-Central Oregon	$1,250,000	$398,158	$1,648,158
PacificSource CCO-Columbia Gorge	$1,250,000	$94,881	$1,344,881
PrimaryHealth of Josephine County	$1,250,000	$78,642	$1,328,642
Trillium Community Health Plan	$1,250,000	$657,284	$1,907,284
Umpqua Health Alliance	$1,250,000	$215,980	$1,465,980
Western Oregon Advanced Health	$1,250,000	$155,788	$1,405,788
Willamette Valley Community Health	$1,250,000	$817,286	$2,067,286
Yamhill CCO	$1,250,000	$189,930	$1,439,930

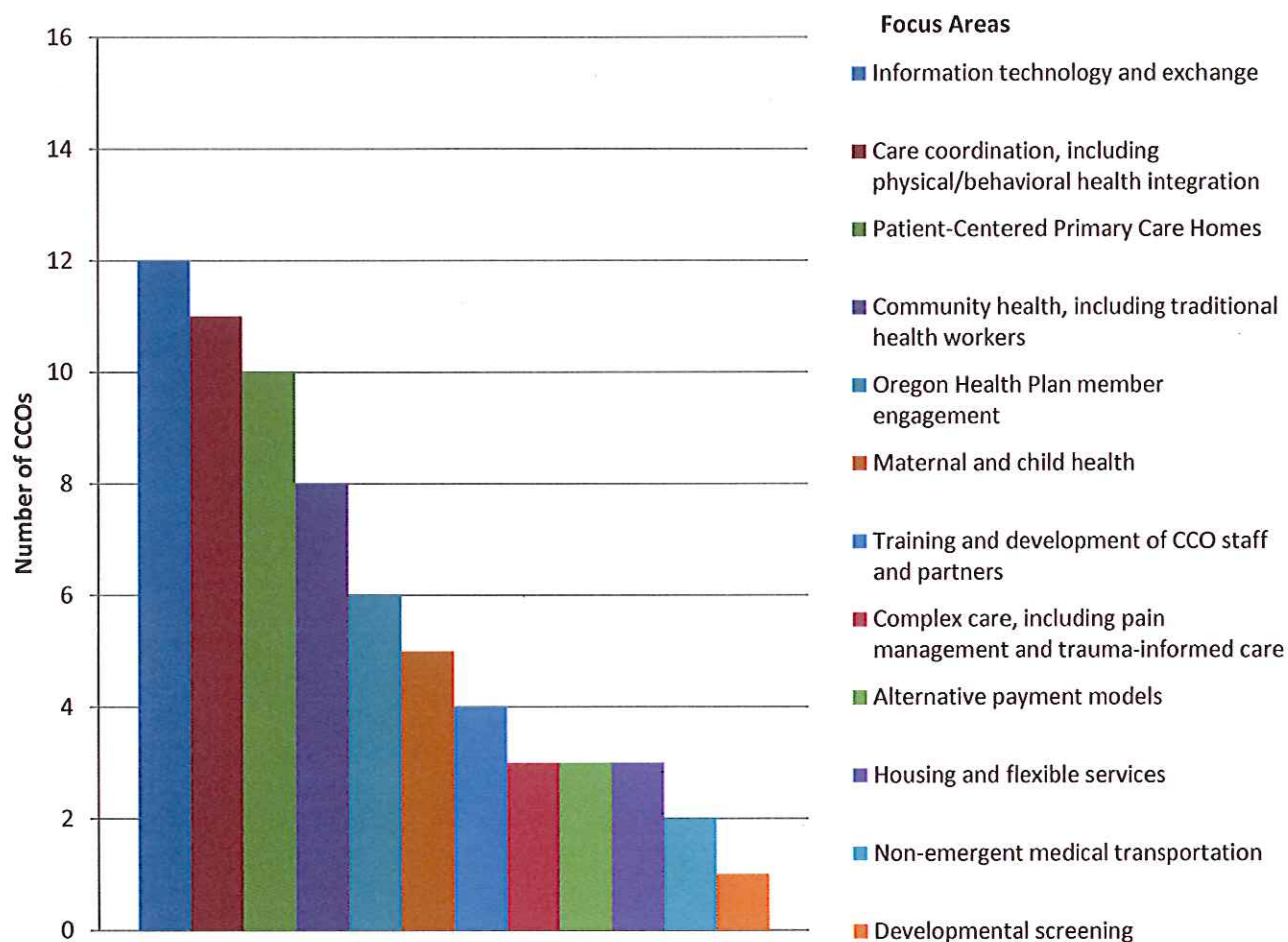# TRANSFORMATION FUND: OVERVIEW OF PROJECTS

Process used for distribution to CCOs

The OHA Transformation Center collaborated with CCOs to develop an application process and timeline to distribute funds to CCOs. OHA also facilitated a discussion with the CCOs that resulted in all 16 CCOs agreeing that $3 million of the fund should be used to maximize the opportunity to leverage 90 percent federal funding to invest in statewide HIT. The remaining funds ($27 million) were distributed based on a budget note in HB 5030. Each CCO received a minimum award of $1.25 million and the remainder was distributed based on the number of members in each CCO (based on average enrollment between January 2013 and April 2013) (see Figure 1). Total award amounts by CCO ranged from approximately $1.3 to 3.2 million. All 16 CCOs had their project proposals approved. There are 120 individual projects; 15 of the 16 CCOs are funding multiple projects.

Summary of CCO Transformation Fund projects

Each project is designed to be innovative, scalable, transferable and related to CCO transformation plans. The wide array of types of projects across the 16 CCOs reflects the individual strengths and needs of each CCO community. Projects are categorized into the 12 focus areas listed in Figure 2.

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Figure 2: Number of CCOs with Transformation Fund Projects by Focus Area

Focus Areas
- Information technology and exchange
- Care coordination, including physical/behavioral health integration
- Patient-Centered Primary Care Homes
- Community health, including traditional health workers
- Oregon Health Plan member engagement
- Maternal and child health
- Training and development of CCO staff and partners
- Complex care, including pain management and trauma-informed care
- Alternative payment models
- Housing and flexible services
- Non-emergent medical transportation
- Developmental screening

Processes CCOs used to develop projects and distribute funds locally
The majority of CCOs (13) used collaborative, internal processes involving the CCO governing boards, community advisory councils and CCO staff to develop project proposals. Three CCOs (Eastern Oregon CCO, PacificSource – Central Oregon and PacificSource – Columbia Gorge) used all of their Transformation Funds for a community grant program to support transformation. They developed community decision-making processes (which included community advisory councils) to determine how to allocate the funds. For example, Eastern Oregon CCO elicited ideas from a broad range of providers across its 12-county service area, resulting in 23 grant awards, with one to three grants in each of the 12 counties.

Preliminary results and outcome measures
In their January 2015 Transformation Fund progress reports submitted to OHA, CCOs indicated that these funds are supporting innovative projects that would not have been possible otherwise. The projects are building a foundation for future innovative projects funded by CCOs. Many are devising plans to sustain the projects beyond the grant period.

The projects are in various stages of implementation. Of the 120 projects:
- Thirty-one projects (26%) are in the early stage of implementation, meaning they have a defined metrics plan, the project team is formed, and activities are beginning to be implemented.
- Fifty-nine projects (49%) are in the mid-stage of implementation and early evaluation data has been collected.
- Thirty projects (25%) are in an advanced stage of implementation. These projects have enough data to inform next steps for spreading and sustaining them.

A detailed summary of the 120 projects, including aims, metrics, status and preliminary results, is provided in Appendix B: Transformation Fund Projects by Coordinated Care Organization. In addition, highlights of health and health system outcomes selected from the thirty projects in an advanced stage of implementation are provided in Appendix C: Preliminary Outcomes for Select Transformation Fund Projects.

Project highlights
The following section highlights one innovative project per CCO. Projects are grouped by the following goals:
- Decreased emergency room visits,
- Expanded provider capacity,
- Advanced care integration,
- Enhanced primary care,
- Improved health outcomes of patients with complex needs, and
- Decreased costs through changing payment models.

Projects designed to decrease emergency room visits: Many projects are diverting emergency room visits and facilitating access to primary care by meeting Oregon Health Plan (OHP) members where they are, such as in schools and service sites for the homeless. CCOs are strengthening multi-sector partnerships with housing, education, corrections and social services. Examples include:
- FamilyCare has used grant funds to connect 317 homeless youth to primary care. Forty-eight participants have received early childhood screenings and 158 were connected to permanent patient-centered primary care homes.
- Cascade Health Alliance developed the first-ever local short-term youth crisis respite program to improve services to youth with behavioral health disorders and keep families and other community supports more closely engaged with fewer transfers outside of the community. Pine View, a 12-bed respite residential program for boys and girls ages 12-18 experiencing a severe behavioral health episode, opened in September 2014 and began serving clients in October 2014.

Projects designed to expand provider capacity: Some projects are improving patient outcomes through increased coordination of care and expanding the capacity to provide care through the use of tele-mentoring and traditional health workers. Examples include:

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- Health Share of Oregon is using an evidence-based tele-mentoring program with Oregon Health & Science University (OHSU) mental health specialists to increase primary care provider capacity for mental health care and decrease the need for specialty visits. Fifteen sessions have been held so far with approximately 15 community primary care providers attending each session. The CCO has committed to funding the program for one year after the Transformation Fund grant ends.
- PacificSource – Columbia Gorge has created a sustainable training center for building capacity of community health workers in the Gorge and integrating them into the Gorge's health care system. The CCO secured a community grant of $75,000 to sustain and expand the program, which has trained:
  - 8 certified trainers;
  - 26 community health workers, outreach workers, case managers and other providers (90 hours); and
  - 12 community health worker supervisors.

Projects designed to advance care integration: Projects are also advancing integration of care, including behavioral and oral health into primary care. Examples include:
- Eastern Oregon CCO is improving access to behavioral health services by co-locating a behavioral health clinician in the Yakima Valley Farm Workers Clinic in Umatilla County. A bilingual behavioral health consultant was hired and started seeing patients in September.
- PacificSource – Central Oregon is reducing dental care costs by implementing and evaluating a community-wide toothpaste distribution campaign enhanced by education and telephone support for OHP children and families in Central Oregon. The program has completed 450 interviews with parents of children under three years old. The program has mailed approximately 42,000 toothpaste kits; sent 71,000 phone messages; and mailed 65,000 informational mailers.
- Yamhill Community Care Organization is improving coordination between physical and behavioral health services by co-locating mental health providers at four practices.
- Trillium Community Health Plan launched a pilot program for integrating primary care and behavioral health care with eight participating clinics.
- Western Oregon Advanced Health is providing members who are concurrently diagnosed with certain persistent mental health conditions and diabetes with active medication therapy management services.
- Intercommunity Health Network is engaging mental and physical health providers to create an integrated, longitudinal medical record, including data from physical and behavioral health organizations.

Projects designed to enhance primary care: Projects are improving primary care delivery systems by increasing the availability of patient-centered primary care homes. Examples include:

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- Willamette Valley Community Health is supporting the development of high-functioning patient-centered primary care homes through targeted learning collaboratives for three types of practices:
  - practices that are not yet recognized as patient-centered primary care homes;
  - practices focused on improving patient experience of care; and
  - more advanced practices.
- PrimaryHealth of Josephine County is improving birth outcomes by partnering with Women's Health Center of Southern Oregon to develop a maternal medical home engaged in education and outreach with care management focused on women at highest risk for poor birth outcomes. In the third quarter of 2014:
  - 75.6% of patients had an initial prenatal visit within 12 weeks;
  - 93% of patients received post-partum depression screening; and
  - The caesarean delivery rate decreased by 42%.

