Report to the House Health Care Committee

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Executive VP Product Line Management

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June 15, 2015
78th Legislative Assembly
House Committee on Healthcare

Chair Greenlick, Vice-Chairs Nosse and Hayden and members of the House Health Care
Committee, PacificSource Community Solutions respectfully submits this report in response to
Chair Greenlick's letter dated May 20, 2015. The letter requested that we be prepared to
present to the Committee and provide information addressing, the following areas:

- Key aspects surrounding CCO governance, structure and system elements
- How we are fundamentally changing the way health care is delivered and financed, as
  well as the metrics and timeframe for demonstrable progress
- Efforts underway that integrate physical, mental and behavioral health
- The three (3) quality measures that yielded the most challenging performance areas
  and what actions are being taken to improve in those areas

This report highlights key data and elements and in addition, you will find a series of
attachments that allow for a more detailed examination. These attachments include (for each
CCO): 1 page Dashboards, the Transformation Plan Milestone Reports and the Transformation
Grant Progress Reports.

Since 2011, the House Health Care Committee has helped to develop and champion Oregon's
signature Medicaid model and we appreciate this opportunity to share some of our
implementation experiences with you. Please don't hesitate to reach out with any follow up
questions.

Sincerely,

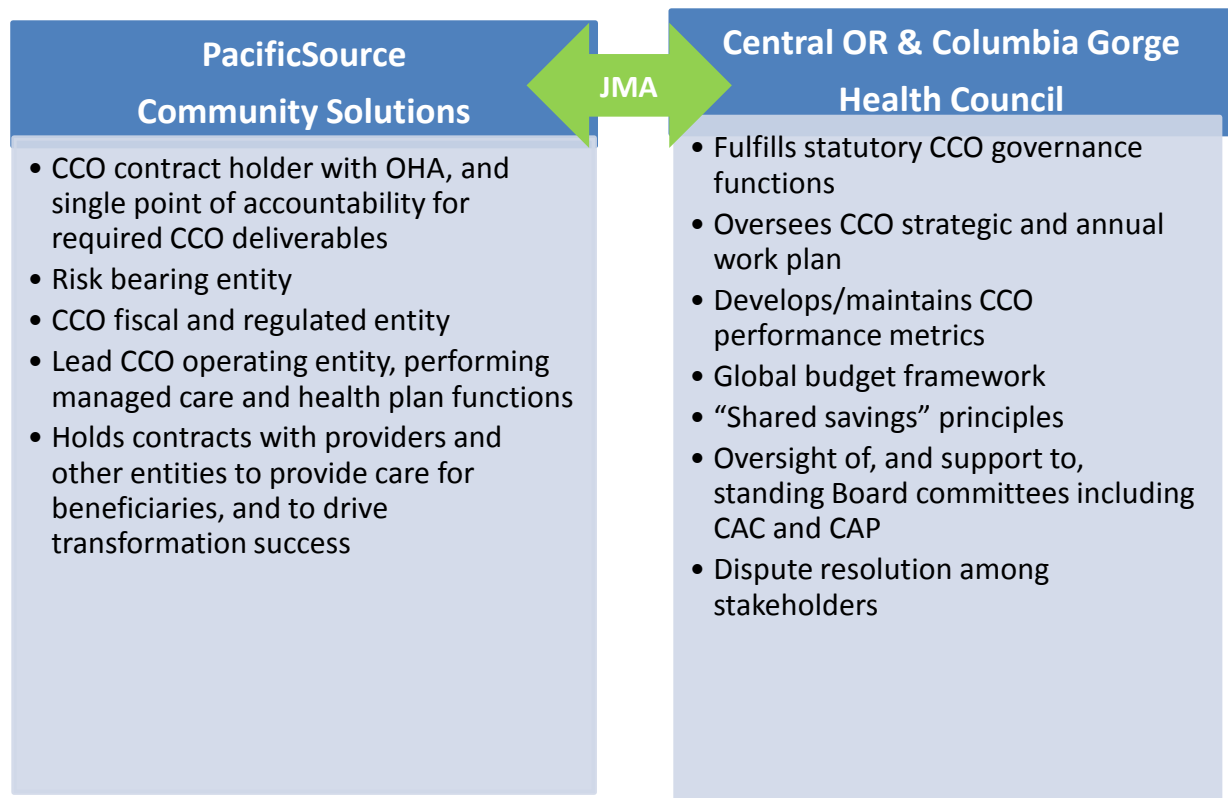Dan Stevens, Executive VP Product Line Management
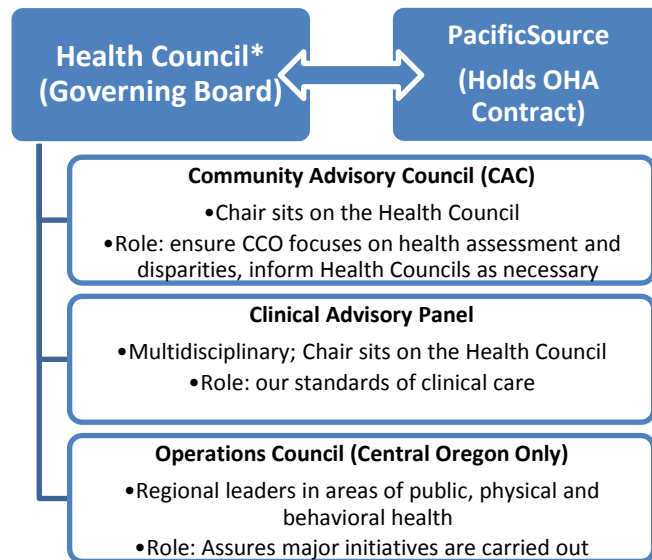PacificSource

Report to House Health Committee

PacificSource Community Solutions is part of the PacificSource family of companies. PacificSource is an independent, not-for-profit health plan based in Oregon and serving Medicaid, Medicare and Commercial members. PacificSource Community Solutions (PCS) serves approximately 55,000 members in the 3-County Central Oregon region of Crook, Deschutes and Jefferson and approximately 13,000 members in the 2-County Columbia Gorge region of Hood and Wasco.

PCS chose a unique, locally-oriented structure for our Coordinated Care Organizations (CCO) in both Central Oregon and the Columbia Gorge regions. Rather than building on a corporate board of directors, PCS helped to convene a local governing board, or "Health Council." Each Health Council is incorporated as a 501(c) (3) organization and is staffed to manage a group of committees and workgroups. The Health Councils work in partnership with PCS to facilitate a robust community process that informs CCO policy, strategy and direction. This relationship is upheld through a Joint Management Agreement (JMA) which delineates the role and function of PCS as the CCO operator and its governing structure.

Governance – Joint Management Agreement

PacificSource Community Solutions	JMA	Central OR & Columbia Gorge Health Council
• CCO contract holder with OHA, and single point of accountability for required CCO deliverables • Risk bearing entity • CCO fiscal and regulated entity • Lead CCO operating entity, performing managed care and health plan functions • Holds contracts with providers and other entities to provide care for beneficiaries, and to drive transformation success		• Fulfills statutory CCO governance functions • Oversees CCO strategic and annual work plan • Develops/maintains CCO performance metrics • Global budget framework • "Shared savings" principles • Oversight of, and support to, standing Board committees including CAC and CAP • Dispute resolution among stakeholders

Governance and Structure

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┌──────────────────────┐      ┌──────────────────────┐
│   Health Council*     │◄────►│    PacificSource      │
│  (Governing Board)    │      │   (Holds OHA          │
│                       │      │    Contract)          │
└──────────────────────┘      └──────────────────────┘
    │
    │   ┌─────────────────────────────────────────────┐
    ├───│   Community Advisory Council (CAC)           │
    │   │  •Chair sits on the Health Council           │
    │   │  •Role: ensure CCO focuses on health         │
    │   │   assessment and disparities, inform         │
    │   │   Health Councils as necessary               │
    │   └─────────────────────────────────────────────┘
    │
    │   ┌─────────────────────────────────────────────┐
    ├───│   Clinical Advisory Panel                    │
    │   │  •Multidisciplinary; Chair sits on the       │
    │   │   Health Council                             │
    │   │  •Role: our standards of clinical care       │
    │   └─────────────────────────────────────────────┘
    │
    │   ┌─────────────────────────────────────────────┐
    └───│   Operations Council (Central Oregon Only)   │
        │  •Regional leaders in areas of public,       │
        │   physical and behavioral health             │
        │  •Role: Assures major initiatives are        │
        │   carried out                                │
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Health Council Representatives (both regions)

Members of the Health Council for each CCO, reflect the communities that they serve and include the following:

- Leadership from hospitals or other large health care organizations
- Central Oregon Independent Practice Association (COIPA)
- Federally Qualified Health Center (FQHC)
- Mental Health or Chemical Dependency Treatment Provider
- Community Members
- One member of the Community Advisory Council
- Dental Care Organization Leadership (Central Oregon)
- At least one elected County Commissioner from each County served

Central Oregon Health Council

Name	Organization & Role
Tammy Baney	Chair, Deschutes County Commissioner
Mike Shirtcliff, DMD	Vice-chair, President Advantage Dental
Dan Stevens	Executive VP, PacificSource
Harold Sexton, M.D., PhD	Director Behavioral Health, Deschutes County Health Services
Greg Hagfors	CEO, Bend Memorial Clinic
Joseph Sluka	President and CEO, St. Charles Health System
Ken Fahlgren	Crook County Commissioner
Linda McCoy	Chair, Community Advisory Council
Megan Haase, FNP	CEO, Mosaic Medical
Mike Ahern	Jefferson County Commissioner
Stephen Mann, DO	President, COIPA
Lindsey Hopper, JD, MPH	Executive Director, Central Oregon Health Council

Columbia Gorge Health Council

Name	Organization & Role
Karen Joplin	Chair, Executive Committee, Hood River County Rep
Kristen Dillon, MD	Vice-Chair, Executive Committee, COIPA Rep
Duane Francis	Executive Committee, MCMC Rep
Ed Freysinger	Providence HRMH Rep
Josh Bishop, PharmD	Executive Committee, PacificSource Community Solutions Rep
Dave Edwards	One Community Health Rep
Molly Rogers	Wasco County Rep
Sharon DeHart PA-C	Community at Large
Kim Humann MD	CAP Co-Chair
Judy Richardson MD	CAP Co-Chair
Ellen Larson RN	CAC Chair
Vacant	Community at Large
Coco Yackley	CGHC Operations Consultant

Community Advisory Councils

Each CCO has one Community Advisory Council (CAC). In PCS's CCO model, they are a standing committee of the Health Council. Each group meets once per month and included on their agendas are topics that are of particular interest to the community at-large related to CCO responsibilities. Areas of interest may include member engagement, performance on certain Quality Incentive Metrics, Transformation Plan development and performance on elements related to health equity, the elimination of health disparities and Community Health Assessment and Improvement planning. In addition, CACs may inform flexible services policies and procedures and certain strategic or transformation fund initiative investments. PacificSource, in partnership with its health councils regularly provides education, analytics support, and performance reports to the CAC so they can then make informed recommendations on such topics as required or requested from their respective Health Councils. The Chair of each CAC is also a member of their respective Health Council.

Risk and Profitability

In the case of both CCO's, PacificSource is the risk-bearing entity on behalf of the regions it operates within. Our community governance model imposes a limit on PacificSource's retained profits in any calendar year. Any profit above a 2% net margin goes back to the Health Councils. The Health Councils, with PCS as one voting member, determine how to invest those 'surplus' dollars within each community. Fiscal 2014 performance in both Central Oregon and the Columbia Gorge CCOs exceeded the 2% cap for the 2014 financial year, with Central Oregon at 4.8% and the Gorge at 4.5%. Current estimates are that $6.6 million will be eligible for Health Council community health investments in Central Oregon, and $474,000 in the Columbia Gorge. Over the summer, both regions will be determining how to most effectively utilize those dollars in a manner consistent with priorities lifted from each region's Community Health Improvement Plan.

PacificSource feels this unique financial arrangement enhances trust levels between the CCO and its vital community partners, increases overall provider and community engagement in the CCO's success, and ensures that health plan profits are not an impediment to advancing a broader community health agenda.

CCO Delivery Systems

Central Oregon

The Central Oregon delivery system is defined by a single-system acute care provider in St. Charles Healthcare System, who operates 4 hospitals throughout the CCO, including 3 smaller community hospitals and one larger hospital with specialty/tertiary capabilities. For professional services, nearly all providers provide care to some portion of OHP members, predominantly in the primary care space by Mosaic Medical which is an FQHC operating several clinics and school-based health centers in the region, another FQHC in La Pine, and a few other notable clinics such as Central Oregon Pediatric Associates, Madras Medical, and St. Charles Medical Group.

The majority of outpatient Behavioral Health (BH) services are provided at the Community Mental Health Programs (CMHPs) in each county. The CMHPs are Lutheran Community Services in Crook County, Deschutes County Behavioral Health, and BestCare Treatment Services in Jefferson County. Since roughly 80% of Central Oregon CCO members reside in Deschutes County we also have a robust panel of providers within that county that members can also be referred to for services. Outpatient services available in this region include mental health, Substance Use Disorder, and Medication Assisted Treatment. This region also has two SUD residential facilities, BestCare Treatment Services for adults and Rimrock Trails for adolescents.

[Columbia Gorge](#)

There are two small acute care hospitals that provide local care for OHP members (Providence Hood River Memorial Hospital and Mid-Columbia Medical Center) both of whom have some primary care clinics as part of their delivery systems that provide primary care to OHP members. A notable FQHC (One Community Health) operates in both Hood River and The Dalles, and provides care to a large portion of OHP members.

Mid-Columbia Center for Living (MCCFL) is the CMHP for both Wasco and Hood River Counties and sees the majority of this region's CCO members for outpatient BH services. Mid-Columbia Outpatient Clinics employ a BHC, as well as a small BH team that provides more traditional BH services, that are embedded within their PCP offices. Additionally, there is a small panel of providers available for specialty services not provided by these two agencies. Creekside, a mental health residential treatment and crisis respite facility resides in Wasco County that is utilized by both counties in this region as well as by other counties around the State. This region uses the SUD residential facilities within the Central Oregon CCO, if needed.

Transforming to Achieve Better Health, Better Care and Lower Costs

The areas in which PacificSource and our Health Council partners are fundamentally changing the way health care is delivered has been well documented in our Transformation Plan and bi-annual reports for the years 2013 through 2015. We track our progress through the established and measurable process and outcome oriented goals and targets set in the planning process and negotiated with OHA as a core deliverable in PCS's CCO contract. We are in the process of negotiating an update to our Transformation Plan for the years 2015 – 2017, which builds on progress in prior years and through which we believe we will continue to advance significant health care transformation priorities.

The core elements of our Transformation Plans include:

1. **Integration** of Mental/Behavioral Health, Dental and other health services areas (e.g. Public Health)
2. Continued development of **Patient Centered Primary Care Homes**
3. **Alternative Payment** Models and Methods
4. **Community Health Assessment** and **Community Improvement Planning** (in partnership with our Health Councils and CACs)
5. **Health Information Exchange** (HIE) and **Health Information Technology** (HIT) development
6. **Tailoring communications** and member outreach/engagement to the cultural, health literacy and linguistic needs of our diverse members
7. Promoting **culturally and linguistically appropriate service delivery** (cultural competency, recruiting a diverse workforce, use of Community Health Workers)

8. Quality improvement planning to **reduce health disparities**

Transformation Fund Projects

With support from the 2013 Governor's Budget, PCS is currently testing a total of 26 transformation fund projects (10 in Central Oregon and 16 in the Columbia Gorge) through a community grant-making process (latest reports attached inclusive of all projects). Each project in its own right was developed to change the way health care is delivered by better meeting quality, cost and population health aims. Included below are two highlighted projects from each region. More detail can be found in the attached reports.

Columbia Gorge

- **Clinical Pharmacy Services**
  → Progress will be measured by decreasing medical costs for enrolled patients, decreasing Emergency Room and In-patient utilization rates and likely increasing medication utilization and adherence.
  → Results first quarter 2016

- **Community Health Team**
  → A team of Community Health Workers organized and staffed by The Next Door, Inc. CHT receives referrals from the community & the CCO for complex & costly patients
  → CHT works with patients to navigate pathways that will improve the patient's overall health & quality of life
  → Results first quarter 2016

Central Oregon

- **Community Paramedicine**
  → Utilizes a relatively new and innovative model of care, Community Paramedicine (CP), to reduce hospital readmissions of frequent 911/ED users, including high cost congestive heart failure (CHF) patients, patients with chronic obstructive pulmonary disorder (COPD) and high risk diabetic patients
  → The initiative will optimize access to care for these members through the use of specially trained EMS personnel in an expanded role
  → Outcome measures include: decreased inpatient and emergency department re-admission rates for patients with CHF, COPD and diabetes related conditions; increase in medication adherence; decrease in no shows at the patients primary medical home
  → Results first quarter 2016

- **Mosaic Specialty Telemedicine**
  → Bridging the barriers to specialty care for rural Mosaic Medical (FQHC) patients by designing, building and implementing a specialty care telemedicine program in Mosaic clinics
  → Utilizes Bend Memorial Clinic (BMC) Cardiologists as a first step towards integrating a wide range of telemedicine specialty care
  → Outcome measures include: Improved access to specialty cardiology (during this grant period but other specialty areas as this project is expanded in the future); increased efficiencies and effectiveness across Mosaic and BMC systems by improved care coordination; improved disease states decreased mortality for cardiac patients; lower

costs per patient through more efficient and effective delivery of cardiology care in the PCPCH setting; increased capacity within specialty care

→ Results first quarter 2016

Specific Efforts to Integrate Physical and Behavioral Health: Columbia Gorge

Per our 2013 – 2015 Transformation Plan Element #1, a first step toward this level of integration was to create an Integrated Care Work Team (ICWT). The ICWT has been established and is meeting bi-weekly on topics and actions including:

- Recommendations to the CGHC based on evaluation of potential transformation fund projects on PH/BH integration
- Learning, evaluating & debating the merits of 1) different integration models from co-location to full integration, 2) Behavioral Health Consultant and Behavioral Health Specialty models of integration
- Developing a general process flow for SBIRT deployment in a clinic encompassing all payer types and establishing a small incentive for clinics to complete SBIRT work (the Gorge CCO region ended up with one of the highest SBIRT QIM rates across all Oregon CCOs in the 2014 measurement period)
- Development of the Physical Health & Behavioral Health Integration Transformation project in partnership with the University of Colorado at Denver (UCD) and OHSU.
- Development of integrated Clinical Pharmacy Services into primary care clinics are being supported by the Transformation Funds.

Through the support of Transformation Funds, the CGHC has endorsed a partnership with UCD and OHSU to develop and evaluate new BH/PH integration sites. In the 3Q2014, this Transformation project began working with local community partners to assess & build on our current integration efforts.

Four primary care practices (Columbia Gorge Family Medicine, Columbia Crest Family Medicine, and Columbia Hills Family Medicine, One Community Health) and one behavioral health agency (Mid-Columbia Center for Living) are actively engaged in the project. These practices provide the majority of care to OHP patients in the region. Each practice has a cross-functional implementation team (CFIT), totaling 24 individuals from diverse clinical roles.

With support from the project team, including conversations during the ICWT meetings and monthly site visits, these partners have been able to re-define their priorities together. The agencies are working towards integration of a behavioral health consultant role and co-located specialty mental health services at OCH Hood River location. OCH plans to expand this model to their location in The Dalles once workflows are more refined. In addition to activities at the primary care clinic, OCH leadership is providing ongoing guidance to MCCFL toward development of an integrated primary care program, targeting MCCFL clients with persistent mental illness. Columbia Hills Family Medicine (CHFM) is piloting a behavioral health consultant (BHC) model in addition to its co-located specialty mental health services. Initially MCOC planned to have the BHC cover 5 clinics – however early implementation efforts and reflection by the project team have made it so she's currently serving one practice.

In addition, clinic-level assessment data (Practice Information Form, Comprehensive Primary Care Monitor/Health Home Monitor, Minimal Data Set Capacity Assessment) have been completed by all five clinics during the monthly on-site PERC visits. The tools are being used to inform quality improvement projects to support integrated care at each clinic.

Specific Efforts to Integrate Physical and Behavioral Health: Central Oregon

As of January 1st, 2015 the Central Oregon CCO region has 14 distinct care sites within which physical and behavioral health services are co-located. The sites are operated by 6 different organizations including St Charles Family Care, Deschutes County, Bend Memorial Clinic, Mosaic Medical, and Central Oregon Pediatric Associates. There are at least 4 additional integrated care sites recently launched in the region, including new school based health centers with physical, behavioral, and oral health service offerings.

The region has had multi-disciplinary work groups discussing and refining care models for over a year, and a new regional Integration Task Force was endorsed by the CCO Board in early 2015. Participants include representatives from the CCO, Health Council, hospital system, primary care, FQHC, behavioral health, oral health, and public health. The Task Force is charged with conducting an environmental scan and a 2-3 year business plan for integrated care including key milestones and funding models.

In addition to this work group, Central Oregon is also placing emphasis on the promising model of "bi-directional" integration, wherein primary care services are embedded in settings that serve Severely Mentally Ill individuals (SMI) and/or individuals with acute substance abuse disorder. Currently, the region has one integrated health home treating the SPMI population. Operated by Deschutes County with physical health services provided by Mosaic Medical, the Harriman Center has significantly increased its level of integrated care since the development of our transformation objectives. Embedded physical health services are now offered at the center 4+ days/week.

Similar to the Columbia Gorge CCO, one of Central Oregon's transformation funding efforts directed dollars toward working with experts from the University of Colorado to inform integration workflows, staffing models, and other key elements utilizing national best practices and evidence based research. The intent of this project is to build capacity amongst providers who operate in integrated settings to track, monitor and sustain integration efforts.

Most Challenging Metrics and Opportunities for Improvement

Central Oregon 2014

Central Oregon hit all of the quality metrics with the exception of Adolescent Well-Care visits and SBIRT. The three metrics that have been the most challenging, yet hold opportunity for improvement in 2015 and beyond, include the following:

Adolescent Well-Care

- Challenge - Lack of consensus for medical evidence behind annual visit as well as difficulty engaging with teens and their parents
- Opportunity - For 2015, exploring partnerships with SBHCs, as well as incentive strategies and targeted clinic approaches

SBIRT

- Challenge - Expansion dramatically increased the denominator, and pay-for-performance efforts were undertaken too late in the year

- Opportunity - P4P strategies have been extended for the first part of 2015, and workflow trainings are being developed

Tech Plan

- Challenge - Lack of understanding around Meaningful Use reporting, technical specifications, and clinics' ability to report – especially for Depression Screening and Follow-Up, since most Meaningful Use-certified EHRs do not have this built in
- Opportunity - For 2015, there is greater understanding of tech plan measures and key stakeholders with technical expertise have been identified

Columbia Gorge CCO 2014

The Columbia Gorge has met all quality measures except the *Adolescent Well Care visits*. The three metrics that have been the most challenging, yet hold opportunity for improvement in 2015 and beyond, include the following:

DHS Custody

- Challenge - Considerable coordination was required between partners who did not typically have working relationships
- Opportunity - For 2015, the relationships and processes have now been established, and planning for dental was initiated early

Adolescent Well-Care

- Challenge - Lack of consensus for medical evidence behind annual visit as well as difficulty engaging with teens and their parents
- Opportunity - For 2015, partnership with SBHC as well as a clinic-specific approach to evaluate workflow

Tech Plan

- Challenge - Lack of understanding around Meaningful Use reporting, technical specifications, and clinics' ability to report – especially for Depression Screening and Follow-Up, since most Meaningful Use-certified EHRs do not have this built in
- Opportunity - For 2015, there is greater understanding of the tech plan measures and a process has been established for monthly review of data coordinated by the health council

This concludes our report. Thank you again for the opportunity to share what we are learning from the early implementation of Oregon's Coordinated Care model. This is critically important work, with early signs of tangible positive impact for Oregon Health Plan members. While it can be challenging to undertake, it is exciting and inspires hope. We are honored to be partnering with the state and our communities on behalf of Oregon's effort to improve the health of our Medicaid population and to bring the cost of healthcare under control.

Attachments

CCO Dashboard — June 5, 2015

Central Oregon Region

CCO Membership (Member Months)

May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15
49,321	50,244	50,940	51,410	52,138	52,607	49,818	50,922	51,570	52,797	54,195	55,269	55,114

FINANCE

2015 Year to Date Income Statement (YTD) Central Oregon

	2015 YTD (Apr)	Budgeted Target 2015 YTD (Apr)	Difference (Variance)
Total Revenue	$88,695,747	$80,166,661	$8,529,086
Medical Claims Expense	($77,335,719)	($70,606,209)	($6,729,510)
General & Administrative Expenses	($5,108,875)	($4,617,600)	($491,275)
Underwriting Income	$6,251,154	$4,942,853	$1,308,301
Net Income	$2,111,903	$1,514,381	$597,521

% of PMPM Total Spend - Central Oregon (Inc thru 2/15, Pd thru 4/15)

	2013						2014						2015					
	OP	IP	Phys	Rx	Misc	BH	OP	IP	Phys	Rx	Misc	BH	OP	IP	Phys	Rx	Misc	BH
	17%	22%	25%	14%	7%	15%	17%	22%	24%	16%	4%	13%	16%	21%	22%	17%	4%	12%

Current ($) PMPM Estimates: Central Oregon (Inc thru 2/15, Pd thru 4/15)

	BH	OP	IP	Phys	Rx	Misc	Phys (YTD)	Phys + BH (YTD)
2012	$39.8	$41.1	$51.8	$64.9	$38.3	$14.7	$210.9	$250.7
2013	$37.5	$44.0	$56.4	$65.7	$36.6	$17.8	$220.5	$257.9
2014	$37.6	$50.1	$63.5	$69.2	$45.5	$12.0	$251.5	$289.1
2015	$37.5	$51.6	$67.7	$70.1	$54.4	$11.4	$279.3	$316.9

Membership Over Time (Gray) % Change from Prior Month (Blue bars)
based on total member months

Current Financial Surpluses need to be interpreted with caution and considering the following:
1) SNRG membership is subject to a risk corridor over a 2-yr period. We reserved for the estimated amount, but actual reimbursement to OHA is subject to final reconciliation.
2) Pent-up demand for new members: We have reserved for this, but it may be inadequate.
3) Chronic disease utilization: We have reserved for this, but it may be inadequate.
4) Provider withholds and bonus agreements have been reserved at currently estimated levels.

MEMBER EXPERIENCE (BOTH CCO REGIONS COMBINED)

Calls Answered Within 30 seconds (Target: 80%)

2014-Q2	46.7%
2014-Q3	86.6%
2014-Q4	80.6%
2015-Q1	73.9%
2015-Q2	86.1%

Claims Turn Around Time (Days) (Target: < 15 days)

2014-Q2	6.5
2014-Q3	7.0
2014-Q4	10.8
2015-Q1	11.0
2015-Q2	11.0

Member Grievances per 1,000 Members

2014-Q2	3.4
2014-Q3	2.9
2014-Q4	4.6
2015-Q1	3.7
2015-Q2	3.4

DATA INSIGHT: READMISSIONS: All Ages, All Causes — Acute IP Readmissions w/in 30 days of Discharge

LINE: Percent of Acute Admits w/ Readmission w/in 30 days (%)

BARS: Count of Readmissions (#)

*BENCHMARK: OHA Hosp. bench-mark ≤ 6.1% 90th percentile for all hospital types (from HTPP)

Quarter	Line %	Bar count
QTR 1 2012	8.3%	79
QTR 2 2012	8.0%	76
QTR 3 2012	6.3%	57
QTR 4 2012	6.9%	61
QTR 1 2013	8.0%	85
QTR 2 2013	9.0%	92
QTR 3 2013	7.3%	71
QTR 4 2013	6.5%	52
QTR 1 2014	6.9%	67
QTR 2 2014	6.0%	60
QTR 3 2014	4.6%	50
QTR 4 2014	5.9%	57
QTR 1 2015	6.8%	60

Benchmark* 6.1%

Definitions

BH: Behavioral Health (mental health, substance abuse and addictions)

Dev'l Screenings: Developmental Screenings. Done to identify developmental delays at an early age. Oregon Health Authority CCO measures only include CPT code 96110, though other procedures are considered developmental screening/assesment.

ED: Emergency Department/ Emergency Room Services

General Administrative Expense: Expenses related to the administration of the plan including, but not limited to, staff salary and benefits, telephone, depreciation, software licenses, utilities, etc.

HTPP: Oregon Hospital Transformation Performance Program, OHA

Medical Claims Expense: Claims-related expenses, including capitation, pharmacy, disease management and network fees, pharmacy rebates (if applicable), health services expenses and IBNR (incurred but not received).

MH/CD: Mental Health / Chemical Dependency

MM: Member Months. One member month = one person enrolled for a whole month. If a person is enrolled for an entire year, that is equivalent to 12 member months. If a person is enrolled for 2 out of 4 weeks in the month, that is 0.5 member months.

Net Income: Underwriting Income combined with results of activities not directly related to continuing operations, on an after tax basis.

PCPCH: Patient-Centered Primary Care Home (as defined by OHA)

PMPM: Per member per month

Premium Taxes & OMIP: State mandated taxes collected on a per member mer month (PMPM) or % of premium basis.

