Umpqua Health Alliance

TRANSFORMATION

Report to House Health Care Committee
June 17, 2015

1813 W. Harvard, STE 448
Roseburg, OR 97471

p. (541) 464-4300
f. (541) 440-6306

www.umpquahealthalliance.org

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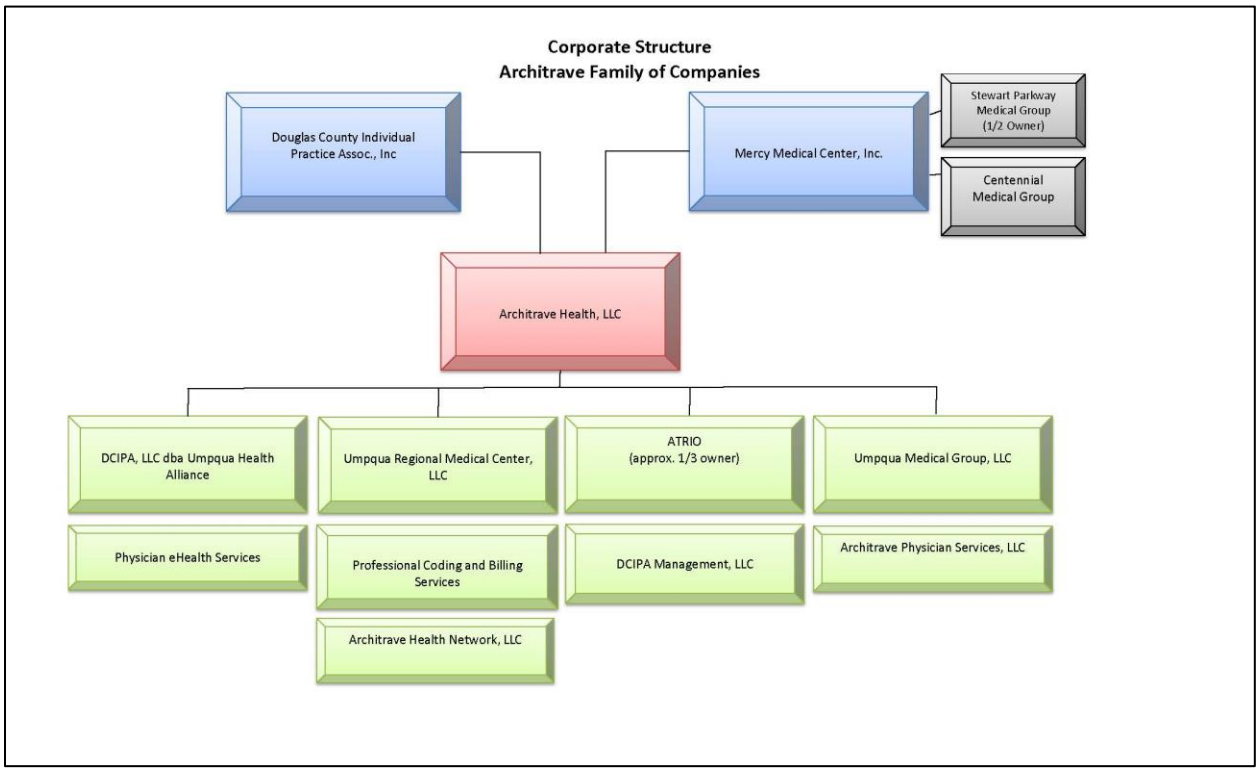
Executive Summary

DCIPA, LLC dba Umpqua Health Alliance (UHA) has a long history of health care innovation and have been early and strong supporters of transformation and integrated health care. More than two years prior to Oregon's Coordinated Care Organization (CCO) initiative, DCIPA and elected officials recognized the need for coordination among health care providers and began meeting with community leaders to talk about the complex needs of Members with co-morbid health conditions. As Oregon introduced the CCO structure of integrated care, this group established Umpqua Health Alliance and became one of the first certified CCOs. UHA has adopted transformative methods and programs based on the Triple Aim that are supportive of a fundamental change in local health care delivery.

