Testimony before the House Committee on Health Care

Representative Mitch Greenlick, Chair

By

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PrimaryHealth of Josephine County, CCO

PrimaryHealth's Mission is to participate in the development of a healthier community, one person at a time.

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Section 1: Organizational Structure

History and Governance Structure

PrimaryHealth of Josephine County is a Coordinated Care Organization which was certified by the Oregon Health Authority in September, 2012. PrimaryHealth was originally founded in 1992 as Oregon Health Management Services (OHMS), a Physician Care Organization (PCO). PrimaryHealth and its shareholders are committed to serving low income and vulnerable individuals in our community. PrimaryHealth serves the residents of rural Josephine County. The PrimaryHealth service area extends into the contiguous zip codes which cover the outskirts of Jackson and Douglas Counties. PrimaryHealth offers Medicaid and Medicare services, Atrio Health Plans is our partner for the Medicare population. Oregon Health Management Services, the current owner of PrimaryHealth, also owns and operates Choices Counseling Center, founded in 1995 to provide Chemical Dependency services to health plan members and other residents of Josephine County.

PrimaryHealth is ultimately governed by a Board of Directors. The Board has three subcommittees that inform the Board of the work of the CCO. These are the Quality and Compliance Committee, Clinical Advisory Panel, and Community Advisory Council. Each of these is comprised of a multidisciplinary group of stakeholders and community partners that represent the overall community of care providers. The Community Advisory Council (CAC) is made up of 51% consumer members and 49% community stake holders. Our governance committees, especially the Board, have had very little turnover in the

time that we have been a CCO, which has provided continuity and a deeper understanding of the complex work to be accomplished. Communication between the PrimaryHealth Board and the governance committees is accomplished through placement of Board representatives on each of the Boards subcommittees. Quarterly reports are made to the PrimaryHealth Board as to the status of the CCO work.

Community Advisory Council

- Meets 10 times per year and our meetings are open to the public. Participants from the community are welcome to attend.
- The CAC currently has 7 participants.
- The CAC is responsible to represent the consumer voice and also for work such as the Community Health Improvement Plan.

Clinic Advisory Panel

- Meets every other month on average.
- The CAP currently has 23 participants.
- The CAP includes a wide range of participants from different sectors. Clinicians (MD, RN, NP, QMHP, CADC) and administrators from multiple sectors participate.
- The CAP reviews data and outcomes from the CCO and the effectiveness of the system as a whole.

Quality and Compliance Committee

- The full QCC meets quarterly, with a subgroup meeting 2-3x per month.
- The QCC includes 18 participants.
- The QCC includes a wide range of participants from the CCOs staff, delegated entities and provider panel.
- The QCC is responsible for oversight of the quality of services offered by the CCO and oversight of the compliance program.

Organizational Culture and Guiding Values

PrimaryHealth's mission guides the work of the CCO at all levels. Our guiding values are *Respect, Enthusiasm, Excellence, and Creativity.*

At all levels, our CCO Governance demonstrates a diverse representation of our delegates and community partners. The organizational culture is built through a focused effort towards relationships built between partners. We are committed to a culture of respect for members, providers, community partners, and our staff. We demonstrate this at every opportunity and in every interaction. Our partnerships are built upon a foundation of trust and mutual regard. Ideas and creativity are welcomed from staff, providers and members in the spirit that innovations are born from creative minds. Finally, our culture values enthusiasm and excellence. We approach our mission with passion. We take pride

that all we do is done to the best of our ability, because the quality of our work and the services we provide are a reflection of our commitment to PrimaryHealth's mission.

Often, collaboration starts just by knowing your connection points and being comfortable using them. Recently, the local hospital's Director of Nursing made a phone call to the CCOs Quality Director. She described a complex patient- a young IV drug abuser who had been hospitalized for serious medical complications. She would require ongoing medical treatments for a period of time in a Skilled Nursing setting. The length of treatment in a Skilled Nursing Facility was more than the OHP guidelines allow, yet the woman did not meet the intake criteria for Long Term Care services. Literally, the woman's needs fell within what we have come to refer to as the "crack," or the usual boundary of service provision for each organization. She had already detoxed from the opiates she had been abusing and was in urgent need of Alcohol and Drug counseling, but a residential A&D provider would not accept her until her medical situation was stabilized.

Through a rapid deployment of resources, a multi-organizational care team was assembled later the same morning. The participants included multiple hospital representatives, CCO staff-including and RN, ENCC, and Community Health Worker, Mental Health, an Alcohol and Drug Counselor, and Long Term Care Services. Administrative personnel from each participating organization were able to participate along with direct care staff. Together, the participants considered ideas until a plan was built that would "wrap" the member with the needed supports. The A&D counselor would visit the woman in the hospital and provide community based support until residential services could be obtained; the CCO would cover the member's stay in a Skilled Nursing Facility longer than the traditional 20-days. The Community Health Worker would engage with the woman and provide assistance along the way, making sure the plan was executed as intended and helping with any roadblocks. The system mobilized in a non-traditional manner to conform to the woman's needs with the intent to give her the best chance of a supported recovery.

Member Demographics

Josephine County is located in Southwestern Oregon. It is a rugged part of the state with multiple climates and geography within its 1,640 square miles. Josephine County is designated as rural by the Oregon Office of Rural Health. The total population in Josephine County is 82,930 (2012) of which approximately 30,000 are assigned to a CCO. Josephine County has only two incorporated cities, Grants Pass and Cave Junction. Grants Pass is the county seat and had a population of 34,805 in 2012. The majority of residents live in over 24 unincorporated areas. According to 2012 census data, 23.6% of the county population is over 65 years old. That is nearly 60% more than the state average of 14.9%. *Nearly one in three children in Josephine County lives in poverty*, creating significant challenges to their overall health and long-term development. *18.8% of the total county lives in poverty*, higher than the state average of 14.8%. Unemployment in Josephine County continues to be higher than state and national averages. *Unemployment rates continue to hover around 11.2-11.3% annually, which is 4% higher than the national average* and higher than any of the contiguous counties. Josephine County has had consistently low percentages of ethnic minorities. Although the percentages have increased over the last decade, they have not increased significantly. 2012 census statistics show that 11.8% of the

population in the county identify as being a minority. Hispanic or Latino represents a 6.6% minority of the population in the county, followed by people identifying as being from two or more races at 3.1%. High school graduation rates at the county level are similar to the state averages, typically showing 87% of the population being a high school graduate or higher. For those with less than a high school degree, poverty is markedly higher. Josephine County residents with less than a high school diploma are two times more likely than those with some college to live in poverty.