Projects designed to improve health outcomes of members with complex needs: Projects are improving the coordination of care for CCO members with complex health needs. Examples include:
- The Expanded Care Clinic at Umpqua Health Alliance has provided coordinated care for 76 high-needs patients through integrated physical health, mental health, addiction, dental and nurse case management services. Preliminary utilization findings in this population indicate a reduction in hospitalization and average length of hospital stay and an increase in number of primary care visits.
- Jackson Care Connect is improving care coordination for members with complex health needs by placing traditional health workers in clinics and the emergency department and implementing innovative initiatives to address opioid pain medication use and share chronic pain management best practices.
- The North Coast Pain Clinic at Columbia Pacific CCO provides integrated treatment for persistent pain, including movement therapy and behavioral health treatment. Twenty-seven people have graduated from the 10-week program. Outcomes include:
  - Fear of Movement: average decrease = 4.7%
  - Depression (PHQ-9 screening): average decrease = 7.3% (decrease is a positive outcome)
  - Patient Self-Efficacy Questionnaire: average increase = 17%
  - Oswestry Disability Index: average decrease = 10% (decrease is positive)

Projects designed to decrease the cost of care by changing payment models: Projects are implementing alternative payment models, including paying for value instead of volume and incentivizing changes in primary care practice patterns.
- AllCare CCO is paying providers differently to improve the quality of care, population health and patient experience at a lower cost. Each alternative payment method being developed has a shared savings component that rewards providers who ensure access to care, manage utilization and perform well on quality metrics.

OHA strategies to support a culture of improvement and innovation
As a condition of receiving Transformation Funds, CCOs were required to designate a portfolio manager to oversee the projects. To help spread effective projects and innovative best practices to other CCOs, the OHA Transformation Center developed a learning collaborative to support the Transformation Fund portfolio managers in all CCOs. The first phase of the learning collaborative involved a three-day Improvement Science in Action training by the Institute for Healthcare Improvement held April 30 – May 2, 2014. More than 120 CCO portfolio managers, quality improvement managers and their project teams gained skills in quality improvement concepts, tools and techniques. All CCOs developed project charters and driver diagrams for at least one project. This framework was designed to assist CCOs and their partners in implementing improvement projects and spreading the change throughout the region. The majority of respondents to the participant evaluation reported that the three-day training was valuable in supporting their work (89.2%) and would improve their ability to lead change in their organization (92.1%). As one participant wrote, "I want more – this was life altering for me." Another participant wrote, "Overall it was an amazing training with so much practical, useful information."

As follow-up to the training, during the fall of 2014 Transformation Center staff visited all 16 CCOs to provide technical assistance on measurement plans for their projects. The third phase of the learning collaborative, launched in December 2014, involved convening the portfolio managers in a Quality Improvement Community of Practice. This group meets every other month to informally discuss lessons learned from project implementation. In addition, the portfolio managers are participating in the Institute for Healthcare Improvement's Leading Quality Improvement for Managers course, a three-month, in-depth virtual program on improvement science, measurement, modeling, coaching and innovation. Finally, in early June, the Transformation Center is hosting the Oregon Innovation Café, which will allow the CCOs' health system transformation champions and other stakeholders to present innovative projects and discuss lessons learned. Topics will include behavioral health integration and complex care, and the event will highlight successful Transformation Fund projects.

Challenges in Transformation Fund grant implementation
Many CCOs have reported challenges in implementing the Transformation Fund grants, especially given the relatively short time frame to disburse and spend the funds. As new organizations, CCOs are still building their organizational structures and operating in a start-up capacity. Hiring and onboarding new staff to manage the funds, and formulating new subcontracts, has taken a significant amount of time. In addition, CCOs have reported delays interfacing with contractors, particularly with HIT vendors, and with clinical delivery partners and community stakeholders who are at varying stages of readiness to implement these initiatives.

Grant period and request for extension

OHA is confident that all the Transformation Funds will be paid to CCOs on or before June 30, 2015. However, due to the delays mentioned above, many CCOs requested extensions from OHA to expend their grant funds through subrecipients and to complete projects. Thirteen CCOs have received OHA Director approval for an extension through December 31, 2015. (Three CCOs – FamilyCare, Intercommunity Health Network and Trillium Community Health Plan – did not request an extension and their grants will end June 30, 2015.) Extensions will allow time for CCOs to fully implement proposed projects, and gather meaningful evaluation data to inform the scalability and transferability of projects.

Health information technology update

In 2013, Oregon's 16 CCOs unanimously agreed that OHA would use $3 million of the Transformation Funds to maximize the opportunity of leveraging a 90 percent federal match to invest in statewide health information technology services. CCOs supported leveraging funds to invest in statewide technology and technical assistance services that support Medicaid providers, CCOs and health system transformation in their efforts to share and aggregate electronic health information. The need for these resources was identified through extensive stakeholder engagement, including listening sessions with CCOs, health plans, providers and other key stakeholders, including Oregon's Health Information Technology Oversight Council.

In 2013, OHA established the Health Information Technology Advisory Group to serve as a governing body on HIT efforts, overseeing and guiding the investment of the $3 million Transformation Funds. The advisory group is ongoing and includes representatives from half of the CCOs.

To date, OHA has leveraged its Transformation Funds to secure nearly $27 million in federal Medicaid funding, launching some services and beginning development for others. Specifically:

- Transformation Funds are leveraging federal funding to support statewide basic health information exchange through Direct secure messaging. Funds are also supporting Oregon's Emergency Department Information Exchange, which provides critical information to emergency departments in real-time for treating high-utilizers. This service was launched in 2014 as a partnership with the Oregon Health Leadership Council, Oregon's hospitals, CCOs and others, and it is live in 55 of Oregon's 59 hospitals.
- Two additional services will be launched in 2015: statewide hospital notifications, which include sending a real-time notice to CCOs and other Medicaid care coordinators when their patient is having a hospital event; and technical assistance for Medicaid providers using their electronic health records and seeking federal incentive payments.

- Funding is secured, and development work has started, on a state-level provider directory and a statewide clinical quality data registry. OHA anticipates additional participants, beyond CCOs and Medicaid providers, will want to use some of these services as they are developed and will contribute to the financing of those services over time.

Next steps

OHA will continue to monitor the grants and provide support around project implementation. CCOs are required to submit final progress reports at the end of the grant period.

ACTION REQUESTED

Acknowledge receipt of report.

LEGISLATION AFFECTED

None

Sincerely,

Lynne Saxton

Lynne Saxton
Director

CC: Linda Ames, Legislative Fiscal Office
Ken Rocco, Legislative Fiscal Office
Kate Nass, Chief Financial Office
Tamara Brickman, Chief Financial Office

Appendix A: Budget Notes on the Health System Transformation Fund
Appendix B: Transformation Fund Projects by Coordinated Care
                 Organization
Appendix C: Preliminary Outcomes for Select Transformation Fund Projects

Appendix A: Budget Notes on the Health System Transformation Fund

HB 5030-A, 2013 Session, Passed June 28, 2013 by the Joint Committee on Ways and Means
http://www.oregon.gov/oha/2013_2015BudgetMaterials/Measure%20Summary%20of%20HB%205030-A.pdf (See Page 5)

The [Human Services] Subcommittee also approved $30 million General Fund for the Health System Transformation Fund to support efforts of Coordinated Care Organizations (CCOs) to transform health care delivery systems. The following budget note was approved regarding the Health System Transformation Fund, to specify the distribution methodology and clarify that no one CCO would receive more than a total of $5.25 million out of the $30 million Fund:

Budget Note:
The Health System Transformation Fund provides a strategic investment in Coordinated Care Organizations to engage in projects that support better health, better health care and lower costs in their communities. Each CCO will be eligible for a minimum potential award of $1.25 million with a possible additional allocation, not to exceed $4 million for an individual CCO, based on the CCO's average monthly member count.

The Oregon Health Authority will establish a process for approving and awarding the Health System Transformation Funds to Coordinated Care Organizations. CCOs will be asked to submit a proposal for up to the total dollar allocation for which they are eligible, describing the project objective, purpose and goals. Projects under implementation or proposed projects should be innovative, scalable, transferable and related to CCO transformation plans and the overall goals of transformation with a focus on, but not limited to:
- Information technology systems and CCO infrastructure including additional investment in electronic medical records (EMR) and claims processing systems
- Population health management, case management, disease management, and achieving quality metrics
- Provider panel and clinic enhancements to provide extended primary care services to high risk Oregon Health Plan members.

The agency will report on the implementation of the program, based on the following budget note:

Budget Note:
The Oregon Health Authority shall report to the Legislature during the 2014 and 2015 legislative sessions on the implementation of a grant program using the Health System Transformation Fund. The reports should include details of the process used for distribution, the dollar amounts distributed, to whom, for what purpose, and expected outcomes. The reports should also describe any preliminary results available, including outcome measures, as well as expected next steps.

Appendix B: Transformation Fund Projects by Coordinated Care Organization

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
AllCare Health Plan				
Alternative payment models	Develop Alternative Payment Methods (APMs) Using a Shared Savings Payment Model	• Adapt a payment model developed for AllCare's recognized patient-centered primary care home providers to address high-risk/high-cost populations using cost-effective providers such as traditional health workers and incorporating patients' social needs into care coordination • Reward providers who ensure access to care, manage utilization and improve quality metrics • Expand compensation for providers who accept larger Medicaid panels • Generate savings by incentivizing reduction of emergency room visits; use of generic drugs; and prevention and referrals to lower cost settings	• Provider participation • Screening for substance use disorder and depression • Return on investment • Emergency department utilization • Readmissions • Cost of care • Relevant Incentive Metrics • Patient experience	• Primary care APM completed first year, pediatric APM in place for 6 months. $1M available to primary care providers in Josephine County. Average payout estimated at 68% of available funds. • Primary care and pediatric APMs now available voluntarily in Jackson and Curry Counties • Specialty care APM in pilot test; includes Educational Collaborative with primary care providers • Training providers on coding and documentation • All APMs include SBIRT (screening, brief intervention and referral to treatment) • 11 funded positions across 3 counties • 600 primary care/pediatric patients surveyed in Josephine County • 93% of providers received satisfactory or very satisfactory rating
Cascade Health Alliance				
Community health, including traditional health workers	Non-Traditional Healthcare Worker and Non-Emergent Medical Transportation	Reduce high-use members' emergency department usage by establishing a health care worker cadre in Klamath County in conjunction with a system of Non-Emergent Medical Transportation (NEMT) separate from the traditional NEMT system	For the population enrolled in non-emergent medical transportation: • Emergency department utilization • Readmissions • Primary care provider enrollment	• 3 community health workers hired • Launched August 1, 2014. As of January 5, 2015, more than 100 members assigned to a health care worker and case manager if warranted. • 150 referrals to non-emergent medical transportation
Care coordination, including integration of physical and behavioral health	Mobile Crisis Team	• Develop a mobile therapeutic team to respond on-site to mental health crises • Reduce number of emergency department admissions • Divert individuals in crisis from penetrating into more intensive levels of care	• Emergency department utilization for mental health crises • Mental health crisis calls to intervention team	• 265 total calls, 75 calls involving 61 members • Responded to 8 in-home crises and 4 school crises • 59% decrease in mental health crisis visits to emergency department for clients from August 2014 to November 2014.
Care coordination, including integration of physical and behavioral health	Youth Crisis Respite and Residential Program	• Develop a local eight-bed, short-term respite program for youth in temporary psychiatric crisis • Provide more effective and efficient crisis services to youth with behavioral health disorders • Keep families and community supports more closely engaged with youth in crisis respite care • Demonstrate significant savings by reducing referrals to out-of-area services and reallocate those funds to local outpatient care	• Youth served • Youth sent out of area • Youth transitioned from out-of-county treatment facilities to the local treatment facility	• First client was received in October 2014 • Seeing clients from both Klamath Falls and out of area
Information technology and exchange	Health Information Exchange System Implementation: Connection to the Jefferson Health Information Exchange (JHIE)	• Provide immediate, real-time notification of members' emergency room visits and hospital discharge to improve care coordination, identify high utilizers and reduce readmissions • Reduce medical errors associated with the inaccurate and incomplete information available to providers • Improve communication among health care providers and their patients to provide the right care at the right time based on the best available information • Improve care coordination for behavioral health patients and bridge the information divide between primary care and behavioral health care	• Provider participation • Mental health clinic participation	• 50 new practices enrolled (495 providers in 91 clinics) • Users able to send and receive Direct Secure Messages with CareAccord

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Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Care coordination, including integration of physical and behavioral health	Care Coordination Program: Electronic Health Record Implementation	• Implement an electronic health record to improve care coordination • Coordinate services for health plan members to achieve positive individual-level health outcomes • Connect members with the health care network and support them as they navigate through it	• Relevant Incentive Metrics • Members assigned to case manager • Members with care plan in place • Patient experience • Members per case manager	Due to staff change over, program implementation was delayed. Currently looking at going live April or May 2015.