Rx: Prescription

SBIRT: Screening, Brief Intervention and Referral to Treatment. A screening and intervention method for alcohol and substance misuse.

Total Revenue: Premiums collected for insurance, net of HRA costs. Premiums for Oregon Health Plan recipients are received from the state of Oregon.

Utilization: Use of a good or service

Underwriting Income: Income after Operations and other activities not directly related to continuing operations...

Important Notes

GENERAL:

All data is subject to revision. Data for each month is updated with the most current and complete estimates at the time of updating.

FOOTNOTES: CLAIMS PMPM ESTIMATES

- MH capitation had been added to the PMPMs and claims processed on the Behavioral Health entitites behalf have been removed to the best of our ability. This presents a change from the methods used to provide PMPMs in previous months.

- Claims Processing Error Correction: St. Charles overpayment estimates for Central Oregon Outpatient in early 2013 have been removed prior to 08/2013 based on estimate from PH Tech. PMPM estimates may be subject to revision based on claims processing errors identified after the paid date.

- For PMPM Estimates: Incurred through 2/2015 paid through 4/2015

- Completion factors applied to PMPM estimates only. Completion factors NOT applied to utilization metrics unless otherwise indicated.

- Excludes: MH/CD Fee-for-service claims and MH ASO and 7 11 drugs. Includes withhold.

- Claims processed on ABHA's behalf are removed by taking 1/3 of total amount of Inpatient, Outpatient and Physician.

- Claims processed on WEBCO's behalf are removed by a flag using logic from PH Tech.

- Behavioral Health coverage in Gorge Region began 11/2012.

Note: Behavioral Health (BH) is excluded from the Chart "% Change in PMPM $ Spend (from Previous)*" because 2010-2012 estimates of PMPM did not include capitation data prior to CCO formation.
Therefore, **a combined PMPM estimates (*Med + BH (YTD)*) from years prior to 2013 are not directly comparable to 2013** since Behavioral Health capitation $ is only included for the time after CCO formation. If you want **to compare over time, instead use *Medical (YTD)*** which includes Medical and Rx but excludes BH.

Gorge Region

CCO Membership (Member Months)

May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15
11,705	11,943	12,171	12,344	12,529	12,626	11,992	12,249	12,412	12,658	13,014	13,299	13,349

FINANCE

2015 Year to Date Income Statement (YTD) Gorge

	2015 YTD (Apr)	Budgeted Target 2015 YTD (Apr)	Difference (Variance)
Total Revenue	$20,422,577	$18,379,372	$2,043,205
Medical Claims Expense	($16,066,387)	($16,186,620)	$120,233
General & Administrative Expenses	($1,176,341)	($1,058,648)	($117,693)
Underwriting Income	$3,179,849	$1,134,104	$2,045,745
Net Income	$1,556,290	$347,856	$1,208,434

% of PMPM Total Spend - Gorge (Inc thru 2/15, Pd thru 4/15)

2013						2014						2015					
OP	IP	Phys	Rx	Misc	BH	OP	IP	Phys	Rx	Misc	BH	OP	IP	Phys	Rx	Misc	BH
28%	22%	18%	11%	6%	15%	31%	18%	16%	11%	4%	15%	29%	16%	15%	14%	4%	15%

Current ($) PMPM Estimates: Gorge (Inc thru 2/15, Pd thru 4/15)

Membership Over Time (Gray) % Change from Prior Month (Blue bars)

based on total member months

Current Financial Surpluses need to be interpreted with caution and considering the following:
1) SNRG membership is subject to a risk corridor over a 2-yr period. We reserved for the estimated amount, but actual reimbursement to OHA is subject to final reconciliation.
2) Pent-up demand for new members: We have reserved for this, but it may be inadequate.
3) Chronic disease utilization: We have reserved for this, but it may be inadequate.
4) Provider withholds and bonus agreements have been reserved at currently estimated levels.

MEMBER EXPERIENCE (BOTH CCO REGIONS COMBINED)

Calls Answered Within 30 seconds

2014-Q2	46.7%	
2014-Q3	86.6%	
2014-Q4	80.6%	
2015-Q1	73.9%	
2015-Q2	86.1%	Target: 80%

Claims Turn Around Time (Days)

2014-Q2	6.5	
2014-Q3	7.0	
2014-Q4	10.8	
2015-Q1	11.0	
2015-Q2	11.0	Target: < 15 days

Member Grievances per 1,000 Members

2014-Q2	3.4
2014-Q3	2.9
2014-Q4	4.6
2015-Q1	3.7
2015-Q2	3.4

DATA INSIGHT: READMISSIONS: All Ages, All Causes Acute IP Readmissions w/in 30 days of Discharge

LINE: Percent of Acute Admits w/ Readmission w/in 30 days (%)

BARS: Count of Readmissions (#)

*BENCHMARK: OHA Hosp. bench-mark $\leq$ 6.1% 90th percentile for all hospital types *(from HTPP)*

Definitions

BH: Behavioral Health (mental health, substance abuse and addictions)

Dev'l Screenings: Developmental Screenings. Done to identify developmental delays at an early age. Oregon Health Authority CCO measures only include CPT code 96110, though other procedures are considered developmental screening/assesment.

ED: Emergency Department/ Emergency Room Services

General Administrative Expense: Expenses related to the administration of the plan including, but not limited to, staff salary and benefits, telephone, depreciation, software licenses, utilities, etc.

HTPP: Oregon Hospital Transformation Performance Program, OHA

Medical Claims Expense: Claims-related expenses, including capitation, pharmacy, disease management and network fees, pharmacy rebates (if applicable), health services expenses and IBNR (incurred but not received).

MH/CD: Mental Health / Chemical Dependency

MM: Member Months. One member month = one person enrolled for a whole month. If a person is enrolled for an entire year, that is equivalent to 12 member months. If a person is enrolled for 2 out of 4 weeks in the month, that is 0.5 member months.

Net Income: Underwriting Income combined with results of activities not directly related to continuing operations, on an after tax basis.

PCPCH: Patient-Centered Primary Care Home (as defined by OHA)

PMPM: Per member per month

Premium Taxes & OMIP: State mandated taxes collected on a per member mer month (PMPM) or % of premium basis.

Rx: Prescription

SBIRT: Screening, Brief Intervention and Referral to Treatment. A screening and intervention method for alcohol and substance misuse.

Total Revenue: Premiums collected for insurance, net of HRA costs. Premiums for Oregon Health Plan recipients are received from the state of Oregon.

Utilization: Use of a good or service

Underwriting Income: Income after Operations and other activities not directly related to continuing operations...

Important Notes

GENERAL:

All data is subject to revision. Data for each month is updated with the most current and complete estimates at the time of updating.

FOOTNOTES: CLAIMS PMPM ESTIMATES

- MH capitation had been added to the PMPMs and claims processed on the Behavioral Health entitites behalf have been removed to the best of our ability. This presents a change from the methods used to provide PMPMs in previous months.

- Claims Processing Error Correction: St. Charles overpayment estimates for Central Oregon Outpatient in early 2013 have been removed prior to 08/2013 based on estimate from PH Tech. PMPM estimates may be subject to revision based on claims processing errors identified after the paid date.

- For PMPM Estimates: Incurred through 2/2015 paid through 4/2015

- Completion factors applied to PMPM estimates only. Completion factors NOT applied to utilization metrics unless otherwise indicated.

- Excludes: MH/CD Fee-for-service claims and MH ASO and 7 11 drugs. Includes withhold.

- Claims processed on ABHA's behalf are removed by taking 1/3 of total amount of Inpatient, Outpatient and Physician.

- Claims processed on WEBCO's behalf are removed by a flag using logic from PH Tech.

- Behavioral Health coverage in Gorge Region began 11/2012.

Note: Behavioral Health (BH) is excluded from the Chart "% Change in PMPM $ Spend (from Previous)*" because 2010-2012 estimates of PMPM did not include capitation data prior to CCO formation.
Therefore, **a combined PMPM estimates (*Med + BH (YTD)*) from years prior to 2013 are not directly comparable to 2013** since Behavioral Health capitation $ is only included for the time after CCO formation. If you want **to compare over time, instead use *Medical (YTD)*** which in-cludes Medical and Rx but excludes BH.

Transformation Plan Milestone Report Template

This form is a template for the Transformation Plan Milestone Report requirement. <u>Use of this form is not required, but the elements outlined below do represent the required elements for reporting for each Transformation Area.</u> You are welcome to use your Innovator Agent to assist you in the completion of this report. Your Innovator Agent can also supply you with a version of this template that includes your individual CCO's Transformation Plan benchmarks and milestones copied within each corresponding section below

Please send your completed Transformation Plan Milestone Report to the CCO Contract Administrator, David Fisher (DAVID.H.FISCHER@dhsoha.state.or.us) by no later than 5:00 pm on July 1, 2014.

Transformation Area 1: Integration of Care - Central Oregon

Milestones for July 1, 2014: Integrated care work team project plan is approved by COHC; ongoing review of cost, quality and experience outcomes being achieved by integrated care sites.

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Activity *(Action taken or being taken to achieve milestones)*	Outcome to Date	Process Improvements
1.	Convene integrated care work team	• Work team has been identified. • Team members include representatives from COHC, CCO, OHA Transformation Center, CMHPs, and Hospital/PC stakeholders	• Leveraged the Physical Health & Behavioral Health Integration Transformation project in partnership with St. Charles Health System, Mosaic Medical and the University of Colorado at Denver (UCD).
2.	Baseline assessment of practices	Project launched and in progress	In order to first collect data on the baseline assessment, practices must be identified who are delivering integrated care – once this is established, the preliminary data collection around the practices' integrated effort can occur. These data will include the type of practice, patients seen in practice, integrated activity, and

			several other key descriptive components.
3.	Baseline cost assessment of integrated effort in practice	In process	Working with an expenditure analysis tool, practices will complete a preliminary cost assessment of their work.
4.	HIT/Data extraction readiness assessment	In process	In order to understand the clinical impact of integration on the population being served by the practice, there must be the capacity for the practice to collect (input) and extract (output) the right kinds of data.
5.	Cost savings	In process	Matching patients from the practices who have integrated to their claims, it is possible to ascertain if there are indeed cost savings through integration. Using a pre/post method of data analysis, practices can determine which patients cost more/saved more from the integrated intervention.

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

Tracking cost, quality and experience outcomes involves significant collaboration between clinics and the project team, particularly around data sharing. The project team has experienced more difficulty than anticipated getting data from the clinics which may be both a product of the strain and demand many PCPCHs are experiencing related to health reform and a lack of internal capacity and/or training to facilitate the data reporting.

The decision to work with subject matter experts at the University of Colorado to support our ability to evaluate and monitor progress toward integration serves the Central Oregon CCO well at this stage in our transformation plan implementation. However, a more robust approach may be required to optimize the model and add additional focus on the participation of other services such as community mental health programs, clinical pharmacy and dental care. The resources to launch this work were secured through the transformation fund RFP process so funds are limited in duration and scope. This places certain constraints on the team such as capacity to serve all clinics and the level of practice facilitation needed to ensure data exchange and tools to track cost, quality and experience outcomes are implemented efficiently and effectively. (The UCD proposal of the Central Oregon CCO transformation fund RFP did not request additional funding for practice facilitation which may be needed to implement at scale, such as the work underway in the Columbia Gorge CCO region).

1 c.) Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

The integration team has requested and has secured a main point of contact at St Charles Family Care and Mosaic and improvements are underway to support the provision of needed data sets. Conversations are underway to explore other opportunities to secure additional resources or partnerships needed for practice facilitation and inclusion of new services into the integration model. The Deschutes County Annex, a county mental health site serving members with severe and persistent mental illness (SPMI) has integrated primary care (partnership with Mosaic Medical). The County has committed to measuring the same metrics of cost, quality and experience that the UCD model is using.

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

This project was selected by the Operations Council, Provider Engagement Panel, Community Advisory Council and Central Oregon Health Council as one of the final transformation fund projects. Integrating Behavioral Health Consultants in the PCPCHs in Central Oregon, however, has been a priority for many years. The original design of behavioral health consultant integration into primary care was a demonstration project of what is now the CCO's Operations Council, therefore the CCO's community governance council and committees have been closely involved in guiding the work from the beginning. Studying outcomes is now the priority, along with standardizing practices throughout the region and state.

Transformation Area 2: PCPCH - Central Oregon

Milestone for July 1, 2014: Assessment of community PCPCH certification opportunities in partnership with COHC is complete. Contractor to increase the number of Members assigned to a PCPCH clinic in places as endorsed by COHC.

1 a.) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

Activity *(Action taken or being taken to achieve milestones)*	Outcome to Date	Process Improvements
1. Contractor ensures the assessment of community PCPCH certification opportunities in partnership with Central Oregon Health Council (COHC) stakeholders is complete.	• In May, 2014, CCO worked with the Central Oregon IPA (COIPA) to conduct and publish an assessment of PCPCH recognition amongst their member practices. • St Charles employed clinics have achieve high levels of PCPCH certification	• CCO is working with providers to ensure clinics are aware of PCPCH requirements and opportunities • CCO is working with COIPA and other stakeholders to identify opportunities to increase PCPCH adoption and PCPCH tier levels
2. Contractor plans to move toward increasing the number of Members assigned to a PCPCH clinic.	• The Central Oregon CCO has achieved high PCPCH adoption and Member assignment with an aggregate weighted score of 94% of Members being assigned to PCPCH certified providers (05/14). 88% of members are assigned to a Tier 3 PCPCH.	• Periodic reports on QIM performance, including Member assignment to PCPCH certified providers are submitted to COHC and its committees. • In 2013 the CCO, together with many providers, reviewed and revised Member auto-assign process to include more providers and to assign based on proximity.

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

The Central Oregon region has been very successful in achieving a high level of PCPCH certification among providers. A challenge will be to move to even higher percentages of members assigned to PCPCH certified providers, which is our expressed goal for the 2015 Transformation Plan milestone. This will involve engaging small private practices where PCPCH certification faces economic and cost effectiveness hurdles. According to the COIPA assessment of PCPCH status amongst member practices, the greatest barriers to smaller clinics achieving PCPCH status is resource limitation. As stated in their report, "…these clinics' OHP enrollment numbers are low enough that the initial incentive of state reimbursements for OHP members with ACA qualifying conditions would not have reimbursed them adequately for the overhead/administrative costs of seeking recognition."

1 c.)Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

In 2012-13, the CCO developed and executed a strategy to increase the PMPM capitation rates to PCPs, beyond the level supported by historical utilization and cost trends, to support investments of PCPs' choosing (e.g., expanded prevention, care coordination, integration, PCPCH adoption, etc.). In addition to this strategy, the CCO proposed and OHA approved implementation of the ACA mandated increase in PCP fees by automatically increasing compensation to all potentially eligible PCPs (as defined by ACA and OHA methodology) retroactive to January 1, 2013, without requiring PCP attestation.

In addition, the CCO has worked with its providers to provide clinical and technical support to clinics pursuing PCPCH certification. According to the COIPA assessment of PCPCH status amongst member practices, "...Small clinics tend to have fairly stable patient and provider bases that encourage long-term patient-PCP relationships, good patient access to care, close follow-up and management of chronic diseases, and provider/clinic involvement in coordination of care. In essence, many of these clinics already provide the level of care the OHA wants OHP members to receive and that PCPCH recognition was created to encourage. These clinics simply lack the depth of resources to be able to dedicate staff and time (uncompensated) to the additional administrative burdens of seeking and maintaining recognition."

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

In Central Oregon, the Central Oregon Health Council (COHC) and the CCO have entered into a Joint Management Agreement (JMA). The COHC and its standing committees – Community Advisory Council, Provider Engagement Panel, Operations Committee, and Finance Committee – include on their agendas all topics related to CCO responsibilities, including provider engagement on specific areas of focus such as QIMs performance, PCPCH certification, EMR adoption, APMs, etc. The COHC and its committees provide direction to the CCO in its execution of business and pursuit of outcomes. Stakeholders participating in these groups contribute to and are subject to discussion and consensus reached on these topics.

As part of the JMA, the CCO regularly provides education, analytics support, and performance reports to the COHC and its committees. Additionally, the COHC and CCO also endorse the following Transformation Fund and Quality Fund projects which will reinforce and potentially improve PCPCH status for the clinics in our region.

- Health Information Exchange: a project to further develop HIE functionality and adoption by partner clinics.
- Telemedicine: a project to pilot and eventually "scale" a more efficient referral interface between primary care and specialty care. The project intends to optimize the referral process, leverage technology to facilitate timely PCP/Specialty referral and communication, and test telemedicine alternative payment methods.
- Clinical Pharmacy Services: these projects will integrate clinical pharmacists into primary care settings at four unique primary care clinics in the region.
- PH/BH Integration: a project to develop and measure the impact of primary care/behavioral health integration in four clinical settings, some of which will be PCPCH clinics.

The COHC and associated committees are chartered to actively monitor the progress of these and other Transformation Fund projects.

Transformation Area 3: Alternative Payment Methodologies - Central Oregon

Milestone for July 1, 2014: Alternative Payment Methodology (APM) work groups are established to develop recommendations on payment methodologies. APM work group recommendations endorsed by Health Councils.

1 a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Activity *(Action taken or being taken to achieve milestones)*	Outcome to Date	Process Improvements
1.	Alternative Payment Methodology work group formed in 3rd quarter, 2013.	APM work group established	N/A
2.	Central Oregon Health Council (COHC) Finance Committee endorses APM work group's charter and scope of work in 3rd quarter, 2013.	Formal endorsement of APM work group charter.	The APM work group's role is formalized within CCO community governance structure.
3.	APM work group and COHC Finance Committee begin formal discussions on guiding principles for CCO reimbursement in 4th quarter, 2013.	Critical path process step to accomplishing #4 below.	Governance and public discussions about APM and its role as a foundational component of the region's health transformation efforts are being held.
4.	COHC Finance Committee and Board endorse APM work group recommendations, respectively, in May and June 2014. (Attached)	CCO governance formal endorsement of APM recommendations.	Health Council and CCO will utilize APM principles to help inform 2015 contracting efforts and global budget allocations.
5.	During the first quarter of 2014, APM principles and recommendations are embedded into the 2014 contracts between the CCO and local providers.	CCO provider contracts now have the following characteristics. - Contracts with largest providers (both physical health and behavioral health) are performance based. - Performance elements are tied to	Following contract implementation, cross-organizational work groups have been formed to monitor progress against quality and cost metrics.

| | | improvements in quality and cost, and include both quantitative (ie; outcomes) and process related measures.
- Performance elements align providers whose contracts were previously independent (ie; joint accountability for quality measures requiring collaboration between two or more entities)
- Significantly higher percentage the CCO global budget is paid on a value/fixed fee schedule rather than on volume/fee-for-service reimbursement. | |

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

Despite experiencing some barriers, the region's providers and CCO have been able to make significant progress over the past year around APM. The following were some of the barriers to achieving milestones in our region's APM work:

- **Concerns about navigating multi-entity contract discussions:** Early APM discussions were somewhat dominated by questions about what level of detail could safely and legally be discussed in public, and with multiple parties each of whose individual contracts are with PacificSource.
- **Transition from FFS to value based reimbursement:** Naturally, concerns surfaced about the risks associated in transitioning from a largely FFS reimbursement structures, to value based methods. These included uncertainty about the impact of the expansion population on utilization and cost, concerns about providers taking higher levels of risk, acknowledgment that we may lack sophisticated analytics tools to provide real-time insights about performance, and anxiety about our region's collective ability to change behaviors even under new reimbursement schemas.
- **Trust:** Developing performance based and risk based reimbursement methods purposefully places higher levels of joint accountability on providers whose contractual performance had previously been independently driven. Establishing bi-directional accountability for a small number of region-wide performance measures was a significant accomplishment and - for the first time – binds the CCO, hospital system, independent providers, and county systems of care to common outcomes.

1 c.) Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

The above mentioned barriers were mainly overcome through dialogue, knowledge sharing, and trust building. Certainly, negotiation and compromise were common strategies employed. Although all CCO stakeholders would doubtless indicate that the Central Oregon region is still at the genesis of its reimbursement transformation, significant leadership and has been exhibited by each of the organizations and their senior teams. Leaders have been willing to create change within their respective organizations by championing the beginning of a patient-centered and community driven system of reimbursement.

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

Governance played a significant role in the CCO's achievement of its 2014 APM milestones. Establishing reimbursement transformation as a concrete CCO governance objective has escalated both the level of visibility and transparency of this work. The consumer representatives on the Health Council were a strong voice, and also provided timely counsel to insist there are mechanisms to ensure that even well-intended reimbursement shifts not impose risk to quality patient care and equal treatment of beneficiaries. Having APM recommendations formally vetted by standing Health Council Committees (in this case the Finance Committee with representation from providers, citizen representatives, and the CCO) and endorsed at the highest level of CCO governance (ie; COHC) provided a level of accountability that helped mobilize and focus contract negotiations between CCO and providers.

Transformation Area 4: Community Health Assessment and Community Health Improvement Plan - Central Oregon

Milestone for July 1, 2014: Contractor standardizes CHA and CHIP updates considering the community partner agencies' community health assessment and plan needs.

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Activity *(Action taken or being taken to achieve milestones)*	Outcome to Date	Process Improvements
1.	The completion of the process for the development and maintenance of the Central Oregon Community Health Assessment and Community Health Improvement Plan.	The process plan is complete.	The written documentation for the update to the CHA/CHIP is complete. It was approved by the CAC on May 1, 2014, was presented to the Central Oregon Health Council on May 12th, 2014 for approval.
2.	Phase 1: Organize the Kick-off event for the community process for updating the CHA/CHIP in Central Oregon.	August 2014	Recruit and create a planning team to include data analysts and partners within the tri-county area. The plan will use the MAPP (Mobilize for Action through Planning and Partnerships) process for community planning.
3.	Phase 2: Plan the Assessment in Partnership	August 2014	• The planning group will develop a vision and charter for the team. • This phase will include the development of a communications plan for the region to be inclusive of community partner in the assessment process.
4.	Phase 3: Assessment and Analysis Process	September 2014 – January 2015	This phase will include: • Primary Data Collection • Collection of Qualitative Data and Quantitative Data • Community Focus Groups, Surveys, Key-informant interviews • Input and participation by the CAC , Ops, and PEP • Analysis of Data • Update of CHA/CHIP
5.	Phase 4: Document into the Updated	April 2015	Completed CHA/CHIP for the Central

	CHA/CHIP and Communicate Findings to the CAC and COHC.		Oregon Health Council and OHA.

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

The lack of funding for this process and staff devoted to the work is the biggest challenge. Currently, the lead is the WEBCO Public Health Staff.

1 c.)Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

WEBCO is working with the Central Oregon Health Council and Pacific Source to dedicate resources to this requirement. The innovator agent assigned to the CCO, Angela Kimball, has been instrumental as the CAC and its role around facilitating the CHA/CHIP has developed. Ms. Kimball is a consistent presence at all CAC meetings where and she has made herself personally available to support the CAC as needed with guidance and technical assistance.

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

The Community Advisory Council will be very involved in this process including participation on the planning group. Their involvement is critical to the development of the updated CHA/CHIP for the region. The COHC considers CHA/CHIP as the main purview of the CAC and therefore, the CAC is responsible to discuss and move endorsements relating to this work forward for consent to the CCO governing board. The Board's support will be crucial in supporting this effort not only financially, but also by allocating staffing support.

Transformation Area 5: EHR, HIE and meaningful use - Central Oregon

Milestones for July 1, 2014: Form a neutral Central Oregon HIE governance entity by the 3rd quarter of 2013, with participation from the region's largest providers. Formalize a business plan and financing plan for a comprehensive community HIE strategy by end of 2013. By July 2014, all providers participating in regional HIE governance will have interfaced their electronic health records to the HIE platform.

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Activity *(Action taken or being taken to achieve milestones)*	Outcome to Date	Process Improvements
1.	Central Oregon Health Information Exchange, Inc. (COHIE) formed as an independent organization in 3rd Quarter 2013. The entity is in the application process for official 501(c)(3) status with the IRS.	Neutral Central Oregon HIE organization formed by end of 2013.	COHIE is governed by a community board of directors, initially consisting of the major health care stakeholders but with plans to expand in the future based on business needs.
2.	COHIE governing Board is comprised of representatives from Bend Memorial Clinic P.C (BMC), Adaugeo Healthcare Solutions, LLC (Adaugeo), St. Charles Health System, Inc. (SCHS), PacificSource Community Solutions (PCS), Central Oregon Independent Practice Association (COIPA), Mosaic Medical (Mosaic) and Oregon Community Health Information Network (OCHIN).	Regional HIE governance and shared decision making model established.	HIE is viewed as a neutral, community health care strategy rather than something owned and operated by a single stakeholder.
3.	In parallel to forming the organization and defining the governance model, COHIE in the 3rd and 4th quarters completed a Phase 1 business and financial plan outlining key deliverables for the region's HIE and initial funding sources for those deliverables. Operating objectives for 2014 were outlined as follows: • Establishment of 3 year technology development plan based on completion of RelayHealth (the region's HIE "platform" and primary vendor) foundational work already completed, and "use case" based needs to meet HIE technology requirements from Central Oregon Health Council (COHC) and the State	Regional HIE Phase 1 business plan and financial plan complete.	All participating organizations have contributed to the phase 1 financing, and deliverables have been endorsed by COHIE Board and all stakeholder organizations.

	• Ongoing work to connect provider EHRs to the HIE • Establishment of provider engagement and on-boarding model and plan • Development and regional endorsement of sustainable, subscription based HIE funding model		
4.	In 2nd quarter 2014, Central Oregon Health Council allocated to COHIE a portion of the CCO's Quality Incentive Measure funds related to achieving the 2013 CCO Technology Plan.	Aligning CCO, CCO governance, and regional HIE objectives to ensure long term sustainability of HIE funding and operations.	Investment of CCO/Health Council funds will further align COHIE and COHC objectives in the HIT arena, and have resulted in a CCO governance representative having a permanent seat on COHIE's Board of Directors. It is also expected that a functioning HIE will assist the region in reaching future QIM targets, a connection that will be monitored by both COHIE and COHC.
5.	Contractor ensures providers participating in COHIE governance are all interfacing their EMRs with the Central Oregon HIE as of July 2014. Dating back to early 2013, the region has leveraged St Charles' relationship with HIE vendor RelayHealth, resulting in Results Repository and Exchange development. These developments have resulted in the exchange of lab/radiology/pathology information from EHRs to HIE, as well as broader health summary documents and patient identification from contributing organizations to the RelayClinical Platform.		Interfaces between local EHRs and the emerging HIE have progressed beyond just providers in HIE governance, and are beginning to include a number of additional providers. HIE functionality will continue to grow as additional interfaces are developed and the clinical platform is enhanced.

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

While there has been significant community alignment around the need for a high functioning regional HIE and a "shared vision" around the primary objectives for HIE, the Central Oregon HIE has experienced barriers common to the HIE experience nationally. Primary barriers have been related to funding early HIE efforts, and dedicated staffing. Although providers and the CCO have contributed to early HIE efforts through investments and in-kind staffing, a sustainable financing and staffing model is under development. Although not truly a barrier, there is early recognition that HIE efforts need to consider the inclusion of care components beyond merely the physical health domain. Traditional HIE efforts nationally have been focused largely on connecting physical health providers and clinical information, but our region's ultimate vision is to be more inclusive. Those efforts will require focus and, likely, additional funding.

1 c.)Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

St Charles Health System has made significant investments in RelayHealth, which has now been endorsed as the preferred vendor for Central Oregon HIE efforts. These early investments, and the information exchange functionality resulting from them, have given regional HIE efforts a significant boost. As a result, ongoing investments have a better chance of being scaled and sustainable. Other efforts to mitigate the financial barriers associated with HIE development are discussions on shared funding models and the establishment of the guiding principle "everyone who benefits pays their share". The region's HIE leaders have also been working with State driven HIE efforts to ensure high levels of alignment and minimal duplication. These discussions have been fruitful and we are gaining confidence that State HIE functionality can provide utility and augment local deliverables. Finally, to try to ensure that HIE efforts will reflect the increasingly integrated CCO global budget components, there is movement toward including both a CCO governance and an oral health representative on the COHIE Board.

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

The primary participants in CCO community governance are also major stakeholders in the regional HIE strategy. This results an up-front recognition at the CCO Board level that clinical information connectivity is fundamental to regional CCO success. Additionally, the COHC Finance Committee established a set of metrics on which members would like to receive quarterly updates. This is an example of how the CCO governance structure is evolving to measure community-wide progress, while holding partners accountable (especially those who have received CCO global budget funding through joint CCO/COHC decision making processes) to delivering on intended outcomes.

Transformation Area 6: Communications, Outreach and Member Engagement - Central Oregon

Milestones for July 1, 2014: Complete written self-assessment to identify at least two (2) areas to improve Member communications with particular focus on Hispanic/Latino and American Indian/Alaska Native (AI/AN) populations; Outline system requirements necessary to implement recommended changes.