In Josephine County there are an estimated 12,555 adults with disabilities according to the recent Area Agency on Aging 2013-2016 plan. *Josephine County was ranked in the lowest percentile of the state for health outcomes*, ranking 29th out of 33 counties in Oregon. Mortality was also ranked 29th out of 32. Morbidity was ranked slightly better at 18 out of 32. The major causes of premature death in Josephine County are chronic conditions, consistent with a nationwide epidemic of chronic disease and conditions. Death from cancer, heart disease and respiratory disease is significantly higher in Josephine County than the state or Healthy People 2020 goal.

The incidences of chronic conditions in Josephine County are close to many state averages, with the exception of a high burden of high blood cholesterol, high blood pressure, asthma, and arthritis in the county. The burden of chronic conditions for those on Oregon Health Plan shows a similar pattern to the county population. In addition Oregon Health Plan members in Jackson and Josephine County show *high rates of tobacco use, diabetes, obesity, and chemical dependency*. Dental decay in the region demonstrated higher percentages of cavities, untreated decay and rampant decay in children. 67% of residents in Josephine County describe themselves as having good mental health. Although that is close to the state average, it still shows that close to *1 in 3 people don't consider themselves as having good mental health.* Josephine County residents have significant issues with addictions of alcohol, tobacco, and drugs. *For example, 14% of Josephine County adults drink excessively*, twice the national benchmark. *Josephine County has one of the highest opioid death rates* in the state and the number of yearly deaths due to opioids is on the rise.

In 2014, largely due to the ACA expansion, PrimaryHealth had a significant increase in the number of enrolled members, which increased rapidly from about 6,000 to nearly 12,000.

PrimaryHealth Provider Network and Delegated Entities

Primary Care

Three major organizations serve the primary care needs of PrimaryHealth members. The first, Grants Pass Clinic, provides primary care for 52% of PrimaryHealth members. Grants Pass Clinic is a large multi-specialty clinic located in Grants Pass. Its providers include physicians and Nurse Practitioners. These consist of Internal Medicine (10), Family Practice (6), Pediatrics (3), General Surgery (1), and Podiatry (1), as well as on-site physical therapy and an Acute Care Clinic. Siskiyou Community Health Center, the local FQHC, houses the second largest group of members, comprising 28% of PrimaryHealth primary care assignments. Siskiyou has two locations; one in Cave Junction and one in Grants Pass. Siskiyou's providers all specialize in family practice and consist of physicians, nurse practitioners, and physician's assistants. Siskiyou is the main source of primary care in the Cave Junction/Illinois Valley area. Siskiyou

also operates a dental facility, has integrated behavioral health, three school based clinics, and offers programs such as Maternity Case Management, Project Baby Check, and Healthy Start. PrimaryHealth also contracts with several independent clinics such as Asante Physician Partners. In addition, Jackson County primary care is available at La Clinica in Medford and Central Point. Hillside Center is another option for primary care services. Established in late 2013, Hillside is a small primary care clinic located within the adult outpatient mental health unit. Primary Care Providers and/or clinic administrators serve on the CCO Board, Clinical Advisory Panel, and also the Community Advisory Council and Quality and Compliance Committee.

Many of the current PrimaryHealth providers are certified under the Patient Centered Primary Care Home Initiative (PCPCH).

In December 2014, 99.5% of PrimaryHealth members were assigned to a Tier 3 certified PCPCH.

Specialty Care

PrimaryHealth is contracted with a wide variety of specialists in Jackson and Josephine Counties. This includes the majority of specialties in Josephine County, as well as the Jackson/Josephine County specialists represented by Prime Care. Out of area specialist referrals are monitored and authorized for services that are not available in our local area.

Hospital Services

Hospital services are primarily provided by the only hospital in Josephine County, Asante Three Rivers Medical Center (part of the Asante system). Asante has representation on PrimaryHealth's Board, Clinical Advisory Panel, and Quality and Compliance Committee.

Mental Health

The local Community Mental Health Program (CMHP) is Options for Southern Oregon. Options provides the majority of the outpatient, residential, and crisis mental health services in the county. Under the CCO's global budget, PrimaryHealth receives funds for mental health services. PrimaryHealth has delegated the mental health operations and delivery system to Options for Southern Oregon, who has become a risk bearing subcontractor of the CCO. Options has representatives on PrimaryHealth's Board, Quality and Compliance Committee, and Clinical Advisory Panel.

Chemical Dependency Services

As stated earlier, OHMS is the founder and owner of Choices Counseling Center. Choices coordinates and provides A&D services for the CCO in close coordination with OHMS. Choices participates on the OHMS Board, Clinical Advisory Council, and Quality and Compliance Committee. Choices counselors are out stationed to two primary care clinics as well as local schools. Choices is also responsible for operating the local Drug Court program. PrimaryHealth's QCC is regularly updated on the Choices services offered to PrimaryHealth members, along with the number of PrimaryHealth members

currently receiving A&D treatment services. The Director of Choices continues to serve as a member of the QCC, Board and CAP.

Dental Care Organizations

Dental care is provided by the Dental Care Organizations (DCO's) in our service area. Dental Care came under PrimaryHealth's global budget in October, 2013. PrimaryHealth has contracts with all four DCOs in our service area, which are Capitol Dental, Advantage Dental, Willamette Dental, and ODS. All four DCOs are risk bearing subcontractors of the CCO. DCOs have been offered the opportunity to participate in CCO governance on the Clinical Advisory Panel or Quality Committee.