Columbia Pacific CCO

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Complex care, including pain management and trauma-informed care	Opiate Performance Improvement Project	• Develop a comprehensive chronic pain treatment program to be piloted in Astoria and then spread to the rest of the CCO • Reduce the number of opioids prescribed by adopting existing opiate prescribing guidelines and prescribing contraindications	• Providers trained • Patients referred • Patients completed program • Opiate prescribing rate • Improvement on Pain Self-Efficacy Questionnaire • Improvement on mental health survey	• 297 patient referrals, orientation sessions for 149 patients, 27 patients graduated from the 10-week program at a pain management clinic Clinical Outcomes for the five completed groups: • Fear of Movement: average decrease = 4.7 • PHQ-9 depression screening: average decrease = 7.3 (decrease is a positive outcome) • Patient Self Efficacy Questionnaire: average increase = 17.0 • Oswestry Disability Index: average decrease = 10% (decrease is positive)
Care coordination, including integration of physical and behavioral health	Crisis Respite Capacity	• Increase the number of crisis respite rooms/beds for secure short-term stays for individuals undergoing psychiatric crisis in Clatsop County • Develop a mobile crisis unit and expand crisis capacity to other CCO counties	• Beds available • Occupancy rate • FTE of Behavioral Health Specialist available for mobile crisis intervention	• Strong partnerships developed and funding gathered • GOBHI purchased a facility in Warrenton. Providence Seaside donated $70,000, Care Oregon willing to donate for remodel and other community donations coming in • Construction manager hired
Community health, including traditional health workers	Community Health Assessment and Community Health Improvement Plan	Conduct a Community Health Assessment and develop and implement a Community Health Improvement Plan	• Priority strategies identified in the CHIP that are implemented	• Regional community health improvement plan completed and approved • Community Wellness Investment Funds have sponsored local projects • Using Transformation Fund technical assistance to support work of CAC • CCO sponsoring The Way to Wellville in Clatsop County to spread community health improvement efforts
Care coordination, including integration of physical and behavioral health	SBIRT Training for Primary Care Providers and Support Team	Increase use of SBIRT (screening, brief intervention and referral to treatment) in primary care	• Rate of SBIRT screening • Providers completed training • Referrals	• 2884 basic SBIRT screens across all insurance carriers • More than 100 full SBIRT screens (DAST and AUDIT) completed for CCO members • All positive screens are referred
Complex care, including pain management and trauma-informed care	Reducing Inappropriate Emergency Department Use in High-risk Patients	Reduce inappropriate emergency department use in the high-risk patient population	• Inappropriate Emergency Department utilization affecting total cost of care	• Developing clinical pharmacy capacity for 2 clinics in Clatsop County • Develop the Health Resiliency Program in Columbia County at 2 clinics
Housing and flexible services	Healthy Homes Demonstration Project	Address unhealthy housing situations and the potential negative effects on member health	• Members provided home screening and assessments • Emergency medical costs	• 20 referrals, 3 projects completed, 1 near completion • Reverse referrals from community action team to CCO primary care
Care coordination, including integration of physical and behavioral health	Detox Bed Capacity	Add local detox capacity for Medicaid patients (previously unavailable in CCO network)	• Beds open • Members receiving detox locally rather than out of area	Projected opening date February 1, 2015, for facility with 6 beds for medical detox level of care
Care coordination, including integration of physical and behavioral health	Telehealth Interventions - CareMessage	Utilize automated text and voice messages, integrated with electronic medical records, to proactively manage chronic/persistent health conditions to help members improve health and avoid preventable health outcomes and inappropriate emergent care use	Under development	Partnership has been developed with CareMessage and volunteer clinics to pilot the text and voice messaging program
Maternal and child health	Prenatal Performance Improvement Project (PIP)	Design a prenatal care incentive program to increase timely, early access to prenatal care, especially for patients for whom English is a second language	Under development	• Work group has been created and the human centered design process has been identified as the best method for creating the program • Research conducted on the current state of prenatal care and access in the service area, existing programs and successes/failures

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Patient-Centered Primary Care Homes	Patient & Population Centered Primary Care Learning Collaborative (PC3)	Continue the Primary Care Learning Collaborative to support clinic and organization leaders in practice transformation to meet patient-centered primary care home requirements and move beyond to meet triple aim outcomes	• Clinics certified as Tier 3 Patient Centered Primary Care Homes • Clinics participating in PC3 Collaborative	• 7 clinics participating • All participating clinics are PCPCH recognized and have made significant progress towards practice transformation and having a greater impact on their clinic populations • PC3 created venue for clinics to learn from each other's experiences
Complex care, including pain management and trauma-informed care	Resilience Trumps ACEs/Trauma Informed Care Project	Adapt and implement the Trauma Informed Care model of the National Council for Behavioral Health at the CCO level. This is the first time that this model is being applied to a CCO-type organization.	• Clinics/hospitals trained • Individuals trained	• Strategic plan developed to fit needs of CCO • Identified two primary clinics for pilot training to take place by June 30, 2015

Eastern Oregon CCO

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Community health, including traditional health workers	South Gilliam County Health District: Wellness Facility	Decrease obesity rates, decrease disease burden and increase access to physical therapy through a wellness facility for patients and the public	• Percent of past and current patients with BMI documented in chart • Wellness program design completed	• Entered baseline BMIs on approximately 80% of patients • Picked patients for a pilot program that would help design and define a wellness program • Working on an evaluation form
Non-emergent medical transportation	Community Connection of Northeast Oregon Union County: Non-Emergent Medical Transportation	Reduce the rate of missed appointments due to lack of transportation and increase the rate of same day deliveries of medication to communities not served by a pharmacy	• Providers in network • Hours available for Call Center use by patients • Same day medical access requests filled • Public outreach ads placed • Discovery of tools, methods and reports	• Same-day medical deliveries up dramatically relative to baseline • Distributed reminder cards and outreach materials to medical care partners • Call center near capacity goal
Care coordination, including integration of physical and behavioral health	Lake County Mental Health: Mental Health First Aid Training	Increase early referrals to mental health services and decrease crisis services by training community health providers	• Percent of individuals trained per agency • Total individuals at each training • Referrals	• Trainings have begun and future ones are being scheduled • Most trainees have requested the additional training targeting the population not addressed in the training they attended • Trainees all report a better understanding of what to look for and how to appropriately refer to services
Community health, including traditional health workers	Malheur County Health Dept.: Community Health Worker Training and Support	Conduct community health worker training for 25 participants in Malheur County	• Recruited trainees • Participants certified	Recruited over 25 interested trainees and confirmed 17
Community health, including traditional health workers	Good Shepherd Health Care System: Community Health Worker Workforce Development	Establish a community health worker program to reduce health disparities among low-income families, children, the elderly and racial/ethnic minorities	• Emergency department utilization • Improvement on patient health risk assessment tool • Duplicated and missed services • Patient experience	• Training and equipment in place • Began serving clients at the end of October 2014 • Held Motivational Interviewing training
Community health, including traditional health workers	Malheur County Lifeways, Inc.: School-based Adolescent Health	Hire and train a certified community health worker to coordinate integrated school-based care and develop culturally and linguistically competent service delivery, co-management and referral services for school age youth and Hispanic families	• Students enrolled • Contacts with community health worker per enrolled student • Contact time per case • Completed referrals • Participants in outreach events • Outreach events • Ratio of health and social service providers to students	• Convened multidisciplinary advisory team: public health, primary care, education, child development, dental, pediatrics, social services, corrections • Fielded parent and student survey on service/support barriers • Hired community health worker
Community health, including traditional health workers	Wallowa County: Youth Fitness and Nutrition Programming (Fit Fridays)	Decrease the percentage of overweight children by increasing knowledge about nutrition and diet and increasing physical activity on Fridays when school is not in session (school is held only on Monday through Thursday)	• Community partners • Fit Friday classes • Proportion of K-8th grade participating in Fit Fridays • Self-reported increase in fitness level • Self-reported percent of participants spending 1 or more hours outside recreating per day • Other self-reported measures	• 20 5-8th graders enrolled in Wallowa Resources Exploration of Nature (WREN) • 10 K-1st graders enrolled in SwimFit • 9 community partners have contributed time or materials

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Maternal and child health	Morrow County CAC: Interdisciplinary Community Care Team	Develop an interdisciplinary care team to provide wraparound services and improve access to prenatal care, well-child checkups including behavioral health services, and developmental screening for underserved children age 0-18 and pregnant women	• Referral packets distributed • Resources identified • Resource guides distributed • Participant survey	• 17 referrals including applications for: Developmental Disability Services, Department of Human Services, HUD housing and Medicaid • Care Packets created and distributed to schools and community agencies
Care coordination, including integration of physical and behavioral health	Gilliam County CAC: Mental health media campaign and services	• Implement mental health media campaign • Reduce mental illness stigma and discrimination • Increase availability of counseling opportunities for school age kids and senior citizens	• Survey data measuring mental illness knowledge • Mental health counseling service utilization	• Media campaign up and running • School counselor started seeing students in September 2014 • Senior citizens are being met with and referred if needed
Community health, including traditional health workers	Wheeler County CAC: Health Education and Outreach Campaign	Conduct a health education campaign to all 1,440 residents of Wheeler county to improve cancer screenings, early childhood screenings, exercise promotion, depression screening and treatment options for alcohol and drug abuse	• Attendance at BMI reduction group meetings • BMI metrics • Scholarships awarded • Phone survey	• Sent first quarterly mailing to 850 households in Wheeler County on weight, risk factors and availability of BMI reduction group and Living Well • Both groups achieved capacity • All but one member of BMI reduction group lost weight in first month
Community health, including traditional health workers	Grant County Community Counseling Solutions: Health Promotion on Obesity, Oral Health and Children's Health	Engage high-risk community members in developing personalized health plans and increase health awareness and education	• Participants • Improvement on awareness and education assessment • Attendance • Support workers	• Coordinator hired and first workshop is scheduled for December 8, 2014 • Comprehensive invitation process including advertising, personal invites, social media and flyers to reach intended audience
Maternal and child health	Center for Human Development, Inc. Union County: Low Birth Weight Social Marketing Campaign	• Implement a "point of sale/service" low birth weight social marketing campaign targeting individuals purchasing or receiving pregnancy tests or contraception • Increase timeliness of prenatal care • Increase availability and use of preconception and interconception health care services • Increase access to health insurance and PCPCH medical homes • Decrease tobacco use and periodontal disease by pregnant women	• Low birth weight babies • Pregnant women using tobacco • Women initiating prenatal care in first trimester	• Multidisciplinary work group established with broad representation from key community partners • Partnering with Moda to mail about project to all EOCCO target clients in Union County
Care coordination, including integration of physical and behavioral health	Lake Health District: Home Health & Hospice Patient Navigation Team	Create and implement a patient navigation team to decrease inappropriate use of the emergency department and increase patient engagement in and accountability for members' own health	• Self-assessment of mental health and physical health services • Enrollment in physical activity program • Referrals to health care and social services • Completed appointments • Health insurance enrollment	• 13 navigation referrals offered and accepted • Collected 8 self-assessments • 14 referrals without first meeting yet
Care coordination, including integration of physical and behavioral health	Lifeways, Inc. Umatilla: Behavioral Health Community Health Workers	• Hire and train two new community health workers • Reduce readmissions and effectively transition patients to outpatient behavioral health services, primary care and community supports • Train the emergency department staff on Mental Health First Aid	• Milestones • Referrals • Patient experience • Provider experience	• 2 behavioral health community health workers trained • Universal referral system created with public health and hospital • Referrals received from outside agencies, partner and self-referrals • One community health worker works three days per week out of the St. Anthony clinic, and is often available to see patients immediately upon receiving referrals from their doctors