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Activity *(Action taken or being taken to achieve milestones)*	Outcome to Date	Process Improvements
1.	PSCS convened a Health Equity Task Force (HETF) to conduct an assessment to identify areas to improve communications and outreach to Hispanic/Latino and AI/AN populations. The HETF used culturally and linguistically sensitive methods to gather member stories and experiences, including Spanish language focus groups, community forums and targeted outreach.	A report of member experiences and recommendations for better serving Hispanic/Latino and AI/AN members was completed and shared with CCO board and standing committees (See appended Central Oregon Health Equity Task Force Report). This report included recommendations on ways to improve Member communications for diverse populations.	N/A
2.	PSCS reviewed the HETF report and identified areas to improve communication with Hispanic/Latino and NA/AI members.	PacificSource is focusing on the following areas to improve communications: • Targeted outreach to Latino/Spanish speaking populations through language-appropriate interactive telephonic outreach. This outreach will point members to resources that can help with the re-determination process; • Recruiting a bi-cultural and bi-lingual member engagement	The bilingual, bicultural specialist position is currently posted, including posting through community groups serving our target populations (the Tribes, Let's Talk Diversity, Latino Community Association, etc.).

		specialist to develop and implement strategies to improve communications with diverse communities; • Providing clinic and provider-level education on the use and availability of professional interpreters to improve the experience of members faced with health disparities and/or limited English proficiency; • Initiating conversations with The Confederated Tribes of Warms Springs to better understand how I.H.S. and the CCO system can come together to improve health care quality for Native American CCO members.	

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

The CCO, COHC, CAC and our other committees are interested in building stronger relations with the Native American and Hispanic/Latino communities as well as other vulnerable populations that may be less likely to engage in a the health care transformation process. Though this process is fraught with barriers, we believe community engagement is a necessary method to gather meaningful member input into areas where gaps in access, communications and/or equity of care may be occurring.

The Task Force also experienced barriers in the engagement of diverse populations. The Task Force engagement project was an opportunity for learning and deeper understanding around successful engagement of minority communities and vulnerable populations. For example, when attendance was minimal at the Deschutes County forum, we learned that no personal invitations were made to community members – instead area agencies set out flyers in clinics, posted the flyer on websites, and/or forwarded the email invite on to other providers.

Finally, issues and areas of improvement in this category are wide-ranging and it is a challenge to communicate findings in a way that allows the system to zero in on tangible activities that may impact a variety of providers on a variety of levels.

1 c.)Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

PacificSource wrote, and was awarded, a grant from the Office of Equity and Inclusion to subcontract with the Let's Talk Diversity Coalition (Jefferson County). The Let's Talk Diversity Coalition is a grass-roots community organization with a long history of serving the Latino and Native American communities in the region. PacificSource worked with Let's Talk Diversity to form a Health Equity Task Force (HETF). For a complete list of

task force members, please see appended Health Equity Task Force Report. Though we still had our challenges, we learned a great deal working with this group and the experience has enhanced the CCO's capacity and effectiveness in engaging populations of interest and identifying needed reforms to achieve health equity and inclusiveness.

PacificSource also sought out and received technical assistance from our Innovator Agent, Angela Kimball, as well as expert staff of the Office of Equity and inclusion to help course-correct and navigate barriers encountered in the course of the project. Both our IA and OEI provided valued support, particularly around positioning data and communications of findings to the CCO and the local health care policy audience.

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

The COHC and its committees provide direction to the CCO in its execution of business and pursuit of outcomes. The COHC approved the submission and acquisition of OEI grant funding to implement the HETF project. Keeping with this model, the Task Force was a work group of the CAC. Three members of the CAC sat on the HETF and provided regular updates at the monthly CAC meetings as the project was being implemented. When the Task Force report and video storytelling project was complete, the CAC reviewed and endorsed the information, which was then forwarded to the COHC, the Provider Engagement Panel, and the Operations Council for review and prioritization of key actions for 2014-2015.

The CCO and COHC encourages and values a high degree of input and authority from its committees and councils Stakeholders participating in each of the CCO committees contribute to and are subject to discussion and consensus reached on all topics that impact the system on the whole. CAC input is sought and valued for those issues that directly impact member experience and access as is the case with elements 6, 7 and 8 in the CCO's transformation plan. The voting membership of the CAC is accompanied by numerous representatives from local health care, social services and educational organizations, providing a valuable forum for collaboration and input, across sectors. When the HETF report was completed, the Task Force presented its findings to the CAC, who reviewed and endorsed the information after a lengthy and meaningful discussion. The CAC's input was then provided to the Health Council to inform another robust discussion and key policy decisions around recommended reforms.

Transformation Area 7: Meeting the culturally diverse needs of Members - Central Oregon

Milestone for July 1, 2014: Engage all appropriate and essential partners throughout CCO to organize a committee to review, define and set Community adopted standards to be established and approved by Central Oregon Health Council.

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Activity *(Action taken or being taken to achieve milestones)*	Outcome to Date	Process Improvements
1.	PacificSource convened a Health	A report of member experiences	See 6.1 above

	Equity Task Force (HETF) to conduct a community engagement assessment to identify areas to improve communications and outreach to Hispanic/Latino and AI/AN populations. The HETF used culturally and linguistically sensitive methods to gather member stories and experiences, including Spanish language focus groups, community forums and targeted outreach.	and recommendations for better serving Hispanic/Latino and AI/AN members was completed and shared with CCO board and standing committees (See Attachment A: Central Oregon Health Equity Task Force Report). The report was used to inform priority actions to be formally adopted by the COHC.	
2.	Task Force presented findings to the Community Advisory Council, including a recommendation to adopt national Cultural and Linguistically Appropriate Services standards (CLAS).	CAC endorsed the report, method and findings.	N/A
3.	A CCO Stakeholder Workgroup was convened after the Task Force completed its report to review the report and outline what will need to happen to impact issues and areas identified in the report, particularly around the adoption of system-level standards. The work group consisted of health care administrators and provider representatives and was chartered to highlight priority findings of the Health Equity Task Force report for Board level endorsement.	The workgroup recognized that to address these findings, the CCO will first need to conduct a self-assessment to compare and contrast current needs and capacities within the system to establish a baseline. The workgroup also recommended adoption of continuing education related to cultural competency and education on the use and availability of professional interpreters to improve the experience of members with limited English proficiency;	N/A
3.	Task Force presented findings to the Central Oregon Health Council (COHC).	Board motioned to conduct a formal assessment of current capacities and gaps in the system in meeting key recommendations in the HETF report. Board also motioned to ensure providers report on continuing education around cultural competency and diversity issues annually.	N/A

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

The goal of element 7 is to create a health care system and workforce that are capable of delivering the highest-quality care to every patient regardless of race, ethnicity, culture or language proficiency. It is incumbent on the system to prioritize this work as it requires action and resources on many different levels. However, because our CCO it is a not one organization but a network of organizations, bringing this goal to fruition requires various actions and investments by various organizations, each with different starting points, approaches and priorities.

- Conceiving the notion that health inequity may exist, particularly aspects such as inconsistent language access or unequal treatment, can be uncomfortable and even unimaginable to some people.
- Moving the Task Force findings through the CCO community process involved some precarious conversations especially given the strain the system is experiencing due to implementation of health reform.
- The different realities, world views (e.g. culture of "evidence") and capacities of provider organizations present further challenges and require sensitivity.
- Analyzing member experiences, and comparing them to the cultural competencies of clinics, may be difficult without an understanding of the current cultural education taking place at each clinic.

1 c.)Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

The community-based Task Force method helped to open the door for these conversations by raising awareness of the experiences and perceptions of impacted communities. Task Force recommendations that were developed for member engagement, provider network and quality improvement initiatives will inform the CHA/CHIP. An official assessment of existing capacities as directed by the CGHC, will help providers understand their baseline in comparison to the national standards. It will also enable the CCO to understand where resources need to be directed over the course of the next 3-5 years, allowing us to make continuous improvements toward the achievement of these standards. Finally, it is important to ensure providers have a voice as to what is possible to accomplish in any given timeframe as the system is experiencing strain related to the ACA and Medicaid expansion. Ensuring the process was balanced with both community and provider input was critical given the timing and environment the system in currently operating within.

PacificSource was able to receive technical assistance from both Angela Kimball as well as expert staff of the Office of Equity and inclusion to help course-correct and navigate barriers encountered in the course of the project. Both our IA and OEI provided valued support, particularly around positioning data and communications of findings to the CCO and the local health care policy audience.

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

To facilitate discussion, the HETF report was provided to all the CCO councils and committees including the COHC board of directors. As mentioned above, the CAC reviewed, discussed and endorsed the report. Specifically in the context of the element 7 deliverable, the COHC Provider Engagement Panel and Operations Council created an ad-hoc work group that reviewed the report and drafted a recommended motion for the COHC's review and endorsement at the June 12th COHC Board meeting, as it has been noted that element 7

has significant relevance to the system as a whole and requires a policy level decision by the COHC. A significant portion of the COHC June agenda was utilized for discussion and decision-making around the element 7 deliverable. The COHC was able to come to consensus on the directive to CCO providers to demonstrate that diversity and cultural competency training is occurring. Moreover, the COHC directed the Operations Council to implement a formal assessment to inform gaps and activities toward better care for diverse populations.

Transformation Area 8: Eliminating racial, ethnic and linguistic disparities - Central Oregon

Milestones for July 1, 2014: Complete written self-assessment of system data gaps; Ensure that at least 2 operational or system changes to improve granular data collection, reporting and analysis related to language, race and ethnicity are completed. Quality Improvement Plan focused on eliminating racial, ethnic and linguistic disparities is adopted.

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

Activity *(Action taken or being taken to achieve milestones)*	Outcome to Date	Process Improvements
1. Complete a self-assessment of PCS data systems to identify current gaps in monitoring, reporting and analyzing data related to race, ethnicity and language.	Assessment complete. Please see appended PacificSource data self-assessment. This assessment indicated that we have many gaps in information relating to tracking and monitoring disparities in health outcomes and quality.	The assessment is being used to identify these gaps and create a basis for further work at the state, CCO and clinic EHR levels.
2. Improve data system structure around race, ethnicity and language reporting.	System assessed and improvements made.	PacificSource was able to make improvements in the way data was categorized in Ph Tech's data warehouse and then imported into the Truven Analytics. This enabled the CCO to track membership demographics and experience by race and language.
3. Develop a system to track disease prevalence rates by race, ethnicity and language (diagnosis codes).	PCS can now separate and report disease prevalence (diagnosis codes) by race and language.	We continue to improve reporting on quality by race, ethnicity and language. Next steps are to work with clinics to

			identify opportunities to pilot quality improvement initiatives to reduce disparities by leveraging EHR data.
4.	Develop a system to report quality metrics by race, ethnicity and language.	PCS can now separate and report quality (claims data) by race and language.	We continue to improve reporting on quality by race, ethnicity and language. Next steps are to work with clinics to identify opportunities to pilot quality improvement initiatives to reduce disparities by leveraging EHR data. In 2014, focus on the 3 clinical quality measures (diabetes A1c control, hypertension control, depression screening and follow-up)
5.	Outline areas for continued improvement in reporting and analyzing quality and health outcomes by race, ethnicity and language.	EHR in combination with claims data identified as potential reliable method to inform quality improvement strategies by race, ethnicity and language.	We have queried clinics to assess opportunities to capture, monitor and report more routinely by race, ethnicity, and language. We are assessing opportunities to track other disparity drivers including health literacy. In 2014, we will begin this discussion around key clinical quality measures for which the CCO is responsible. We are exploring overlaying data by county and zip code to inform strategies to address needs related to geography and social determinants of health.
6.	Develop and adopt a Quality Improvement Plan to address findings from the Health Equity Task Force work (see elements	QI Plan established and adopted. Plan outlined for July 2014 – July 2015, components include: • CCO network assessment (using CLAS standards as a guide)	

6, 7) and establish an annual quality work plan to improve data reporting and analysis.	• Cultural competency and diversity training: Phase I
	• Integration of health equity and disparities focus into PacificSource CCO QI Program
	  - Member engagement strategy
	    ▪ Member engagement staffing roles and their intersection with quality
	    ▪ Member engagement coordinator (CO & CG)
	    ▪ Member education (videos in English and Spanish)
	    ▪ Coverage continuation (re-determination)
	    ▪ Focused program around dual eligible
	  - Addressing social determinants of health
	    ▪ Health literacy
	    ▪ PS "plain language" campaign
	    ▪ CHW Capacitation Center
	    ▪ Pathways Community Hub
	  - Data reporting and analysis
	    ▪ Data improvement processes
	    ▪ Interpreter service data tracking
	    ▪ Deeper data dives
	      o Medication adherence by race, ethnicity and language
	      o Re-enrollment by race, ethnicity and language
	      o Assess clinic EHR data in comparison with PS enrollment data; identify areas to improve or develop "supplemental data" to inform outreach and engagement strategies	

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

The data in our system are passed through via the state enrollment system. The enrollment system captures race and ethnicity data on a voluntary basis and the forms include a limited number of race/ethnicity and

language categories and therefore are often incomplete or miscategorized. Therefore, there are many missing/unknowns contained in enrollment data. The level of data around ethnicity is especially imperfect and may not be mapping correctly in our system. In certain quality and disease prevalence categories, the denominators are very low and the rates have high variability. This makes it challenging to identify the presence, magnitude, and significance of disparities that may be occurring in our membership. Moreover, these data may be subject to misinterpretation due to the small numbers and because they do not accurately reflect potential cultural or linguistic access barriers. Finally, there are limited data relating to health literacy and socio-economic status which makes pro-actively identifying these barriers – in particular prevalence of multi-generational poverty – complex.

1 c.)Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

It is incredibly challenging to overcome barriers relating to the state enrollment system. We do not have control over that system or issues around having relatively small numbers in certain quality and disease prevalence categories. Therefore, we have to rely on qualitative data (such as findings from the Task Force), state and national level trends and aggregated public health data sources to inform our quality improvement activities. As highlighted in the "process improvement" column above, we are also looking to clinic level data in 2014 to cross walk with claims data and explore whether or not this source is something we need to build upon in the future.

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

The CCO's standing boards and committees were informed of the self-assessment oriented to PacificSource's data reporting and analytic capabilities and improvements, which was also a part of element 8. The CAC, Ops/PEP workgroup and ad-hoc HETF in particular played a very influential role in setting the stage for COHC decision making and informing the development of a quality improvement plan to address health care disparities and inequities, including priority areas as identified in the Task Force Report.

The goal of the QI plan is to capture all of the work underway in the CCO's community network as well as activities that PacificSource itself will be implementing July 2014 – July 2015, to improve culturally and linguistically appropriate communications, member outreach/engagement and data systems. This element 8 deliverable is a tool the CCO will be using to address community and Task Force identified priorities within element 6 and 7 of our Transformation Plan. The QI plan highlights the rich community process behind this transformative work including the work of the HETF and subsequent health council committee deliberation and decisions. This includes the decision to conduct a network assessment of culturally and linguistically appropriate services as well as further assessment into areas of generational poverty and analysis around socio-economic drivers of health disparities. The QI plan will also include support for promising transformation project work that has been approved, funded and is getting underway. The CCO will be held accountable by its board, councils and committees to report on progress and measure outcomes related to the implementation of the plan as well as updating the plan on an annual basis in an effort to continue to move QI goals in a forward direction toward the elimination of disparities in health and health care.

Transformation Plan Milestone Report Template

This form is a template for the Transformation Plan Milestone Report requirement. <u>Use of this form is not required, but the elements outlined below do represent the required elements for reporting for each Transformation Area</u>. You are welcome to use your Innovator Agent to assist you in the completion of this report. Your Innovator Agent can also supply you with a version of this template that includes your individual CCO's Transformation Plan benchmarks and milestones copied within each corresponding section below.

Please send your completed Transformation Plan Milestone Report to the CCO Contract Administrator, David Fisher (DAVID.H.FISCHER@dhsoha.state.or.us) by no later than 5:00 pm on July 1, 2014.

Transformation Area 1: Integration of Care
Columbia Gorge
Milestones for July 1, 2014: Work team members are identified and charter established by the end of the 2nd quarter 2013 via CGHC; Project plan reviewed and approved by CGHC by the end of the 3rd quarter of 2013; At least 4 integrated co-location sites in the Columbia Gorge Service Area are available to the Members by end of June 2014.

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Activity *(Action taken or being taken to achieve milestones)*	Outcome to Date	Process Improvements

1.	Contractor ensures work team members are identified and charter established by the end of the 2nd quarter 2013 via CGHC.	• Work team has been identified and chartered.
		• Team members include representatives from CGHC, CCO, OHA Transformation Center, CMHPs, and Hospital/PC/MH stakeholders
			• Integrated Care Team (ICT) meets bi-weekly on topics and actions including:
			   - Recommendations to the CGHC Board based on evaluation of potential transformation fund projects on PH/BH integration
			   - Learning, evaluating & debating the

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		• Bi-weekly meetings started June 2013 • Work team received training on SBIRT	merits of 1) different integration models from co-location to full integration, 2) Behavioral Health Consultant and Behavioral Health Specialty models of integration - Developing a general process flow for SBIRT deployment in a clinic encompassing all payer types and establishing a small incentive for clinics to complete SBIRT work - Development of the Physical Health & Behavioral Health Integration Transformation project in partnership with the University of Colorado at Denver (UCD) and OHSU. - Development of integrated Clinical Pharmacy Services into primary care clinics are being supported by the Transformation Funds.
2.	Contractor ensures work team project plan reviewed and approved by CGHC by the end of the 3rd quarter of 2013.	• Work team established long-range goals for: Patient Care Venues; Data for Action; Access; Safety Net; Payment Models; and Becoming a 'learning community' • Received Board approval to spend up to $5000 on integrated care process improvements • Dental services integration into the CCO is anticipated to go-live on 7/1/14, including maintenance of dental services in One Community Health	• CGHC Board is regularly informed on work team topics and activities • CGHC is actively guiding ICT work related to: - Integration of dental services (01/2014 – 06/2014) - Global budget integration across physical health, behavioral health and dental health (monthly) - Community Mental Health Program financing and operations (01/2014) - Integration of Clinical Pharmacy Services into primary care clinics

		primary care clinic	
3.	Contractor ensures at least 4 integrated co-location sites in the Columbia Gorge Service Area are available to the Members by end of June 2014.	• Co-location of behavioral health and social services is occurring at The Next Door • A co-location partnership between Mid-Columbia Center For Living and One Community Health currently exists • Dental services are integrated at One Community Health via an agreement with Capitol Dental) • Advanced co-location of PH/BH integration is occurring at multiple Mid-Columbia Outpatient Clinics in The Dalles • A new Behavioral Health practitioner has recently been hired at Summit Family Medicine • Clinical Pharmacy Services are integrated at Columbia Gorge Family Medicine • An integrated Behavioral Health Consultant has been hired at Deschutes Rim Health Clinic in Maupin.	• With the support of Transformation Funds, up to four BH/PH integration sites will be developed or refined with guidance from UCD and OHSU in the next year. • The Community Mental Health Program is continually evaluating opportunities for additional co-location and funding opportunities for full integration. Current possibilities include expansion of the One Community Health integration partnership and Columbia Gorge Family Medicine • Additional integration of Clinical Pharmacy Services into two One Community Health clinics and Providence Hood River clinics is currently being implemented. • The BH/PH Transformation Fund project includes an analysis of Physical Health integration into the MH venues for patients with severe MH conditions.
4.	Annual review of number of co-location services completed; includes report of scope of services and Member experiences to determine whether additional sites are required to meet Benchmarks. Benchmark to be achieved as of July 1, 2015	TBD	• Through the support of Transformation Funds, the CGHC has endorsed a partnership with UCD and OHSU to develop and evaluate new BH/PH integration sites. This work will also evaluate the relative merits of different integration models in partnership with the Integrated Care Team.

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

While no barriers have limited our ability to achieve the stated milestones in this area, it is apparent that cultural and operational challenges exist that limit our ability to fully integrate the traditional Community Mental Health Program services and Safety Net responsibilities with integrated physical and behavioral health services in primary care settings. In some instances, these cultural and operational challenges have resulted in our inability to integrate behavioral health practitioners into certain primary care clinics. Specifically, these challenges include varied expectations about the clientele to be served, the behavioral health practitioners to be co-located and the management responsibility of embedded clinicians.

1 c.)Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

As described above, a work team of local experts (Integrated Care Team) has been convened to research and evaluate Behavioral Health integration opportunities. The CCO OHA Innovator Agent is an integral member of this team and has often pursued questions and validation from peers around the state. CCO leadership has actively worked with community stakeholders and the Columbia Gorge Health Council to improve the understanding of safety net services and global budget allocations, that currently fund behavioral health services in the community, to responsibly integrate the delivery of care into primary care settings. Through knowledge gained from our CCO Innovator Agent, other CCO communities and our local stakeholders, we are confident that the Integrated Care Team will be able to successfully work through the challenges experienced to date. The engagement of UCD and OHSU to help facilitate this work is strong progress toward meeting the 2015 benchmarks established for this Transformation Plan.

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

In the Columbia Gorge, the Columbia Gorge Health Council (CGHC) and the CCO have entered into a Joint Management Agreement (JMA). The CGHC and its committees – Community Advisory Council, Clinical Advisory Panel, Integrated Care Team, and Finance Committee – include on their agendas all topics related to CCO responsibilities, including the integration of physical health, behavioral health and dental services . Stakeholders participating in these groups contribute to and are subject to discussion and consensus reached on these topics.

The CAC led the Community Health Assessment survey work which included evaluating barriers to care for medical, dental, and Behavioral Health services. The results from the survey work showed very different barriers for access to care in the Behavioral Health domain as compared

to physical health and dental. In addition, several Transformation Fund projects offering additional services, new care venues and enhanced emotional literacy training were reviewed and endorsed by the CAC, before being approved by the CGHC.

The CGHC and associated committees are also chartered to actively monitor the progress of our Transformation Fund projects. This includes oversight of the PH/BH Integration project by the Integrated Care Team with guidance from the CGHC board.

Transformation Area 2: PCPCH
Columbia Gorge
Milestone for July 1, 2014: Assessment of community PCPCH certification opportunities in partnership with CGHC is complete; Contractor plans to move toward increasing the number of Members assigned to a PCPCH clinic in places as endorsed by CGHC.

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

Activity *(Action taken or being taken to achieve milestones)*	Outcome to Date	Process Improvements
1. Contractor ensures the assessment of community PCPCH certification opportunities in partnership with Columbia Gorge Health Council stakeholders is complete.	• In May, 2014, CCO worked with the Central Oregon IPA (COIPA) to conduct and publish an assessment of PCPCH recognition amongst their member practices.	• CCO is working with the COIPA, CGHC and its Clinical Advisory Panel (CAP) to ensure clinics are aware of PCPCH requirements and opportunities • CCO is working with COIPA and other stakeholders to identify opportunities to increase PCPCH adoption and PCPCH tier levels
2. Contractor plans to move toward increasing the number of Members assigned to a PCPCH clinic in place as endorsed by Columbia Gorge Health Council.	• The Columbia Gorge CCO has achieved high PCPCH adoption and Member assignment with an aggregate weighted score of 96.38% of Members being assigned to PCPCH certified providers (01/2014). 94.53%	• Periodic reports on QIM performance, including Member assignment to PCPCH certified providers are submitted to CGHC and its committees. • CCO and CAP reviewed and revised Member auto-assign process to include more providers and to assign based on proximity.

		of members are assigned to a Tier 3 PCPCH.	
3.	Increase the number of Members attributed to PCPCH clinics by 10% or achieve at least 85% PCPCH enrollment. Baseline and method of measurement to be determined and mutually agreed upon by Contractor and OHA. Benchmark to be achieved as of July 1, 2015	See above	• CCO worked with CGHC and its CAP and OHA Innovator Agent to examine data discrepancies identified between OHA reported Tier 3 PCPCH certification and internal reporting • CCO is continuing discussion with CGHC and its CAP to explore possibilities of reinforcing member assignment to PCPCH clinics. • CCO is continuing to work with COIPA to provide member practices with data, quality requirements, care coordination services and application. assistance that support the PCPCH application.

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

The CCO, CGHC, and stakeholders have been very successful in achieving a high level of PCPCH certification among providers. A challenge will be to move from a PCPCH QIM score of 96% to 100%, which would involve engaging small private practices where PCPCH certification faces economic and cost effectiveness hurdles. According to the COIPA assessment of PCPCH status amongst member practices, the greatest barriers to smaller clinics achieving PCPCH status is resource limitation. As stated in their report, "…these clinics' OHP enrollment numbers are low enough that the initial incentive of state reimbursements for OHP members with ACA qualifying conditions would not have reimbursed them adequately for the overhead/administrative costs of seeking recognition."

In late 2013, discrepancies were identified between OHA reported Tier 3 PCPCH certification and CCO internal reporting based on information from PCP stakeholders.

1 c.)Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

In 2012-13, the CCO developed and executed a strategy to increase the PMPM capitation rates to PCPs, beyond the level supported by historical utilization and cost trends, to support investments of PCPs' choosing (e.g., expanded prevention, care coordination, integration, PCPCH adoption, etc.). In addition to this strategy, the CCO proposed and OHA approved implementation of the ACA mandated increase in PCP fees by automatically increasing compensation to all potentially eligible PCPs (as defined by ACA and OHA methodology) retroactive to January 1, 2013, without requiring PCP attestation.

When data discrepancies were identified between OHA reported Tier 3 PCPCPH certification and internal reporting, the CCO worked with the CGHC, CAP and OHA Innovator Agent to ensure that accurate data are reported for the 2013 year end reports.

In addition, the CCO has worked with the CGHC, CAP and COIPA to provide clinical and technical support to clinics pursuing PCPCH certification. According to the COIPA assessment of PCPCH status amongst member practices, "…Small clinics tend to have fairly stable patient and provider bases that encourage long-term patient-PCP relationships, good patient access to care, close follow-up and management of chronic diseases, and provider/clinic involvement in coordination of care. In essence, many of these clinics already provide the level of care the OHA wants OHP members to receive and that PCPCH recognition was created to encourage. These clinics simply lack the depth of resources to be able to dedicate staff and time (uncompensated) to the additional administrative burdens of seeking and maintaining recognition."

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

In Columbia Gorge, the Columbia Gorge Health Council (CGHC) and the CCO have entered into a Joint Management Agreement (JMA). The CGHC and its committees – Community Advisory Council, Clinical Advisory Panel, Integrated Care Team, and Finance Committee – include on their agendas all topics related to CCO responsibilities, including provider engagement on specific areas of focus such as QIMs performance, PCPCH certification, EMR adoption, APMs, etc. The CGHC and its committees provide direction to the CCO in its execution of business and pursuit of outcomes. Stakeholders participating in these groups contribute to and are subject to discussion and consensus reached on these topics. Through this collaboration, the Clinical Advisory Panel has developed the following action plan to further support PCPCH adoption in our region:

- Identify clinics who are not at a level today (Completed)
- Reach out to each clinic to determine what assistance they may need to apply/certify (Completed for 3 of the 4 clinics)
- CAP directive is to use 'carrots' for remaining organizations.

- Given positive performance in this area, reserve negative reinforcement at this time
- Auto-assignment of new members should not be shifted away from non PCPCH clinics at this time
- PacificSource and COIPA shall keep an eye out for any new clinics to reinforce our CCO's desire for PCPCH status

As part of the JMA, the CCO regularly provides education, analytics support, and performance reports to the CGHC and its committees.

The CGHC and CCO also endorse the following Transformation Fund projects which will reinforce and potentially improve PCPCH status for the clinics in our region.

- Health Information Exchange: a project to further develop secure messaging and Health Information Exchange adoption by partner clinics.
- Community Health Team: a project to provide care coordination resources to primary care clinics serving the highest risk patients in the region.
- Clinical Pharmacy Services: these projects will integrate clinical pharmacists into primary care settings at four unique primary care clinics in the region.
- PH/BH Integration: a project to develop and measure the impact of primary care/behavioral health integration in four clinical settings, some of which will be PCPCH clinics.

The CGHC and associated committees are chartered to actively monitor the progress of these and other Transformation Fund projects.

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Transformation Area 3: Alternative Payment Methodologies

Columbia Gorge

Milestone for July 1, 2014: Alternative Payment Methodology (APM) work groups are established to develop recommendations on payment methodologies. APM work group recommendations endorsed by Health Council.

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Activity *(Action taken or being taken to achieve milestones)*	Outcome to Date	Process Improvements
1.	Contractor ensures Alternative Payment Methodology (APM) work groups are established to develop recommendations on payment methodologies. APM work group recommendations endorsed by Columbia Gorge Health Council.	• CGHC Board and Finance Committee actively review APMs and direct CCO contracting strategies. This includes specific direction related to the integration of dental services, NEMT, MH residential and AoD residential. • APM webinars were held for the Finance Committee in 1Q2014 to reinforce knowledge of current state and future contracting opportunities. • Finance Committee Guiding Principles were presented to and endorsed by the CGHC.	• CGHC Finance committee agenda includes topics of global budget and APMs. • CGHC Board periodically receives presentations and reports on provider contracts, transformation plan elements, and QIMs • With guidance from the CGHC, the CCO meets with institutions and providers to inform on and negotiate movement towards APMs and outcomes
2.	APM recommendations embedded into 2015 CCO provider contracts. Columbia Gorge Health Council establish a formal process to evaluate the ongoing impact of	• CGHC has chartered the Finance Committee to become familiar with CCO financial reports and contracting methodologies. With	• CCO, with guidance from the Finance Committee and CGHC board, is continuing to incorporate & refine APM principles in contracts with PCPs, CMHPs,

reimbursement changes in relation to overall CCO outcomes, and make changes as necessary. Benchmark to be achieved as of July 1, 2015	this information the Finance committee is tasked with guiding future contracting strategies, to include incorporating APMs.
	