II. Fundamental Changes in the Delivery System and Efforts to Integrate Care

Overall Summary

There are many small and large scale pilot projects underway at the CCO. Themes from these projects include the following elements:

- A focus on the overall health of the population-not just those who are showing up in clinics.
- A shift from providing services within each entity's "four walls" to providing services collaboratively, in places where our members feel comfortable receiving them.
- Utilizing data and outcomes to determine where and how to provide support and evaluate the effectiveness of the CCOs efforts.
- Expansion and refinement of the Medical Home Model.
- A deep understanding that the social determinants of health play a huge role in the overall stability and wellness of our members, and that we will not succeed at shifting health outcomes until we can better address these issues.
- Development of a system where the resources of the whole system can be opened through opening a single door.

Examples of Priority Projects

Co-location of Mental Health Clinicians in Medical Homes

The advent of the CCOs provided the impetus for the integration of mental health services into multiple physical health clinics in our community. Our integration efforts provide co-located mental health therapists in targeted medical clinics with high numbers of Primary Health members. They include: Grants Pass Clinic with multiple primary care physicians, pediatricians and specialists; Siskiyou Federally Qualified Health Center; Women's Health Center, where half the children are born to women on the Oregon Health Plan; Debbie Ayoli, Pediatric Nurse Practitioner; and, Lisa Callahan, Pediatric Nurse Practitioner. Primary Health CCO has funded many of these efforts and helps "pave the way" for the system realignments that need to occur to make them successful.

"Every day I encounter patients who are struggling with their mental health. Issues from depression and anxiety to suicidality and bipolar frequently arise during patient visits. This situation is not unique in

primary care. What is unique is the ability to tell my patients, "We can help you. There are counselors right here in the clinic that can see you right now if you would like". I find myself saying this often and see the surprise in the patient's eyes when they realize that they won't have to struggle alone any longer."-Grants Pass Clinic PCP

"Recently, I saw a very sick teenager who was struggling with severe anxiety, depression, and suicidal ideation. They were already established with Kyle {therapist} and even had an appointment with him following our visit. The patient needed IV fluids and because Kyle was on site, he was able to come to the patient's room and counsel them while they received further treatment. I saw that patient for follow up this week and they were doing significantly better in every way. The partnership with Options is a gift to both the providers and the patients. Having them onsite to support out patients is crucial in managing the influx of patients who have not seen a provider in years and suddenly have the opportunity to receive help. This program is very valuable! "–Grants Pass Clinic PCP

"Another good part about PrimaryHealth CCO is the Maternity Case Management and follow through. PH works well with Options (mental health) and Women's Health Center to collaborate and help clients."-Quote from co located Mental Health Therapist

Leadership and System Change via our Early Learning Hub

Primary Health CCO and its mental health risk-bearing partner, Options for Southern Oregon, provide leadership to the Early Learning Hub through the Hub's Executive Council and subcommittees.

For the last year, Early Childhood Specialists (mental health therapists) have been stationed in all 18 Head Start classrooms in our coverage area. As a result of work being done under our Early Learning Hub and with our HUB partner Head Start, we will be implementing a system change between Mental Health and Head Start. This system change will educate parents at the time of Head Start enrollment as to the availability of early childhood specialists in the classrooms and that these specialists will be screening each child alongside the classroom teacher, at least twice a year for emotional, mental health and developmental needs. This screening will enable us to identify not only the number of children screened, but also referral and engagement into treatment. The CCO and its mental health partner will reach out to parents whose child may have additional needs and work to engage the child and family into treatment. This work supports both the HUB and CCO's mandate to improve population health by intervening and treating early.

In 2014, 100% of children assigned to PrimaryHealth were assigned to Tier 3 Patient Centered Primary Care Homes.

PrimaryHealth's rate of Developmental Screening for children 0-36 months was 72.2%.

Connection of High Medical ER Utilizers to Mental Health

Primary Health has been identifying members who are high utilizers of emergency rooms for medical issues who also have a suspected underlying mental health treatment need. This information is shared with our mental health partner, Options, who reaches out to the member and works to engage the member in a mental health assessment and treatment, if indicated. This is ground-breaking work for a CCO as we are intervening through the use of mental health services, with a group of expensive members with high medical use who, prior to the CCO's development, mental health had no information on.

Increased availability of Mental Health Peer Recovery Specialists

Primary Health financially supports the education and certification of mental health Peer Recovery Specialists. This has benefited the evolution of Peer services in our member area and provides another area of employment for individuals with this training. Peer Recovery Specialists are hired at our local peer-run drop-in center and at Options, and provide a needed specialization particularly with engagement and outreach from a first-person perspective.

Tier Three Medical Home within a Mental Health Clinic

Primary Health has been a supporter both programmatically and financially with the development of the first "Tier Three Patient Centered Primary Care Home (PCPCH)" in the state that is embedded within a mental health clinic. This PCPCH located at Options, provides wrap-around physical and mental health treatment to a population who struggles with compliance with medical treatment or who may just feel more comfortable receiving physical health services within their mental health clinic.

Options frequently accesses Primary Health CCO's Exceptional Needs Coordinators (ENCCs). These ENCCs assist the member in barrier busting in a number of areas including engagement with the primary care physician or reassignment to the PCPCH imbedded in the mental health clinic.

Quote from a mental health therapist: "One great thing about Primary Health is the ENCCs. Clients report feeling helped by the ENCCs; that they are heard, and I believe this has helped them to heal and access health care services. Also the YMCA (flexible service) program has been transformative for clients, both for their physical and mental health, and the Primary Health process for getting them YMCA passes is super easy. The ENCCs do a lot of work to help clients get the YMCA pass and use it."

Systems integration with Adults and Person with Disabilities (APD)

Adults and Persons with Disabilities (APD) and CCO systems provide coordinated services via regular joint meetings which include APD, mental health and physical health representation. Case reviews ensure that the appropriate treatment services are being provided and transition planning takes place. These meetings also focus on cross system development, further supporting our ability to work together and provide coordinated care for our shared clients. The CCO and APD just completed the third revision of our shared MOU.