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Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Care coordination, including integration of physical and behavioral health	(Malheur County) Saint Alphonsus Medical Center Follow-up After Hospitalization for Mental Health and Substance Use	• Reduce emergency department readmissions among high-utilizers by effectively transitioning patients to outpatient behavioral health services, primary care and community supports • Increase capacity of social work and patient navigation staff to respond effectively to patients with complex health needs by providing training and support	• Emergency department utilization for mental health and substance use • Patients making and keeping referral appointments • Patients receiving screens for depression and/or anxiety	• Staff are oriented and trained • Hospital staff report satisfaction with resources for patients • Emergency department staff report decreased "high utilizers" since project inceptions
Care coordination, including integration of physical and behavioral health	Umatilla County: Yakima Valley Farm Workers Clinic	Improve access to behavioral health services by co-locating behavioral health clinician in primary care clinic	• Patients seen by Behavioral Health Consultant • Improvement pre- and post- on mental health screening • Patients screened • Patients with billable behavioral health codes in electronic medical record • Patient experience	Hired a bilingual behavioral health consultant who has been seeing patients since September 2014
Care coordination, including integration of physical and behavioral health	Harney District Hospital: Embedded Behaviorist in Primary Care	Embed a behavioral health counselor in a primary care clinic to identify current gaps in mental health services and develop plans to address them with care coordination	• Milestone • Enrollment	• Talked with 3 licensed social workers about the position, but have not yet hired for the position • Signed an agreement with a recruiting firm
Care coordination, including integration of physical and behavioral health	(Gilliam County) St. Alphonsus Medical Center: Nurse Navigators & Care Coordinators	Reduce emergency room visits, increase access to care and increase preventive screenings (depression, colorectal cancer, high blood pressure) through services provided by nurse navigators and care coordinators	• Patients seen by behavioral health specialist • Emergency Department utilization for depression diagnosis • Medical home enrollment	• Hiring a liaison • Added depression screening tool (PHQ-9)
Care coordination, including integration of physical and behavioral health	North Central Public Health District: Public Health Nursing and Care Coordination	Decrease emergency department visits and hospital readmission by doing home visits with high utilizers. Home visits will be provided by public health nurse home visitors.	• Milestones • Participants • Patient Activation Measure	• Purchased patient disease self-management program • Trained staff
Community health, including traditional health workers	Wallowa Memorial Hospital: Complete Health Improvement Program	Implement 12-week, evidence-based intensive lifestyle intervention program, "Complete Health Improvement Program (CHIP)," to support adults with chronic disease to adopt healthier lifestyle habits, improve cardiovascular health and decrease use of health care services	• Attendance • Blood glucose levels • Cholesterol (total and LDL) • BMI • Medication usage	• 1 of 3 18-session series completed • Second series beginning in January 2015 and third to begin in April 2015 • Positive feedback from participants (feel better, motivated to continue healthy habits)
Information technology and exchange	Blue Mountain Home Health & Hospice: Improved Communication for Hospice and Home Health	Increase efficiency so workers can spend more time with each patient and patients have a shorter wait time to first visit	• Milestones	• Electronic devices purchased and policies in development • Intermediary data program is in place
Care coordination, including integration of physical and behavioral health	Blue Mountain Hospital District: EHR Enhancement and Patient Portal	• Enhance electronic health records and patient portal • Improve communication among providers • Enable patients to access their health information and communicate with care team • Enable reporting on usage and core measures	• Patients seen • Nurse time spent charting • Patient experience	• Provider-to-provider: Started implementation • In clinic: Equipment and vendor in place to begin. Staff training scheduled • In hospital: Implementation complete
Patient-Centered Primary Care Homes	Warner Mountain Medical Clinic Lake County: Patient Centered Primary Care Development	Obtain patient-centered primary care home (PCPCH) status to become the first PCPCH-recognized clinic in the county	• Acute patient openings per day • 12-18 year olds who had well care visit • Children in first 36 months who have a developmental screening recorded and reviewed	Clinic has implemented an electronic health record and completed several other steps necessary to obtain patient-centered primary care home status

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
FamilyCare, Inc.				
Community health, including traditional health workers	Community Health Education (Homeless Youth Care Team, Family Resource Coordination)	• Develop community-based education programs for members and the community • Coordinate care and community-based partnership of health-supporting social services for homeless youth (includes Outside In, New Avenues for Youth, and Janus Youth programs) • Support a family resource coordinator at Gladstone Center for Children and Families	• Milestones	• Increased connection to Outside In's clinic for preventive care for youth • Average clinic interactions per youth increased from 2.34 to 3.1 • 317 participants received direct services including 48 early childhood screenings and 158 connections to pediatricians and medical homes. Ninety percent of the participants followed through with the agreed upon referrals and recommendations. • RFP issued for community health education programs; 32 proposals received; hiring a Community Health Improvement Plan Coordinator
Community health, including traditional health workers	Promoting Nutritional Emphasis	Establish nutritionist services to promote enhanced health and wellness to members and the broader community	• Nutritionist visits to providers • Nutritionist visits to classes in schools • Collaboration with providers FamilyCare Care Management team	Registered dietician nutritionist: • Facilitated Cooking Matters program (nutrition and cooking classes) • Visited FamilyCare providers to assess nutrition-related practices • Provided trainings to three providers Dietetic interns placed at clinics
Oregon Health Plan member engagement	Re-Engineering Integrated Care	Implement patient/provider oriented resource teams (P²ORTs) to achieve effective, timely and positive connections between providers and members	• Milestones • Provider satisfaction • Patient satisfaction • Emergency Department utilization • Hospital readmissions	• 9 P²ORTs operational • Asian Health Services Center community health workers provided welcome calls, redetermination calls and health risk assessments to newly assigned Asian members (3722 member contacts) • Assigned all primary care physicians to a P²ORT (over 600 providers at over 160 clinics)
Care coordination, including integration of physical and behavioral health	Improving Health Information Technology Infrastructure	• Identify and assess current provider use of electronic health records and other care management applications • Identify barriers to provider use of electronic health records and health information exchange • Implement tools to support provider panels	• Use of electronic health record • Provider comments regarding resistance to electronic health record implementation • Link to Patient/Provider Oriented Resource Teams	• Surveyed all contracted primary care providers (approximately 30% of providers in the FamilyCare network) about electronic health record systems used, plans for change, progression on the "Meaningful Use" continuum and data export capabilities • Created the Year 1 Technology Plan • Initiated implementation of a utilization analytics solution to help identify opportunities to improve care management and care integration • Implementing the Pre-Manage function of the emergency department information exchange (EDIE) system to provide alerts to care management staff, providers and community health resources on specific emergency department and hospital admissions
Patient-Centered Primary Care Homes	Patient Centered Primary Care Home (PCPCH) Technical Assistance	Increase the number of practices in the provider network that are certified as an Oregon patient-centered primary care home	• Members assigned to a Tier 2 or Tier 3 Patient Centered Primary Care Home • Clinic certification renewal at a higher tier • New clinics certified	• Provided one-on-one practice coaching technical assistance to 12 primary care provider groups in pursuit of Tier I-III PCPCH Certification • Member assignment to Tier III clinics increased from 74% to 76%, even with doubling of membership through Medicaid expansion

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Health Share of Oregon				
Patient-Centered Primary Care Homes and information technology and exchange	Strengthening Primary Care Capacity: Telementoring (Project ECHO) and development of an Advanced Primary Care Model	Expand Primary Care capacity with Project ECHO (Extension for Community Healthcare Outcomes), an evidence-based telementoring program with mental health specialists to increase primary care provider capacity for mental health care and decrease the need for specialty visits. Develop an Advanced Primary Care Practice Model. Create clinic-based multidisciplinary teams skilled to help manage patients with complex medical and non-medical socio-behavioral issues (focus: patients with avoidable ED/inpatient hospital use). This work builds upon the Health Resiliency Program, in which Health Resilience Specialists engage highest acuity and costliest patient population in meaningful 'wellness' partnerships that are less medical and more sensitive to their needs. Services are offered where members are - in their homes, homeless shelters and community centers.	• ECHO clinics held • Primary care providers participating via video per clinic • Primary care providers self-report level of knowledge and skills for managing patients with psychiatric medication needs **Adventist – Resilience Center** • Patient goals met • Patient experience • Hospital days and Emergency Department utilization • Per member per month cost **Central City Concern - Old Town Clinic** • Preventable hospital utilization • Patient health outcomes • Patient experience **Legacy - Good Samaritan** • Emergency Department utilization • Mental health screening • Percent of population with a Patient Centered Care Plan **Multnomah County - Northeast** • Clients engaged •Hospital days and Emergency Department utilization • Patient Activation Measure	• Held 15 ECHO clinic sessions (~15 providers each) • Didactic presentations are posted online after each clinic session • Health Share has committed to fund this project for one year after grant ends • All advanced primary care clinics have developed teams, finalized program descriptions and identified metrics • Held three learning sessions with all clinic teams together for three half days; topics included: defining your program, effective teams, program descriptions and metrics, role of the clinical champion, patient case studies, focus on addictions, team accomplishments, Health Resilience Program, team learning systems and addictions resource center
Community health, including traditional health workers	Enhancing Community Health Integration: Community Health Improvement Plan	Support community-based organizations to employ community health workers and peer support specialists to work with members with chronic disease and behavioral health issues	**North by Northeast Community Health Center** • Patients assigned to community health worker • "Clinical topics for community health workers" trainings held and # of attendees • New primary care patients established through outreach efforts **Familias en Accion** • Referrals and enrollments • Trainings provided and participants • Completion of programs **Northwest Family Services** • Clients served • Peer Support Specialists trained • Trainings provided and participants • Community presentations delivered **Center for Intercultural Organizing** • Wellness Life Guides contracted with • Members participating in intercultural group process work • Group process workshops offered • Community specific events held and participants	**North by Northeast Community Health Center** • Provided six-week, 24-hour training • 14 patients assigned to community health worker **Familias en Accion** • Received 49 referrals that became 30 new, low-income clients • Helped with social services, food, insurance applications, medication reconciliation, medical referrals and chronic disease management **Northwest Family Services** • 29 referrals for additional services • 37 individuals receiving mental health support services • Held peer support specialist and Mental Health First Aid training **Center for Intercultural Organizing** • Hired 4 Life Guides • Started monthly community wellness cohorts (Somali, Latino, Marshallese and Iraqi communities)