Governance

Key Partners

The Umpqua Health Alliance (UHA) Board of Directors has representation by Advantage Dental, ATRIO Health Plans, Douglas County Individual Practice Association, Inc., Douglas County Commissioners, Mercy Medical Center, Umpqua Community Health Center, Adapt, Greater Oregon Behavioral Health, Inc., Architrave Health and the UHA Community Advisory Council (CAC). These key partners are from several different areas of health care in Douglas County; including mental health, physical health, addiction treatment, oral health, and senior health insurance coverage. Several UHA Board members met for many weeks in 2011 to discuss the underlying principles were later reflected in SB 1580 and the formation of Coordinated Care Organizations (CCOs). They are working together with the goals of meeting the Triple Aim of better health, better experience and quality, and lower cost for UHA Members.



Profitability, Transparency & Risk Bearing

The accountability and flexibility afforded by the CCO global budget has built strong relationships amongst UHA community partners and spurred innovative health system change and delivery. Shared financial responsibility and risk has increased collaboration and coordination of services, and evoked a focus on common goals by the key stakeholders involved in the patient care continuum. By working together, the health care providers serving UHA Members and the surrounding community have shifted the focus to disease prevention and

chronic illness management that supports effective resource stewardship. UHA conveys regular reports of quality and access data, financial information and progress toward benchmark attainment to the Oregon Health Authority; reinforcing transparency of activities and operations supporting transformation of health care delivery. UHA is also collaborating with providers, to identify clinical processes that support the Triple Aim. Incentivizing quality and efficient resource stewardship, via rewarding provider performance of fixed and collaboratively identified measures. Primary Care Provider measure performance is evident now via the CCO Performance Measures; and other provider performance measures are being developed as we move forward.

The indeterminate risk associated with maturation of the Oregon Health Plan (OHP) expansion population resulting from the Affordable Care Act impairs UHA's ability to employ a predictive strategy to safeguard resource adequacy and gauge prosperity. OHP coverage of gender reassignment treatment and surgery, revised autism treatment coverage and new hepatitis C medication further increase the difficulty of developing a plan to meet the needs of UHA Members.

Below is a summary of DCIPA, LLC dba Umpqua Health Alliance financial performance for the past three years. Net Income was steady in 2012 and 2013 at 6% and 5% of Revenue respectively. . Results for 2014 need to be seen in the context of a 60% increase in enrollment and higher capitation rates for the expansion population. It is anticipated that claims experience with that enrollment segment will increase as it matures. It is estimated that UHA will return to the State of Oregon approximately $9.2 million in the form of taxes and rebates..