	• Current contracts that incorporate Advanced Payment Methodologies:
	   - COIPA PCPs are contracted under PMPM capitation payment with a risk withhold to incentivize outcomes.
	   - MCCFL (local CMHP) is contracted under a sub-capitated arrangement with a performance withhold to incentivize outcomes.
	   - Mid-Columbia Medical Center is contracted under a DRG with a risk withhold.
	   - AoD Res Treatment providers are under episode based capitation with performance bonuses motivating better coordination with OP CD treatment
		hospitals and AoD Res Treatment providers
		   - 1st Phase: In 2013, introduced APM as revenue neutral sub-capitation for primary care providers.
		   - 2nd Phase: In 2014 we are working to include QIMs and other performance metrics in sub-capitation contracts & service agreements
		   - 3rd Phase: In future years, we are working to further implement the APM guiding principles developed by the Finance Committee and supported by the CGHC.. into all of our major provider and vendor contracts.

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

Incorporating Advanced Payment Methodologies into all of the provider and vendor contracts impacting the CCO global budget is a challenging endeavor due to the complexity of our current payment constructs, the degree to which our existing infrastructure is embedded in the communities they serve and the varied incentives that are in place across the healthcare silos. This is exacerbated by the lack of alignment in contractual timing and incentive across organizations and healthcare disciplines. Some of the challenges we have experienced are described below:

- Providers who are part of a continuum of care but who are compensated separately can impact their individual performance against outputs (e.g., screenings, exams, etc.) involving their scope of services but have less ability to improve performance on outcomes that are dependent on multiple providers in the continuum of care, and so are reluctant to accept performance metrics that are not completely within their control. This hampers our ability to fully align incentives across the CCO community.
- NEMT Transportation brokerages, as quasi-government entities, have demonstrated an unwillingness/inability to take any financial risk in their contracts with the CCO.
- Dental Care Organizations have effectively lobbied in the State legislature to ensure that dental services remain consistent (scope of work, reimbursement, network) over the short-term. This has created a challenging environment for developing innovative contracting methodologies that incorporate Advanced Payment Methodologies.
- CMHPs are challenged to provide data and reports that quantify the number of CCO Members served and the amount and cost of un-encounterable services delivered to CCO Members. CMHPs often are required to provide a greater range of services (such as Safety Net services, rehabilitative services, etc.) than CCO Covered Services and to treat a broader range of patients (such as undocumented, indigent, OHP ineligible poor, etc.) than just CCO Members. They have developed such programs using multiple sources of public revenue and have not traditionally been required to track and report on unique clients, services, and outcomes to the extent desired by a CCO in its management of the global budget and performance against QIMs.

1 c.)Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

CCO leadership has worked diligently with the CGHC board and Finance Committee to better inform all parties about the current contracting methodologies in place as well as the practical distribution of the global budget to our provider and vendor partners. Armed with this knowledge, we are actively seeking CGHC Board and Finance Committee guidance on the future deployment of Advanced Payment Methodologies and alignment of our community stakeholders. Some examples of the CGHC, Finance Committee and CCO working together to promote APMs in the Columbia Gorge are as follows:

- To provide providers with security in their acceptance of capitation, the CCO ensured that capitation would be revenue neutral in the first year (2012-2013).
    - In addition, the CCO increased capitation rate to PCPs, beyond what OHA provided the CCO in its rates for services provided by PCPs, to incentivize PCPs to invest in and provide an increase in preventive and more coordinated services under their capitation contracts/agreements.
- The CCO negotiated with COIPA to agree to a substantial risk withhold that effectively lowered global capitation payments and simultaneously increased community awareness of critical performance metrics, including global budget performance.
- The 2014 CMHP contract and applicable sub-contracts (MCOC) were developed to include performance withholds which incentivize performance on critical behavioral health performance metrics important to the community.
    - The CCO is also working with CMHPs to improve data collection and reporting on encounterable and non-encounterable services provided by CMHPs.
- With significant support from the Finance Committee, the CCO is currently working with the region's hospitals to find alternative contracting strategies that will meet the intent of the Rural Health Reform Initiative and preserve the integrity of the CCO global budget.

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

In the Columbia Gorge, the Columbia Gorge Health Council (CGHC) and the CCO have entered into a Joint Management Agreement (JMA). The CGHC and its committees – Community Advisory Council, Clinical Advisory Panel, Integrated Care Team, and Finance Committee – include on their agendas all topics related to CCO responsibilities, including CCO financial performance, provider contracting, and specific areas of focus such as Flexible Services, APMs, etc. The CGHC and its committees provide direction to the CCO in its execution of contracts and pursuit of outcomes, both clinical and financial. Stakeholders participating in these groups contribute to and are subject to discussion and consensus reached on these topics. As part of the JMA, the CCO regularly provides education, analytics support, and performance reports to the CGHC and its committees.

A tangible outcome from this collaboration is the Guiding Principles document developed by the Finance Committee and approved by the Columbia Gorge Health Council. These principles are guiding the work outlined above and it is our hope that they will help to bring financial alignment to our community stakeholders. Those principles are as follows:

- Sustain or improve the quality of care provided

- Sustain or improve the patient experience
- Create a sustainable global budget
  - Remember: what we don't spend goes back to the community
- Maintain & improve breadth & depth of services to ensure healthcare stays local
- Fund transformation initiatives that get upstream
  - True prevention, 3-10 year returns
- Develop innovative payment mechanisms that incentivize outcomes & align partners
- Leverage existing community resources
- Ensure community parity (cost, quality & service)
  - Applies to members and service providers

Consistent with these guiding principles, the CGHC and PacificSource negotiated to leverage 2013 Quality Incentive Metric bonus payments to support transformation initiatives in the community despite a global budget deficit for the 2013 fiscal year. This action demonstrated a commitment to balance quality, experience & financial goals for our CCO.

Transformation Area 4: Community Health Assessment and Community Health Improvement Plan
Columbia Gorge
Milestone for July 1, 2014: Contractor completes first CHA and CHIP updates.

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

	Activity _(Action taken or being taken to achieve milestones)_	Outcome to Date	Process Improvements
1.	Develop and establish a Health Equity Task Force to assess system gaps, inform the CHA/CHIP and develop recommendations for member engagement, provider network and quality improvement initiatives.	HETF Activities are described areas 6-8	
2.	Complete integrated Community Health Assessment (CHA) for Hood River and Wasco Counties	CHA Complete and approved by CAC and CCO Board	- CGHC led a formal collaboration with 11 partners, including Contractor, yielding a more accurate and actionable result, while all partners

			satisfied regulatory requirements.
			- Concentrated focus on Hood River and Wasco Counties, with lesser focus on surrounding counties reflective of use of services in Hood River and Wasco (eg. from across the state of Washington).
			- Robust quantitative and qualitative approaches.
			- Focused inquiries of populations with known health disparities
			- Broad input from health care, social services, education and early childhood sectors.
			- Robust consideration of social determinants of health.
3.	Complete integrated Community Health Improvement Plan (CHIP) for Hood River and Wasco Counties	CHIP Complete and approved by CAC and CCO Board	• CHIP design followed CHA, identifying 10 areas of focus, supported by substantial data. - CHIP is a process, not a one-time summary of action. - CGHC will convene stakeholders in each focus area to respond to CHA findings, propose solutions and present to CAC for endorsement. - Alignment of identified community needs with transformation funds and resources from community partners toward shared objectives.

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

Local aspirations amongst key stakeholders to conduct one collaborative regional Community Health Assessment (CHA), vs. the historic practice of multiple, independent, small and disconnected needs assessments presented numerous challenges. Hospitals, FQHC, Health Departments and the Coordinated Care Organization each had different or overlapping reporting requirements, timelines and defined service areas. Intentions to

collaborate were further challenged, by a lack of models in which partners contributed both cash and in-kind efforts (vs. complete outsourcing of the deliverable to a third party). Finally, the ideal structure to facilitate ongoing collaboration on a CHIP proved elusive as organizations were reticent to have resources to address identified needs pledged beyond their individual control.

1 c.) Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

In January, 2013 the Community Advisory Council (CAC) hosted presenters from The Coalition on Local Health Organizations (CLHO) to present training on the MAPP model of health assessment. CGHC board members and other interested community partners also participated. In the following weeks, recent needs assessments throughout the region were assembled, compared and evaluated for best practices. A "collective impact" approach was embraced by 11 partners, including Contractor, who formalized their contributions and accountabilities in a MOU in October, 2013. Essential to this achievement was the broad agreement across stakeholders that the Community Advisory Council would serve as a neutral convener of stakeholders across the region.

Following the CHA, the Community Health Improvement Plan (CHIP) evolved to become a Community Health Improvement *Process*, wherein each identified focus area is scheduled for a disciplined evaluation by an "Integrated Response Team" of identified stakeholders with expertise, influence or accountability in that area. For example, the focus area of "Dental Access for Adults", will bring together local dental providers, hospitals (who see substantial dental needs in their Emergency Departments), Dental Care Organizations, a partial dental coalition, a project access model currently limited to one county, and local foundations interested in addressing dental needs. These stakeholders will address a set of questions and propose collaborative solutions to the CAC.

The innovator agent assigned to Contractor, Angela Kimball, was instrumental throughout this process. Ms. Kimball was a consistent presence at all CAC meetings where the collaborative CHA was designed and approved and she made herself personally available to record notes at provider forums. In addition, Ms. Kimball sought clarification and approval from OHA as Contractor and partners pursued an innovative approach to the CHA and CHIP.

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

The CGHC encourages and values a high degree of input and authority from the CAC. The voting membership of the CAC is accompanied by numerous representatives from local health care, social services and educational organizations, providing a valuable forum for collaboration and input, across sectors. However, the voting members, and especially the consumer members hold special authority and their voices and

experienced are often amplified as key decisions are approached. The CGHC has unanimously endorsed all recommendations from the CAC with regards to the CHA and CHIP. The CAC was instrumental in design, review, analysis and approval of every aspect of CHA/CHIP. CAC activities in this area include:

- Adoption of a modified MAPP framework for assessment
- Selection and approval of the consumer survey themes and specific questions
- Identification of populations of Interest: Limited English Proficiency, Migrant and Seasonal Farmworkers, People living with Disabilities, <200% Federal Poverty Level and people 65 years old and older
- Reimagining the CHIP as a Collective Impact *process*, partnering with multiple agencies, across sectors. For each focus area, an Integrated Response Team of stakeholders presents their recommendations for each focus area to the CAC, as the pathway for CGHC endorsement and support
- Serving as the review and approval body for transformation funds. CAC reviewed 16 proposals and approved 4 significant projects. Selection criteria for the proposed projects included the CHA and the degree to which projects could respond to identified needs.
- CAC serves as the ongoing evaluation body for transformation projects where consumer perspectives are recognized as essential for project success.

Finally, the CHIP outlines aspirations for further development of the CAC in the Gorge, in order to serve more-effectively as a "backbone organization" (from the lexicon of Collective Impact), facilitating collaboration, consumer perspectives, and relevant solutions for the region. The CAC aspires to:

- Provide tangible member feedback on PacificSource - Columbia Gorge CCO services and programs, and systems
- Be available for organizations beyond the traditional Oregon Health Plan/Medicaid services seeking member input on program and process designs
- Identify topics of concern from the Community Health Assessment
- Amplify the impact of agencies and healthcare providers by convening all participants on a specific focus area.
- Improve community integration by connecting organizations

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Transformation Area 5: EHR, HIE and meaningful use

Columbia Gorge

Milestones for July 1, 2014: Assess current capabilities and build consensus among the Columbia Gorge stakeholders on a vision for HIE infrastructure, Milestones and Benchmarks. Create and implement elements of a community HIE development plan with specific goals for each HIE functional element.

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

Activity *(Action taken or being taken to achieve milestones)*	Outcome to Date	Process Improvements
1. During the development of our Year 1 CCO Technology Plan, the region completed an environmental scan and assessment of the Columbia Gorge's technological landscape and the region's readiness and capabilities for Health Information Exchange (HIE) and Health Information Technology (HIT) adoption and expansion. Most notably, the region has a very high rate of electronic health record (EHR) use in clinics and hospitals, and many of these groups plan to improve or expand upon their existing technologies and infrastructure in the next two years. In partnership with their Health Information Exchange (HIE) vendor Medicity, the Gorge Health Connect (GHC) assigns and administers a secure health domain address (similar to an email address) for all registered providers. In this system, providers can share referrals and transmit clinical documentation to other registered providers through the iNexx application.	Assessment of current HIE capabilities completed.	There are opportunities to leverage the relationship with Jefferson HIE to further develop local HIE capabilities. These opportunities are being pursued but are currently in early stages.

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2.	The Gorge Health Connect has developed a vision to establish an HIE infrastructure for the Columbia Gorge service area that meets the needs for data exchanges as defined by the Columbia Gorge Health Council and CCO. Modeled toward the Jefferson Health Information Exchange (JHIE), the region's vision for the GHC HIE is to leverage and enhance the existing technology, information and operational solutions to support a robust point-to-point and virtual coordinated care secure messaging plus health information exchange across all primary points of care and social service delivery for OHP clients.	Consensus among Columbia Gorge Stakeholders on a vision for the HIE, infrastructure have been established.	The region's vision for the GHC HIE is to leverage and enhance the existing technology, information and operational solutions to support a robust point-to-point and virtual coordinated care secure messaging plus health information exchange across all primary points of care and social service delivery for OHP clients.
3.	During the 1st quarter of 2014, the Gorge Health Connect and the Columbia Gorge Health Council developed a Community-Wide HIE Project Plan. The overall project goal was set by the shared vision to leverage and enhance the existing key technology and information solutions to support robust point-to-point and virtual coordinated care secure messaging plus health information exchange across all primary points of care and social service delivery for OHP clients. The project outlined the business and funding model as well as key objectives and outcome timelines. Five primary components necessary to achieve the goal were outlined as follows:	Creation of a community HIE development plan with specific goals completed.	Leverage and establish a health information exchange hub capability and connect the primary Gorge PCP clinics and health departments serving OHP clients today. Information exchange will not be limited to OHP client data. • Connect both hospital systems using existing and new solutions to establish sufficient capability to support all aspects of Admits, Discharges and Transfers (ADTs) for all patients – not just OHP. • Establish a common secure-messaging framework that supports both point-to-point and coordinated care scenarios. • Support Hood River Health Department in its pursuit of moving to an Electronic Health Record system that is suited to its services. (HRHD is the last significant organization serving OHP clients on a

			paper-based system.) • Support the Community Health Worker initiatives sponsored by the Columbia Gorge Health Council through the deployment of a standard software platform (Clara) specifically tuned for coordinating access to social services. GHC's immediate priorities are to Mid-Columbia Medical Center (MCMC) (49 staffed beds) and Providence Hood River Hospital (25 staffed beds) with 8 clinics and their EHRs comprising 75 providers. Connectivity with primary care clinics will take priority. Data exchange shall initially include secure messaging and CCD exchange as well as clinical referrals at one pilot site to support meaningful use and PCPMH requirements.
4.	In 2nd quarter of 2014, PacificSource Community Solutions awarded the Gorge Health Connect with a Transformation Grant toward the establishment of an HIE hub for the Gorge area. Approved for total of $366,000, funding will be used encompass several specific initiatives: • Connect up to 8 clinics and the 2 hospitals. • Establish capabilities to support secure messaging for up to 75 licensed users. • Develop exchange of Admission, Discharge and Transfers (ADTs) with hospitals and clinics and CCD information.	Alignment of CCO, CCO governance and regional HIE objectives to achieve the triple aim of better care, better quality and lower cost of health care services.	Hood River County Health Department (HRCHD) has selected the Ahlers EHR system. HRCHD has a goal of initial installation by the end of 2014.

	• Include at least 1 pilot of referral capability to meet either CCO metric or PCPCH requirement. • Cover software purchase, licensing, recurring fees, project management and support (based on the assumption2 clinics per quarter connecting to the hub).		

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

While there has been significant community alignment around the need for a high functioning regional HIE and a "shared vision" around the primary objectives for HIE, Gorge Health Connect has experienced barriers common to the HIE experience nationally. Primary barriers have been related to funding early HIE efforts as well as establishing a shared HIE vision and roadmap amongst the Columbia Gorge Stakeholders.

Some of the barriers we've faced (and overcome) during our Transformation work include:

- Investments and costs: Lack of capital and financial resources associated with establishing interoperability within the HIE and technology support needed to develop and implement the information system is a large barrier. Many providers in the Gorge recently made large investments to update or replace their systems to achieve meaningful use requirements. Uncertainty on sustaining models has been a concern.

- EDIE: The Emergency Department Information Exchange effort is overlapping with HIE efforts. In smaller communities with limited bandwidth, having competing efforts undermines achieving the objectives. Ideally, OHA would encourage or require the EDIE team to connect with regional HIE systems

- OCHIN (and other 'cloud-based' technology providers): Decision-making for technology adoption and information exchange is constrained to solutions adopted by OCHIN. As a small region, the Gorge's ability to influence and shape direction is limited.

- Privacy/Security Requirements and Data Integrity: HIPAA Security Rule requires authentication of users or entities accessing patient information. Ensuring patient consent and data management requirements, while keeping costs low, are just a few of the privacy and security challenges faced in expanding HIE and HIT.

Although not truly a barrier, there is early recognition that HIE efforts need to consider the inclusion of care components beyond merely the physical health domain. Traditional HIE efforts nationally have been focused largely on connecting physical health providers and clinical information, but our region's ultimate vision is to be more inclusive. Those efforts will require focus and, likely, additional funding.

1 c.)Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

The Gorge region has had direct conversations with Susan Otter and her team to outline some of these issues. By working together, GHC and JHIE will benefit from economies of scale with State projects as well as with vendor contracting and purchasing. The region's HIE leaders have also been working with State driven HIE efforts to ensure high levels of alignment and minimal duplication. For example, the State's EDIE/Pre-Manage program offers functions that duplicate services provided by the HIE. JHIE and Oregon Health Authority (OHA) are discussing options to leverage existing investments in the HIE (e.g., interfaces, data management, member file standardization, etc.) that will save time and cost of implementation for the EDIE/Pre-Manage program. GHC will benefit from this work and provide additional credence to the conversation.

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

The primary participants in CCO community governance are also major stakeholders in the regional HIE strategy. This results an up-front recognition at the CCO Board level that clinical information connectivity is fundamental to regional CCO success. The value of a HIE rests in the promise that more efficient and effective access to health information will improve care delivery while reducing administrative health care costs. The Columbia Gorge Health Council has demonstrated their dedication and belief in the value of the Gorge Health Connect' s success, more recently through their support and partnership in the Community-Wide HIE Transformation project and achievement of grant funding.

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Transformation Area 6: Communications, Outreach and Member Engagement
Central Oregon

Milestones for July 1, 2014: Complete written self-assessment to identify at least two (2) areas to improve Member communications with particular focus on Hispanic/Latino and Indian/Alaska Native (AI/AN) populations; Outline system requirements necessary to implement recommended changes.

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

Activity *(Action taken or being taken to achieve milestones)*	Outcome to Date	Process Improvements
1. Convene a Task Force to conduct CCO assessment to identify areas to improve communications, engagement and outreach, conducted via community engagement strategies. The Task Force gathered this information through a variety of methods and settings, including focus groups and past assessments.	Assessment for Hispanic/Latino population completed. Please see attached Cultural Competency Report. CGHC Board requested further assessment, based on CLAS (Culturally and Linguistically Appropriate Service) standards, be complete between July 2014 and July 2015. Assessment will be inclusive of current programs, quality and services supporting members of multi-generational poverty and Native American backgrounds.	This Task Force was originally envisioned to be more closely affiliated with the Community Advisory Council. Only one update and a final presentation was given, however, findings from the assessment will be included in the Community Health Assessment and Health Improvement Plan.
3. At PacificSource level: Identify at least 2 areas where PacificSource can invest and improve upon around member outreach and communication.	Areas identified to address: 1) targeted communication to Latino/Spanish speaking populations through language appropriate interactive telephonic outreach to point members to resources that can help with the re-determination process; 2) Providing clinic and provider level education on the use and availability of professional interpreters to improve the experience of members with limited English	N/A

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		proficiency.	

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

The CCO, COHC, CAC and our other committees are interested in building stronger relations with the Native American and Hispanic/Latino communities as well as other vulnerable populations that may be less likely to engage in a the health care transformation process. Though this process is fraught with barriers, we believe community engagement is a necessary method to gather meaningful member input into areas where gaps in access, communications and/or equity of care may be occurring.

Issues and areas of improvement in this category are wide-ranging and it is a challenge to communicate findings in a way that allows the system to zero in on tangible activities that may impact a variety of providers on a variety of levels.

1 c.)Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

PacificSource wrote and was awarded a grant from the OHA Office of Equity and Inclusion to conduct this work. We subcontracted with Nuestra Comunidad Sana of The Next Door, Inc. to form a Task Force "to enhance the capacity and effectiveness of the Coordinated Care Organization (CCO) network in the Columbia Gorge to identify and bring about needed reforms to achieve health equity and inclusiveness." This community-based organization had existing capacities and relationships and an extensive history serving the Latino community.

The Task Force conducted the outreach and engagement aspects of the project, working in parallel to the CAC-driven community health assessment. Focus groups and data from past assessments conducted by Nuestra Comunidad Sana of The Next Door, Inc. provided data and insight essential to the conversation at the CCO board level (all community input was gathered via safe and culturally competent methods). This process allowed PacificSource to zero in on specific areas of priority, based on findings directly from the populations of interest.

PacificSource was able to receive technical assistance from both Angela Kimball as well as expert staff of the Office of Equity and inclusion to help course-correct and navigate barriers encountered in the course of the project. Both our IA and OEI provided valued support, particularly around positioning data and communications of findings to the CCO and the local health care policy audience.

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

The CGHC and its committees provide direction to the CCO in its execution of business and pursuit of outcomes. Stakeholders participating in

these groups contribute to and are subject to discussion and consensus reached on these topics. For example, a key member of the Task Force sits on the CAC as well. As previously mentioned, the CGHC encourages and values a high degree of input and authority from the CAC, particularly around issues that directly impact member experience and access as is the case with elements 6, 7 and 8 in our transformation plan. The voting membership of the CAC is accompanied by numerous representatives from local health care, social services and educational organizations, providing a valuable forum for collaboration and input, across sectors. When the report was completed, the Task Force presented its findings to the CAC, who reviewed and endorsed the information after a lengthy and meaningful discussion. The CAC's input was then provided to the Health Council to inform their review, discussion and decisions.

Transformation Area 7: Meeting the culturally diverse needs of Members
Central Oregon
Milestone for July 1, 2014: Engage all appropriate and essential partners throughout CCO to organize a committee to review, define and set Community adopted standards to be established and approved by Central Oregon Health Council.

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

Activity (Action taken or being taken to achieve milestones)	Outcome to Date	Process Improvements
1. Task Force gathered information to identify potential standards and community needs relating to topics such as cultural competency, language access, inclusive environments, building trust and equitable treatment.	• Assessment Complete - see note above • CLAS standards recommended as a potential framework.	See 6.1 above
2. Task Force presented findings to the Community Advisory Council, including a recommendation to adopt national Cultural and Linguistically Appropriate Services standards (CLAS).	• CAC endorsed findings and recommended the development of a phased-in plan. • CAC also revised the plan to leverage and drive community-wide approaches rather than individual organizations implementing independently.	N/A

3.	Task Force presented findings to the Columbia Gorge Health Council (CGHC).	• The CGHC adopted CLAS standards as a guiding framework against which to conduct a formal assessment of current capacities and gaps in the system in meeting those standards. • The CGHC is directing the CCO to develop a 5-year work plan to implement improvements based on the assessment and as informed by community identified priorities outlined in the Cultural Competency Report. • The CGHC also requested the CCO and work team to crosswalk other federal and state regulations and standards with CLAS to help establish a framework to meet multiple requirements and not just CCO requirements.	N/A

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

The goal of element 7 is to create a health care system and workforce that are capable of delivering the highest-quality care to every patient regardless of race, ethnicity, culture or language proficiency. It is incumbent on the system to prioritize this work as it requires action and resources on many different levels. However, because our CCO it is a not one organization but a network of organizations, bringing this goal to fruition requires various actions and investments by various organizations, each with different starting points, approaches and priorities.

• Conceiving the notion that health inequity may exist, particularly aspects such as inconsistent language access or unequal treatment, can be uncomfortable and even unimaginable to some people.
• Moving the Task Force findings through the CCO community process involved some precarious conversations especially given the strain the system is experiencing due to implementation of health reform.

- The different realities, world views (e.g. culture of "evidence") and capacities of provider organizations present further challenges and require sensitivity.

1 c.)Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

The community-based Task Force method helped to open the door for these conversations by raising awareness of the experiences and perceptions of impacted communities. Task Force recommendations that were developed for member engagement, provider network and quality improvement initiatives will inform the CHA/CHIP. An official assessment of existing capacities as directed by the CGHC, will help providers understand their baseline in comparison to the national standards. It will also enable the CCO to understand where resources need to be directed over the course of the next 3-5 years, allowing us to make continuous improvements toward the achievement of these standards. Finally, it is important to ensure providers have a voice as to what is possible to accomplish in any given timeframe as the system is experiencing strain related to the ACA and Medicaid expansion. Ensuring the process was balanced with both community and provider input was critical given the timing and environment the system in currently operating within.

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

Please see element 6 above. Elements 6, 7 and 8 are interwoven in terms of process (topics, Task Force, engagment of CCO standing committess and governance). The Task Force included a member of the CAC, who led the Task Force findings and recommendations presentation to the CGHC, which consists of key CCO providers and high level administrators, during their May board meeting. This process worked well, given the amount of information gathered and discussions that ensued as a direct result of the Task Force report.

Transformation Area 8: Eliminating racial, ethnic and linguistic disparities
Central Oregon
Milestones for July 1, 2014: Complete written self-assessment of system data gaps; Ensure that at least 2 operational or system changes to improve granular data collection, reporting and analysis related to language, race and ethnicity are completed. Quality Improvement Plan focused on eliminating racial, ethnic and linguistic disparities is adopted.

1. a) Please describe the actions taken or being taken to achieve milestones in this transformation area. For each activity, describe the outcome and any associated process improvements.

Activity *(Action taken or being taken to achieve milestones)*	Outcome to Date	Process Improvements
1. Complete a self-assessment of PCS data systems to identify current gaps in monitoring, reporting and analyzing data related to race, ethnicity and language.	Assessment complete. Please see appended PacificSource data self-assessment. This assessment indicated that we have many gaps in information relating to tracking and monitoring disparities in health outcomes and quality.	The assessment is being used to identify these gaps and create a basis for further work at the state, CCO and clinic EHR levels.
2. Improve data system structure around race, ethnicity and language reporting.	System assessed and improvements made.	PacificSource was able to make improvements in the way data was categorized in Ph Tech's data warehouse and then imported into the Truven Analytics. This enabled the CCO to track membership demographics and experience by race and language.
3. Develop a system to track disease prevalence rates by race, ethnicity and language (diagnosis codes).	PCS can now separate and report disease prevalence (diagnosis codes) by race and language.	We continue to improve reporting on quality by race, ethnicity and language. Next steps are to work with clinics to identify opportunities to pilot quality improvement initiatives to reduce disparities by leveraging EHR data.

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4.	Develop a system to report quality metrics by race, ethnicity and language.	PCS can now separate and report quality (claims data) by race and language.	We continue to improve reporting on quality by race, ethnicity and language. Next steps are to work with clinics to identify opportunities to pilot quality improvement initiatives to reduce disparities by leveraging EHR data. In 2014, focus on the 3 clinical quality measures (diabetes A1c control, hypertension control, depression screening and follow-up)
5.	Outline areas for continued improvement in reporting and analyzing quality and health outcomes by race, ethnicity and language.	EHR in combination with claims data identified as potential reliable method to inform quality improvement strategies by race, ethnicity and language.	We have queried clinics to assess opportunities to capture, monitor and report more routinely by race, ethnicity, and language. We are assessing opportunities to track other disparity drivers including health literacy. In 2014, we will begin this discussion around key clinical quality measures for which the CCO is responsible. We are exploring overlaying data by county and zip code to inform strategies to address needs related to geography and social determinants of health.
6.	Develop and adopt a Quality Improvement Plan to address findings from the Health Equity Task Force work (see elements 6, 7) and establish an annual quality work plan to improve data reporting and analysis.	QI Plan established and adopted. Plan outlined for July 2014 – July 2015, components include: • CCO network assessment (using CLAS standards as a guide) • Cultural competency and diversity training: Phase I • Integration of health equity and disparities focus into PacificSource CCO QI Program	

	- Member engagement strategy
	    ▪ Member engagement staffing roles and their intersection with quality
	    ▪ Member engagement coordinator (CO & CG)
	    ▪ Member education (videos in English and Spanish)
	    ▪ Coverage continuation (re-determination)
	    ▪ Focused program around dual eligible
	- Addressing social determinants of health
	    ▪ Health literacy
	    ▪ PS "plain language" campaign
	    ▪ CHW Capacitation Center
	    ▪ Pathways Community Hub
	- Data reporting and analysis
	    ▪ Data improvement processes
	    ▪ Interpreter service data tracking
	    ▪ Deeper data dives
	        o Medication adherence by race, ethnicity and language
	        o Re-enrollment by race, ethnicity and language
	        o Assess clinic EHR data in comparison with PS enrollment data; identify areas to improve or develop "supplemental data" to inform outreach and engagement strategies	

1 b.) Please describe any barriers to achieving your milestones in this Transformation Area.