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Housing and flexible services	Enhancing Community Health Integration: Chronic Disease Management Programs in Supported Housing	Integrate chronic disease management supports in supportive housing environments	• Residents who participate in Living Well with Chronic Conditions program • Level of self-efficacy after participation • Sustainability goals and strategies developed by partners	• Public health nurse has engaged 162 clients; top three self-reported chronic conditions include depression, diabetes and hypertension; two highest risk factors identified are obesity and tobacco use • Public health nurse interventions include health teaching, referral and follow-up; counseling; advocacy; screening; and case management • Held community events to introduce the "Nurse in the Neighborhood" • Made improvements to community spaces as identified by residents
Housing and flexible services	Enhancing Community Health Integration: Expand Healthy Homes Asthma Program	Expand Multnomah County's Healthy Homes Asthma Program to Washington and Clackamas Counties to provide home visits to identify and remove asthma triggers for children in the home	• Emergency department utilization by asthmatic children after the first nurse home visit for a period of 12 months • Hospitalization of asthmatic children after the first nurse home visit for a period of 12 months • Score of the Test for Asthma Control in Kids • Score of the Environmental Assessment for all children	• Developed internal systems to manage and assign referrals • Created program supply kits for public health nurse and community health worker (CHW) • CHW and RN have contacted 38 families (23 total cases: 19 open) • 9 initial nursing assessments • 6 initial environmental assessments • 9 initial track/act assessments
Maternal and child health	Enhancing Community Health Integration: Future Generations Collaborative	• Improve the health of urban Native communities by identifying and addressing the causes of substance-exposed pregnancies among 15-24 year olds • Implement a community-based participatory planning process to develop a community action plan for reducing the impact of substance use on pregnancy in local Native communities • Empower elders and Natural Helpers to steer the project, ensuring trust and interaction between the Collaborative and community	• Reported increase in knowledge of effect of historical and intergenerational trauma on health inequities and health outcomes • Satisfaction with collaborative process • Stakeholder organizations committed to engage in mutually reinforcing activities that address priorities to reduce substance exposed pregnancies	• Awarded a $200,000, 3-year Implementation Grant from Northwest Health Foundation • Engaged 19 elders and natural helpers in winter self-care retreat facilitated by the Native Wellness Institute • The elders and natural helpers were honored by the Native American Rehabilitation Association • Survey shows high rates of satisfaction for capacity building and organizational partner work. • Recruited, oriented and trained 3 new elders/natural helpers
Maternal and child health	(New) Project Nurture: Improve care for pregnant women with substance abuse	• Pilot integration of prenatal services in an addictions treatment setting and integration of addictions treatment services in a midwifery clinic • Improve outcomes for women with substance abuse • Improve rate of substance use recovery • Improve neonatal outcomes	• Enrollment in Project Nurture • Engagement in substance use disorder services prenatal and postpartum • Days in the Neonatal Intensive Care Unit	**Pilot 1: CODA/OHSU Family Medicine** • Two doulas added to team • Held first clinic day **Pilot 2: Legacy Midwifery/Lifeworks** • Created new peer mentor/doula position • Hired case manager • 3 patients scheduled to see certified alcohol and drug counselor • Identified 31 women with substance use disorder (24 prenatal and 7 postpartum)
Oregon Health Plan member engagement	Engaging Members	Increase new member access by changing workflows so clinic staff are working at the top of their license (increase role of RN in patient visits) and develop and pilot a new Member Navigator role to assist members with complex needs	• Hire Member Navigator **Neighborhood Health Center** • Patients attended group new patient appointment • Patients who establish care through progressive visit process • Nurse triage visits provided • Percentage of new CareOregon patients engaged in primary care **Virginia Garcia** • New patients outreached to and patients successfully contacted • New patients assessed and established through new nurse visit process	• Neighborhood Health Center doing patient orientation visits and progressive visits • Close review of new patient process has led to updating forms • Virginia Garcia implemented Swarm Family Nurse Practitioner concept at Beaverton clinic, adding team capacity • Virginia Garcia has been successful in establishing new patients in primary care: Beaverton Clinic established 566 new patients, Hillsboro Clinic established 133 new patients, and Cornelius Wellness Center established 160 new patients.

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Care coordination, including integration of physical and behavioral health	Addictions Provider Education	Upskill primary care providers in basic knowledge of addictions medicine and treatment modalities as well as knowledge of local treatment resources	• Milestones	• Curriculum under development • Day-long CME conference for primary care and behavioral health providers planned with Northwest Addiction Technology Transfer Center • 2 addiction education sessions delivered at grand rounds/trainings with 6 more confirmed
Care coordination, including integration of physical and behavioral health	Improving Community Care Coordination through Information Sharing	Convene partners to align existing efforts in order to optimize multi-system care coordination through the Emergency Department Exchange (EDIE) platform	Under development	• Drafted EDIE Care Guideline template with regional partners
Care coordination, including integration of physical and behavioral health	Leveraging Health Information Technology	Improve Health Share's data aggregation, analysis and reporting solution that will inform transformation and strategic initiatives	• Enhance reporting to include member engagement, geo mapping, etc. and improve data integrity	Project completed; report changes made
Care coordination, including integration of physical and behavioral health	Behavioral Health Promotion/ Prevention	Develop regional approach to community-level behavioral health promotion/prevention activities that promote positive behavioral health and well-being	• Milestones • Outreach to target population in each county • Regional anti-stigma media campaign	• Hired regional coordinator, created regional planning team • Developed website concept including registration, payment platform, data collection and links to resources. Clackamas County will host the website and be the fiduciary agent for the secure payment system. • Helping counties to collaborate on trainer capacity
Intercommunity Health Network				
Information technology and exchange	Regional Health Information Collaborative	Create an integrated longitudinal medical record including alcohol and drug data with mental and physical health providers engaged	• Milestones • Partner organizations engaged • Validation that longitudinal record includes data from health plan, electronic medical record, mental health, alcohol and drug • Signed data share agreements • Organizations contributing data • Usage	• Contract completed with Inter-Systems to implement HealthShare product • Samaritan test clinical data and payer data is currently being tested in the HealthShare product environment
Jackson Care Connect				
Information technology and exchange	Data Sharing and Health Information Technology: Jefferson Regional Health Information Exchange (JHIE)	• Deepen connectivity to the Jefferson Health Information Exchange (JHIE), a collaborative HIE including shared electronic health records, for major addiction and mental health services providers across multiple counties and CCOs • Support adoption of electronic records for the CCO's major addiction service providers • Create a network of service providers committed to the "No Wrong Door" philosophy through Vistalogic (Community Connect Network). Note: Vistalogic is spearheaded by Jackson County Health and Human Services for their new comprehensive building, and will support the local Early Learning HUB work	• Milestones • Addiction service providers using electronic health record • Participating social service, education and health care organizations • System available for production use for all critical participating partners	• System anticipated to be available for use for all partners, including 5 CCOs and 3 hospital systems, by July 31, 2015 • Core clinical partners are being identified, engaged and enrolled in Phase 1, which includes referrals and direct secure messaging • Four core clinical partners are connected • Staff trained on the Community Health Record function • JHIE has expanded HIE, entering into contracts with Mid-Columbia Medical Center, Providence Hood River Hospital and PacificSource Community Solutions CCO • One service provider is completing testing • One provider is working with a consultant on process mapping • Created physical space for the new systems; training employees • Both Jackson County A&D providers have adopted the same electronic health record, as has a service provider in Josephine County

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Complex care, including pain management and trauma-informed care	Care Coordination: Pain Management and Opiate Prescribing Guidelines; Traditional Health Workers; and Case Management Program	• Address chronic pain management and develop standards of coordinated care through comprehensive provider collaboration to reduce opiate misuse and death • Initiate and support programs that improve coordination of care for members with complex health needs • Create and nurture partnerships to improve quality, decrease overall costs and enhance member care. Partnership formed with Jackson Care Connect, AllCare and Jackson County Mental Health (Birch Grove) to support access to primary care services for patients with high acohol and drug treatment needs and mental health needs.	• Chronic pain treatment best practices implemented • Settings with Traditional Health Worker in place • In partnership with AllCare and Jackson County Mental Health, provide primary care services to patients with high alcohol and drug treatment needs and high mental health needs by including screening and educational components	• Implementation of 120mg Morphine Equivalent Dosage policy and provision of alternative pain management options in Jackson County to lower the number of opiates prescribed. • Planning for The Pain Resiliency Program is near completion • Jackson Care Connect/Care Oregon opioid assessment and support team regularly reviews appeals, makes decisions and supports providers • Placed three traditional health workers • Hired nurse case manager; working with CareOregon to develop case management program • Contracted with Cambridge Management Group to work on community linkage mapping and communitywide quality improvement projects • Financial model for the behavioral health clinic in development, one year pilot to implement case rate reimbursement methodology with fee-for-service components • Emergency department visits for patients at one alcohol treatment center have been reduced by > 40%
Patient-Centered Primary Care Homes	PCPCH Capacity Building and Learning	Establish patient-centered primary care home (PCPCH) learning collaborative to build new capacity in primary care clinics Provide support to partners recognized as PCPCH who are committed to deeper dive into this work	• New clinics certified as PCPCH • Percent of members receiving care at a PCPCH • Engage clinical partners on projects related to access, team-based care, and/or integration of behavioral health • Pay for Performance incentives will be offered to PCPCH clinics incentivizing quality measures	• 3 clinic systems enrolled in Pay for Performance incentives to PCPCH clinics incentivizing quality metrics (OHA and others) • Began conversations at 4 of the 6 identified core PCPCH partner clinics to work on self-identified projects related to incentive metrics, access and addressing high risk populations. • 3 additional clinic systems at 9 sites have achieved recognition as PCPCH • Moved from 50% to 70% of members receiving care at PCPCH clinics
Training and development of CCO staff and partners	Systems Management	Ensure resourcing for CCO partners, providers and staff to successfully implement transformation projects	• Relevant training opportunities provided	• Provided training on motivational interviewing • Sponsored staff, board, community advisory council and clinical advisory panel members to attend the Coordinated Care Model Summit (over half of CAC members participated)
PacificSource Community Solutions – Central Oregon				
Care coordination, including integration of physical and behavioral health	Community Paramedicine Project & Medical Transportation System Optimization	• Optimize the medical transportation system for improved quality, cost containment and outcomes • Implement a pilot community paramedicine initiative designed to reduce non-emergent ambulance rides • Contract with transportation systems experts to identify gaps in services and opportunities to improve cost, access and quality of medical transportation options	• Time spent with patient • Access to integrated in-home preventive care • Re-admission rates to ER or hospital in the past year + post intervention; at 30, 60, 90, 120 days. • Medication adherence rates • Number of non-emergent medical transports	**Community Paramedicine Project** • 26 referrals to community paramedic from providers; 26 patients seen (22 of them more than once) • Simplified intake forms and referral process • Anecdotes from patients and providers show increased patient satisfaction due to program **Medical Transportation System Optimization** • Commute Options consultant met with 8 partner agencies • Updated "current conditions" list regarding access to medical services • Commute Options portion of project in holding pattern until further notice from Central Oregon Health Council
Oregon Health Plan member engagement	Member Engagement	• Optimize Oregon Health Plan member utilization, experience and continuity of care within the CCO system by engaging and orienting members with events and social media • Produce 3-part video series and print materials	Members who successfully renewed coverage before their termination date/number of members due to renew	• Held two community events (reached 600 people) • Hired member engagement coordinator and member engagement specialist • Developed materials • Attempted 21,349 member outreach calls (through interactive voice response reminders) about OHP renewal • Finalized evaluation plan