From DCIPA LLC Audited Financials now DBA Umpqua Health Alliance*

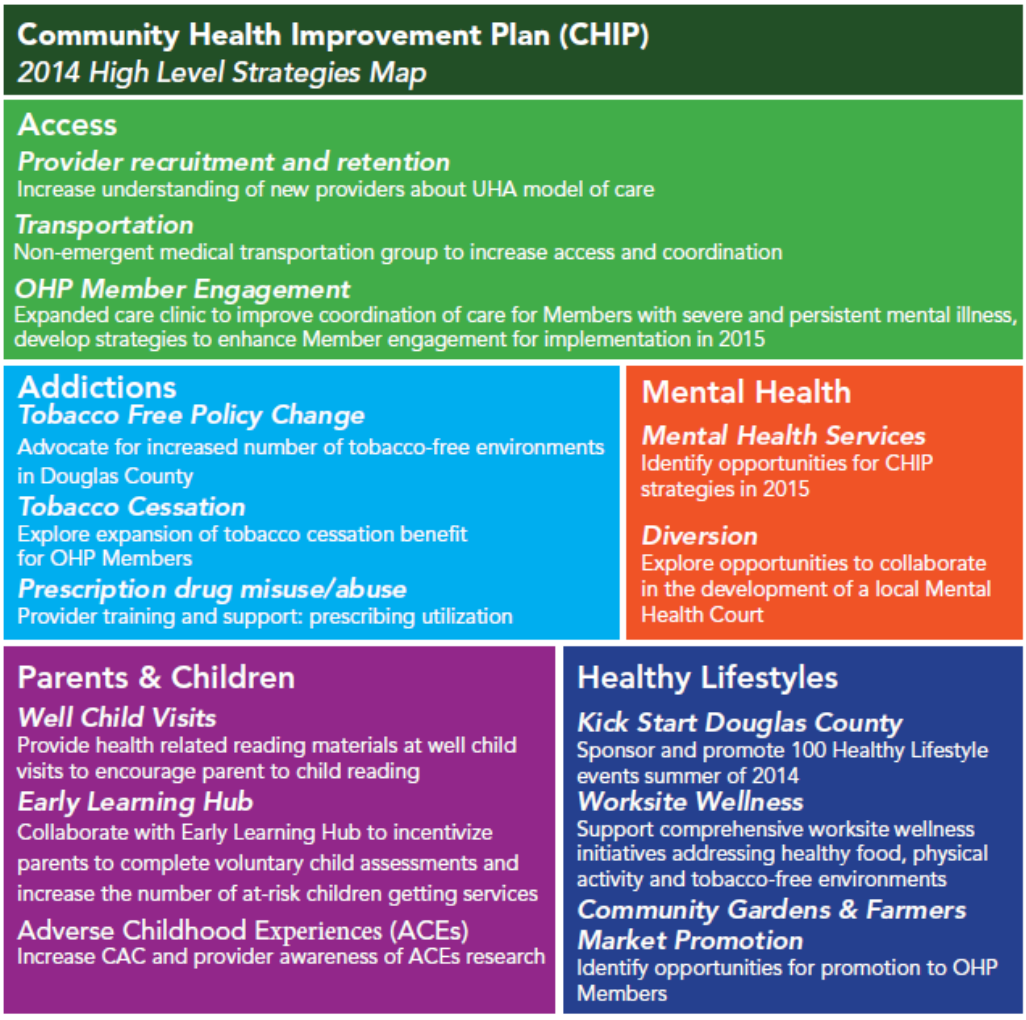
	2012	2013	2014
Revenue	$ 61,220,936	$ 67,787,201	$ 126,183,388
Expenses	$ 54,657,379	$ 61,940,427	$ 103,536,527
Gross Income	$ 6,563,557	$ 5,846,774	$ 22,646,861
estimated Taxes	$ 2,756,694	$ 2,455,645	$ 9,511,682
Net Income	$ 3,806,863	$ 3,391,129	$ 13,135,179
OHA Rebate			$ 7,545,879

*2014 estimate based on completion of current audit

Umpqua Health Alliance Community Advisory Council

The UHA Community Advisory Council (CAC) is broadly representative of the local population, and includes positions filled by consumers and community members with interest or knowledge of seniors and people with disabilities, mental health and addictions, physical health, dental health, education, local government, children, tribal members, housing and the faith community. Several CAC members are also members of the early learning council. The UHA CAC advises UHA in matters concerning health care needs of the consumers and the community; the chairperson of the UHA CAC is also a member of the UHA Board of Directors. The UHA CAC holds four quarterly meetings that are open to the public.

The UHA CAC has played an integral role in the development of the UHA Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP); diligently assessing



the CHA and determining high level strategies to support the priority health issues.

The UHA CAC membership contributed efforts toward activities that support identified focus areas. Partnership and collaboration on CHIP activities has included representation of local physical and oral health providers, the public health authority, mental health authority, domestic violence prevention agency, addiction treatment and prevention provider, early learning council, first responders, Department of Human Services, teachers and librarians, and local citizens.