In 2014, the work underway to integrate efforts between APD and the CCO was particularly evident in the following example. A PrimaryHealth member with a debilitating neuromuscular disease was

struggling with poor health outcomes. She reported that she was not satisfied with her care. She had multiple hospitalizations-nine in total in 2013 and 2014. She was having trouble managing her medications. Her nutritional status was poor. Despite significant efforts of the individual organizations providing services, her outcomes were not improving. A large care team was assembled, including her Community Health Worker, Primary Care Physician and PCPs Nurse, ENCC, APD Caseworker and APD Administration, the In-Home Caregiver's Organization, and CCO Administration. Unfortunately, the woman was not able to participate in person or by phone, so the Community Health Worker visited her the day prior to the meeting to capture, in the members own words, what her goals were. They were surprisingly simple. She wanted to be able to have regular showers rather than bed baths. She wanted changes to her toileting routine. She wanted more interaction from her caregivers. She wanted to have more home-cooked meals rather than prepackaged items from the freezer. Participants in the care conference reported that the outcome has been better than any had imagined. She was awarded additional care hours through APD-84 more than the typical maximum limit, to help accomplish her care needs. A plan was established for healthy, fresh meals to be prepared and readily available. Her medication management was turned over to the caregiver agency. She has the equipment and staffing necessary to receive a regular shower. She reports being happier with her care. She also has not had a hospital admission since the meeting took place.

Collaborative Case Management for Complex Mental Health Clients

"Priority 1" meetings are held weekly and hosted by our mental health partner, Options. All community partners are actively recruited to attend and Primary Health CCO and our local emergency room are regular participants. At this meeting we trouble shoot solutions for clients who are interfacing ineffectively with multiple systems. The resulting "Community Care Plans" incorporate innovative intervention strategies that promote positive treatment engagement and ensure that all agency providers are all "on the same page."

Community Health Workers

The Community Health Worker works collaboratively with a team of health professionals to provide patients with opportunities to stabilize and improve their health and serves as a bridge between the community and the system of health and social services. This position serves individuals with complex medical, mental health and/or chemical dependency needs. Patients are seen in their homes or similar environments.

PrimaryHealth started a pilot with Community Health Workers (CHW) in May 2013. Specific goals of the pilot were to engage actual or potential "Super Utilizers" in community based case management services, in an effort to improve outcomes and reduce costs. PrimayHealth has 3 CHW on staff. The current caseload for CHW is very small, approximately 15-20. Outreach workers will engage with members in a creative fashion to address modifiable risk factors in a non-traditional format. All outreach workers have completed Oregon Health Authority approved Community Outreach Worker training and are now certified.

Early data indicates that the CHW program may be effective in lowering costs. The most recent measurement in April 2015 indicates a cost reduction of 20% from the pre-engagement baseline for "super utilizer" members that have received CHW services. This data will be monitored over time to determine if cost reductions are sustained.

This story about one Primary Health member is relayed by one of Options' mental health therapists. "This Primary Health member is a middle-aged male with developmental disabilities, as well as mental health issues. He has a long history of trauma due to family abuse and severe bullying throughout his school years. He reports that he has trust issues because people are constantly taking advantage of him. He reports that he has "always fallen through the cracks". He has had difficulty getting services and consequently has isolated himself in his broken down trailer. He began getting assistance from Primary Health's Community Health Worker. This member states that his Community Health Worker has helped him get his own cell phone, get membership for YMCA, and has helped him apply for housing. He states she will come and check on him at his trailer. She has attempted to get his social security documents to try and get them reviewed. He also states that "she has really done a lot for me and I really like her a lot as a person". He states, "She is always willing to help me and has never let me down. She is always there when I need help." This Community Health Worker accompanied the member when he came to Options for his mental health assessment. She was very helpful in providing information and history about the member. She acted in a caring, yet professional manner. She was concerned that the member get connected to other services, such as case management and an adult skills trainer. She has been in contact with his therapist to collaborate in maintaining care for the member. Both the member and this therapist are impressed with this Community Health Worker's dedication and positive representation of Primary Health by going above and beyond her duty to make certain that this member "does not fall through the cracks ever again".

"Our CHW established care with a woman who had recently been treated for breast cancer and some related complications. Her cancer had gone into remission, but she still needed assistance with social supports. She had untreated anxiety and chronic pain, and a complex family situation. The CHW formed a great working relationship and they had been able to address many of her concerns. Unfortunately, the woman's cancer reoccurred a few months later and she was told her only options were palliative. The CHW was able to provide unbelievable support to the woman as she established with hospice. She helped her come up with a way to reach out to her estranged family and notify them of her terminal illness, which was a big source of stress for her. The family responded well, and wanted to reunite with her before it was too late. It actually turned out that the CHW was able to work with hospice to help her qualify for a special program that flew her out to meet her family. She was able to meet her grandchildren for the first time. As her condition progressed, the CHW helped her to coordinate her medical needs as well as discuss her personal concerns. After her death, the CHW was given a handwritten letter that the woman had left her, letting her know how much her support meant to her at the end of her life. It is possible, based on previous utilization trends, that the support of the CHW saved money through coordination of resources. But even more, I connect to the raw humanity of this story. That we were able to help another person in our community at the end of her life move towards a much

more peaceful death than she might have had. That is work that really matters in the end."-Community Health Worker Program Supervisor

Integration of Chemical Dependency Services

Chemical Dependency services are provided and/or coordinated by Choices Counseling Center, a subsidiary of OHMS. Choices has co located Alcohol and Drug counselors into the two largest primary care clinics in the PrimaryHealth network. This has allowed an easier access point to A&D services, and providers report that they feel that individuals have accepted help that they didn't think would engage in the traditional service model.

PrimaryHealth's ENCC and Community Outreach Workers remain actively involved in the collaborative efforts with Choices and provide referrals to Choices and ongoing assistance to members needing or engaged with CD services. Outreach workers also attend a weekly staffing at Choices to facilitate collaborative case management for their clients in treatment.