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Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Community health, including traditional health workers	Bending the OHP Dentistry Cost Curve in Central Oregon by Reducing the Burden of Oral Disease	Implement and evaluate a community-wide toothpaste distribution campaign enhanced by education and telephone support for OHP children and families in Central Oregon	• Families using the tooth brushing kits by intervention group • Families reporting the telephone support as positive among the enhanced intervention group • Families reporting that the SMS messages were helpful • Cost of dental services • Rate of hospitalizations for oral health issues	• Completed 450 pre-program interviews with parents of children under 36 months • Collected baseline data • 42,387 kits mailed • 70,724 Televox automated voice messages sent • 64,782 informational mailers sent
Care coordination, including integration of physical and behavioral health	Pediatric Health Engagement Team	Deploy the Health Engagement Team model to advance coordinated service delivery and improve health for up to 60 of the highest cost Medicaid/CHIP children in the St. Charles and Central Oregon Pediatric Associates networks, specifically those with multiple inpatient stays and emergency department visits related to poorly managed diabetes	• Patient health outcomes (EHR) • HbA1c levels Patient compliance • Inpatient admissions • ED admissions • Patient and caregiver's disease-related anxiety and depression level • Patient school attendance • Caregiver work attendance	• Terminated original contract; new vendor identified • One participant had 4 hospitalizations in 2013 (20 inpatient days). Since enrollment (June 12, 2014), he has had zero emergency department and inpatient admissions. • Developed Bluetooth capability for participants to test their blood sugar, which is sent to their care teams • Patient portal is available to participants, family and care team
Maternal and child health	Public Health/Primary Care Partnership: Maternal, Infant, and Child Health (through 12/2014)	Continue systems work with public health and primary care to enhance integration, increase communication and enable new and more efficient processes to serve high-risk pregnant women, infants and children	• Members served • Referrals	• Established new partnerships with primary care by embedding public health maternal health educator (8 hours/week) • 48 clients served • 144 referrals (avg. 3/client) • Services included OHP application support, WIC certifications, and referrals to home visiting, dental, primary care and behavioral health, social and community outreach agencies
Maternal and child health	Pediatric Hospitalist Program	Develop a pediatric hospitalist program to provide greater continuity of care, care coordination, increased access to care and to bring new inpatient care options to the region	• Patient satisfaction • Length of hospital stays • Patient access to care • Hospital re-admission rates	• Weekly collaborative meetings of providers • Program administrator/medical director hired • Half-time hospitalist hired • Positive reviews from all areas, especially emergency department and pediatric nurses • Providing care continuity not available previously
Alternative payment models	Global payments for practices that integrate behavioral health into primary care	The project identifies integrated practices, prepares practices to collect data that will inform integration efforts and builds infrastructure to evaluate a global payment model. The global payment model aims to improve quality and reduce costs by facilitating the coordination of behavioral and physical health care.	Integrated practices identified, completing a comprehensive work flow documenting their model, using a cost tool	• Completed site visits and initial assessments for two practices • Team will select 2-4 more practices to participate
Housing and flexible services	Flexible Services Fund	Determine if funding items/services not currently covered by Medicaid will enhance patient experience and quality of life, and reduce overall health care costs within the target population	• Patients receiving documented flexible items/services • Provider satisfaction with process • Engagement of patient with primary care provider, related to flexible services	• Project implementation complete • Providers selected and invited to participate • Evaluation in process with Central Oregon Research Coalition
Care coordination, including integration of physical and behavioral health	Central Oregon Clinical Pharmacy Services (CPS)	Demonstrate a reduction in medical and prescriptions costs for patients with chronic conditions via an ambulatory clinical pharmacist embedded in primary care practices	• Rate of adverse Rx events due to polypharmacy and non-adherence • Patients enrolled • Provider satisfaction • Inpatient and Emergency Department utilization	• Pharmacist hired • 71 patients have received a comprehensive medication review • Identified 228 medication related problems (average 3/patient). • Pharmacist connected to prescription claims data and communicates medication adherence problems to provider • Decreased workload for providers
Information technology and exchange	Telemedicine: Bridging Specialty Care Barriers for Mosaic Medical Patients	Improve access to specialty care through telemedicine services, thus removing geographic, economic, social and cultural barriers	• No show/show rate for scheduled appointments • Process time; length of time from primary care provider referral to telemedicine consult completion	• Launched with first patients October 21, 2014 • Purchased and installed hardware and software • Trained staff • Scheduling two patients every other week • Included RN to explain tests • Positive feedback from patients

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Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
PacificSource Community Solutions – Columbia Gorge				
Community health, including traditional health workers	Meals on Wheels for post-surgical patients	Prevents avoidable rehospitalization and minimizes adverse outcomes following surgery or hospitalization through delivery of meals	• Clients enrolled • Meals delivered • Food insecurity • Risk of malnutrition	• Served 243 meals • Outreach to discharge planners, outpatient clinics, same-day surgery staff and surgical specialist offices • Gaining interest from community • No re-hospitalizations or infections • All clients reported satisfaction with services, reports of alleviated stress • Created meaningful measures, analysis plan and reporting tools
Community health, including traditional health workers	Community health worker training center	Builds workforce capacity through a sustainable training center for community health workers	• CHWs trained • Supervisors trained • CHWs certified • CHWs trained to teach	• Implemented Train the Trainers program, certified 8 trainers • Trained 26 CHWs, outreach workers, case managers and other providers (90 hours) • Trained 12 CHW supervisors • Developing advanced CHW certification • Secured additional $75,000 funding to sustain and expand program
Community health, including traditional health workers	Community Action Plan for Reducing Childhood Obesity	Develop a community coalition that agrees to a collective impact plan to lower the percent of overweight and obese elementary school children in Wasco County	• Children measured • Percent overweight • Percent obese • Process measures: partners engaged, meetings held, participant feedback, Declaration of Cooperation	• Change of scope from short-term solutions to consortium building and long-range planning; approved by clinical advisory panel • Produced an educational video on the obesity epidemic (http://youtu.be/ZAdz2pkW4f0) • Produced exhaustive report to analyze childhood obesity and related factors in The Dalles (in North Wasco County elementary schools, 38% overweight, 22% obese -- compared to 30%/15% in Oregon)
Community health, including traditional health workers	Intentional Peer Support (IPS) Training	Contribute toward a stronger, healthier, inter- connected community by supporting training for at least 20 persons in the region in the Intentional Peer Support model	• Participants	• One-week course held • 21 participants representing 6 agencies • Participants said class increased their skills and was personally enriching
Care coordination, including integration of physical and behavioral health	Network Coordination "Hub"	Develop, coordinate and connect a region-wide network of staff embedded in multiple agencies and sectors in our region and positioned to find community members in need of specific services, across which multiple health outcomes related to those services can be pursued in a Pathways Community Hub model	Process steps: Declaration of Cooperation, program manager hired, CGHC-PacificSource agreement, steering group formed	• 501(c)3 application accepted • Project manager hired • Commitments from over 20 regional agencies across health care, housing, social services and education (including early learning)
Complex care, including pain management and trauma-informed care	Community Health Team Phase II	Improve the activation and health behaviors and reduce the costs of at least 120 OHP members predicted to be "high cost" in the Columbia Gorge	• People enrolled 6 months pre & post enrollment: • Emergency Department utilization • Activation of enrollees • Total allowed costs of enrollees	• 36 patients currently or previously enrolled (28 current, 8 graduated) • Use agreement signed with Central Oregon Independent Practice Association for Patient Activation Measures • Received 77 referrals
Complex care, including pain management and trauma-informed care	Chronic Pain Strategic Education for Providers	Develop a regional strategy for managing chronic pain patients with the goals of improving quality, reducing risk for patients and community, reducing cost and improving health	• Presentations • Providers trained • Population claims data	• Provided 11 presentations to 190 primary care providers and allied health workers • Implemented opiate utilization management strategies on Dec. 1
Oregon Health Plan member engagement	Proactive Health Screening & Orientation	Proactively identify and engage OHP members new since January 1, 2014, who have been identified as high risk by collaborating with medical homes and contacting members to understand their needs, to facilitate their establishment of care and coverage and to provide information on health plan benefits	• Identified members • Identified members reached • Established care with primary care provider • Videos produced	• Member engagement coordinator hired • 3 videos produced • Identified 70 new members and 59 previous members as high utilizers • Secured 200 licenses for Patient Activation Measure
Patient-Centered Primary Care Homes	Care Management Training	Using a "train the trainer" model, disseminate high-quality training about chronic disease management and care coordination within and between PCPCHs and the CHW Hub, to Develop Nurse Care Managers at all 5 Primary Care Clinics in the Mid-Columbia Outpatient Clinic system	• People trained • Emergency department visits • Rate of SBIRT (screening, brief intervention and referral to treatment) for acohol and drug use • Rate of developmental screenings	• Two RNs certified in OHSU's Care Management+ program • These certified RNs trained 7 other RNs, 6 have completed certification • Increased 6-month average monthly emergency department visits (491, compared to target of 404) • Increased percentage of SBIRT screenings (31%) • Increased percentage of developmental screenings (33%)

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Care coordination, including integration of physical and behavioral health	Clinical Pharmacy Services Project, Phase I	Improve health status and clinical outcomes, and reduce medication- related problems and/or overall health care costs through the use of a clinical pharmacist embedded in primary care and working directly with patients in a collaborative, inter-agency effort	• Patients enrolled • Provider satisfaction • Inpatient hospital utilization • HbA1C (blood sugar average) • LDL cholesterol • Adverse pharmacy events	• 108 patients seen by clinical pharmacist (28 had second visit, 5 had third visit) • Identified 441 medication-related problems (avg. 4/patient) • Of problems needing provider approval, 94% of recommendations were accepted
Care coordination, including integration of physical and behavioral health	Clinical Pharmacy Services Phase II	Improve health status and clinical outcomes, and reduce medication-related problems and/or overall health care costs through the use of a clinical pharmacist embedded in primary care and working directly with patients in a collaborative, inter-agency effort	• Patients enrolled • Provider satisfaction • Inpatient hospital utilization • HbA1C (blood sugar average) • LDL cholesterol • Adverse pharmacy events	• 6 of 27 referred patients have agreed to medication therapy management services and met at least once with pharmacist • Average of 6 clinical interventions per patient seen • 85% of interventions accepted by patient or provider • Barrier of transfering information between hospital and clinic electronic medical records has been resoolved
Care coordination, including integration of physical and behavioral health	Practice Facilitation support with Behavioral and Physical Health Integration Modeling	Assist primary care practices and a community mental health center to develop capacity for integrating behavioral health and primary care	• Clinics participating • Minimum data set • Agency for Healthcare Research and Quality (AHRQ) lexicon • Use of CoACH cost tool	• Memoranda of understanding with five practices • All-provider meetings with two of the participating clinics • CoACH cost tool piloted, introduced to five practices • AHRQ replaced by Comprehensive Primary Care Monitor • Behavioral health agency therapists now able to view electronic health records at community health clinic
Information technology and exchange	Community-wide Health Information Exchange	Leverage and enhance existing technology and information solutions to support robust point-to-point and virtual coordinated care secure messaging plus health information exchange and data aggregation across the primary institutions of health care and social service delivery for OHP clients	• Licensed users for secure messaging • Referrals tracked • Agencies using referral tracking • Providers using secure messaging/ providers with access to secure messaging	• 9 organizations on first wave of registration process • Hood River County Health Dept. go live on Ahlers electronic health record November 19, 2014
Maternal and child health	Emotional Literacy Training	Increase parents' awareness and understanding of children's social/emotional needs	• Parents trained • Children completing • Parental self-report • Engagement of physicians	• 200 posters produced • Over 10,000 direct mail cards sent • Project coordinator trained • Presented at Making the Connection Conference • Began contract to track participant engagement
Oregon Health Plan member engagement	Enrollment Continuity	Increase the rate of continuous enrollment in the Oregon Health Plan for those members who continue to qualify	Successfully renew coverage/ due to renew coverage	• Implemented interactive voice response reminders to members nearing redetermination deadlines • Connected with Columbia Gorge enrollment assisters • Contracted with high-performing enrollment assister not funded by OHP
Complex care, including pain management and trauma-informed care	Persistent Pain Education Program for Patients	Correct maladaptive pain cognitions amongst program participants and instruct them in self-directed lifestyle changes to improve overall health and function while decreasing pain perception through an 8 session curriculum, using expert presenters	• Participants • Provider survey At entrance/exit: • Reported pain • Locus of control • Patient activation • Opioid use	• Completed 5 cycles of the 8-week program • 100 people completed some or all classes • Videos posted: http://mcmc.net/News/1193/persistant-pain-education • 26.3% of participants had clinically significant improvement in pain score with activities of daily living (ADLs) • 31.3% of participants had clinically significant improvement in depression score • Average 5.61 point improvement for the Chronic Pain Acceptance Questionnaire • Multidimensional Health Locus of Control: Largest change in score was in the "Internal" locus of control category (considered the most beneficial)