Following is a progress report of action plans developed to address the UHA CHIP:

Priority Heath Issue	High Level Strategy	Objectives/Tasks	Activities
Improve Access to Health Care Services			
Access	Provider Recruitment & Retention	Provide tools and resources about the UHA model of care to recruit and retain providers and to increase access to providers accepting Oregon Health Plan Members	From June 30, 2014 to June 10, 2015, there have been 17 new physicians, and 11 new nurse practitioners/physician assistants recruited to the community and credentialed to accept Oregon Health Plan (OHP) Members. Information regarding the UHA model of care is shared during the provider recruitment process and has been communicated to providers already established in the community. Oregon Health Authority (OHA) communication of the OHP renewal and closure updates are sent to provider staff. Downloadable resources and tools are included in a quarterly newsletter to providers.
	Transportation	Convene non-emergent medical transportation (NEMT) workgroup to increase access and coordination of transportation in Douglas County	To reduce barriers to access due to transportation, a workgroup of community transportation stakeholders was convened over several months, which resulted in six conceptual options for NEMT delivery in the service area. Consensus of the workgroup was to contract with a brokerage and include performance and quality incentives, and opportunities to develop innovative programs to support efficient and effective service delivery. UHA is proceeding with brokerage negotiations to integrate NEMT into plan services.
	OHP Member Engagement	Expanded care clinic to improve coordination of care for Members with severe and persistent mental illness, develop strategies to enhance Member engagement for	To support OHP Member engagement, the Expanded Care Clinic (ECC) staff at Umpqua Community Health Center (UCHC) have been trained to use motivational interviewing as a tool to facilitate behavior change of Members. The model uses engaging, focusing, evoking and planning processes to support healthy,

		implementation in 2015	sustainable behavior by ECC Members with Severe and Persistent Mental Illness (SPMI) and chronic illness.
	OHP Member Engagement	Expanded care clinic to improve coordination of care for Members with severe and persistent mental illness, develop strategies to enhance Member engagement for implementation in 2015	To further increase Member engagement, an intensive primary care model is being implemented at Umpqua Regional Medical Center (URMC), a UHA network clinic, where approximately one-third of our Membership identified with Severe and Persistent Mental Illness (SPMI) are assigned. The model includes physician-led care teams, extended evening and weekend hours, mental health, and behavioral health services on-site and contiguously located addiction services.
Priority Heath Issue	**High Level Strategy**	**Objectives/Tasks**	**Activities**
Addictions	**Reduce Number of Individuals Addicted to Alcohol, Tobacco and Other Drugs**		
	Tobacco Free Environments	Advocate for increased number of tobacco-free environments in Douglas County	To support decreased tobacco use, advocacy is being directed toward increasing the number of tobacco free environments in Douglas County. Two of the largest UHA network primary care clinics and Advantage Dental are participating in the Strategies for Policy and Environmental Change (SPArC) Tobacco-Free Project, a grant funded project led by Adapt – local provider of addiction treatment and prevention services and a UHA community collaborator. The project addresses tobacco use through implementation of organizational policy, system, and environmental change aimed to create tobacco-free environments and encourage tobacco users to quit. Staff from medical and dental health clinics participated in training, assessment and policy development to identify opportunities for system environmental change. There are now over 20 tobacco-free campuses in Douglas County.
	Tobacco Cessation	Explore expansion of tobacco cessation benefit for OHP Members	The CAC is actively involved in working with the CCO Medical Director, Pharmacist and team to review current cessation benefits available to Members. A CAC champion is working with the tobacco prevention education program manager of Douglas County public health and the SPArC grant manager at Adapt to research best practices for tobacco cessation in preparation of a