The following is a story collected from a provider at a clinic where A&D services are co-located. "I have a patient in his twenties with at least two prior alcohol-abuse related hospitalizations, who had always refused referral for A & D treatment. He presented to the clinic with alcoholic hepatitis, jaundiced with a distended abdomen from ascites. A significant percentage of these patients do not survive, but this one luckily improved in the hospital with supportive care. He returned to clinic and again declined to be referred for treatment, but agreed to meet our in-house A&D provider, who provided contact information. None of us involved felt the patient was likely to engage, in fact we were worried it was likely they would relapse and not survive the next hospitalization. However, the patient soon thereafter contacted the treatment provider, has been actively engaged, and has improved significantly. I don't think this would have happened without the "warm handoff."

Community Health Assessment and Community Health Improvement Project

PrimaryHealth's CAC has collaborated with the Jackson Care Connect and AllCare Community Advisory Councils on the research and development of both their Community Health Needs Assessment and their Community Health Improvement Plan. Collaboration with the other CCO CACs was critical in this work as our service areas overlap across three counties. Collaboration helped the CACs to identify the following three areas of priority:

- *Healthy Beginnings*- to engage in efforts to improve the health of children, adolescents and young adults from age 0-24
- *Health Equity*- to promote healthy lifestyles and improve health outcomes
- *Healthy Living*- to increase awareness of health equity and address social determinants of health

PrimaryHealth's CAC continues to participate in and support multiple community events that focus on children's health, alcohol and drug recovery, dental education, and early childhood reading. Educational opportunities for both the CAC and the PrimaryHealth board will continue to be an area of focus.

CAC members partnered in the Kid's Care Fair and distributed nearly 700 books to kids in the community. CAC members also joined in the summer lunch program and distributed books to kids in an effort to promote literacy.

Members of the CAC attended the Chronic Pain Symposium in September as a learning collaborative with neighboring CCO's.

CAC attended a Health Equity webinar hosted by the OHA featuring Dr. Cliff Coleman in December 2014. Its success prompted a larger community wide training with Dr. Coleman in 2015, which included many PrimaryHealth PCPs, community partners, and clinic administrators.

Maternal Medical Home

PrimaryHealth is involved in a pilot project to support the design and implementation of a Maternal Medical Home at the Women's Health Center of Southern Oregon, a local OB/GYN clinic. The goals of the MMH are to improve birth outcomes through systematic enhancements in the delivery system.

PrimaryHealth contracts with Women's Health Center of Southern Oregon for OB/GYN services. WHCOSO is the only OB/GYN clinic in Josephine County. In 2014 most pregnant women on PHJC were under the care of physicians at WHCOSO. WHCOSO cares for a challenging population of patients in terms of risk factors. Josephine County has historically shown a high rate of tobacco, alcohol, and illicit drug use by pregnant women. An increasing number of babies are born each year in Josephine and Jackson counties are treated for drug withdrawal. Josephine County also has a high rate of poverty, with over 60% of pregnant women insured under the Medicaid program during their pregnancy.

PrimaryHealth and WHCOSO began working together on development of a Maternal Medical Home concept in 2012, and in 2013 the clinic and CCO came together to create a project plan and an alternate payment methodology to fund the project.

WHCOSO moved forward in 2013 with medical home infrastructure development, such as hiring and coordination of co-located staff and building systems and workflows internally to support the flow of information between OB providers and new staff. This included hiring a full-time "Behavioral Health Coach" position, which will help to coordinate care and provide health coaching for high risk mothers. In addition, WHCOSO arranged with Options for Southern Oregon (the CMHP) to co-locate an Options therapist at WHCOSO part-time. WHCOSO has also co-located a Maternal Fetal Medicine provider part-time to see high risk individuals. Previous to this pilot, MFM services were not available in Josephine County. A screening protocol was developed, which integrated alcohol and drug, domestic violence, tobacco, and depression screening and follow up into routine prenatal care. Additional resources to the clinic (smoking cessation therapy, educational resources) have been developed. Team workflows have also been refined. For example, early in the project teams began sharing a direct phone number to the "team phone" with a pregnant woman. Now, when a pregnant woman calls WHCOSO, she can call the team directly to talk about concerns or issues.

OHA Incentive Measure Baseline Data in 2011 indicated that only 65.1% of mothers had timely access to prenatal care (within the first trimester or 42 days of enrollment in Medicaid). In 2014, PrimaryHealth improved this rate to 83%.

In the last 6 quarters, 99-100% of pregnant women under the care of WHCOSO were screened for depression, domestic violence, alcohol and drug abuse, and tobacco use. Approximately 25% of the SBIRT screenings billed to the CCO were conducted by WHCOSO.

Approximately 40% of the mothers seen at WHCOSO meet medical or socioeconomic criteria for "high risk."

A WHCOSO physician that had been trained to review depression with post-partum patients through a series of a few questions in a face-to-face interview began using the PHQ9 as part of her team's standard process. She went into the exam room of a lovely post-partum patient who was well groomed, smiling, happy, in no distress. The patient had her beautiful, healthy baby with her; the patient appeared to be doing well. In the past she admits that given this patient's perceived external happy disposition, she might have briefly asked her how she was doing, to which the physician believes the patient would have smiled and said, "I'm doing fine" and they would have moved on. The physician was surprised when she looked at the form that had been filled out by the patient and saw that some of the answers to the question raised a red flag. This prompted her to sit and ask some more direct questions about how the patient was feeling. The patient subsequently broke down, crying openly, and began talking about her depression, giving an opening for the physician to help her. The physician believes that this patient's post-partum depression may not have been discovered if not for the standard process of having the PHQ9 form completed for each and every post-partum patient, regardless of their presentation.

"I have become more cognizant of social issues that surround patients and how this directly affects patient care and patient health. Sheri highlights patients at her intake exams who are at high risk from a socioeconomic standpoint or who face specific challenges in the personal lives. I more frequently now continue to re-address bad habits (smoking, marijuana use, etc.) during pregnancy instead of simply stating the risks of these habits at the first OB visit and not giving it much thought afterwards, assuming patients will make their own choices. I have begun to hold patient more accountable to their actions and emphasize how their actions directly affect their unborn child. "-WHCOSO provider

Behavioral Health Literacy

The behavioral health literacy focus area will promote strategies for improved knowledge of behavioral health conditions and communication techniques for physical health staff. This is being completed through the provision of an educational program/training for PrimaryHealth's clinics and community providers, Mental Health First Aid. The overarching goal is to develop skills and knowledge that will enhance each participant's ability to communicate with and provide care for individuals with significant mental illness. If successful, this endeavor will have the dual effect of meeting the needs of the mentally ill while also creating heightened satisfaction and effectiveness for medical staff and community members who are working with this subpopulation.