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Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
PrimaryHealth of Josephine County				
Maternal and child health	Maternal Medical Home	Maternal medical home engages in education and outreach with care management focused on women at highest risk for poor birth outcomes	• Timeliness to prenatal care • Prenatal screening for clinical depression • Prenatal substance abuse screening • Elective delivery before 39 weeks	• PrimaryHealth and Women's Health Center of Southern Oregon launched pilot project for the Maternal Medical Home in August 2013 • An alternative payment method for the pilot was transitioned under the Transformation Grant in October 2013 • Providing PrimaryHealth with a risk stratified monthly roster of pregnant patients under their care • Increased access to first prenatal visit (in the third quarter of 2014, 75.6% of patients had initial visit within 12 weeks representing an 18% increase over first quarter); increased screening (93% of patients received postpartum depression screening representing a 365% increase over first quarter); and decreased caesarean delivery rate (decreased by 42%).
Training and development of CCO staff and partners	Transformation Training Programs	Staff, clinics, and community partners participate in educational activities that support the development of an enhanced delivery system	• Primary care clinics, staff and ancillary providers who have participated in educational programs • Trainings and attendees	• The Quality Improvement Director took on the role of Portfolio Manager • An experienced RN/CPHQ within the CCO has taken on the role of CCO Transformation Guide to implement grant related activities and evaluate and collect data • Hired and trained two new outreach workers
Care coordination, including integration of physical and behavioral health	Information Technology	Implement software and enhanced reports to guide transformational efforts and create enhanced CCO utilization reports and/or dashboards for CCO staff and clinics to guide improvements	Primary care clinics having access to data/dashboards	• PrimaryHealth secured a licensing agreement with a software vendor, Architrave. The Inteligenz software was implemented May 1, 2014, and identifies at-risk and high-utilizer populations. • Assisted Choices Counseling Center in implementing electronic medical records to improve communications between alcohol and drug treatment providers and other providers
Care coordination, including integration of physical and behavioral health	Enhanced Care Delivery System Pilot	Make improvements on quality and outcome measures, total cost of care, and patient satisfaction with care through enhancements in the delivery system	• Individuals who receive a behavioral health assessment following referral • Adolescent well visits	• Developed and implemented Behavioral Health Therapist, Alcohol and Drug Counselor, Medical Home Assistant, Community Outreach Worker, and Education to Support Transformation positions • Only 43% received a behavioral health assessment following a referral (target 60%), but potential data calculation discrepancy. Exceeded behavioral health target to increase referral 15% over baseline. Screenings conducted increased from 50% to 80%, and 100% of behavioral health encounter treament plans shared with primary care provider. • SBIRT (screening, brief intervention and referral to treatment) encounters are increasing rapidly and alcohol and drug treatment referrals engaging individuals unable to engage prior • Original pre-visit screening process for Medical Home Assistants was piloted and not successful • Two Community Health Workers manage a caseload of 30-40 high utilizers. Per member per month costs for these members has decreased 46% from the pre-engagement median of $1826 to the post-engagement a median of $989. • Hired nurse case manager
Information technology and exchange	Network Health Information	Increase participation in a regional platform to allow community providers to coordinate care effectively and may connect to other regional platforms in the future	Primary care clinics able to securely share a portion of health information in real time	• The Jefferson Health Information Exchange (JHIE) currently has 250+ providers enrolled in Josephine, Jackson and Klamath Counties. Jackson Care Connect, Cascade Health Alliance and AllCare are also members and financial supporters of JHIE. • Public health is actively involved on the following JHIE committees: Finance, Policy and Procedures, Behavioral Health • Encouraging providers to enroll, prioritizing contact with larger clinics to impact the largest number of providers and assigned CCO members • The IT staff hired has been instrumental in implementation of the Inteligenz software and ECHO implementation for Choices Counseling Center

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Patient-Centered Primary Care Homes	Patient Centered Primary Care Home Development Support	Increase the number of clinics certified as patient-centered primary care homes (PCPCHs)	Members assigned to PCPCHs certified in Tier 2 or 3	• >99% of members receiving care at a certified patient-centered primary home clinic (increase from 95%) • One clinic certified as a Tier 3 PCPCH in May 2014 • Two remaining sites are not certified with 100 (of 10,564) members assigned to sites' primary care providers. One plans to apply for PCPCH soon and another is still considering an application. • Primary care is embedded into the Community Mental Health Program. • Conducted 7 learning sessions and 4 collaborative learning lunches for PC3 learning community, with 3 additional trainings related to quality improvement. • Funding a 0.5 FTE alcohol and drug counselor to work on site at an FQHC
Training and development of CCO staff and partners	CCO Staff Transformation Development	Ensure this work is prioritized by adding staff FTEs in transformational roles and/or with time dedicated to project facilitation and transformational work	Community health worker costs per member per month	• Supported staff at trainings: Medical Home Practice Coach, IHI Improvement Leader, SBIRT, End of Life, Compliance, ACEs and Trauma Informed Care • Supported multiple staff and CAC member attendance at 8 local and national conferences • Supported multiple staff attendance at local complex care management meetings, leadership retreats, learning collaboratives and policy meetings
Trillium Community Health Plan				
Information technology and exchange	Shared Care Plan: Enhance and facilitate Health Information Exchange	At the core of the Shared Care Plan project is a web-based platform, Care Team Connect © (CTC), a secure, web-based integrated care management tool that brings together disparate care team members across the health delivery network to coordinate care within a shared, patient-centric care plan	• Milestones • Providers utilize health information exchange • Provider satisfaction using health information exchange	• Technology plan updated • IT designed workflows and developed configurations • Proof of concept approved by OHA • Environmental scan of primary care offices' electronic health records • Retained TransforMED to assist 8 medical practices with redesigns needed before Crimson Care Management could be developed and configured
Care coordination, including integration of physical and behavioral health	Shared Care Plan: Integration of Physical and Mental Health and Development of PCPCH	A CCO pilot project in which behavioral health is integrated into four primary care clinics and physical health is integrated into four behavioral health clinics. Sites have the capacity to serve 14,603 CCO members in the primary care clinics and 2,300 in the behavioral health clinics.	Under development	• Launched pilot program for integrating primary care into behavioral health care with eight clinics participating • A full-time Transformation Plan Project Coordinator is coordinating the administrative transformation to support the project • TransforMED was retained to consult with 14 clinics in 2014 to assist with rapid cycle change for the development of care coordination, access, practice-based team care and population health management • Hired a Performance Metrics Coordinator to assist PCPCHs with improving quality rates. This individual runs monthly Metrics Learning Collaboratives and visits clinics to provide direct support of business processes. • In the process of hiring and training 12 Clinic Performance Assistants to be embedded in clinics to assist with workflow that affects performance
Care coordination, including integration of physical and behavioral health	Shared Care Plan: Improve Care Coordination and Disease Management	Improve care coordination and disease management to ensure improved outcomes for quality measures	• Calls after emergency department use • Follow-up visits after mental health assessment • Mental health and physical health visits for DHS kids • Relevant quality and incentive metrics • Provider satisfaction	• Second Crimson Care Management training for Lane County Perinatal staff completed. Information exchange active • All Trillium Physical Health / Behavioral Health Care Coordinators and community health workers are using care managment system • Implemented complex case management • Shared care plan functioning for Medicare and Medicaid members • Hired Health Integrated to perform health risk assessments and manage disease management programs

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Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Oregon Health Plan member engagement	Shared Care Plan: Engage Members in Their Care and Well-Being	Engage members in in their care and well-being by assigning them to a community health worker and engaging them in writing a care plan	• Members assigned a community health worker or engaged in goals for a care plan accessed Crimson Care Management • Patient satisfaction with shared care plan • Outcomes for members engaged in shared plan vs. those who did not	• Smoking cessation program launched • The clinic performance assistant program will incorporate a patient engagement component and connect with members • Developed a member incentive program that provides members with a $15 gift card for certain services (up to $45/member) • Working with Health Integrated to perform member health risk assessments and engage members in disease management programs • Community health worker program overall savings-to-cost ratio is 2.71
Umpqua Health Alliance				
Care coordination, including integration of physical and behavioral health	Expanded Care Clinic	This specialized clinic for patients with complex conditions provides coordinated care through integrated physical and mental health, addiction, dental and nurse case management services. Serves as a "hot spot" and provides high staff-to-patient ratios, much improved access and other co-located services.	• Emergency department utilization • Hospital utilization • Pharmacy reviews • Patient satisfaction	• Assigned 76 members to expanded care clinic • Preliminary results: 1% fewer inpatient hospitalizations; 19% decrease in average length of hospital stay; 1% average monthly decrease in emergency department visits; and 50% increase in number of primary care visits.
Community health, including traditional health workers	Implementation of Community Wellness Services	Offer wellness services for members, using Community Health Improvement Plan as a guide	• Wellness events offered during grant period • Community partners involved in program offerings	• Launched pilot project for a physician-referred 12-week outcome based health and wellness program • Members >21-years referred by primary care provider to Healthy Living Challenge program receive comprehensive health assessment, exercise and nutrition logs, weekly weigh-ins, pedometers, BMI and body-fat analysis, fitness classes, nutrition and motivational workshops, and incentives for participation • Initial observations demonstrate active participation and some very engaged participants
Non-emergent medical transportation	Non-Emergent Medical Transportation Services	Develop and implement a plan to best serve the transportation needs of members and maintain non-emergent medical transportation as a community endeavor	Transportation services provided by the CCO	• Non-emergent medical transportation services to be transferred to CCO on July 1, 2015 • Met with consultant • Proceeding with option to improve existing brokerage model • Preliminary contract in development
Patient-Centered Primary Care Homes	Expansion of Patient Centered Primary Care Homes	Expand the patient-centered primary care home (PCPCH) to smaller and more rural practices	• Members served in Tier 2 clinics • Members served in Tier 3 clinics • Clinics certified as patient-centered primary care homes at any level • Clinics certified at increased tier level	• New PCPCH coordinator hired • Coordinator conducted visits with network providers about methods to assist with initial and increased-level PCPCH attestation • Coordinator developed tools to assist with preparing for PCPCH site visits • 89% of CCO members are served in Tier 2 or Tier 3 recognized PCPCH (1.5% Tier 2 and 87.5% Tier 3
Care coordination, including integration of physical and behavioral health	Co-location of Addiction and Primary Care Services	Increase the number of patients who see addiction counselors by co-location of services	Patients referred to addiction services who attend first visit	• Co-location of Addiction and Domestic Violence Advocacy Agency well established in an office sharing a campus with large primary care clinic • Two agencies providing routine service delivery in co-location office • Gradual increase over prior 6-months for member referrals to the two agencies • Exceptional appointment follow-through rate for referred members
Care coordination, including integration of physical and behavioral health	IT Population Metrics Solutions	Use patient-centered electronic health record to make it easy for providers to know who needs the services and prompt them to perform the service	• Population health staff meetings with provider clinics • Providers engaged in population health metrics • Providers who receive reports regularly • Providers using population health staff outreach	• Population health staff continue to conduct outreach visits with primary care provider clinics and share provider performance • Implemented new provider portal; gives providers access to individual performance for applicable CCO and state performance measures • Primary care providers actively using CCO and State performance measures to support member panel health management