The data in our system are passed through via the state enrollment system. The enrollment system captures race and ethnicity data on a voluntary basis and the forms include a limited number of race/ethnicity and language categories and therefore are often incomplete or miscategorized. Therefore, there are many missing/unknowns contained in enrollment data. The level of data around ethnicity is especially imperfect and may not be mapping correctly in our system. In certain quality and disease prevalence categories, the denominators are very low and the rates have high variability. This makes it challenging to identify the presence, magnitude, and significance of disparities that may be occurring in our membership. Moreover, these data may be subject to misinterpretation due to the small numbers and because they do not accurately reflect potential cultural or linguistic access barriers. Finally, there are limited data relating to health literacy and socio-economic status which makes pro-actively identifying these barriers – in particular prevalence of multi-generational poverty – complex.

1 c.)Describe any strategies you have developed to overcome these barriers and identify any ways in which you have worked with OHA (including through your Innovator Agent or the learning collaborative) to develop these alternate strategies.

It is incredibly challenging to overcome barriers relating to the state enrollment system. We do not have control over that system or issues around having relatively small numbers in certain quality and disease prevalence categories. Therefore, we have to rely on qualitative data (such as findings from the Task Force), state and national level trends and aggregated public health data sources to inform our quality improvement activities. As highlighted in the "process improvement" column above, we are also looking to clinic level data in 2014 to cross walk with claims data and explore whether or not this source is something we need to build upon in the future.

1 d.) How was the community governance model (ie; Board and standing Board committees including the Community Advisory Council) influential in informing and implementing the activities for this transformation area?

The CCO's standing boards and committees were informed of the self-assessment oriented to PacificSource's data reporting and analytic capabilities and improvements, which was also a part of element 8. The CAC and ad-hoc Task Force in particular played a very influential role in setting the stage for CGHC decision making and informing the development of a quality improvement plan to address health care disparities and inequities, including priority areas as identified in the Task Force Report.

The goal of the QI plan is to capture all of the work underway in the CCO's community network as well as activities that PacificSource itself will be implementing July 2014 – July 2015, to improve culturally and linguistically appropriate communications, member outreach/engagement and data systems. This element 8 deliverable is a tool the CCO will be using to address community and Task Force identified priorities within element 6 and 7 of our Transformation Plan. The QI plan highlights the rich community process behind this transformative work including the work of the

Task Force and subsequent health council committee deliberation and decisions. This includes the decision to conduct a network assessment of culturally and linguistically appropriate services (based on CLAS standards and HETF priority issues) as well as further assessment into areas of generational poverty and analysis around socio-economic drivers of health disparities. The QI plan will also include support for promising transformation project work that has been approved, funded and is getting underway. The CCO will be held accountable by its board, councils and committees to report on progress and measure outcomes related to the implementation of the plan as well as updating the plan on an annual basis in an effort to continue to move QI goals in a forward direction.

Oregon Health Authority
May 23, 2014

Transformation Grant Progress Report

Date: January 15, 2015
Name of CCO: PacificSource – Central Oregon
Reporting Period: July 1, 2014 –December 31, 2014
Contact person for this report: Therese Madrigal, Community Health Development Coordinator
Contact information: therese.madrigal@pacificsource.com, (541)506-7006

Progress reports for the 10 Transformation Grant-funded projects from PacificSource Central Oregon CCO are enclosed. All projects have been implemented and are serving as powerful catalysts for innovation, collaboration and a growing sentiment that things can and will be different on this journey of transformation.

With the Central Oregon Health Council, and numerous other local community partners, we are learning valuable lessons about the realities of implementing new programs and models of care across organizations. Observing the project's success is strengthening our culture of collaboration and our determination to improve. We are also finding value in discovering the many barriers to success, so that those can be understood and addressed, often yielding system improvements beyond the scope of the transformation projects themselves.

However, as of 12/31/2014, only 37% of the total grant has been expended. Delays in project implementations, including OHA funding delay, Transformation Center contract negotiations and challenging community processes, will make complete expenditure of grant funds by 6/30/2015 difficult or even impossible for some projects. We are concerned that these funds will not have their intended impact this timeline and that both outcomes and learnings will be diminished.

We request a 6-month no-cost extension, for the Transformation Grant Project Agreement Number 144326 and Amendment 01, awarded to PacificSource Community Solutions, Inc. This would allow us to expend the funds no later than 12/31/2015, with progress and expenditure reports provided by 7/30/2015 as planned, in final form whenever possible, and a final report for those projects that require more time by 1/15/2016. This extension will allow projects to complete their scope of work, conduct a thorough analysis, and meet overall project objectives.

Project 0
Name of Project: Portfolio Management
Project Team Lead: PacificSource Community Solutions, Central Oregon CCO

1. Overview of activities/progress made

   - 100% of projects funded and underway.
   - Flexible services/Patient Support Fund project implemented.
   - New partnership with the Central Oregon Cover Oregon Collaborative, a network of local organizations and agencies dedicated to bringing health coverage to Central Oregon residents.
   - Facilitation of new processes/systems to administer several transformation projects.
   - PacificSource contracted with Central Oregon Research Coalition (CORC) to offer technical assistance to those projects with limited capacity for evaluation. CORC worked with5 projects teams to develop metrics and possible data analysis methods. Evaluation plans will be shared in the final OHA report.

2. Outcomes/successes

   - Project status review by the Central Oregon Health Council and its various subordinate committees are ongoing, and have provided an appropriate forum for project updates, accountability for results and approvals for necessary changes in timeline or scope.
   - Submission of a driver diagram and charter as requested in September, 2014.
   - A written plan of project aims, measures, and targets was submitted and approved by OHA in October, 2014.
   - Participation in Portfolio Managers' Breakfast at Coordinated Care Model Summit
   - Transformation fund project reports have been submitted on schedule; 1/15/2014, 7/15/2014 and 1/15/2015.
   - Continue to provide technical assistance and guidance with IHI Member Engagement project to La Pine Community Health Center.

3. Challenges/barriers

   - Delays in project implementations, as cited in 7/15/2014 report, will make complete expenditure of grant funds by 6/30/2015 challenging or even impossible for some projects. A "no-cost extension" would allow these resources to deliver their full impact, as intended.
   - See additional remarks at the end of this report addressing challenges/barriers for all transformation fund projects.

4. What have you shared about your projects with other CCOs and what would you like to share?

We remain eager to share our successes and lessons learned as we proceed with the projects and learn from our experiences.

5. Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).
None at this time.

Project 1
Name of Project: Pediatric Health Engagement Team (PHET) Rapid Prototype
Project Team Lead: St. Charles Health System

1. Overview of activities/progress made:

In our previous submission we noted some challenges with our contracted software vendor. In early September we felt obliged to terminate our contract with Kannact, Inc due to conflicting priorities. Kannact, Inc was gracious enough to allow continued use by the project participants until October 1. This allowed us enough time to identify another software vendor we felt we could continue the project with. However, it also created a significant delay in project activities as we on boarded and educated the new vendor. In reflection though there were some really positive outcomes from this switch:

i. Participants would no longer have to carry a cumbersome tablet that was really only usable for the purpose of uploading blood sugar information. This was a dissatisfier for participants who usually had an additional tablet that they were using for classwork, social media, etc.
ii. Participants were able to use the blue tooth technology on their android phones to upload blood sugar information, message and conference/skype with identified care team members.
iii. Participants are able to access the patient portal to view their blood sugars, run reports, track their A1C, ketones and the portal is accessible easily by family members, their primary care providers and the PHET care team members.

Patient Name	Date of Enrollment	1st A1C	2nd A1C	1st BG Assessment	2nd BG Assessment	CES - Depression	Anxiety Screening	Diabetes Distress Scale
PK	6/12/14	7.8	7.3	125 readings	120 readings	1st - 22 2nd – 19	1st - 11 2nd - 6	1st - 21 2nd - 21
RP	*12/11/14	12.6	9.3	64	90	N/A	N/A	N/A
AR	8/6/14	7.5	8.0	250	240	1st- 16 2nd - 22	1st – 2 2nd – 12	1st- 18 2nd – 20
TL *CGM	8/5/14	15.4	6.7	240	150	1st – 15 2nd - 12	1st - 2 2nd - 0	1st- 22 2nd – 19

started								
ST	7/31/14	9.6	9.4	210	168	1st – 22 2nd - 26	1st – 5 2nd – 0	1st- 36 2nd - 26
KW	12/4/14	8.6	N/A	80	N/A	1st - 17	7	48
DN	12/12/14	5.6	N/A	111	N/A	In process	In process	In process
SW	7/31/14	N/A	N/A	Approx. 30	98	26	9	49

2. Outcomes/successes

    a.   Participant #1: PK

PK is a 17 y/o male who was diagnosed with Type 1 Diabetes at the age of 5. In 2013 he had 4 hospitalizations for DKA for 20 inpatient days. The average Medicaid payment for those hospitalizations was around $10,000 per admit. His pharmacy costs for the 2014 year were over $8,000. Additional costs such as provider fees, laboratory and other outpatient expenditures were not available at the time of this report. However, the average spend PMPM for a Medicaid patient is less than $500. This puts PK at approximately 700% above his peers for annual spend. His Truven score was assessed at 599 prior to project participation. PK was also experiencing multiple psychosocial stressors. He was being shuffled between his divorced parents, neither of which provided any oversight or assistance with his diabetes care. He was failing his classwork finally un-enrolling in high school and he was socially isolated once his older brother left the home.

At the time PK was enrolled in the PHET project he had been moved into foster care. By September, PK was reenrolled in school and this past December he received straight A's. PK was a camp counselor at the The Diabetes Summer Camp in July and was seen as a role model by several peers who he continues to meet with at least monthly along with a larger group of families. PK's primary provider, Dr. Peoples at COPA, had been working with him daily with little to no positive response. With the ability to provide increased services throughout the day and in person PK began to test his blood sugars more frequently, correct his highs/lows, test for ketones and begin to manage his diabetes. As of this report, PK has had no ED or inpatient admissions since enrollment.

    o   Additional Successes

- Development of Bluetooth capability for participants to do no other action but test their blood sugar which will then be sent via SMS to their identified care team.
- Patient portal is available for viewing by participants, family, care team members and primary care.
- Bluetooth notification infrastructure is going well and will be applicable to other projects and additional notification types.
- Development for other operating systems will be an easy and quick move (ie. Ipad, Iphone, windows OS).

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3.   Challenges/barriers

    a.   Termination of contract with original project software vendor
    b.   Identification and education of a new software vendor
    c.   Consistent reliability of Bluetooth technology: There are currently no US companies that support blue tooth technology in the manner that we are testing. We have spoken to several companies, Glooko and IFora who report they will not be pursuing Bluetooth capabilities for their products to pair with their patient portals until end of 2015.
    d.   Identification and acquisition of cell phones that are compatible with the IFora Bluetooth blood sugar testing supplies.
    e.   Project participation of identified high cost/high risk patients: we have had success with many participants under the age of 18. However, our 18-26 y/o identified population is often experiencing frequent housing transitions, difficulty with accessing and safely storing supplies and experiencing burn out related to their chronic diabetes care with no partner relationship for support, familial or otherwise. The challenge has been to find and maintain a relationship with this age group which would help to boost our overall participant numbers.
    f.   IRB resubmission (due to change in software vendor)

4. What have you shared about your projects with other CCOs and what would you like to share?

There has not been an opportunity to share current information with other Oregon CCO's. However, attend the Institute for Healthcare Improvement Annual 2014 Conference generated a request for a learning lab to be conducted and the PHET transformation project was a part of the presentation. Multiple requests were received for additional information from Wisconsin, California, North Carolina, and Virginia Mason, in Seattle. It was a great opportunity to learn ideas from other innovative organizations nationwide and even other countries.

5. Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).

Our project manager, Therese Madrigal, has been supportive and available as needed. We will be making a request in the next week to identify any new patients with high utilization in the past 6 months as well as for data on patients we currently have enrolled.

Project 2
Name of Project: Clinical Pharmacy Services
Project Team Lead: MTMCare, Inc.

1. Overview of activities/progress made

Contracting was revised between PacificSource and St. Charles Medical Group (SCMG), Bend Memorial Clinic (BMC), Mosaic Medical (Mosaic), and MTMCare. Mosaic agreed to provide their own 1.0 FTE in-kind pharmacist in addition to taking responsibility for the management and data collection for their portion of the project going forward. In August, MTMCare hired a pharmacist to provide the Clinical Pharmacy Services. The pharmacist has been trained on the fundamentals of patient appointments, medication therapy management and documentation requirements.

Providers and staff from SCMG and BMC have been helpful and supportive of the pharmacist and this project. The staff at both entities has provided initial training and ongoing support. Currently the pharmacist divides their time seeing patients at SCMG on Monday, Wednesday and Friday while BMC's patient visits are on Tuesdays and Thursdays. With SCMG, the pharmacist has prioritized patients of the Prineville clinic. This clinic has a large number of patients identified and this has helped with establishing relationships with providers. Communication between the pharmacist and providers occurs via electronic medical records (or verbally in a few cases). It is has been a collaborative process and useful for the pharmacist, providers and the patients to have a cohesive healthcare team. Providers were given a pre-survey before pilot began.

To date, 71 patients have received a comprehensive medication review (CMR) by our clinical pharmacist. For all patients who agree to the clinical pharmacy service (CPS), a one-hour initial CMR appointment is scheduled with the pharmacist at the clinic. Patients are encouraged to bring all prescriptions, OTCs and supplements to their visit. Patients are given time to ask all their questions and to share any concerns or problems that may not be addressed in the typical provider appointment.

2. Outcomes/successes

As of 12/23/14 the pharmacist has identified 228 medication related problems with an average of 3 per patient. The top three reported medication related problems include: *treatment not optimal based on current evidence/guidelines, medication underuse/non-adherence* and *drug dosing not adequate for treatment goals*. Of the total population, 100% are covered by Medicaid, 87% are adult and 38% are diabetic.

Through this program we have been able to reach out to patients that may have otherwise fallen through the cracks. For example, some patients have not kept appointments with their provider. Had these patients not been identified by PacificSource, they would not have been connected with a pharmacist.

PacificSource has also been able to supply the pharmacist with recent prescription claims data. With this data, the pharmacist can evaluate and communicate medication adherence problems to the provider. This allows for accurate medication reconciliation and improved patient adherence (as documented in the claims data).

The pharmacist addresses potential adherence problems by clarifying patient dose/frequency and inquiring about possible side effects or cost influences. Patients are

given a weekly medication box to help them remember multiple maintenance medications. Patients who have demonstrated non-adherence and not meeting health care goals are placed on a list to have the health plan claims data rechecked for potential further pharmacist intervention.

Patients received pre-assessment surveys in person, or by mail (patients with phone appointments only). Post assessment surveys will be mailed 6 months after the last pharmacist intervention.

The program has resulted in a decreased workload for the providers. For patients in the program, the pharmacist handles all questions that the patients have regarding their medication therapies. In addition, the pharmacist coordinates care regarding medication coverage to follows up on medication starts and changes.

3. Challenges/barriers

Scheduling the CPS appointments is an ongoing challenge. Often times the Medicaid population can be a challenge to contact and then schedule. Once scheduled, the patients are at high risk of not showing up to their appointment. If a patient fails to attend a scheduled appointment twice, then the pharmacist attempts to complete the comprehensive medication review via telephone. Another barrier is pharmacist time spent scheduling. We are currently brain-storming options to shift the burden of scheduling from the pharmacist to clinic staff. This would allow the pharmacist time to meet with more patients.

Another challenge has been the extensive documentation required of this program. Primary documentation occurs within the electronic medical record while additional recording of pharmacist recommendations must occur within Accumentra. The additional data entry is too much for the full time clinical pharmacist to accomplish and requires an additional employee.
Travel time between different clinics is also a barrier. A mileage reimbursement program was established after the onset of the pilot to compensate the clinic pharmacist for expenses. The pharmacist was also provided a cell phone by one of the clinics to help with coordination of care and scheduling.

4. What have you shared about your projects with other CCOs and what would you like to share?

Nothing at this time.

5. Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).

None

Project 3
Name of Project: Flexible Services/Patient Support Fund
Project Team Lead: CAC, COHC

1. Overview of activities/progress made

- New project name adopted: Patient Support Fund.
- Consensus has been reached among the CAC Flexible Services workgroup and PacificSource operations teams to define project aims while considering differing priorities concerning cost and quantitative data analysis and member quality of life. All partners have agreed to utilize flexible services to fund non-covered items or services in order to address the Triple Aim; 1.) improve the patient experience; 2.) improve overall health and; 3.) prevent subsequent, high-cost, covered expenses in the future.
- Regular project status reports are provided by the Portfolio Manager to the CAC and PacificSource operations team, in writing and at monthly meetings.
- 2 pronged item/service identification process developed; data analysis approach, Provider identified approach.
- Data analysis completed. Based on cost and prevalence of claims, focus areas and targeted outreach to providers are as follows:
  - Asthma
  - Oral health
  - Maternity care
  - COPD
  - Mental health
  - Diabetes
  - Substance use disorder
  - Coronary artery disease
  - Home health
  - Kidney disease
- Expressed interest in participating from many local Providers.
- Project Framework established with key drivers:
  - Triple aim objectives
  - Sustainability
  - Community process

2. Successes/Outcomes

- Project implementation complete.
- A PacificSource team comprised of representatives from Health Services, Finance, Data Analytics, Provider Network, and Community Health has been convened to administer the Patient Support Fund project.
- Systems to integrate this work into existing health plan operations have been developed.

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- Review committee and process established to manage provider requests.
- Accounting process established.
- Provider outreach packet completed:
  - Introductory letter – project framework and parameters
  - Item/service request forms
  - Patient information flyer
- Providers selected and invited to participate.
- Evaluation plan is in the process of developed with the assistance or Central Oregon Research Coalition (CORC).

3. Challenges/barriers

- Ongoing and substantial resources are required from PacificSource to launch, administer, evaluate and report on this project.
- Distinct differences in project ideology among partners (CAC workgroup and PacificSource operations team).
- Navigating this project with strategy and efficiency while also benefiting from the wisdom of our CAC members.

4. What have you shared about your projects with other CCOs and what would you like to share?

No formal sharing at this point, however, other CCO's have been asked for templates and examples of similar project documents and work and conversations continue to happen at conferences, statewide meetings and off line as the project commences.

5. Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g., site visit, conference call, webinar, or another form of support).

Assistance from the Transformation Center to facilitate learning among CCO's specific to Flexible Services; i.e. sharing of policies, program operations, technical aspects, and processes, would be very valuable.

Project 4 – Component 1: Community Paramedicine Project
Name of Project: Community Paramedicine Project & Medical Transportation System Optimization
Project Team Lead: Redmond Fire and Rescue and Commute Options

1. Overview of activities/progress made

Community Paramedic, Dan Cox, has received 26 referrals from providers in the central Oregon region, resulting in a total of 26 patients seen, to date. Twenty two (22) patients receiving paramedic visits have been seen more than once. Patient intake

forms have been pared down in response to providers' feedback and the referral process has been simplified as well. During the course of six (6) months in which the Community Paramedic has been on the job, he has visited patients from only Mosaic Medical and St. Charles clinics. He is now receiving referrals from many providers including the complex care clinic (BRIDGES), Lynch Elementary School Based Health Center in Redmond (operated by Mosaic Medical), Bend Memorial Clinic (BMC), St. Charles family care clinic in Redmond, St. Charles hospital in Prineville and from Community Health Workers at multiple Independent providers' offices. Redmond Fire and Rescue continues to visit these clinics in order to attempt an increase in the number of providers referring and patients seen.

As a result of an evaluation consult with Central Oregon Research Coalition (Dr. Jackie Shannon and Ms. Paige Farris), we also gained an MPH student, Mr. Dave Huntley, who is interested in using this project as his student project – contributing 100hrs to the project. Ms. Farris has worked very closely with the Community Paramedic to develop data collection tools that will be useful for merging data sets (patient visits with PacificSource claims) at the end of the project as well as providing data project management in collaboration with Ms. Sarah Kingston (data analyst at PacificSource).

Mr. Huntley is providing assistance toward organizing and conceptualizing the data/cost analysis plan of this project. He has spent some time talking with Mr. Kelly and Mr. Wright in order to better understand and work through a plan for cost analyses; requesting a baseline data set from Ms. Kingston to use as a comparison group. Mr. Huntley developed a draft report into which claims data and baseline (comparison) data will be inserted; it is currently in incomplete form as we await end-of-project and better-refined baseline claims data.

Over the course of the next 6 months and in collaboration with Mr. Huntley, the data analysis will focus on evaluating the outcomes of patient emergency transports and re-admission incidents as well as evaluating the baseline data. The initial evaluation of claims data used existing report age groups of children (0-17), adult (18-64) and assumed-retired adults (65+). The disease states and typical treatment for the project's three diseases of interest begin in later life; it will therefore be necessary to separate younger adults (18-44) from older adults (45-64). Separating these age groups (in the baseline data set) further by gender and race/ethnicity may provide additional insight into that patient population upon whom we have chosen to focus the intervention.

2. Outcomes/successes

- The evaluation consult with CORC resulted in clear and re-defined project aims, metrics, and plans.
- This program, paired with provider offices, has built relationships that are showing positive outcomes and a renewed belief in healthcare with the patients

involved. Anecdotes from patients and providers are describing how much patient satisfaction has increased due to this program.

3. Challenges/barriers

    Educating the various physicians and groups has gone well and efforts to gain support from various groups continue. Although there has been overwhelming support from all the physicians and physician groups, patient enrollment is low. There has been 100% positive feedback from all medical disciplines and no negative feedback from any medical specialty or community group.

4. What have you shared about your projects with other CCOs and what would you like to share?

    Doug Kelly spoke at the Oregon Office of Rural Health Conference about the Community Paramedic grant/project. He gave a joint talk with Home Health about how the two programs can benefit each other and patients.

5. Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).

    The Community Paramedicine project team eagerly anticipates continued support from Ms. Farris, Mr. Huntley and evaluation/ data analyses oversight by Dr. Shannon, the CORC team. They will be available to assist in data export from the fillable pdf forms and merge with data at PacificSource as soon as their data sharing agreement (via OHSU) is in place with PacificSource (in process).

Project 4 continued – Component 2: Medical Transportation System Optimization
Name of Project: Community Paramedicine Project & Medical Transportation System Optimization
Project Team Lead: Redmond Fire and Rescue and Commute Options

1. Overview of activities/progress made

    Commute Options Consultant has met with staff members of 8 partner agencies. Presentations were made to both patients and staff about the availability of Transportation Options. Consultant also obtained information regarding members' access to medical services in order to update the "current conditions" list compiled in early 2014. This list was shared in a meeting of the Integration of New Services: NEMT Workgroup convened by the Central Oregon Health Council where it was utilized to create recommendations as part of a plan for NEMT integration. This plan was submitted by the workgroup to the Central Oregon Health Council's Operations Committee for review. It will be submitted to the CCO's governing board for further direction in 2015.

2. Outcomes/successes

   Follow up meetings took place with staff members of the following partners:

   St. Charles Bend
   La Pine Community Health Clinic
   Bridges to Health
   CERC
   La Pine Rural Fire Protection District
   Mosaic Medical-Redmond
   Crook County Health Department
   Deschutes County Health Department

   Another success is that Commute Options can already be helpful to patients by inviting them to use the www.drivelessconnect.com website to find ride matches. While this is not the answer to the larger issue of medical service transportation, it is another tool to create more access for patients to the care they need. Commute Options provided Drive Less Connect information with staff, encouraging them to share this transportation resource with their patients.

3. Challenges/barriers

   The Commute Options portion of this project is in a holding pattern until further notice from Central Oregon Health Council. Awaiting follow up and next steps from the October meeting of the Integration of New Services: NEMT Workgroup.

4. What have you shared about your projects with other CCOs and what would you like to share?

   A meeting with Paul McGinnis of the Easter Oregon CCO resulted in a discussion about transportation challenges in Eastern Oregon, where distance is an even bigger problem for the patients, than in Central Oregon. PacificSource Central Oregon and Eastern Oregon CCO share the service area of Lake County. Solutions in frontier Oregon relating to chronic disease prevention and transportation problems were shared.

5. Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).

   It has been illuminating to focus on one sector of the community to hear specific examples of issues around access. One area where more information would be helpful, is the specific rules and regulations on volunteer driver training and reimbursement. Cascades East Ride Center (CERC) shared some of the complexities of this process, but more information is necessary to make progress in this area. A visit to the Oregon Health Authority or Medicaid office on a fact finding mission would be helpful. Also,

Clackamas County Health Department has a robust volunteer driver program that could be investigated as a possible model program.

Project 5
Name of Project: Creating an Infrastructure to Evaluate a Global Payment in Integrated Primary Care Practices
Project Team Lead: University of Colorado, Denver

1. Overview of activities/progress made

   Leadership from St. Charles and Mosaic Medical each selected one practice from their respective system: St. Charles Redmond practice and Mosaic Bend (Greenwood) practice. Prior to visiting these practices, we asked that each practice manager complete the Practice Information Form (PIF) to collect unique site-specific information about the practice including items around patient and provider demographics. The University of Colorado team spent a half day at each practice, meeting with the practice manager, health information technology/quality improvement reporting leads, and a multidisciplinary team of providers and staff. More information on the outcomes of these meetings is highlighted below.

   The University of Colorado team is in the process of planning a next trip to Bend, OR and leadership will select one or two additional practices per organization to participate in the project. The current participating practices will next complete the CoACH (Cost Assessment of Collaborative Healthcare) Cost Tool and continue to monitor their data collection and reporting capacity. This tool provides a baseline expenditure for practices around behavioral health.

2. Outcomes/successes

   Site Visits (to participating practices to engage staff and provides, learn about integrated care delivery and complete assessment tools) – complete for two practices
   Practice Information Form (collects practice demographics) – complete for two practices
   AHRQ Lexicon Checklist (practice self-assessment for how fully key functions of integrated behavioral health have been implemented) – complete for two practices
   Minimal Data Set Capacity Assessment (assesses the practice's ability to collect and report on a set of medical and behavioral health clinical quality measures) – complete for both organizations; see QIM Report for more information.

   After the practice-wide meeting at St. Charles Redmond, we met with Dr. Rob Ross, Medical Director of Community Health Strategy, and Emily Salmon, Program Manager, to discuss the benefits and outcomes practice facilitation can produce. While still in discussion with St. Charles, the Central Oregon Health Council has approved a proposal for University of Colorado Denver to support practice facilitation at St. Charles through training and resource sharing. Details of this arrangement are still in development as St.

Charles decides how to proceed (hiring a practice facilitator, using current staff in the role, etc.)

3. Challenges/barriers

We continue to have challenges in communication and engagement with practices and leadership from the two organizations. We have had a few calls with the St. Charles' leadership and have a plan for weekly or bi-weekly calls to begin after the New Year. They are planning for us to speak with their Physician Champions group to utilize the physicians to help with practice engagement.

Additionally, we spoke with Lindsey Hopper, the Central Oregon Health Council Executive Director, about our engagement and communication challenges and are optimistic that, with her support and the engagement of leadership from both organizations, all deliverables for this project will be achieved by the end of the contract. These challenges are not unique to Oregon, and much of this work requires establishing relationships with very busy practices. We anticipate that as this project progresses we will continue to build relationships with administration and practice leadership, providers, and staff.

4. What have you shared about your projects with other CCOs and what would you like to share?

Our team continues to work with the Oregon Rural Practice-Based Research Network on a Transformation Grant project for the Columbia Gorge CCO. The two projects are closely aligned in creating capacity for integration and evaluation. The projects are utilizing the same set of data collection tools (with the exception of the AHRQ Lexicon – the Columbia Gorge CCO practices have completed the Comprehensive Primary Care Monitor and companion tool, the Home Health Monitor, since a behavioral health organization is participating). Practices in both CCOs have agreed to a set of measures pulling from the QIMs, PCPCH, and the SHAPE minimal data set being used in Colorado.

5. Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).

As listed above, the biggest challenge of this project is engagement and communication with the practices and organization leaders. We are working with Lindsey Hopper and others to overcome these barriers and develop plans for better success. Any opportunity for other Oregon leaders to assist in highlighting the importance of this project may prove to be beneficial for practices on the ground that are quite busy and may question which initiative to prioritize.

Central to much of the success of this CCO project as well as others focused on integration will be the need to have a relationship with the Transformation Center.

Because integration is an action item and strategic priority for many of the CCOs, there may be resources, data, and stories helpful for the state that emerge from this effort. While not technical assistance per se, it is an issue that may warrant further attention in the project. Dr. Miller has taken active steps to engage some of the Transformation Center leadership including Dr. Ron Stock. Having a strategic plan for each CCO around integration may prove to be helpful long term in having a collective impact on the state as well as creating a more organized and consistent approach to integration.