To date, four sessions of Mental Health First Aid have been offered serving up to 120 participants. Most participants have been from community organizations, including the CCO.

Maternity Case Management

Oregon Health Management Services began providing Maternity Case Management internally for our members since 2009. The health plan employs an RN trained in OB care and case management. In review, OHMS shifted to internal MCM after analysis that, due to budget cuts at the County Health Department, the number of OHMS members who were seen for MCM during pregnancy was significantly decreased. In addition, babies admitted to the NICU at birth also appeared to be increasing.

The PHJC Maternity Case Manager, a registered nurse, provides home visits to pregnant PrimaryHealth members. These members varied in risk category and educational level. Participants are given home assessments, risk screenings, and education on a variety of topics from healthy eating to newborn care. PrimaryHealth is pleased with the opportunity MCM brings to allow us to engage directly with the member and become directly involved in case management. The MCM also participates in local community committees related to perinatal health, such as the Southern Oregon Perinatal Task Force (PNTF). The PNTF currently focuses on community actions to reduce prenatal substance abuse and improve birth outcomes.

In 2014, the MCM made a total of 233 home visits, an average of 3.5 visits per mother. Nearly 60% of the mothers seen were classified as "High Risk."

One third of the PrimaryHealth mothers who delivered a baby in 2014 received in-home education and support by a Maternity Case Manager.

Exceptional Needs Care Coordination

As in the past, ENCC services continued to be offered to any health plan member who needed assistance. The purpose of ENCC services is primarily for case coordination of special needs members. ENCCs provide case coordination services to guarantee that a member's needs are met and resources are effectively utilized by facilitating coordination of various disciplines and agencies for provisions of all health plan services to special needs members as defined by DMAP. In 2014, some examples of work done by ENCC's includes:

- Emergency Room follow-up and Case Management
- New Member Outreach
- Health Risk Assessments for members with complex needs
- Collaboration with Maternity Case Manager
- Foster Parent Education and Assistance
- Smoking Cessation Outreach Calls
- Community Committees, such as Pathways to Care Network and Options External QI Committee
- Representation on the PrimaryHealth QCC

- Coordination with community partners, such as Options (mental health), Choices (Chemical Dependency), the four Dental Organizations, and APD
- Provider Assistance with difficult situations
- Grievance Follow-Up
- Involvement in Bi-Weekly Care Coordination calls with the local AAA/APD
- Tracking trends and providing care coordination for individuals who have been dismissed by their PCP

Durable Medical Equipment/ Diabetic Case Management

PrimaryHealth's DME program distributes medical equipment like diabetic supplies and nebulizers directly from our office. This program has also increased our ability to engage and provide case management with members. Through this process, PrimaryHealth is also able to better monitor appropriate utilization of supplies and encourage preventive care and healthy behaviors.

This is especially evident with our diabetic members. Members with diabetes meet directly with a nurse case manager or health coach. The health coach downloads the diabetic meter at every visit, and reviews the results with the members. At that time, education and health coaching is provided on the blood sugar trends and any concerns. The coach or nurse, based on a protocol, contacts the PCP and endocrinologist (if applicable) with the results of the download if there are concerns. Sometimes members use these sessions to check in, set goals, and evaluate their progress. Providers are satisfied with our ability to provide them with blood sugar profiles whenever necessary. The PrimaryHealth case management nurse travels to Cave Junction once each month as well to distribute supplies to our CJ members. During this outreach the case management nurse utilizes space in our FQHC to meet with members and distribute supplies.

The DME Specialist recently helped a man who was caring for his disabled wife. He reported that he was exhausted. His wife was incontinent, and he struggled to keep her dry and comfortable through the night. He set an alarm to get up every two hours to change her undergarments. Through consultation with the DME specialist, a plan was put in place to try a different type of "overnight" product which had never been offered to him by other DME vendors. He later reported he and his wife had been able to start sleeping through the night due to the success of this product.

Tobacco Cessation Services

Tobacco cessation efforts at PHJC continue in 2014. In the 2013 CAHPS adult member survey, 24% of OHMS members reported that they smoke every day, which had decreased from 29% in 2011 and 35% in 2007. To support tobacco cessation, PHJC has educational packets regarding cessation. Current smokers stated that they were advised to quit by a doctor 61.5% of the time. An increasing percentage of members also report that their doctor discussed strategies, including medications to help them stop smoking.

A Member who is quitting tobacco can request written materials and a proactive call from the PHJC ENCC, who explains the tobacco cessation benefits, like classes, that are available through PHJC. The

ENCC also can mail a packet of information on quitting smoking to members who wish to receive this information.

PHJC includes cessation medications to the formulary and recently reduced prior authorization restrictions. PHJC members may now use Chantix, Nicotine Patches, Gum, or Lozenges, or Zyban to help with cessation. These may be used for two 90-day trials per year.

PrimaryHealth recently certified a Community Health Worker in the provision of the American Lung Association's "Freedom From Smoking" curriculum. A collaborative effort is underway between the two local CCOs and the Public Health Department to coordinate efforts in the provision of tobacco cessation classes.

Dental Promotion

PHJC supports preventive dental care for children through ongoing efforts to collaborate with DCO's. In 2014, PrimaryHealth partnered with the Siskiyou Dental Clinic (operated by the local FQHC) at a local health fair. This partnership allowed for free dental screenings and fluoride varnishes for those in attendance.

Other dental coordination includes the promotion of routine preventive dental care for pregnant mothers. Dental visits are strongly encouraged by the PrimaryHealth Maternity Case Manager, and dental visits are tracked for each pregnant member engaged in Maternity Case Management. PrimaryHealth ENCC's coordinate referrals for hospital dental services for members who require anesthesia for dental procedures. ENCC's also assist members seeking emergency dental care in the Hospital Emergency Room with coordinating follow-up dental care in the ambulatory setting.