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Western Oregon Advanced Health				
Care coordination, including integration of physical and behavioral health	Advanced analytics to identify needs of patients requiring complex care	Allows ambulatory care providers to access patient information which risk stratifies those with high needs. Data informs development of cost-effective coordinated care plans. The provider at the point-of-care, with full access to risk analytics, is quickly able to discern the patient's: risk factors for multiple health conditions; overall risk score; total potential cost; risk acuity level; early morbidity potential; and whether or not the patient's medical condition is trending in an improving or deteriorating direction and how rapidly.	• CCO physicians able to access advanced analytics • CCO Medicaid members whose medical information may be accessed through advanced analytics system • Ambulatory Care Sensitive ratios • Cost avoidance values	• The project has identified baseline Ambulatory Care Sensitive Ratios, by zip code, for the general population, based on calendar year 2011-2012 data • Risk stratification tool is operational at multiple pilot physician practices • Hired a data analyst dedicated to the advanced analytics program • Contractor will be working with Bay Area Hospital to develop systems for populating recent and real-time data to hospital admissions, discharges, and emergency department visits
Care coordination, including integration of physical and behavioral health	Medication Therapy Management	Provide CCO members who are concurrently diagnosed with certain persistent mental health conditions and diabetes with active Medication Therapy Management services	CCO Medicaid members diagnosed with bipolar or psychotic conditions and diabetes who receive Medication Therapy Management services	• At least 40 percent of all CCO members who are concurrently diagnosed with certain persistent mental health conditions and diabetes are receiving active Medication Therapy Management services • Using three strategies: 1) Medication Therapy Management, 2) Medication Reconciliation, and 3) 340b Pharmacy Pricing • Currently conducting PDSAs for hospital readmissions • Medication Reconciliation has commenced at Waterfall Community Health Center for patients discharged from Bay Area Hospital. Anecdotal feedback from patients and providers has been positive.
Information technology and exchange	Planning and Implementation for Analytics and Shared Community Health Information	Advance the planning, development and implementation of a community health information exchange	Milestones	• Planning phase completed • Established free-standing legal entity and governance structure
Training and development of CCO staff and partners	Strategic Transformation Planning and Portfolio Management	Establish transformation charters for all aspects of the organization's undertakings through a consolidated strategic and transformation plan	Portfolio projects brought to completion, resolution or appropriate development level	• Multiple projects brought to completion: Spanish Language Health Interpreter Training, onboarding the Child and Adolescent Needs and Strengths (CANS) assessment, further integration of addiction and primary care services through the retention of a health psychologist who works in multiple settings, and advocacy for the local delivery of accredited training for traditional health workers • Review of operating systems informed the strategic decision to retain the services of a Chief Operating Officer and a Customer Service Manager
Willamette Valley Community Health				
Developmental screening	Early Learning Developmental Screening	Increase community-wide documentation of developmental screens Enhance the coordination of developmental screens across the health care and early learning education system Increase CCO developmental screening rate	Screens administered in the community	• Distributed a community survey to identify the frequency of developmental screens administered in the community • Partnering with the Early Learning Hub to upgrade software systems to enable documentation of developmental screens outside medical system • Will be coordinating with the Early Learning Hub's new Screening and Care Systems Coordinator to promote use of the Ages and Stages Questionnaire (ASQ) developmental screening tool • Held ASQ train-the-trainer sessions • Developing a strategy for electronic transition of developmental screens
Care coordination, including integration of physical and behavioral health	Care Coordination for Children with Complex Medical Needs	Develop a centralized care coordination system that supports the provision of services across physical, mental and children's health services	Families served	• Held kickoff meeting with care coordination stakeholders • Trained Family Support Coordinators in wrap-around care models • Participating clinics held information sessions about the program

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Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Information technology and exchange	Community Health Information Sharing	Pilot software solution for data aggregation, analytics, and population health management	Members served	• Finalized agreement with Arcadia Health Solutions • Shared claims information with Arcadia for the pilot
Patient-Centered Primary Care Homes	Patient Centered Primary Care Home Development	Develop high-functioning medical homes by hosting learning collaboratives	• Clinics certified as patient-centered primary care homes • Learning collaborative attendance	• Hosted first of three PCPCH Basics Learning Collaborative sessions, partnering six primary care providers with the Oregon Rural Practice-based Research Network • Contracted with the Oregon Pediatric Improvement Partnership (OPIP) to lead a Patient Engagement Learning Community. OPIP has completed clinic site visits and held a kick-off meeting with all participating clinics.

Yamhill Community Care Organization

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Oregon Health Plan member engagement	Population Health Management Clinical Initiatives	Assist members gain access to appropriate settings of care and decrease costs by facilitating efficient use of network services: **Provoking Hope** • Connect at-risk expecting mothers to OHP, primary care and community support programs **Community-based EMS Model Program** • Provide routine primary care services outside the clinic or hospital to members in rural areas with limited transportation **SNACK Program** • Improve health and wellness by providing nutrition education and physical activity services to adolescents and families **Newborn Tool Kit** • Reduce emergency department use in the first year of life in the newborn population born at Willamette Valley Medical Center	**Provoking Hope** • Expectant mothers referred • Expectant mothers engaged with their patient-centered primary care home • Addicted and/or recovering mothers served **Community-based EMS Model Program** • Members served per quarter • Types of services provided • Follow-up care post hospital discharge • Treatment and education of high-frequency users **SNACK Program** • Nutrition classes held • Children/families in nutrition classes **Newborn Tool Kit** • Tool kits given out • Newborn visits to emergency department	• Engaged 57 moms through the Provoking Hope project • Referred three members to primary care services through the Community Based Emergency Medical Service Model Program • Provided nutrition education to 24 children, ages 11-17, through the Student Nutrition and Activity Clinic for Kids (SNACK) Program • Created the Newborn Tool Kit, which aims to reduce emergency department use in the first year of life of newborns born at Willamette Valley Medical Center
Complex care, including pain management and trauma-informed care	Chronic Pain Management Solution	Implement a systemwide program to address member's needs facing chronic pain and to provide a place of referral for these individuals	• Opioid prescriptions written • Patients referred to pain clinic • Patients who attended orientation • Patients who started pain school; completed • Cost per patient per year for pain school • Percentage of patients diagnosed with chronic pain enrolled in chronic pain management program • Providers trained in chronic pain management • Providers who adopt Community Prescribing Guidelines	• Developed Community Prescribing Guidelines • Developed a model of care • Identified a behaviorist • Held a pain summit • Will soon launch the Persistent Pain and Wellness Center
Alternative payment models	Value-based payments in a maternal medical home	Coordinate value-based payments for behavioral and physical health services at a maternal medical home. Rewards providers for value, not volume.	• Alternative payment models developed for patient-centered primary care home and maternal medical home • Providers who apply for alternative payment method • Providers receiving alternative payment method	A consultant is working on a Maternal Medical Home alternative payment model

Focus Area	Project	Aim(s)	Metric(s)	Status and Preliminary Results (January 2015 Report)
Care coordination, including integration of physical and behavioral health	Embedded Behaviorist Program Expansion	Expanded delivery of behavioral health services in physical health settings to allow for better coordination and delivery of patient-centric care in a single setting	• Expectant moms who saw behavioral health provider • Expectant moms entering care in first trimester • Expectant moms screened for depression • Expectant moms receiving SBIRT screening (alcohol and drug misuse)	• A behaviorist was hired and is beginning to see patients • Conducted site visits as part of the Villa Medical Behavioral Health Expansion project • Site visits for women's clinic behavioral health expansion projects and Psy D program are scheduled
Care coordination, including integration of physical and behavioral health	Primary Care Provider Team Expansion and Bilateral Integration Support	Increase access to primary care services as well as streamline and better coordinate the delivery of physical and behavioral health services in a single physical location to provide timely care	• Patients assigned to each clinic • New patients engaged in care	• Approximately 500 members were assigned to Willamette Heart Clinic • 130 members were assigned to Villa Medical Clinic • Approximately 800 members were assigned to Virginia Garcia Memorial Health Clinic
Information technology and exchange	Local Health Information Exchange Tool Implementation/ Support	Effeciently use and coordinate health care resources through electronic exchange and analysis of health information	• Milestones • Yamhill CCO providers enrolled in health information exchange tool	PreManage has been chosen as the health information exchange tool. It includes a flexible notification system and care coordination platform.
Care coordination, including integration of physical and behavioral health	Data Coordination & Health Strategy Support	Manage and analyze multiple data feeds consisting of utilization, cost, quality and performance information to support clinic level activities	• Agencies represented in work group • Milestones	• Onboarded staff to work on program development, program management and data analytics • Quality Program work group meets regularly
Patient-Centered Primary Care Homes	Medical Home Model Development	Help advance all providers to the tier 3 medical home level as well as develop maternal medical homes for all OB/Gyn providers	**Patient-centered Primary Care Home (PCPCH) Collaborative** • Clinics in service area at least tier 2 • Clinics involved in learning collaborative **Member Engagement Specialist** • Expectant moms contacted • Expectant moms engaged in PCPCH • Expectant moms provided assistance connecting to their PCPCH	• A PCPCH learning collaborative, supporting providers/clinics in obtaining Tier 3 status, will launch in February 2015 • Hired and trained a member engagement specialist • Developed a Maternal Medical Home model

Appendix C: Preliminary Outcomes for Select Transformation Fund Projects

CCO	Project	Preliminary Outcomes (January 2015 Report)
Cascade Health Alliance	Mobile Crisis Team	• 59% decrease in emergency room mental health crisis visits
Columbia Pacific CCO	Opiate Performance Improvement Project	• 17% increase in self-efficacy and 7.3% decrease in depression for 27 pain-clinic clients
FamilyCare, Inc.	Community Health Education	• 317 homeless youth gained access to a medical home
Health Share of Oregon	Project ECHO	• 15 primary care clinicians expanded their capacity to serve patients with behavioral and mental health issues
Jackson Care Connect	Care Coordination: Pain Management and Opiate Prescribing Guidelines; Traditional Health Workers; and Case Management Program	• 40% decrease in emergency department visits for patients at one alcohol treatment center
PacificSource Community Solutions – Central Oregon	Central Oregon Clinical Pharmacy Services	• 228 medication problems identified for 71 patients
PacificSource Community Solutions – Central Oregon	Bending the OHP Dentistry Cost Curve in Central Oregon by Reducing the Burden of Oral Disease	• 42,387 dental tool kits in English and Spanish mailed to the homes of all OHP members
PacificSource Community Solutions – Columbia Gorge	Meals on Wheels for Post-surgical Patients	• 243 meals served; no re-hospitalizations or infections occurred
PacificSource Community Solutions – Columbia Gorge	Persistent Pain Education Program for Patients	• 26.3% pain-score improvement and 31.3% depression score improvement for 100 people
PacificSource Community Solutions – Columbia Gorge	Care Management Training	• 31% increase in SBIRT screenings and 33% increase in developmental screenings at partner clinics
PrimaryHealth of Josephine County	Maternal Medical Home	• 18% increase in access to first prenatal visit, 365% increase in post-partum depression screening and 42% decrease in caesarean delivery rate
PrimaryHealth of Josephine County	Enhanced Care Delivery System Pilot	• 46% decrease in monthly costs for over 30 high-need patients