Project 6
Name of Project: Bending the OHP Dentistry Cost Curve in Central Oregon
Project Team Lead: Advantage Dental

1. Overview of activities/progress made

   Advantage Dental Services is conducting a community-wide toothpaste distribution campaign enhanced by telephone support. A tool kit with toothpaste and toothbrushes for the whole family together with oral hygiene instructions in both English and Spanish will be mailed to the homes of all OHP members every three months. Half of the population, the enhanced group, will be randomly assigned to also receive telephone support (one-to-one calls), informational mailers, and automated messages with oral hygiene tips. Bilingual culturally competent staff members of Advantage, trained in oral hygiene and behavioral change techniques, will be available to support families in overcoming the barriers to implementing tooth brushing into their family routines. Advantage will document the personnel and financial costs, and evaluate, through a randomized controlled design, using interviews of 450 randomly selected participants with children less than 36 months old, participants' satisfaction with the program and its usefulness. Below outlines what activities have been completed thus far:

   ☐ 450 pre-program Interviews with parents of children under 36 months of age completed
   ☐ 1 informational package insert designed
   ☐ 9 Mailers designed
   ☐ 9 Televox messages recorded
   ☐ 42,387 kits mailed
   ☐ 70,724 Televox messages sent
   ☐ 64,782 informational mailers sent

2. Outcomes/successes

   The interview questions were designed and pre-program interviews were completed to establish a baseline for the evaluation.

   Below is a depiction of the evaluation design. The narrative presents results from the baseline interviews.

2136 families with a child < 36 months

↓

450 families

↓

Group A
Enhanced (toothbrushing kit every 90 days , automated messages, and mailers)
150

Group B
Basic (toothbrushing kit every 90 days)
150

Group C
Control (one toothbrushing kit, Spring 2015)
150

Description of the Evaluation Sample at Baseline (Pre-Program)

Caregiver Level of Education & Intent to Brush their Child's Teeth:

• 20% less than High School
• 66% completed High School
• 83% strongly agree or agree that they intend to brush child's teeth for the child twice a day
• Mean parental efficacy in relation to child toothbrushing in this sample was 4.17 (Standard Deviation (SD): 0.66) on 0-5 scale
• Mean importance and intention to brush child's teeth was 4.19 (SD: 0.53) on 0-5 scale

Current Brushing Habits:

• 79% of the participants reported they brush their child's teeth at least once a day
• 39% once a day
• 20% 1 to 2 times a day
• 34% 2 times a day.
• 70% reported that both child and parent brushed the child's teeth
• 27% only the caregiver brushed
• 3% the child brushed alone, without help from an adult

In this sample of caregivers of Medicaid-enrolled infants and toddlers, daily toothbrushing of the child's teeth was frequent and brushing was a joint activity of caregivers and children. Perceived toothbrushing efficacy and intention to brush reported by the caregivers were high.

3. Challenges/barriers

Overall, we have only received negative feedback from a small percentage of the participants. Comments have included:

☐ Dislike of the automated voice messages
☐ Caregivers of adult patients with special health care needs are offended by the mailer messaging, due to the childlike design
☐ Members who already incorporate daily toothbrushing feel like the kits are a waste of resources
☐ Lack of explanation on why members are receiving these supplies

Additional challenges encountered by the program were:

☐ Contact information for the members is incorrect causing individuals not on OHP to receive the mailings and messages.
☐ Program specific phone numbers, listed, aren't used by members.
☐ The initial fulfillment center that was hired for mailing of kit #1 increased the rates to agree to future mailings which caused the need to seek out another fulfillment center.

4. What have you shared about your projects with other CCOs and what would you like to share?

To date, the only information that has been shared with other CCO's, is a verbal description of the project summary. At this time there is nothing that we would like to share. Once the program is completed, our desire is to have a manual to make available for CCO's that would be interested in implementing a toothbrush distribution program.

5. Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support)?

Project 7
Name of Project: Pediatric Hospitalist Program
Project Team Lead: Central Oregon Pediatric Associates (COPA)

1. Overview of activities/progress made

• The BMC and COPA providers continue to meet every other week in a collaborative effort to move the program forward. Agenda topics include recruiting efforts, workflow and process efficiencies for hand-off, education and training for new hospitalists, scheduling, etc.

• St. Charles Medical Group has abandoned their efforts to start their own independent program and have been meeting with the program partners and pediatricians for the past

two months. Dr. Absalon, Dr. Boileau, Bob Gomes, and Dr. Nunes have been in attendance at each meeting as they agree that approaching this program as a community offers the highest opportunity for success. Next steps are to 1) clearly define shared governance between the groups and 2) begin meeting with hospital departments (ED, Neonatologists, Anesthesia, etc.) to complete a needs assessment and dialog on how best to serve the patients.

• Recruiting is a full time effort using BMC's recruiting director to screen candidates and facilitate the interviews. At this time we have two additional strong candidates coming to Bend mid-January to round out the staffing for the program.

2. Outcomes/successes

    • A HUGE score in recruiting occurred when the lead hospitalist from Packard's Childrens Hospital, who has set up several Pediatric Hospitalist programs in her past, was hired. She will be the program Administrator/Medical Director when she arrives on 06/15/2015. A third half-time hospitalist has been hired. Several other candidates have been interviewed but did not meet position requirements. Recruiting efforts continue.

    • The program is getting rave reviews from all areas of the hospital and in particular the ED and nurses on the Pediatric floor. They are excited to have the continuity of care and a program dedicated to the inpatient population.

    • We have received a lot of support from the medical community including La Pine Community Health Center, Highlakes, Healthcare, Mosaic Medical, and others. We have been discussing ways in which we can receive feedback and input from our community partners and are anticipating this part will really take off when our director arrives this spring.

    • Dr. Chi-Yu Chen, our first hire from Seattle Children's hospital, will be receiving her 90 day review and the feedback has been excellent clinically as well as from patients and hospital staff. Her schedule allows her to be on five (5) consecutive days or nights to provide continuity previously not available.

3. Challenges/barriers

    • **Recruiting is slower than expected:** The difficultly in recruiting into a new program was unanticipated. In particular, searching for a candidate with experience to help launch the program, administer the daily operations, and provide the confidence to new recruits. However, once a mew Medical Director was found to lead the program, recruiting has picked up.

4. What have you shared about your projects with other CCOs and what would you like to share?

• **Communication is critical:** With three distinct organizations (A hospital system, a private pediatric group and a large multi-specialty group) that have not historically worked together or co-managed a program, keeping everyone up to speed has proved difficult. Initially, communication was poor, perhaps somewhat based on history and relative competition. This was not only frustrating, but also contributed to issues with mutual trust. All partners are working together to resolve this issue and have set up regular standing meetings with e-mailing of notes/next steps following each meeting. Work continues in this area and partners remain committed to the success of this program.

5. Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).

    • While the team is treading in some uncharted territories, COPA has been taking inpatient hospital call for 40 years for their patients and for BMC's Pediatricians for nearly a decade. This provides for a lot of expertise on the clinical side of the project. As the project got off the ground, a consultative meeting occurred with Randall Children's Hospital in Portland to discuss possible approaches to project implementation. Outreach to them at some point in the future is a possibility, especially as implementation of key projects components, such as quality improvement, best practices and metric tracking occurs.

Project 8
Name of Project: Telemedicine: Bridging Specialty Care Barriers for Mosaic Medical Patients
Project Team Lead: Mosaic Medical

1. Overview of activities/progress made

    From July –October, the final preparations were made to launch the program connecting patients in the rural primary care clinic in Madras with cardiologists at Bend Memorial Clinic in Bend.

    Final preparations entailed:

    1) Purchasing the Vidyo telemedicine hardware and software from OneVision
    2) Installing and configuring the server and remote hardware and software
    3) Purchasing and installing the accessories for Cardiology
        a. EKG w Bluetooth integration
        b. Telemedicine Stethoscope
    4) Building custom internal cardiology referral workflow in the Mosaic Epic EMR.
    5) Training
            a. Train the BMC Cardiologists on
                i. Mosaic's Epic EMR
                ii. Vidyo Technology navigation
                iii. EKG and Stehoscope accessories

          b.   Train the Mosaic Madras Medical Assistants on
            i.   Vidyo Technology navigation
           ii.   Cardiology visit differences

<u>We launched our telemedicine program with our first patients in our Mosaic Madras Clinic on October 21st!</u>

We are scheduling 2 patients every other Tuesday with a goal to see 4 patients every other Tuesday as efficiency and learning curve improves.

We saw patients on:
October 21st
November 4th
November 18th
December 2nd
December 16th
December 30th

At each visit, IT support staff from Mosaic have been positioned at both the Mosaic Madras Clinic and the BMC Cardiology Clinic.

Some of the improvements made as live telemedicine visits are conducted:
- Added a dedicated phone for the two entities to communicate easier during technical video challenges
- Moved from a wireless connection to a wired set up in Madras
- Included RN in the process to help explain cardiology tests to the patients

2. Outcomes/successes

The successes have undoubtedly been the patients' satisfaction and the knowledge that many of these patients would not have seen a cardiologist at all had they had to travel to Bend to do it.

Note the differences between referral dates and visit dates.

Patients w Telemedicine Visits	Referal dates	Telemedicine office visit date	Patient feed back
719754	2/27/2014	10/21/2014	satisfied
756382	not referred	10/21/2014	satisfied
707288	5/27/2014	11/4/2014	satisfied
703367	2/11/2014	11/042014	satisfied
743738	4/8/2014	11/18/2014	satisfied
715940	11/17/2014	12/2/2014	satisfied
727916	2/5/2014	12/16/2014	satisfied
724399	7/18/2012	12/16/2014	satisfied
717337	9/14/2010	12/30/2014	satisfied

3. Challenges/barriers

Most have the barriers have been technical. This program involves new and sophisticated video hardware and software that inevitably has had some glitches as we've used it in live situations. These glitches with sound or the accessories have been overcome quickly by our resident IT team and then workflow adaptations have been put in place to prevent the error from repeating itself.

4. What have you shared about your projects with other CCOs and what would you like to share?

Nothing has been shared yet, as it is still early. Mosaic plans to share everything from the technical understanding gained, to specialty selection, to patient experience anecdotes.

5. Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).

No technical assistance needed.

Project 9
Name of Project: Member Engagement
Project Team Lead: PacificSource Community Solutions

1. Overview of activities/progress made

PacificSource is implementing activities in both Central Oregon and the Columbia Gorge to optimize Members' utilization, experience and continuity of care within the CCO system. Goals include: member engagement in care through outreach and education, PCP care establishment and OHP enrollment continuity. In the Columbia Gorge region, PCP care establishment will be supported by pro-active risk identification targeted to Medicaid members with no prior established care.

The Member Engagement project is tailored to the needs of the local CCO. Based on these needs, there will be region-specific strategies as well as strategies that are shared across CCO systems.

Strategy 1: Member education and orientation to OHP benefits
Multimedia education campaign
Video: Production of 3-part video series

- Video 1: "Understanding your Oregon Health Plan Benefits." Covers what to do with their OHP and PacificSource member ID cards, how to find who their PCP is, covered benefits, and contact information if they need help or have questions
- Video 2: "Your Primary Care Provider." Covers where to find who their PCP is, changing their PCP twice per year, importance of preventive care, how to make an appointment, and interpreter and transportation services available to members.
- Video 3: "Know where to Go for Care." Covers the benefits of going to their PCP when sick or hurt, promoting urgent care over ER, and enforcing that their PCP should be their first call for any medical needs or questions.

Video scripts and topics were designed to appeal to a multi-cultural and 6th-grade literate audience and will be available in both English and Spanish. Feedback was obtained from a variety of stakeholders including subject matter experts at PacificSource (e.g. customer service, operations representatives, community health, communications), as well as external stakeholders that have experience with and understand common OHP consumer questions and misperceptions (including area enrollment assisters, Community Advisory Council (CAC) members and members of the Hispanic/Latino community. The series will be produced professionally and available for distribution on January 30th. All videos will live on PacificSource's website and be distributed through various channels, including: 1) thumb drives with link pre-loaded handed out at community events and at various clinics and locations; 2) a link to each video loaded onto tablets and given to pilot clinic sites to show to OHP members during their PCP visit; 3) promoted online via social media, newsletters, and PacificSource website.

Print Materials: Materials will complement the look and feel of the video series.

- Illustrated stories: Spanish only, targeted to Hispanic/Latino community. Comic style, illustrated short tales are culturally familiar to Hispanics and Latinos of all ages. This method of communication has been used successfully by health educators to champion important health messages. This story will mirror characters in the video. It touches on preventive services and the renewal process

using images and scenarios to tell the story. The pamphlets and posters will be posted online and distributed through community partners.

- Four page brochure: Designed to mirror video series themes.

Community Events: Our outreach efforts include participation at community events, hosting workshops with community partners that serve OHP members and hosting educational meetings in the community. Each of these events is designed to generate dialogue with our members.

- To date, we have reached approximately 600 people in two events. The first one was at the Saint Francis Catholic Church in Bend, on October 25th and, 26th. We participated with another 13 nonprofit organizations during the visit of the Mexican Consulate. The other event was an "End of the Year" (Posada) for the Latino Community on December 20th at the Boys and Girls Club in Bend.

- Workshops are being planned to give members an overview of their benefits, including: the use of interpreters, transportation to medical appointments, and available preventive care services. Another educational goal of the workshops is to encourage members to see their PCP for regular check-ups and to explain the importance of timely OHP renewal. The two-hour workshops are held in partnership with other non-profit organizations who serve OHP members. In January and February workshops (held in Spanish) will be co-hosted with the Latino Community Association (LCA). Events will be held throughout Central Oregon.

Social Media: Facebook posts and Twitter tweets have been developed to complement and direct traffic to the video series on PacificSource Community Solutions website.

Strategy 2: OHP Re-enrollment

PacificSource has employed several approaches to successfully navigate the OHP renewal process.

- *Eliza* - a health information management platform delivering interactive voice response (IVR) reminders to members nearing their redetermination deadlines. This technology refers members to the OHA call center or to a PacificSource customer service team member who then triages the member to local enrollment assisters who are available to help complete the application process.

- *Provider engagement:* Through the regular dissemination of OHP member renewal files, many CCO contracted providers have been willing to provide

personalized outreach, prompting members to renew coverage and offering assistance when possible.

- *Enrollment Assisters*: Connection with the Central Oregon Community Partner program to engage enrollment assisters and partners in member engagement. Partners have been instrumental in providing updated information around OHP renewals, assisting members through the process, and informing and vetting educational materials created by PacificSource.

Strategy 3: Dedicated program positions

Member Engagement Coordinator – A shared position between CCO regions, focusing on print materials and digital strategies.

Member Engagement Specialist – Central Oregon position, focusing on community based engagement and strategies.

2. Outcomes/Successes

Education
   - Positions hired
   - Material developed
   - Stakeholder engagement

OHP Coverage Continuation

   - Provider engagement around redetermination (including collaboration with community partners and enrollment assisters) through regular dissemination of files of OHP members due to renew coverage
   - Eliza outreach, originally budgeted through Member Engagement transformation project funds to engage 20,000 members, has been prioritized by PacificSource leadership with additional funding allocated to this effort to provide reminder calls to all OHP members through June, 2015. Year to date statistics, through December 31, 2014, including both PacificSource CCO regions (Columbia Gorge and Central Oregon) are below:

     - Attempted calls (best call result; i.e. the best record/member) – 21,349
     - Unreachable (wrong number, disconnected, busy, no-answer) - 4,330
     - Reachable but declined (either a hang-up or declined to take a message) - 2,017
     - Reachable – (message left - either machine or human) - 7,534
     - Reached (called back to Eliza after left message) - 3,627

- Reached (Eliza outbound call connected with member and member engaged) - 3,841
- Reached and transferred (# folks transferred to PS customer service) - 1,292

Data points of special interest:

- Low numbers of members reporting that they received OHP renewal materials - approximately 50% of the English population and 57% of the Spanish population had received their materials at the time of call.
- Approximately 45% had already renewed their coverage, and 89-92% were planning to renew.
- Only 26% of the Spanish population had correct addresses vs the 33% for the English population.

Larger variances we see with these two populations was the level of additional touch points desired among the groups:

- 67% of the Spanish population wanted to transfer to Customer Service vs 57% of English
- 83% of the Spanish population wanted someone to call them back vs 49% of English
- 94% of the Spanish population found the Eliza portion of the call valuable vs 70% of English
- More of the English population wanted the information via email (38%) vs Spanish (29%).

- We compared redetermination files with current membership files, to identify which members have successfully redetermined and renewed their OHP coverage. Our best approach to identifying members who have successfully renewed is by searching the 820 and 834 files to identify recent enrollment start dates. Members who are considered currently enrolled have an enrollment start date and no enrollment termination date in the 820/834 reconciled files. Future termination date is listed in Medicaid Redeterminations files provided by OHA. It is possible that some members with termination dates listed in the redetermination files have not had their paperwork processed yet at OHA in order to have a term date. Therefore, it may be that the number of members who both re-enrolled and who terminated are potentially underreported at this time and are highly susceptible to delays in document processing at the State.

# of Members Up for Re Enrollment by 10/31/2014	14,593

% currently enrolled	75.9%
# currently Enrolled	11,081
% enrolled after Sep 2014	7.1%
# enrolled after Sep 2014	1,037
% enrolled after Oct 2014	7.0%
# Enrolled after Oct 2014	1,015
% Termed (no longer enrolled)	24.1%
# termed	3,512

- An evaluation plan has been finalized with the help of Central Oregon Research Coalition (CORC) that clearly defines project aims and metrics.

3. Challenges and barriers

This project includes many components, requiring an exceptional amount of administration and resources. Capacity of external partners, vendors, and PacificSource staff has impacted project implementation, as have complexities and delays in the OHP renewal process, and recruitment and training of project-dedicated staff.

- CCO operations in two regions; e.g. identifying efficiencies and ensuring organizational responsiveness to local conditions.
- Logistical challenges in working with a multitude of internal and external partners
- Multimedia strategies required new systems and organizational capacity to develop infrastructure to evaluate distribution methods.
- Recruitment and training of two staff positions dedicated to this project took longer than expected.
- Complications and complexities related to OHP re-enrollment; e.g. high percentage of inaccurate contact information for members, continual changes to renewal process and parameters communicated from the State, challenges to provide accurate renewal information and updates to community partners, difficulties in developing internal systems to manage the renewal process.
- Long wait times for members and enrollment assisters when contacting OHA/CoverOregon call centers has been reported as a significant barrier to timely re-enrollment.

4. What have you shared about your projects with other CCOs and what would you like to share?

A networking breakfast at the Oregon CCO Summit on December 4th provided an opportunity for transformation project portfolio managers to gather and share information specific to their respective projects and overall transformation grants. The majority of attendees, including PacificSource staff, discussed the lessons learned to date, successes and challenges related to transformation projects.

5. Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance(e.g., site visit, conference call, webinar, or another form of support)

It would be very helpful for OHA to provide data at a member or CCO level that could guide future strategies and track progress. For example, adding termination dates to 834 files so that members due to renew can be anticipated and proactively supported by their PCPCH and their CCO. It would also be helpful if OHA could share with CCO's the reasons, broken down by percentages, that members do not redetermine successfully. This would be particularly helpful to understand if a member lost coverage because they did not submit an application, if they lost coverage because they were no longer eligible for OHP coverage with PacificSource, or if they gained coverage with a different CCO and therefore did redetermine successfully.

Project 10
Name of Project: Maternal Child Health Initiative (MCHI)
Project Team Lead: Wellness and Education Board of Central Oregon (WEBCO)

1. Overview of activities/progress made:

The Tri-County MCH team has continued to enhance, sustain and integrate lessons learned from the initial phase of the MCH Initiative by providing the following services:
- Continued systems integration work with primary care providers to enhance integration, increase communication, and enable new and more efficient work flow processes all in support of increasing capacity for regional services for high risk women and families within the tri-county community.
- Established new partnerships with primary care (St Charles Center for Women's Health) by providing embedded (8 hours per week) public health maternal health educator and establishing referral processes.
  - o 48 clients provided services during the period 7 OCT – 30 DEC 2014.
  - o 144 total referrals (averaging 3 per client)
  - o Services included OHP application support, WIC certifications, referrals to home visiting programs, dental, primary care and behavioral health, social and other community outreach agencies.

- Continued partnership with other community home visiting programs (Healthy Families, COPA and Mosaic) to coordinate services, improve continuum of care and establish regional referral processes.
- Continued partnership with COHC, CCO and public health to identify long-term, sustainable funding strategies and/or payment methodologies through transition of Medicaid Targeted Case Management in support of an enhanced maternal child health care coordination system.
- Continued to provide updates to key stakeholders from PacificSource, public health and local partners.

2. Outcomes/successes:

- MCHI Qualitative Report Summary (SEP 2013 – SEP 2014) completed during LAUNCH Grant closure activities.
- Central Oregon NFP Outcome Report for the period 1 OCT 2013 – 30 SEP 2014 included the following highlights:
   - 90.9% of infants with up-to-date immunizations at 6 months and 95.2% at 12 months.
   - 100% of infants screened with ASQ-SE at 6, 12 and 18 months.
   - Decrease of 16.7% in smoking status during pregnancy phase.
   - 0% total very low birth weight and 6.1% total low birth rate for 49 total births during the period.
- In addition, system-wide outcomes for this period included:
   - Sustainable regional Nurse Home Visiting Services (Nurse Family Partnership and CaCoon) as the transition occurs to a new funding model beginning in July 2015.
   - Strong and sustained partnership with primary care (St Charles Center of Women's Health, COPA and Mosaic), community home visiting programs as evidenced by more efficient and streamlined referral processes across the region.
   - Forward progress on the contract agreement between COHC, CCO and public health outlining long-term, sustainable funding strategies and payment methodologies through transition of Medicaid Targeted Case Management. Meeting with PacificSource held 29 DEC 2014. Next internal tri-county follow-up scheduled for 9 JAN 2015.

3. Challenges/barriers

- Spent an extraordinary amount of time and energy working out current compensation structure and details for this six month period. This has been noted on the Expenditure Progress Report.

4. What have you shared about your projects with other CCOs and what would you like to share?
- Team members presented MCHI Summary findings at OHA MCH/CCO Conference in November 2014.

5. Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).

None at this time.

Is there any additional information you would like to share with the Transformation Center about your projects?

We would like to share the following overall themes:

- Delays in project implementations, as cited in 7/15/2014 report, will make complete expenditure of grant funds by 6/30/2015 challenging or even impossible for some projects. A "no-cost extension" would allow these resources to deliver their full impact, as intended.
- Several project teams have discovered a lack of capacity to conduct comprehensive evaluation. Further consultations with CORC and PacificSource's data analytics team confirmed that at least five of the 10 transformation projects would require some level of technical assistance to accurately capture, analyze and report project data.
- At least five of the 10 transformation projects will require a significant amount of time to analyze and report project data. For example, analysis for many of our projects depends on claims data using a 6 months pre-post methodology, plus an additional 3 months for run-out of claims data. This means that outcomes in claims for someone who became enrolled in a transformation grant-funded project today could not be analyzed until 9 months from today, at the very earliest.
- Several projects have experienced need for project management, evaluation and reporting skills beyond the degree originally anticipated.
- By contracting with Central Oregon Research Coalition (CORC), PacificSource Community Solutions was able to provide additional consultation on the evaluation plan for many projects.
- The portfolio manager has assumed more project management and technical assistance than was originally anticipated in order to ensure the success of all projects.
- As the transformation grant has funded the implementation of numerous new services for OHP members, we have discovered new challenges: making room for innovative practices within the traditional structure of the health care delivery system and gaining the engagement and consent of members who are offered the services.
- It would be very helpful if the Transformation Center could share examples of these transformation grant reporting materials from other CCO's.

Transformation Grant Progress Report

Date: 1/15/2015
Name of CCO: PacificSource - Columbia Gorge
Reporting Period: 7/1/2014 to 12/31/2014
Contact Person for This Report: Mark Thomas, Community Health Development Coordinator
Contact Information: mark.thomas@pacificsource.com, 541-550-0978

Progress reports for all 16 Transformation Grant-funded projects from PacificSource Columbia Gorge CCO are enclosed. All of our projects are up and running. They are serving as powerful catalysts for innovation, collaboration and a growing sentiment that things can and will be different on this journey of transformation.

With the Columbia Gorge Health Council, and numerous other community partners in the Gorge, we are learning valuable lessons about the realities of implementing new programs and models of care across organizations. Seeing the success of the projects is strengthening our culture of collaboration and our determination to improve. We are also finding value in discovering the many barriers to success, so that those can be understood and addressed, often yielding system improvements beyond the scope of the transformation projects themselves.

However, as of 12/31/2014, only 44% of the total grant has been expended. Delays in project implementations, including OHA funding delay, Transformation Center contract negotiations and community processes, will make complete expenditure of grant funds by 6/30/2015 challenging or even impossible for some projects. We are concerned that these funds will not have their intended impact on this timeline and that both outcomes and learnings will be diminished.

We request a 6-month no-cost extension, for the Transformation Grant Project Agreement Number 143840 and Amendments 01 and 02, awarded to PacificSource Community Solutions, Inc. This would allow us to expend the funds no later than 12/31/2015, with progress and expenditure reports provided by 7/30/2015 as planned, in final form whenever possible, and a final report for those projects that require more time by 1/15/2016. This extension will allow projects to complete their scope of work, conduct a thorough analysis, and meet overall project objectives.

Table of Contents

Project 0
Name of Project: Portfolio Management
Project Team Lead: PacificSource Columbia Gorge CCO

Overview of activities/progress made:
- 16 Transformation Grant projects
- 19 Services Agreements
- 15 Community Partners, some with multiple services agreements
- Over 60 outcome and process measures being tracked
- 100% of projects funded and underway

Outcomes/successes:
- Project status reviews by the Columbia Gorge Health Council and its various subordinate committees are ongoing, and have provided appropriate forums for project updates, accountability for results and approvals for necessary changes in timeline or scope.
- Submission of a driver diagram and charter as requested in September, 2014.
- A written plan of project aims measures and targets was submitted and approved by OHA in October, 2014.
- Participation in Portfolio Managers' Breakfast at Coordinated Care Model Summit
- These transformation project reports on grant activities, budget changes and expenditures have been submitted on-time for the reporting deadlines of 1/15/2014, 7/15/2014 and 1/15/2015.

Challenges/barriers:
- Minimal barriers in hiring staff for the Portfolio Management position.
- The position has required additional funds from PacificSource.
- See remarks regarding challenges/ barriers cited for each transformation fund projects, and general themes at the conclusion.

What have you shared about your projects with other CCOs and what would you like to share?
- A networking breakfast at the Oregon CCO Summit on December 4th provided an opportunity for transformation project portfolio managers to gather and share information specific to their respective projects and overall transformation grants. The majority of attendees, including PacificSource staff, discussed the lessons learned to date, successes and challenges related to transformation projects.

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).
- We have not yet submitted our request for hours from the Technical Assistance bank. We are aware of this resource and anticipate making an informed request in Q1, 2015.

The following transformation projects have been principally developed by the CCO partner organizations, with the support of PacificSource. Every effort has been made by PacificSource staff to compile and report on these projects in a consistent manner.

Project 1
Name of Project: The Dalles Meals on Wheels, Inc.
Project Team Lead: The Dalles Meals on Wheels, Inc.

Overview of activities/progress made:
- Since our project began, we have served 243 meals and continue to serve some existing clients and get new clients each week. We have done outreach to the MCMC discharge planners, outpatient clinics, same day surgery staff and surgical specialist offices. We have even used the radio to get the word out about the program and its importance. As the community becomes more aware of our program and referral parameters have been simplified, we are getting more calls and more individuals wanting to work with us or learn more about what we are doing and what we are learning in this project.

Outcomes/successes:
- We have had all positive outcomes with no re-hospitalizations or infections. All clients have reported satisfaction with our service. Something we had not anticipated was that these clients cited significant alleviation of stress due to not having to worry about how they were going to eat after a hospitalization. They also enjoyed receiving a friendly visit from our drivers, 5 days per week, which gave them peace of mind.
- With the help of PacificSource and MCMC we are now receiving more referrals and are able to contact more possible clients.
- With the help of Central Oregon Research Coalition and PacificSource, we arrived at a simplified list of meaningful measures, a plan for analysis and better reporting tools.
- Presentation to the Clinical Advisory Panel of the Columbia Gorge Health Council resulted in approval of these measures and in collaboration with local hospitalists to discuss options to "hardwire" home delivery of meals to OHP members upon hospital discharge.

Challenges/barriers:
- Since we revised the criteria and process for enrollment, some barriers to receiving referrals have been reduced. However, a new challenge has been helping referring partners to understand the simplified approach, which reduces the burden of paperwork on their end.
- Data entry and management has also been a challenge, but we have improved our system to be more streamlined and user-friendly.

What have you shared about your projects with other CCOs and what would you like to share?
- Information on the project was presented at the CAC Summit in Eugene on May 29th.

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support):

- Meals on Wheels has received technical support from Paige Farris, Jackie Shannon, and Mark Thomas. They have been integral to helping us realign the parameters of the grant and find new energy for the project. As of right now things are lined up very well, and we have the proper people to contact if we need the help.

Project 2
Name of Project: Community Action Plan for Reducing Childhood Obesity
Project Team Lead: North Central Public Health District

Summary:
The focus of the CAPRCO has changed from the creation of short-term solutions, to one of consortium-building and long-range planning. The remaining funds are being used to facilitate an Oregon Solutions Project on Pediatric Obesity in Wasco County. Local civic, business, health, education and philanthropic leaders will be attending a series of 4 monthly meetings, with the goal of executing a "Declaration of Cooperation" from community leaders pledging their respective actions to address the pediatric obesity epidemic in Wasco County in a model of collective impact.