In 2014, 67% of pregnant mothers seen by the MCM had a dental visit.

Drug Court

Choices Counseling Center is responsible for the local operations of the Drug Court program. To date the local drug court program has 327 graduates.

There have been 28 drug-free babies born to participants in Drug Court.

Medication Assisted Treatment

PrimaryHealth and Choices Counseling Center has teamed up with other providers, local professionals and community members in an effort to develop wrap around services to individuals traveling out of county to receive medication assisted treatment. We are involved in a major effort to recruit physicians to work with us in the development of more office based buprenoriphine (Suboxone) treatment. We have developed specific programs at Choices Counseling Center to attend to the needs to individuals struggling with opiate additions.

Grants Pass Sobering Center

PrimaryHealth and Choices have been a supportive and intricate part of the development of a facility in Grants Pass to appropriately serve intoxicated individuals. This facility will reduce the use of inappropriate and expensive resources such as hospital and jail beds. This program is slated to open in January 2016.

Medical Home Leadership Group and Support for Medical Homes

A highly functional medical home is the most basic building block for a successful CCO. PrimaryHealth's recognition of this has resulted in provision of resources to help clinics in our network become ever stronger medical homes.

In 2012-2014, PrimaryHealth has hosted learning collaborative for local Primary Care clinics which focused on expanding and refining skills as medical homes. The name of the collaborative was PC3- Pateint Centered, Population Centered, Primary Care. This was facilitated in coordination with CareOregon, and consisted of several all-day learning sessions and trainings. The curriculum included content areas such as Leadership/Leading Change, Data, Empanelment/Access, Team Based Care, Care Management, Population Management, and Quality Improvement.

In 2014, following the completion of the PC3 collaborative, providers expressed a desire to continue to meet and collaborate on their progress as medical homes. The group evolved into the "Medical Home Leadership Group" which is facilitated by the CCO and meets in a relatively informal fashion with the following purpose:

- Continue to share collectively their efforts to further improve and implement Medical Home infrastructure.
- Act as "experts" in the community and for the CCO for guiding transformation in primary care.
- Act as a steering committee for the CCO in developing strategies to affect improvement in primary care sensitive clinical outcome measures (likely with a focus on the CCO Incentive and Performance Measures).
- Work with the CCO on the development of meaningful data and reporting for the CCO to provide to guide improvement efforts.
- Discuss and create potential payment models for primary care that further the "Triple Aim."
- Decide upon/request ongoing learning sessions/curriculum that would benefit participants' ongoing efforts.

Other examples of supports to medical homes include financial support for projects, educational support, and sponsorship of employees that contribute to the Medical Home team.

Flexible Services

PrimaryHealth has created a framework whereby flexible services can be requested by providers, community partners, CCO staff, or even member's themselves. Many different types of flexible services

were approved in 2014. Often, these come as requests from the Community Health Workers for barrier removal.

The most common service approved was a YMCA/health club membership. If granted, PrimaryHealth requires that the membership is used, on average, 10 times per month. The ENCC provides support and care coordination to all members receiving YMCA memberships.

To date, 85 members have received health club memberships as a flexible service.

"A member is on the 2nd renewal of his YMCA membership. He started out at 338 pounds, and he is now at 256 pounds. He is less than 50 pounds from his goal. He says that he is now able to keep a part time job, and he doesn't feel that he would have been hired or done the job at 338 pounds. He feels the weight isn't coming off as fast now as in the beginning, but he has seen his PCP and they have talked about how he might alter his exercise to keep his weight loss moving. He is way above our required attendance guidelines, going as much as 17 times in a month. He feels great, and he is proud of his accomplishments."- PrimaryHealth ENCC

Community Wellness Education

PrimaryHealth found several opportunities to collaborate with the OHMS-Community Health Education Center (OHMS-CHEC) in 2014. OHMS assisted in curriculum development for several health and wellness focused classes in 2014. The most popular program offered at OHMS-CHEC is a free healthy cooking series. OHMS-CHEC and PrimaryHealth recognize the connection between obesity, chronic disease, and poor diet. In addition, it was recognized that many people in the community do not know basic food preparation skills. OHMS-CHEC addressed this need by offering weekly healthy cooking classes in the OHMS-CHEC Community Kitchen. Cooking classes serve up to 18 participants and are an interactive demonstration which includes samples of the prepared foods and recipes to take home. Classes have included a focus, such as "Dinner on a Dime," "Heart Healthy," and "Diabetic Holiday." One class per month is designated as "Cooking with Kids," and is an interactive cooking class for children and their parents or grandparents. Cooking classes are free to participants, and are nearly always full with a waiting list.

The OHMS-CHEC classroom and kitchen are also available to be used by other wellness-related community programs free of charge. The classroom was used many times in 2014 by agencies such as DHS, the local FQHC, and Asante. PrimaryHealth staff participates in the daily operations of OHMS-CHEC, and also serve as volunteers in several CHEC programs.

Sponsorship of Cooking Classes in 2014 allowed for space for 864 participants to participate.

Jefferson Health Information Exchange

PrimaryHealth participates in the JHIE as a CCO system user and financial supporter, PrimaryHealth also holds a seat on the JHIE Finance Committee. The Jefferson HIE has enrolled 120 Clinics and 576 Providers throughout Josephine, Jackson and Klamath County as well as the Columbia Gorge region.

The Jefferson HIE currently provides secure messaging and referrals to enrolled providers. Moving forward, the following services will be developed.

Electronic Health Record Connectivity **-** The Jefferson HIE has work underway to implement Electronic Health Record Connectivity. The JHIE will work with EHR vendors to deliver results from any of the participating data sources directly into the User's EHR. EHR connectivity will also include a summary of care document exchange from the EHR, supporting Meaningful Use Stage 2 requirements.

Clinical Alerts – Participating CCOs provide the JHIE with a daily eligibility feed. Users will be able to set alerts to let them know when their patients are treated at the emergency department or are discharged from the hospital. The alerts will support care coordination, post-discharge follow up as required for Stage 2 Meaningful Use.