Overview of activities/progress made:
- Dr. McDonell presented BMI data to District 21 Superintendent Armstrong, Dry Hollow Principal Peters, Colonel Wright Principal Bigalow, and Chenowith Elementary Principal Evans.
- Dr. McDonell presented data and quarterly report information to the Columbia Gore Health Council's Clinical Advisory Panel.
- Dr. McDonell, Teri Thalhofer and Mark Thomas had a conference call discussing the ability to change the focus of the grant towards community leader education and involvement.
- Revision/request for approval of grant focus presented to Clinical Advisory Panel.
- Consultation via email and in-person meeting with Central Oregon Research Coalition.
- Oregon Solutions (OS) application completed, initial application approved. Jill Testerman, DNP student, contacted (via CORC connection) and able to spend 2-4 hours/week working on data analysis.
- Weekly meetings with John Hardham, videographer, and Michael Friend, producer, for development of short video documenting childhood obesity epidemic in Wasco County.
- Successful meeting with representatives of the Mid-Columbia Health Foundation held, to request matching funds for Oregon Solutions Project.

Outcomes/successes:
- Approval of proposed revisions to the scope of this project by the Clinical Advisory Panel of the Columbia Gorge Health Council.
- An educational video on the obesity epidemic was produced. Link to video http://youtu.be/ZAdz2pkW4f0
- Exhaustive report produced to analyze childhood obesity and related factors in The Dalles.
- Matching request approved from Mid-Columbia Health Foundation for $4,000.00.
- CAPRCO received Governor Kitzhaber's designation on 12/12/2014, and become an official Oregon Solutions project. Kickoff meeting occurred on 1/9/2015.

	North Wasco Co. SD elementary schools N = 1053	Oregon children	U.S. children
Overweight[1]	38%[a]	30%[b]	34%[c]
Obese[2]	**22%**[a]	**15%**[b]	**18%**[c]

Definitions:
1. Overweight = ≥ 85th percentile of BMI for age
2. Obese = ≥ 95th percentile of BMI for age

Sources:
a. North Central Public Health District, 2014
b. Oregon Healthy Growth Survey, ages 6-9, 2012
c. National Health and Nutrition Examination Survey, ages 6-11, 2012

Challenges/barriers:
- Financial- There was a $4000 shortfall with funding remaining from initial grant and the cost of Oregon Solutions project. The Mid-Columbia Health Foundation was able to donate $4000 to the project.
- Many unknowns remain and our process with Oregon Solutions will invariably present new challenges and opportunities.

What have you shared about your projects with other CCOs and what would you like to share?:
- Efforts have still not been formally shared with other CCOs, due to limited time and resources available for work on this project.

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support):

- With the Oregon Solutions designation, we now have excellent technical support.

Project 3
Name of Project: Clinical Pharmacy Services Project
Project Team Lead: MTMCare and Columbia Gorge Family Medicine

Overview of activities/progress made:
The integration of pharmacy services at Columbia Gorge Family Medicine (CGFM) has been deemed a success. To date, 108 patients--the pilot requirement--have had at least one initial visit with the clinical pharmacist. Of those patients, 28 have had a second visit and five have had a third visit with the pharmacist. PacificSource has aided the pharmacist with timely claims data and formulary support. CGFM staff have secured patient appointments and staff have been an ongoing resource to the clinical pharmacist. Data entry is ongoing into the Acumentra database. Of the 108 patients seen, 98 patients were PacificSource and were either identified by the health plan or physician referred. Fifty-five percent of the patients were categorized as Medicaid, 23% were Medicare, 21% were from commercial plans and 1 patient was dual eligible. Forty-seven percent of the patients had the diagnosis of Hyperlipidemia, 46% Hypertension, 37% have Diabetes. Pediatric patients made up 11% of the population. For the next 3 months, the pharmacist will focus on follow-up visits/calls with those patients still not meeting their goals. It is estimated 10-15 patients will require a follow-up call. Post provider surveys will be distributed at the end of the project.

As of 11/30/14, all Acumentra data and patient survey data were given to PacificSource for analysis and collaboration. Two patient baselines and one post pharmacist visit Blood Pressure, LDL and HA1C (if yet available) was included in this data. Since the last report, PacificSource now has made Medicaid psychiatric medication claims data available for review. This has been a very useful tool during this pilot.

Outcomes/successes:
As of 12/18/14 the pharmacist has identified 441 medication related problems with an average of four per patient. Of the medication related problems needing provider approval for change, 94% of recommendations were accepted. The top three recommendations needing provider approvals include: *Treatment not optimal based on current evidence, Drug dosing not adequate for treatment goals,* and *Untreated medical problem.* The top two overall reported medication related problems were *Medication underuse/non-adherence,* and *medication overuse/misuse.*

Through this program we have been able to reach out to patients that may have otherwise fallen through the cracks. Many patients would have missed annual lab draws and appointments of disease state visits. During the pilot the pharmacist has referred patients to local community programs and worked with providers to restart lifesaving

medications. A common patient scenario is patient non-adherence to maintenance medications leading to over prescribing of medications and polypharmacy. Another is overutilization of beta-agonists with non-adherence to maintenance respiratory medications leading to exacerbations of respiratory disease.

Final claims analysis will be included in the transformation grant report in July.
.
Challenges/barriers:
Initially, scheduling the CPS appointments was a challenge. As the pilot progressed both the patient scheduler and pharmacist were able to schedule the majority of the patients. For those patients who were unable to visit the clinic or no-showed more than 2 appointments, the pharmacist reached out to the patient via telephone. During the pilot, Medicare patients were more easily scheduled as compared to other patients. Often, commercial and Medicaid patients are younger and had jobs or were enrolled in school.

What have you shared about your projects with other CCOs and what would you like to share?:
MTMCare has developed and shared patient and provider satisfaction surveys with other CPS service providers.

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support):
None at this time.

Project 4
Name of Project: Care Management Training
Project Team Lead: Mid-Columbia Medical Center

Overview of activities/progress made:
- Two designated staff RNs attended OHSU's Care Management training and accomplished certification within the Care Management+ program.
- Certified Care management RN's provided training activities to 7 RN's at Mid-Columbia Outpatient Clinics.
- 6 of 7 RNs have so far completed study and received MCOC Certificates for completion of Care Management training.

Outcomes/successes:
- Training for care-management of patients with chronic disease and social problems was successful.
- Healthy Communities Grant from PacificSource has been received to provide training to all clinic nurses in Care management. American Academy of Ambulatory Care Nursing's "Care Coordination and Transition Management" course started by nursing staff in December 2014. Planned for completion in June 2015.

- Training for Care Manager Team was completed on December 23rd.
- We anticipate migration to Epic EHR supported Care management tools in mid-2015.
- Organizational support of Care management team is strong. Team is organizing to work together out of specific clinics in order to prioritize time and space for care management activities, to begin March, 2015.

Outcomes:

Measures	Targets (by 6/2015)	July – December 2014
# of people trained	≥ 7	6
# of ED visits for MCOC patients	6 month average monthly ED visits by MCOC patients = 404	6 month average monthly ED visits by MCOC patients = 491. (=35.2 visits /1000 patient months) ↑ trend
# of SBIRT completed	8.6% patients > 65 yrs receive SBIRT screening	31 % patients > 65 yrs receive SBIRT screening ↑ trend
# of Developmental Screenings completed	20.7% patients age 1-3 receive ASQ screening	33% patients age 1-3 receive ASQ screening ↑ trend

Challenges/barriers:
- Technical difficulties in updated EHR templates resulted in delays in training and implementation. Most problems are now fixed.

What have you shared about your projects with other CCOs and what would you like to share?:
- Nothing at this time.

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).
- Nothing at this time.

Project 5
Name of Project: Community Health Worker Capacitation Center for the Columbia Gorge
Project Team Lead: The Next Door, Inc. (NDI)

Overview of activities/progress made:
As of December 31, 2014, 26 people have been trained utilizing the 90 hour "We Are Health" curriculum during the month of August including eight trained trainers. Additionally, a Community Health Worker (CHW) supervisor training was held in November and 12 CHW supervisors were trained. Through the Community Health Worker Education / Training / Employment Grant, a contract with Columbia Gorge

Community College (CGCC) will be executed in order to continue project activities. As a result of the collaboration and several planning meetings between NDI staff, Multnomah County Health Department Community Capacitation Center (CCC) and CGCC, an advanced certification for CHWs is being developed to further the training opportunities of the currently certified CHWs. Finally, we are planning dates for the next CHW training which will be facilitated by local trained CHWs to be held in February, 2015.

Outcomes/successes:
- Adapted "We Are Health", a curriculum approved by the Oregon Health Authority which qualifies participants for inclusion in Oregon's Traditional Health Worker registry, to fit the needs and strengths of the Columbia Gorge;
- Used an approach that is based on best practices;
- Selected Trainers for "We Are Health";
- Implemented "Train the Trainers" Training (90 hours) resulting in 8 Certified Trainers;
- Held one 8-hour CHW Supervisor Training – 12 completed training;
- Trained 26 local CHW's, outreach workers, case managers and other health and wellbeing providers in the "We Are Health" curriculum.
- Additional $75,000 was secured from 3 other funding sources to sustain and expand program beyond original expectations!

Challenges/barriers:
- Due to inclement weather in November of 2014, only 12 of the 16 enrolled participants were able to attend the CHW supervisor training.
- It has been difficult to get the number of certified CHWs as the Traditional Health Worker registry is not working properly. OHA is working on resolving the issue and we anticipate being able to provide this count in our final report.
- Scheduling meetings when working with many different partners has been a challenge. Some members are not able to be in attendance due to their other commitments or scheduling conflicts.

What have you shared about your projects with other CCOs and what would you like to share?
- We have discussed this project with the Greater Oregon Behavioral Health, Inc. (GOBHI), which is an invested partner in the Eastern Oregon Coordinated Care Organization (EOCCO), Columbia Pacific CCO and the CCO for Douglas County, and they are interested in potentially replicating this model in their service area.
- We anticipate that, at the completion of this project, there will be many successes and learned lessons that we could share with other CCOs should there be an interest in replicating this project.

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).

- We truly appreciate all the TA and support that Mark Thomas has provided for this project.

Project 6
Name of Project: Building Capacity for Integrated Behavioral Health and Primary Care
Project Team Lead: Oregon Rural Practice-based Research Network (ORPRN) and University of Colorado Family Medicine Program

Overview of activities/progress made:
Four primary care practices (Columbia Gorge Family Medicine, Columbia Crest Family Medicine, and Columbia Hills Family Medicine, One Community Health) and one behavioral health agency (Mid-Columbia Center for Living) are actively engaged in the project. These practices provide the majority of care to OHP patients in the region. Each practice has a cross-functional implementation team (CFIT), totaling 24 individuals from diverse clinical roles: physicians, psychiatrist, registered nurses, medical assistants, licensed clinical social workers, behavioral health referral coordinator, front and back office leads, practice managers, IT staff, medical directors, and CEOs.

Collaborative Partnership:
- The Oregon Rural Practice-based Research Network (ORPRN) and University of Colorado Department of Family Medicine (UCD) project teams have worked collaboratively to achieve project milestones, holding weekly meetings and additional consultation as needed.
- We have successfully engaged with five participating practices (2 of which are part of the Mid-Columbia Outpatient Clinics).
- Memoranda of Understanding (MOU) detailing project activities by quarter have been signed and fully executed by all practices.

Steering Committee: During the current reporting period, project team members attended the July, August (by phone), September, November and December Integrated Care Work Team (ICWT) meetings. The ORPRN/UCD project team gave presentations to the ICWT at the August and December meetings to provide project updates and participated in the ICWT's September discussion of nomenclature and language around behavioral health service delivery in specialty mental health versus primary care venues. During the September meeting, the ICWT agreed upon a general framework for coordinating behavioral health services across venues, while maintaining a patient-centered approach.

Stakeholder Engagement: Initial contact and start-up meetings with each of the five participating clinics were completed by August 2014. By the end of September all five clinics had identified clinical and administrative practice champions and at least one data manager, and had formed cross-functional project implementation teams that included key representation from all practice-roles. In August, the project's Practice Enhancement Research Coordinator (PERC) convened an all-provider meeting with 2 of the five participating clinics. Additional all-provider meetings are planned for the other three

participating clinics, as schedules and resources permit. Establishing mechanisms for provider and all-staff engagement in practice change is an early foundation that many clinics are still working to establish. Since July 2014 the project's PERC has met with each practice's CFIT at least monthly to complete practice assessment forms, review models of integration, and discuss community-wide needs to support integrated care (see details below). Key findings, lessons learned, and achievements have been informally shared by project and practice team members during the monthly ICWT meetings to facilitate a community-wide conversation on the importance of and structures needed to enable integrated care in this CCO. The ORPRN/UCD team is collaborating with the Columbia Gorge Health Council to refine the best venue(s) for all-staff meetings as well as cross-clinic collaboration and practice report-outs are planned for the next ICWT meetings in early 2015.

Practice Assessment and Progress Review (Baseline): Clinic-level assessment data (Practice Information Form, Comprehensive Primary Care Monitor/Health Home Monitor, Minimal Data Set Capacity Assessment) have been completed by all five clinics during the monthly on-site PERC visits with phone/email follow-up. The tools are being used to inform quality improvement projects to support integrated care at each clinic. Aggregate data will be summarized and submitted to the CCO at the end of the project. Selected baseline assessment data were presented at the poster session of the December 2014 Oregon Coordinated Care Organization (CCO) Summit in Portland. Practices began work on the on-line version of the CoACH Cost tool in November, and are expected to complete the tool in January. The UCD team piloted the web-based tool in November. Practices received an instructional video and UCD will continue to provide technical assistance by phone and email as needed. Each tool is summarized briefly below:

- *Practice Information Form:* All five practices have completed a Practice Information Form recording demographic information. The four primary care practices represent more than 75% of the CCO's Medicaid population.
- *Minimum Data Set Capacity Assessment:* This tool assesses a practice's capacity to report select medical and behavioral health clinical quality measures. All five clinics have completed the assessment and are working at generating reports on available measures.
- *Comprehensive Primary Care Monitor (and Home Health Monitor)*: This tool assesses how a variety of elements related to practice transformation are applied to and support integration while simultaneously helping practices self-assess, prioritize work, and monitor progress. This tool is being used in place of the AHRQ Lexicon Checklist because of its companion tool, the Home Health Monitor, which is appropriate to use with the behavioral health agency. All five clinics have completed a Monitor.
- *CoACH Cost Tool (Cost Assessment of Collaborative Healthcare Cost Tool).* This interactive web-based tool provides an annual estimated incremental expenditure of integration and produces a high-level workflow of integrated care delivery for primary care practices. All five practices have been introduced to the

tool and received initial training. We expect that all five clinics will complete the tool by end of January 2015.

Below are the aggregate baseline responses to the Behavioral Health Integration section of the Comprehensive Primary Care Monitor from the four primary care practices:

Baseline Responses to Behavioral Health Integration Section (includes 4 primary care practices)	Average Score (Self Report)				
	0 Not at All	1	2	3	4 Completely
Our practice has a shared vision for behavioral health integration that everyone understands		X			
Our practice has identified behavioral health conditions for focused quality improvement		X			
A system has been implemented to screen for patient behavioral health issues				X	
We have reliable registry data to identify and manage specific populations of patients with behavioral health concerns			X		
Our patients have easy access to comprehensive, coordinated behavioral health services in our own clinic or with community partners		X			
Protocols and work flows have been implemented for effective handoffs to and standardized follow up with our behavioral health providers		X			
A behavioral health professional has been fully integrated into patient care in our practice		X			
Our practice's business model supports the consistent delivery of integrated behavioral and medical services		X			

Personalized patient care plans are shared between behavioral health and primary care providers		X		

Intervention/Technical Assistance: The project's intervention includes four key components, which are conducted on site at each clinic through monthly practice facilitation meetings with the CFITs. Between visits the practice facilitator continues to support the practices through email and phone communication to achieve project deliverables and work on integration efforts. Intervention elements are designed to: 1) support process mapping/workflow development; 2) build capacity to create and maintain minimal data set; 3) assist practices as they implement systematic screening; and 4) facilitate cross-practice communication to support integration. The practice facilitator has completed a total of 34 visits with the five participating clinics since July 2014.

As described above, participating clinics are currently prioritizing the CoACH Cost Tool, and related workflow mapping activities. With capacity assessments for minimal data set complete, the team will provide targeted technical assistance as clinics begin to generate reports using their, EHRs and other data sources.

During the second of half of the project (January 2015-May 31, 2015, the ORPRN/UCD project teams will continue supporting practice improvement. Additionally, the team will collaborate closely with the CCO and Columbia Gorge Health Council to facilitate new opportunities for cross-clinic collaboration and sharing of best practices or needs for integrated care regionally. Starting in January, sites will report their progress to date during the monthly ICWT meetings. Each clinic will report their progress and answer questions from their peers at least twice before the end of the project (currently planning for report-outs in January and February and again in May and June).

Outcomes/successes:

We have had many early successes on this project and have highlighted a few below.

Success with Community Partners: The behavioral health agency (MCCFL) and large community health center (OCH) participating in the project have engaged in successful collaboration towards bi-directional integrated care. MCCFL therapists are currently embedded at two OCH locations. Through a series of joint meetings around integration, it became clear that the agencies initially had different views of what "integrated care" was. MCCFL thought they were meeting the clinic's needs by implementing a traditional mental health therapist. OCH really wanted a behavioral health consultant (BHC) model. With support from the project team, including conversations during the ICWT meetings and monthly site visits, these partners have been able to re-define their priorities together. The agencies are working towards integration of a behavioral health consultant role and

co-located specialty mental health services at OCH Hood River location. They plan to expand this model to their location in The Dalles once workflows are more refined. Additionally, prior to this project the embedded MCCFL therapists were unable to access or document in the OCH electronic health record. Through conversations resulting from monthly meetings, the two organizations have been able to clarify some misunderstandings regarding their existing contract for services and capacities to view patient information in one another's electronic health record. MCCFL therapists now have access to view patient information the OCH electronic health record.   They plan to next figure out billing and coding and templates for the MCCFL therapist to document and track their work.

In addition to activities at the primary care clinic, OCH leadership is providing ongoing guidance to MCCFL toward development of an integrated primary care program, targeting MCCFL clients with persistent mental illness.

Success with Comprehensive Behavioral Health: Columbia Hills Family Medicine (CHFM) is piloting a behavioral health consultant (BHC) model in addition to its co-located specialty mental health services. The process has involved intensive quality improvement effort with the PERC, including workflow development and implementation, as well as documentation and coding of BHC services. The practice has observed that internal referrals to specialty mental health that originate from the BHC seem to have lower no-show rates at the first scheduled visit than those who were referred directly by the PCP, as well improved efficiency in the office. Initially MCOC planned to have the BHC cover 5 clinics – however early implementation efforts and reflection by the project team have made it so she's currently serving one practice. This raises an important point around staffing ratios for integrated care (something that will be made more apparent as teams review the COACH Cost Tool moving forward). The following email from a participating provider at CHFM highlights the helpful role of the BHC, and the importance of keeping her available to the team versus spreading her out so she cannot be accessed in real-time:

> *Hey [Practice Manager],*
> *Just wanted to say thank you and attest to the immeasurable good [Behavioral Health Consultant] is doing to improve access to behavioral health here at CHFM. She has already improved my productivity and ability to see patients in a… timely manner. On Wednesday we were able to squeeze in a couple more people, because she was absorbing time I would have normally spent in counseling (especially the surprise, time consuming issues, like the depressed teen in for a WCC, or a new patient presenting with anxiety). The other day I had a*

patient tell me that with the breathing exercises she taught him he hadn't had a panic attack in 2 weeks.

Now for my request. Please, PLEASE do not stretch her over multiple clinics. Her presence here works because she is here and accessible. She is needed as a regular resource. I do not want to share... and if you want me to keep seeing 8-10 patients per half day (which I can do with her help), please keep her here. THANK YOU!!"

Challenges/barriers:

We have encountered the following operational challenges/barriers to implementing the project as originally described in our scope of work:

- It is difficult to identify a time and venue for cross-clinic communication that is convenient for all participating practices. We are working with the CCO and CGHC to identify additional opportunities to share best practices, successes, and challenges.
- We had intended to disseminate project goals and engage support for integrations through presentations at all-staff meetings. While two practices have been able to share information on this project during *all-provider* meetings, few if any of the practices have standing all staff meetings. We are currently working to identify how practice changes are communicated across these settings, to use these mechanisms for sharing about this project, and to begin discussions with the CFIT teams about the importance of a standing structure to educate and engage all practice members in change initiatives.

In addition, practices have identified various key challenges around funding for integrated care at their sites:

> *I see a current need for access to Medicaid funds to support treatment provided within our clinic. For those of us who serve multi-payer populations, we need help negotiating with insurance companies and Medicare so that we can receive financial support to provide equitable care to all our patients.*

> *There needs to be funding for services across the board with insurance companies. Access to Medicaid funds and negotiating a payment mechanism for behavioral health services with our commercial PacificSource contract would be a great starting point.*

What have you shared about your projects with other CCOs and what would you like to share?

The InteGreat project was featured in a poster session at Oregon's Coordinated Care Model Summit: Inspiring Health System Innovation (Dec 3-4, 2014) in Portland, OR. The audience included more than 1,000 participants from around the state, with plenary session presentations by Governor John Kitzhaber and Don Berwick, MD, Former

Administrator, Centers for Medicare and Medicaid Services
and Founding CEO, Institute for Healthcare Improvement.

In addition, UCD and ORPRN are engaged in multiple projects that address behavioral health integration, including a Transformation Grant for the PacificSource Central Oregon CCO to assess integration efforts and increase data infrastructure of six primary care practices (three from St. Charles Health System and three from Mosaic Medical) and ORPRN's work with the Oregon Health Authority's Addictions and Mental Health Division and Office of Health Analytics on the Behavioral Health Home Learning Collaborative. ORPRN and UCD are also leads on the national Behavioral Health Integration Action Group of the CMS Comprehensive Primary Care Initiative, and ORPRN is an active member of Oregon's Integrated Behavioral Health Alliance working group. Additionally, UCD and ORPRN team members collaborated on a study of exemplars of integrated care and are working to prepare a "how to" journal supplement that will be published in Fall 2015.

Because of the similar goals of these ongoing integration efforts, sharing of progress either during or after completion might prove to be mutually beneficial.

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).

Practices have requested additional data and/or research that shows the long-term benefits of integrated care to patients. This information will be valuable to build a case for support of integrated models by insurance companies:

> *If behavioral health services enable positive health outcomes in addition to decreasing healthcare costs from an insurance company perspective then we are more likely to reach agreements. We need assistance proving the value to an insurance company's bottom line.*

In addition, our team has observed that practices continue to struggle with limited ability to share electronic health records between physicians and behavioral health providers when services are co-located or coordinated. Additional training in health information technology and regulations around confidentiality and record sharing would be helpful. Understanding how other CCOs have managed partnerships and HIPAA requirements between collaborating clinics/mental health agencies could be beneficial.

One of the challenges of this project has been consistently informing the rest of the CCO on integration activities. Practices who are interested in integrating care, but are not involved in this effort would benefit from shared learning. Since the goal is a more robust infrastructure for the CCO, others across the CCO may find great benefit from what is working and what is not as these practices build infrastructure and capacity for

integration. Future efforts with this project should better engage non-participating practices to help spread lessons learned across the CCO.

Project 7
Name of Project: Proactive Identification of High-Risk, New CCO Members
Project Team Lead: PacificSource Columbia Gorge CCO

Overview of activities/progress made:
PacificSource is implementing activities in both Central Oregon and the Columbia Gorge to optimize Members' utilization, experience and continuity of care within the CCO. Goals include: member engagement in care through outreach and education, PCP care establishment and proactive identification and outreach to our highest risk/highest needs members. The activities of this project are tailored to the needs of the Gorge CCO.

Strategic Outreach to High Risk New OHP Members:

- Development of multiple claims analysis techniques to identify new members demonstrating concerning patterns of utilization, such as the Emergency Department visits in the absence of primary care visits as well as more-complex risk predition algorhythms.
- Planning to disseminate such lists in primary care homes in coordination with Columbia Gorge Health Council support of CMS "Coverage to Care" materials. .
- PDSA design of outreach to identified members to facilitate establishment of care with assigned PCP, education on appropriate use of Emergency Department, opportunities for preventive care QIM's and OHP renewal, as applicable.
- Columbia Gorge Health Council Finance Committee decision to redirect previous plans of incentivizing high risk new members to establish care with PCP when an initial PDSA yielded a very low response.
- Study of Patient Activation Measure (PAM) as a meaningful metric of member engagement.
- Consultation with other CCO's experienced in successful use of incentives to drive member behavior for preventive care.

Member education and orientation to OHP benefits
Video: Production of 3-part video series

- Video 1: "Understanding your Oregon Health Plan Benefits." Covers what to do with their OHP and PacificSource member ID cards, how to find who their PCP is, covered benefits, and contact information if they need help or have questions.
- Video 2: "Your Primary Care Provider." Covers where to find who their PCP is, changing their PCP twice per year, importance of preventive care, how to make an appointment, and interpreter and transportation services available to members.

- Video 3: "Know where to Go for Care." Covers the benefits of going to their PCP when sick or hurt, promoting urgent care over ER, and enforcing that their PCP should be their first call for any medical needs or questions.

Video scripts and topics were designed to appeal to a multi-cultural, 6th-grade literate audience and will be available in both English and Spanish. Feedback was obtained from a variety of stakeholders including subject matter experts at PacificSource (e.g. customer service, operations representatives, community health, communications), as well as external stakeholders that have experience with and understand common OHP consumer questions and misperceptions (including area enrollment assisters, Community Advisory Council (CAC) members and members of the Hispanic/Latino community. The series will be produced professionally and available for distribution on January 30th. All videos will be live on PacificSource's website and distributed through various channels, including: 1) thumb drives, with the link pre-loaded, handed out at community events and at various clinics and locations; 2) a link to each video loaded onto tablets and given to pilot sites in PCP clinics and social service venues where their viewing by OHP members will be facilitated. 3) promoted online via social media, newsletters, and the PacificSource website.

Print Materials: Materials will complement the look and feel of the video series.

- Illustrated stories: Spanish only, targeted to Hispanic/Latino community. Comic style, illustrated short tales are culturally familiar to Hispanics and Latinos of all ages. This method of communication has been used successfully by health educators to champion important health messages. This story will mirror characters in the video. It touches on preventive services and the renewal process using images and scenarios to tell the story. The pamphlets and posters will be posted online and distributed through community partners.

Outcomes/successes:
- Member Engagement Coordinator hired in late September, 2014
- 3 videos produced with dissemination scheduled for January, 2015, via multiple community partnerships.
- Identification of members with ED utilization but no PCP visits since 1/1/2014 is complete, finding 70 such members new to PacificSource OHP since 1/1/2014 and 59 such members who had PacificSource OHP prior to 1/1/2014. These are being prioritized for our high-utilizer intervention.
- New reports identifying high-risk members complete January, 2015, for dissemination to providers.

- 200 licenses secured for Patient Activation Measure, to be applied to multiple projects. Training on PAM scheduled for January 14, 2015.
- PDSA cycle completed, cross referencing new members identified with ED visits, but not PCP visits with OHP renewal deadlines and Quality Incentive Measure opportunities for targeted outreach, yielding few actionable responses. About half of identified members could not be contacted due to missing or inaccurate information.

Challenges/barriers:
- This project is comprised of many components, requiring an exceptional amount of administration resources.
- CCO operations in two regions; e.g. identifying efficiencies and ensuring organizational responsiveness to local conditions.
- Logistical challenges in working with multitude of internal and external partners
- Multimedia strategies required new systems and organizational capacity to develop infrastructure to evaluate distribution methods.
- Recruitment and training of staff position dedicated to this project took longer than expected.
- Very high degree of inaccurate contact and demographic information for OHP members has limited our ability to conduct focused interventions.
- No apparent response to incentives from members. Reasons not understood.
- Difficulty of reconciling lists of members due for OHP renewals with enrollment files to determine which members, due to redetermine, successfully did so.
- Accuracy and meaning of the field "term date" in redetermination files and clarity of renewal process.

What have you shared about your projects with other CCOs and what would you like to share?:
- We will be eager to share our successes and failures as we proceed with this project and learn from our experiences.

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support):
- This project includes substantial efforts to use membership enrollment and claims data to inform strategic, targeted interventions. In multiple iterations, our outcomes are significantly diminished by a high degree of inaccuracy in member phone numbers, addresses, preferred languages, race and ethnicity. When possible, we have tried to partner with providers whose information is often more-accurate than what we receive from OHA. While we appreciate the more-transient nature of the OHP population, in which accurate contact information is difficult to maintain, we hope that the redetermination process will be a vehicle to update this going forward. It would also be helpful if more-accurate information collected from Providers and CCO's could more easily be used to update enrollment

information without being overwritten by membership files containing the inaccurate information.

Project 8
Name of Project: Chronic Pain Strategic Initiatives [for Providers]
Project Team Lead: Mid-Columbia Medical Center

Overview of activities/progress:
From October 1 to December 11 2014, we provided 11 educational presentations to 190 primary care providers and allied health workers throughout Hood River and Wasco counties. We provided clinics with opiate management strategic initiatives which reflect current best practices as well as a "tool kit" with information to assist providers accomplish best care practices.