Patient Search – Users who have a clinical relationship with a patient will be able to query the JHIE for test results, discharge summaries, clinical reports and more. Use of this aspect of the JHIE will provide the most current test results to participating providers when and where they need it. This will increase provider efficiency and timeliness of care, reduce the need for duplicative tests and related time and stress to the patient as well as reducing the cost of care.

III. Analytics, Quality Improvement, and Quality Pool Measures

Overview

PrimaryHealth has significantly increased our capability to review outcomes for our transformation efforts underway.

- First, PrimaryHealth has promoted and sponsored education on *how* to lead improvement throughout the system. This has improved our organization's efforts to create and evaluate CCO projects that are underway.
- Second, PrimaryHealth has moved forward with software that allows us to capture and report CCO outcomes more readily.
- Third, PrimaryHealth now systematically utilizes baseline and outcome data whenever possible to guide the decisions we make as an organization.

CCO MetricsManager Implementation/ Inteligenz

In 2014, PrimaryHealth implemented CCO MetricsManager, an analytic tool that provides member, provider, clinic, and population level data. This information has been used to inform the population health efforts of the CCO and guide our strategic planning for improvement efforts.

- Inteligenz allows PrimaryHealth to drill down to member, provider or clinic level data to help refine QI efforts towards CCO Incentive Measures. It is more timely than OHA data and updated weekly.
- Data is sorted to distinguish clinics that are high performers on specific measures. This helps PrimaryHealth focus improvement efforts where they are needed most.

- Actionable data ("Gap Lists") from Inteligenz give providers a clear pathway to improvement, at the member level.
- CCO, Clinic or provider specific rates can be reviewed over time to evaluate improvements.
- Data can be presented in multiple ways, depending on the audience.
- PrimaryHealth, like many CCOs, has multifaceted strategic plans to help achieve improvement on the incentive measures. Inteligenz allows the CCO to evaluate these strategies as pilots are carried out.

PrimaryHealth uses Inteligenz to look proactively for high utilizers. In addition, it helps evaluate programs focused towards high utilizers, such as our Community Health Worker program.

PrimaryHealth has been working toward implementation of the SBIRT measure. By looking at clinic specific data, PrimaryHealth identified one clinic with a jump in performance. By drilling down further into the data, PrimaryHealth identified that most claims from this large clinic have actually come from just three providers. These three providers have refined the SBIRT process and developed a successful workflow. PrimaryHealth is working with these providers in an effort to help this improvement spread throughout this clinic.

PrimaryHealth creates a bi-monthly dashboard that displays the current quality pool outcomes for all of PrimaryHealth's PCP clinics-side by side. PrimaryHealth's Board, Clinical Advisory Panel, Quality Committee, and Medical Home Leadership Group use this dashboard to evaluate the quality of services offered by the CCO and the effectiveness of improvement efforts. Clinics use this data to help recognize areas of strength and opportunities for improvement. At year end, this dashboard is used to determine outcomes for an Alternate Payment Methodology.

Quality Pool Measures

PrimaryHealth has made improvements on all 17 of the quality pool measures. The three most difficult measures in 2014 for the CCO were SBIRT, Colorectal Cancer Screening, and Adolescent Well Care. All three of these targets were not met in 2013, but 2 of the 3 have been met in 2014. The strategies to improve on these measures were multifaceted. They included elements such as:

- Sharing dashboards with providers and clinics, some of which transparently displayed performance of all CCO primary care clinics side-by-side.
- Creating provider or clinic level "gap lists" which provided clinicians with specific patients to target with the desired service.
- Utilizing analytics to find both care gaps and areas of high performance.
- Sharing data regularly and creating channels of communication.
- Facilitating training, such as on SBIRT screening, for providers throughout the network.
- Learning about our Medical Home providers and working to provide the necessary supports to meet the goals.
- Investing time, energy, and resources in strategies that will be sustainable over time and create changes to the infrastructure of care delivery.

The strategies listed above can be seen in place through our work with the Grants Pass Clinic, our largest clinic on panel, which provides primary care for 52% of our members. The clinic and CCO worked together to form a strategy. Monthly provider level dashboards were created and shared at the provider meeting, along with the CCOs high level report that showed the Grants Pass Clinic's performance compared to our other network providers. At the same time, gap lists were distributed to providers, who worked along with their team to address the gaps between meetings.

The CCO also sponsored two positions for "Medical Home Assistants." Medical Home Assistants scrub the charts of all patients coming in for annual visits to highlight care gaps. These gaps are systematically brought to the attention of the provider team and they are addressed at the visit.

In addition to highlighting care gaps, the clinic is also utilizing methods such as shared decision making to improve communication with patients about preventive services. The clinic tracks the use of these decision making tools as part of their improvement efforts.

The care team shares responsibility for conducing and recording screenings, such as SBIRT and depression screening, so the sole responsibility for screening does not fall on the provider. Co located staff, such as behavioral health and alcohol and drug counselors, are available for "warm handoffs" when there are positive screenings.

In 2014, the Grants Pass Clinic met all 11 primary care sensitive targets that applied to the clinic site. This was an improvement from the previous year, when three targets were not met.

Conclusion

When PrimaryHealth set out as a CCO in 2012, our providers and community partners set forth with a commitment to transform care. There was no clear or easy path to the transformation we desired. We set out together with a series of projects and pilots to see what might be effective. Through these tests, we have been able to light a clearer path to where we may be headed. Not all of our ideas have been successes. There have been discoveries along the way that have surprised us, and helped us learn where our strategies needed to change and what we were doing right. We've worked to spread successful practices throughout our network, or even share the ideas outside of our CCO. While we may have more direction than we did in the beginning, we are still just getting started. The work of the CCO in our community has been positive and important. Nothing has been a more powerful indicator of our success than capturing the stories of how care transformation has affected our members in a positive way, one person at a time. In some cases, it may have even changed the trajectory of their life. The way we deliver care is becoming fundamentally different. The words of one stakeholder capture it best, "No matter what happens, we will never go back to providing care the way it used to be."