In addition, we worked with PacificSource Community Solutions to implement opiate utilization management strategies to limit the quantities allowed on December 1st. These quantity limits were based on the daily morphine equivalent and applied in the PacificSource claims configuration system.

Objectives:
- To limit and to reduce the quantity of prescriptions and quantity of tablets dispensed for narcotic/opiate medications.
- To reduce the overall prescription cost and to reduce the prescription cost associated with narcotic/opiate medications.
- To reduce overall healthcare costs and healthcare utilization in chronic pain patients
- To reduce the incidence of addiction to prescription narcotic/opiate medication and to reduce the risk of complications including death from overdose.
- To assure that non-pharmacologic therapies are integrated and maximized before starting and while prescribing chronic opiate therapy.
- To improve function capacity and quality of life in chronic pain patients
- To reduce the incidence and risk of diversion of narcotic/opiate medications
- To enhance education and understanding of current concepts, guidelines, and risks of chronic opiate therapy amongst primary care providers in the region.

Outcomes/successes:
We have been able to create a successful collaboration between our community providers and PacificSource Community Solutions to encourage best practices related to opiate prescription management and reflect those best practices in the claims adjudication system. In short, prescription management strategies have been implemented to ensure that the quantity of opiate tablets allowed meets the community standards for safety & efficacy.

Challenges/barriers:

It was necessary for PacificSource to implement the new opiate management policies across all of the regions they serve. This required collaboration with the Central Oregon CCO, which is also served by PacificSource. While ultimately successful, it did take additional time to implement.

What have you shared about your projects with other CCOs and what would you like to share?

We hope to share successes with other CCOs and suggest statewide initiatives to reduce and limit opiate burden in our communities.

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Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).

We would like to meet with representatives from other CCOs that may have ongoing projects related to opiate management strategies.

Project 9
Name of Project: Emotional Literacy Training
Project Team Lead: County of Wasco

Overview of activities/progress made:

- This past 6 months has concentrated on establishing the protocols for the Boot Camp phase of the project.
- Project Coordinator received ASQ and ASQ-SE training and met with the developers of ASQ Oregon.
- ASQ Oregon and the University of Oregon have agreed to enter into an agreement where our project will have the ability to be tracked through their system.
- Made additional connections with Trauma Informed Oregon (Portland State University) to begin a possible partnership with including ACE's into our Boot Camp lesson plans.
- Met with Dr. Kristen Dillon to begin dialog with Hood River physicians.
- Established connection with Next Door, Inc. to assist in recruitment of Boot Camp parents.
- Presented at the Making the Connection Conference in Eugene, Oregon where we were also able to share our efforts with ASQ Oregon and Trauma Informed Oregon. We were told that this project was shared with the Governor.

Outcomes/successes:

- 200 English/Spanish Emotional Literacy Posters produced and will be distributed to The Dalles and Hood River Elementary Schools as well as Early Intervention classrooms.

- Over 10,000 direct mail cards were sent to residents of Wasco and Sherman Counties. Began contract with Act-On for CRM work to track engagement of participants.

Challenges/barriers:
The new partnerships with the University of Oregon and Portland State University have slowed our progress down just a bit in that we have had to make sure we had additional protocols in place but overall those challenges are turning out to be big pluses in the additional attention the project is receiving.

What have you shared about your projects with other CCOs and what would you like to share?:
We shared project highlights at the Making the Connection Conference in Eugene where several CCO representatives attended. We are eager to share results after our first Book Camp completion.

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support):
We have received a request from Mark Thomas to help with our project and we will be following up with him. He has been very supportive.

Project 10
Name of Project: Maintaining Continuity of Oregon Health Plan Member Enrollment
Project Team Lead: PacificSource Columbia Gorge CCO

Overview of activities/progress made:
PacificSource is implementing activities in both Central Oregon and the Columbia Gorge to optimize OHP enrollment continuity. We have employed several approaches to help our members navigate the OHP renewal process as successfully as possible in the Columbia Gorge.
- *Eliza* - a health information management platform delivering interactive voice response (IVR) reminders to members nearing their redetermination deadlines. This technology refers members to the OHA call center or to a PacificSource customer service team member who then triages the member to local enrollment assisters who are available to help complete the application process.
- *Provider engagement:* Through the regular dissemination of OHP member renewal files, many CCO contracted providers have been willing to provide personalized outreach, prompting members to renew coverage and offering assistance when possible.
- *Enrollment Assisters*:
  - Connection with Columbia Gorge enrollment assisters, who have been instrumental in providing updated information around OHP renewals, assisting members through the process, and informing and vetting educational materials created by PacificSource.

       o   Contracted with a high-performing enrollment assister, who was otherwise unfunded on OHP to focus on renewal efforts.

Outcomes/successes:

We compared redetermination files with current membership files, to identify which members have successfully redetermined and renewed their OHP coverage. Our best approach to identifying members who have successfully renewed is by searching our 820 and 834 files to identify recent enrollment start dates. Members who are considered currently enrolled have an enrollment start date and no enrollment termination date in the 820/834 reconciled files. Future termination dates are listed in Medicaid Redeterminations files provided by OHA.

We believe it is possible that some members with termination dates listed in the redetermination files may have not had paperwork processed yet at OHA to have a term date. Therefore, it is possible that the number of members who both re-enrolled and who termed are potentially underreported at this time and are highly susceptible to delays in form processing at the state.

Without certainty of this dynamic at the state, our best analysis of the wave of members whose coverage was scheduled to close on 10/31/2014 without successful redetermination appears as follows:

# of members whose coverage was scheduled to close on 10/31/2014 without successful redetermination	**3,581**
% currently enrolled	**78.8%**
# currently enrolled	**2,823**
% enrolled after Sep 2014	**6.8%**
# enrolled after Sep 2014	**244**
% enrolled after Oct 2014	**6.8%**
# enrolled after Oct 2014	**243**
% termed (no longer enrolled)	**21.2%**
# termed	**758**

Amongst this group of members, PacificSource used telephonic interactive voice response to reach out to 1117 members age 18 and older. Members had the option to confirm/select their preferred language, confirm their identity, receive more information and be transferred to a customer service agent for additional help. The preliminary analysis of that work, when compared with recent OHP enrollment files show the following:

Population	Result	Analysis
Members age 18+ attempted	1117	31% of members whose coverage was scheduled to close on 10/31/2014 without successful redetermination
OHP renewal message delivered	810	73% of attempted
OHP coverage continued	611	55% of attempted 75% of those to whom the message was delivered
Member reported "renewed"	154	19% of those to whom the message was delivered
OHP enrollment files show renewal	135	88% of members who reported "renewed"

In addition, the following information was gathered from members in response to questions asked. Responses are reported by Eliza from their outreach to OHP members across both PacificSource CCO's from October through December, 2014. Percentages are amongst those reached, excluding those for whom any message was delivered, on voice mail or an answering machine. Thus the variance from the table above.

Question	Choices	English	Spanish
Have you received these materials yet?	YES	50.4%	57.7%
	NO	49.6%	42.3%
Have you renewed your coverage yet?	YES	45.7%	44.8%
	NO	54.3%	55.2%
Are you planning to renew your coverage?	YES	89.2%	91.9%
	NO	10.8%	8.1%
Is this your correct address?	YES	67.3%	73.5%
	NO	32.7%	26.5%
Would you like me to transfer you now?	YES	56.8%	66.7%

	NO	43.2%	33.3%
Would you like us to have someone call you back?	YES	49.1%	83.0%
	NO	50.9%	17.0%
Did you find the information in this call valuable?	YES	69.7%	93.9%
	NO	30.3%	6.1%
Would it be okay if we send you an email with this information?	YES	38.2%	28.6%
	NO	61.8%	71.4%

We are taking particular note of the following as we learn about the needs and preferences of our members and differences between ethnicities:
- Only 26% of the Spanish population had correct addresses vs the 33% for the English population.
- 67% of the Spanish population wanted to transfer to Customer Service vs 57% of English
- 83% of the Spanish population wanted someone to call them back vs 49% of English
- 94% of the Spanish population found the Eliza portion of the call valuable vs 70% of English
- More of the English population wanted the information via email (38%) vs Spanish (29%).

Challenges/barriers:
- CCO operations in two regions; e.g. identifying efficiencies and ensuring organizational responsiveness to local conditions.
- Logistical challenges in working with multitude of internal and external partners.
- Complications and complexities related to OHP re-enrollment; e.g. high percentage of inaccurate contact information for members, continual changes to renewal process and parameters communicated from the State, challenges to provide accurate renewal information and updates to community partners, difficulties in developing internal systems to manage and measure the renewal process.
- Long wait times for members and enrollment assisters when contacting OHA/CoverOregon call centers has been reported as a significant barrier to timely re-enrollment
- Enrollment assisters report members are commonly misplacing their expedited renewal forms, requiring them to attempt to renew via telephone or to complete a full application.

- Enrollment assisters report member Confusion as to who is included to renew on the expedited renewal form, when the form is due back to OHA, and when benefits would close.
- Transition to healthcare.gov introduced complexities and delays in processing renewals.
- Communication barriers and unclear division of labor between OHA call center and CoverOregon resulted in difficulty confirming member renewal status.
- Member who wanted to proactively renew their coverage have not had clarity that their efforts have been successful.

What have you shared about your projects with other CCOs and what would you like to share?:
- We will be eager to share our successes and failures as we proceed with this project and learn from our experience.

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support):
- It would be very helpful if OHA would provide data at a member or CCO level that could guide future strategies and track progress. For example, adding termination dates to 834 files so that members due to renew can be anticipated and proactively supported by their PCPCH and their CCO. It would also be helpful if OHA could share with CCO's the reasons, broken down by percentages, that members do not redetermine successfully. This would allow us to understand if a member lost coverage because they did not submit an application, if they lost coverage because they were no longer eligible for OHP coverage with PacificSource, or if they gained coverage with a different CCO and therefore redetermerined successfully.
- We encourage OHA to thoughtfully and swiftly implement the recommendations of the Medicaid Advisory Committee (MAC) in their August 2014 report, Addressing Churn: Coverage Dynamics in Oregon's Insurance Affordability Programs., and the subsequent 1/9/2015 memo from the MAC, *Renewal and Reenrollment in Oregon Health Plan (OHP) for 2014/2015.*

Project 11
Name of Project: Intentional Peer Support
Project Team Lead: Columbia Gorge Health Council

Overview of activities/progress made:
- One week course held in late October.
- 23 registered participants, 21 attended.
- 6 different agencies were represented.
- Post training follow up meetings have not yet been set.

Outcomes/successes:

- A broad cross section of participation attended the training.
- 2 participants are candidates of advanced certification to allow them to host classes in the future.
- Very positive feedback from class participants was received.
- Participants voiced that the class gave them increased skills and left them feeling personally enriched by being able to attend the training.

Challenges/barriers:
- We are still clarifying how the graduates of this program can be most productively integrated into local care, and what agency or agencies will be able to employ and or supervise them in this capacity.
- We would like to continue to bring this group together for continued connection in a self-sustainable way.

What have you shared about your projects with other CCOs and what would you like to share?
- We will be eager to share our successes and failures as we proceed with this project.

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support):
- None needed at this time.

Project 12
Name of Project: Community-Wide Health Information Exchange Support and Development
Project Team Lead: Columbia Gorge Health Council

Overview of activities/progress made:
- Engagement with Gorge Health Connect and Columbia Gorge Health Council
- Joint agreement to utilize Jefferson HIE platform
- Mid-Columbia Medical Center project planning for HIE interfaces started
- Project planning for secure email in 8 clinics, 2 hospitals and 2 health departments started
- Review and selection of Ahlers and Assoc for Hood River County Health Department EHR, to bring all clinical services into an HIE-compatible platform.

Outcomes/successes:
- Registering providers and partner organizations. Nine organizations on 1st wave of registration process.
- Hood River County Health Department successful go-live on Ahlers EHR 11/19/2014.

Challenges/barriers:
- Navigating the simultaneous development of EDIE and MCMC's conversion to OHSU Epic platform
- OCHIN's willingness to adopt HIE systems outside 'their own'
- Ongoing monthly service charges from vendors after identified funds are exhausted
- Software development timelines and ability to conclude by June 30, 2015

What have you shared about your projects with other CCOs and what would you like to share?
- We will be eager to share our successes and failures as we proceed with this project

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support):
- Meeting scheduled for TA follow up in early January, 2015.

Project 13
Name of Project: Year One Continuation of Community Health Team Effort to More Effectively Manage Historic and Predicted High Users of Health Care Services
Project Team Lead: The Next Door, Inc.

Overview of activities/progress made:
- Phase I was completed with initial set-up and program foundation created to initiate Phase II of Community Health Team (CHT).
- Original project manager resigned to pursue higher education and a part time project manager has been hired.
- Phase II of the project is well underway; as of January 1, 2015, 36 patients are currently or have been enrolled to receive CHT program services.
- Home/office visits with patients and exchange of information and communication with Primary Care Providers and social service providers is ongoing.
- Weekly CHT meetings take place for ongoing management of program and coordination of services.
- Monthly Systems Implementation Team (SIT) meetings take place with eight partners to help address systemic barriers faced by CHT and community members utilizing various systems of care. SIT is hoping to add a consistent presence of representatives from agencies that address the social determinants of health as they relate to the needs of CHT program participants.
- Partnership with COIPA to utilize Patient Activation Measures (PAM) tool has been established. A Use Agreement was signed 1-5-15 between NDI and COIPA for the use of 120 instruments of measure for CHT program participants.
- Training on how to implement secure email and referral system for improved communication among community partners occurred in 1-6-15. Implementation of secure email is projected in next few months.

Outcomes/successes:

 Referral pathways and clinic workflows have been established and improved for maximum effectiveness including direct referrals from PacificSource.

- A "Systems Implementation Team" has been convened to ensure the integration and success of the Community Health Team and other case management programs for the highest needs CCO members.
- The success of the CHT included the changes it is helping to bring about on the systems' level, not only in individual patients' lives, including:
  - ED utilization feeds established to clinics (resulting in 100% follow up at FQHC)
  - Clinic/agency contact information shared (enabling early referral notification and collaboration with PCPCH's)
  - Referral workflows shared (improving identification of eligible patients, ROI steps, and coordination of care with PCPCH's)
  - Opportunity to make use of existing case management programs (CaCoon, APD, Palliative Care, adding more)
  - Improvements to Complex Care reports shared (resulting in more effective use of list for all high-risk patients, beyond T200)
  - Barriers identified in Medicaid coverage for: (both topics are being raised at the CGHC CAP and within PacificSource for evaluation)
  - Physical Therapy and Occupational Therapy
  - Specialty Care for Pain
- CHT has received 77 referrals, of whom:
  - 28 are currently enrolled in program
  - 8 participants have graduated from the CHT
  - 19 individuals have refused services
  - 18 patients are pending
  - 4 were inappropriate referrals (those who are not on the T200 list or moving out of the area shortly)
- Average time from enrollment to care plan submission is 23.5 days.
- Primary Care Show rate for patients enrolled in CHT is 87%
- Behavioral Health Show rate for patients enrolled in CHT is 89%
- Pre-post claims data on ED utilization, IP utilization, and risk score pre-post data on enrolled clients is pending sufficient claims run-out and analysis. This information will be included in the final transformation grant report in July.

Challenges/barriers:
- Six months of start-up time was needed to build relationships with partners leading to a slow start up and lower patient load than anticipated.
- Co-location (BAA related issues) at One Community Health was not possible, resulting in further slowing down the implementation phase of the project.
- Inappropriate referrals took time from enrollment of appropriate referrals.
- Initial slow referral rate from providers as providers began to learn about the CHT.
- Coordination between service providers providing care for the same patients is often lacking.
- Despite member consent for referral, a significant number of members (~20%) have refused enrollment. We are working with partners to understand how the intervention can be best presented and a "warm handoff" ensured to gain member engagement.

What have you shared about your projects with other CCOs and what would you like to share?
- We will be eager to share our successes and failures as we proceed with this project. A collaboration with COIPA has led to free utilization of PAM for enrolled CHT patients, which will be one outcome measure worth sharing.

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support):

- The CHT is working with PacificSource to identify outcome measures and develop an appropriate database. Other assistance that would be helpful and appreciated is assistance with coordinating care meetings with different agencies dealing with the same patient. We are grateful for Columbia Gorge Health Council assistance in coordinating the SIT meetings. Other communication and technical assistance provided thus far has been greatly appreciated.

Project 14
Name of Project: Persistent Pain Education Program [for Patients]
Project Team Lead: Mid-Columbia Medical Center

Overview of activities/progress made:
We recently completed the fifth cycle of the 8-week Persistent Pain Education Program presented in 2015. At this time over 100 individuals have completed at least one of the classes offered this year. The presenters have refined their presentations such that each successive class builds on the last one and we are consistently referencing other presenters' key points in order to "tie it all together" for the students.
We have collaborated with the Central Oregon Research Coalition as well as Katie Corson and they have provided input regarding data collection and outcome measures. Based on their recommendations, we changed from using the Beck Depression Inventory

to the Multidimensional Health Locus of Control-Form C as one of the three outcome measures we are using. We are also changing from using the full CPAQ to the briefer CPAQ-8.

Outcomes/successes:
Including this current cycle of PPEP, we have had 100+ people dealing with chronic pain come to all of or some of the classes. The most recent class cycle had the best showing so far (20+ attendees per class for first two classes), in part due to improved marketing of the program.

 We now have a webpage devoted to the Persistent Pain Education Program. Patients can peruse the course outlines, register for classes and watch complete videos of all eight talks here: http://mcmc.net/News/1193/persistant-pain-education

Summary of Outcome measures:
- 26.3% of class participants had a clinically significant improvement in their Brief Pain Inventory score reflecting decreased pain levels with ADL's
- 31.3% of class participants had a clinically significant improvement in their Beck Depression Inventory
- Average change in score for the Chronic Pain Acceptance Questionnaire was 5.61 point improvement
- Multidimensional Health Locus of Control: Largest change in score occurred in the "Internal" locus of control category. Internal locus of control is considered to be the most beneficial.

Challenges/barriers :

(The following references challenges that were identified in the 6/30/14 Progress Report)
- Data collection: Getting complete data sets from patients continues to be a challenge. We successfully received final outcome measures from all attendees of the last (eighth) class of the most recent PPEP cycle. However, since attendance was poor at that final class, we still received only five complete data sets.
- Marketing:
1. We have identified and marketed to all Gorge providers with the help of MCMC's Sharla Weber. She has taken informational pamphlets to all medical provider offices in Hood River, Wasco and Sherman counties. Our latest outreach efforts have targeted the more rural areas. The plan is that those clients that live at a great distance from The Dalles can still be given information by their PCP's that helps them find the online version of the classes.
2. We gave an Evening Lecture Series presentation on 12/9/14 to approximately 50 local providers. People in attendance included MD, FNP, PA, Psychology, Counseling, Massage Therapy, Occupational Therapy and Physical Therapy professionals from multiple settings. The evidence base for pain neuroscience education was presented along with a version of the Explain Pain talk (the first lecture in the 8-week series). By increasing providers' awareness of what this program is about, we expect to see increased referral numbers in 2015.

3. We will be giving a joint talk regarding Pain Management to providers and the general public in February, 2015. Ongoing educational outreach to the general patient and provider population continues to increase the visibility of the program.

- We need to target this PacificSource population better. Increasing marketing to One Community Health should help us gain more referrals of this specific population of covered lives.

What have you shared about your projects with other CCOs and what would you like to share?

I am currently in touch with Mary Wells, LCSW, who is a key member of the central OR CCO's progressive chronic pain educational program. As of the writing of this progress report, we have simply made email contact but will plan on sharing information regarding the programs in 2015. My main focus is to learn what data they are capturing, how successful they are at capturing complete data sets and strategies they use to insure patient compliance with completing the paperwork.

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g., site visit, conference call, webinar, or another form of support):

The support we have received from the Central Oregon Research Coalition has been very helpful. They helped identify a more appropriate outcome measure for our population, gave advice on how to be more successful in capturing data from patients and also partnered me with a regional graduate student who performed data analysis for this program.

Katie Corson has been instrumental in helping us select outcome measures that are brief, appropriate to the reading level of our students and that capture change in the domains that we are interested in tracking. She also put me in touch with the Central Oregon Health Council and we will plan on furthering our conversation in 2015.

Project 15
Name of Project: Clinical Pharmacy Services Project Phase II
Project Team Lead: Providence Hood River Memorial Hospital and Once Community Health

Overview of activities/progress made:
At Providence Medical Group:
- Providers and clinical support staff have received education regarding MTM services and the goals of the PacificSource Demonstration project.
- Additionally, an EMR based referral system has been established to support identification and communication of patient needs between provider and pharmacist.
- All 27 of referred PMG patients have been mailed an introductory letter regarding the MTM program and have received a phone follow-up call offering services when a current phone number is available.

- The Emergency Department, Inpatient Departments, and Ambulatory Areas of the hospital are screened twice weekly for PacificSource project patients with current or future appointments. Every effort is made to contact the patient in person while on campus to offer MTM services and set up an appointment. To date, this has been the only successful means of establishing care.
- Private visitation space to conduct patient encounters has been obtained at the Providence Hood River Hospital directly off of the main lobby, and at both the Family Medicine and Internal Medicine Clinics.
- To date six out of 27 patients PMG patients have agreed to MTM services and presented to at least one visit with the pharmacist.
- The Pharmacist attended a Family Medicine clinical staff meeting in October and an Internal Medicine staff meeting in December 2014 to further discuss the goals of the MTM program and solidify an electronic communication process.

At One Community Health:
- A telephonic referral system has been created between One Community Health and Providence Clinical Pharmacy Services via a specific OCH RN coordinator.
- OCH RN staff have received education regarding Providence provided welcome packets, requirements of program, chart review, required labs/clinical metrics, and phone consultations.
- Providers presented with program overview and completed a pre-program survey.
- Private visitation space to conduct patient encounters identified in Hood River and The Dalles clinic locations.
- Five team RNs manage patient lists provided by PacificSource to contact patients about the program, assist with pre-participatory lab work, and facilitate referral process.
- Difficulty exists in identifying interested PacificSource patients that are actionable with set forth criteria, so alteration to process includes elimination of pre-lab work and open enrollment to any patient that could benefit from service. All clinical staff notified of changes in process to enhance number of referrals made.
- One RN assigned to oversee the entire program/process to simplify patient identification and referral.
- Lead project RN has shadowed the Providence Pharmacist and staff during a patient visit at Providence to ensure full understanding of program, visit flow, encounter goals.

- Clinical Support Director has consulted with Columbia Gorge Family Medicine to learn from successful referral process and identify differences between the OCH process.
- An attempt made to have an OCH RN shadow the Columbia Gorge Family Medicine staff member responsible for this program was unsuccessful due to their completion of the current program and no further patients left to contact regarding the demonstration project.
- The Providence Clinical Pharmacist attended a medical provider meeting in December 2014 to discuss the MTM program and further establish rapport with providers.

Outcomes/successes:

A total of eight unique patients have been seen by the pharmacist in an outpatient setting. From these visits an average of six clinical interventions were completed per patient. Of these interventions, the acceptance rate, by either the patient or the provider, was 85%. Intervention categories included the following:

- Medication Therapy Change, D/C Med
- Medication History
- Adverse Drug Event Prevention Major
- Lab Ordered
- Drug Information Given
- Education- Patient
- Medication Use Evaluation

Challenges/barriers:

Earlier reported barriers regarding electronic documentation and transfer of information between hospital and clinic EMRs have been resolved. A new ambulatory pharmacy department has been built within the Providence Epic system to support this. Appropriate meeting space for visitation with patients has also been determined for all clinic sites as well as the Providence Hood River Hospital.

Ongoing challenges are significant and the net effect of these has resulted in enrollment of far fewer patients than the targeted goal. A total of 253 unique patients have been referred by PacificSource to their respective clinics (27 Providence Medical Group, 226 One Community Health). Of these, only six PMG patients and two OCH patients have been scheduled and presented for their appointments with the pharmacist. A list of identified barriers to successful patient care appears below.

- Limited patient motivation to participate, due to any combination of barriers. These barriers have included lack of transportation, limited social support in the home environment, overpowering life events, mental health, motivation, health literacy, and availability based on the patient's work schedule/commitments.

- A majority of patients lack of pre-existing relationship between the pharmacy provider and patient.
- Currently there is a very high cancellation rate for scheduled patients. Reasons stated by patients include lack of transportation, illness, and weather related concerns.
- Limited overlap currently exists in patient and pharmacist scheduling. The pharmacist is typically only available to provide MTM services one day per week. Because of this it is difficult to coordinate pharmacy visits with patient visits to their provider. In addition, this limits the opportunity for a warm handover from provider to pharmacist.
- To date there has been a very low rate of response to the voluntary survey (Appendix B).
- The provided PacificSource list of patients contains a large amount of dated information to include inaccurate phone numbers and patients who have terminated care with the listed provider.
- The lack of a physician driven referral system until very recently may have slowed the patient enrollment process.
- One Community Health cites inadequate staffing resources as a limitation.
- At OCH, the pharmacist operates outside of the team-based care model and has no access to the internal OCH medical record.
- A means for actively engaging patients prior to "cold call" by the RN at OCH does not exist.
- Duplication of calls to patients for multiple competing health projects discourages patient utilization of the program.
- Patients with high no-show rate less likely to attend set appointment time with new and unknown pharmacist. OCH recommends PDSA cycle of open access model for warm –hand off by medical teams to on-site pharmacist

What have you shared about your projects with other CCOs and what would you like to share?
An ongoing partnership with Clinical Pharmacy partners at Providence Health Plan and Providence Medical Group in the Oregon Region has allowed for shared resources in policy and procedure development surrounding MTM, streamlining of patient documentation, sharing of clinical successes, and provided assistance with troubleshooting barrier removal. This partnership will continue and expand, further supporting the goals of the CCO. The OCH Clinical Support Director has consulted with Columbia Gorge Family Medicine (CPS Phase I) to learn from successful referral process and identify differences between the OCH process.

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).
This is not currently a barrier to patient care.

Project 16
Name of Project: Network Coordination for Cross Agency "Hub"
Project Team Lead: Columbia Gorge Health Council

Overview of activities/progress made:
- 501(c)3 application completed, submitted and tax exempt status awarded.
- Applied for and received PacificSource Foundation grant.
- Applied for but did not received NW Health Foundation Grant.
- Project Manager, Suzanne Cross hired and in place with Columbia Gorge Health Council.
- Registration in progress with Federal Government for HRSA grants.
- Domain name obtained for B2health.org and bridgestohealth.org.

Outcomes/successes:
- Strong participation and commitments from over 20 regional agencies, across sectors of health care, housing, social services and education (including Early Learning).
- With Project Management in place, we plan to convene the steering committee and implementation team starting in the next quarter.
- We are closely shadowing another Transformation Project, Community Health Worker Capacitation Center to observe barriers encountered while working on cross organizational issues such as data sharing, as the network hub is likely to encounter similar barriers.

Challenges/barriers:
- We currently have the ability to get basic referral and attendance data shared between various agencies and PCPCH's with PacificSource in a very manual way. However the challenge will be getting a system in place to make the process less manual and more seamless for all participants.
- The creation of a legal Release of Information (ROI) that is accepted cross organizationally as well as by the community population is challenging.
- The ROI will be seen as a request for services and will be received with the expectations of true coordinated care. Meeting those expectations from the beginning will be vital to the adaption of the project.

What have you shared about your projects with other CCOs and what would you like to share?:
- We will be eager to share our successes and failures as we proceed with this project.

Any technical assistance you would like to receive to support your project, and how would you like to receive this assistance (e.g. site visit, conference call, webinar, or another form of support).

- We would benefit from knowing if other CCO's have implemented a cross agency release of information and if examples could be shared. We would be particularly interested in legal and also plain language versions of those.

CONCLUSION:

Is there any additional information you would like to share with the Transformation Center about your projects?

We would like to share the following overall themes:

- Delays in project implementations, as cited in 7/15/2014 report, the introduction to this report will make complete expenditure of grant funds by 6/30/2015 challenging or even impossible for some projects. A no-cost, six-month extension would allow the Transformation Grant to deliver its full impact, as intended.
- Several projects have experienced need for project management, evaluation and reporting skills beyond the degree originally anticipated.
- By contracting with Central Oregon Research Coalition (CORC), PacificSource Community Solutions was able to develop high-quality evaluation plans for selected projects.
- Several projects have discovered a lack of capacity to conduct comprehensive evaluation. Further consultations with CORC and PacificSource's data analytics team confirmed that these projects would require some level of technical assistance to accurately capture, analyze and report project data.
- Several projects whose evaluation plan involves claims data will require a significant amount of time to analyze and report outcomes. For example, many of projects are using a 6 months pre-post methodology, plus an additional 3 months for run-out of claims data. This means that outcomes in claims for someone who became enrolled in a transformation grant-funded project today could not be analyzed until 9 months from today, at the very earliest.
- The portfolio manager has assumed more project management and technical assistance than was originally anticipated in order to ensure the success of all projects.
- As the transformation grant has funded the implementation of numerous new services for OHP members, we have discovered new challenges: making room for innovative practices within the traditional structure of the health care delivery system and gaining the engagement and consent of members who are offered the services.
- It would be very helpful if the Transformation Center could share examples of these transformation grant reporting materials from other CCO's.