			proposal to the UHA board. The goal is to deliver evidence based best practice cessation benefits to Members.
	Prescription drug misuse/abuse	Provider training and support for prescribing utilization	To support provider education and Member engagement, local providers are provided the UHA Opiate Use Policy and a toolkit to support dosing and tapering education. Providers are also provided with Member education resources regarding pain management. UHA has a monthly pain management committee that meets to offer a forum for prescriber support, education and evaluation of patient education resources for Members. The UHA pharmacy director is an active member of the local opioid task force, working closely with law enforcement, treatment providers, local pharmacies, violence prevention advocates, DHS and the Veterans Administration to increase awareness of the prescription drug use epidemic, with a goal to reduce risk factors for drug diversion, misuse and abuse.
Priority Heath Issue	**High Level Strategy**	**Objectives/Tasks**	**Activities**
Mental Health	**Increase Integration of Services for Severe and Persistent Mentally Ill**		
	Diversion	Explore opportunities to collaborate in the development of a local Mental Health Court	Architrave Health has supported the start-up of the Douglas County Mental Health Court (DCMHC), via a generous monetary contribution. The UHA Community Advisory Council has received presentational information regarding the DCMHC, and continue to explore opportunities to support development and sustainment of these services.
	Mental Health Integration	Identify future opportunities for CHIP to support mental health integration in 2015	To support mental health integration, a large primary care clinic, with a significant patient panel with Severe and Persistent Mental Illness (SPMI), is implementing an intensive primary care model that has physician-led care teams, extended evening and weekend hours, mental health and behavioral health services on-site and contiguously located addiction services. The UHA Board, in collaboration with Greater Oregon Behavioral Health, Inc.

			(GOBHI), approved funding for housing for individuals with SPMI. The funding will cover six individuals for six months. Eligibility requirements include active participation in the DCMHC. This pilot program will determine if these individuals may be more engaged in their mental health services when the basic need of housing is met. An outcome report will be provided to the UHA board within six months.
Priority Heath Issue	**High Level Strategy**	**Objectives/Tasks**	**Activities**
Healthy Lifestyles	**Increase Access to Physical Activity and Healthy Food Choices**		
	Kick Start Douglas County	Sponsor and promote 100 healthy lifestyle events	To encourage healthy activity, the CAC and UHA collaborated with other area organizations to sponsor and promote over 340 healthy lifestyle events for the summer of 2014 by establishing *Kick Start Douglas County*, and are supporting a similar project for 2015. UHA contracted with the YMCA to offer two 12-week pilot programs, *Healthy Living Challenge*. The first 12-week session concluded in February; the second is underway, and will conclude, as Kick Start 2015 begins.
	Worksite Wellness	Support comprehensive worksite wellness initiatives addressing healthy food, physical activity and tobacco-free environments	UHA actively promotes community-wide Worksite Wellness training in collaboration with Douglas County Public Health. The next training is scheduled for June 19, 2015. UHA and Douglas County Public Health are working closely with other key stakeholders in the community to promote tobacco-free worksite policy, resulting in over 20 tobacco-free campuses in Douglas County; including Douglas County Public Health, Advantage Dental Clinics, Umpqua Regional Medical Center, South River Community Health Center, Harvard Medical Park (multiple providers and clinics), Mercy Medical Center, Edenbower Medical Park, Evergreen Family Medicine (multiple providers and clinics), Adapt Crossroads Inpatient and Outpatient facilities, Lower Umpqua Hospital, Reedsport Medical Clinic, Dunes Family Medicine, Umpqua Community College, Housing

			Authority of Douglas County, Family Development Center (includes Head Start), Leiken Shopping Center, Roseburg Forest Products, Eastwood Townhouse Apartments, Neighbor Works Umpqua, Garden Valley Shell, and City of Roseburg Parks.
	Community Gardens Farmers Markets Promotion	Identify opportunities for promotion to OHP members (e.g., food stamp accessibility)	The CAC supports and promotes seasonal and year-long Farmers Markets and community gardens. Umpqua Health Alliance provided funding for matching Supplemental Nutrition Assistance (SNAP) benefits at the Umpqua Valley Farmer's Market and CAC champions are working with other markets and local plant and seed growers to establish EBT access for SNAP.
Priority Heath Issue	**High Level Strategy**	**Objectives/Tasks**	**Activities**
Parents & Children	**Improve Outcomes for Children by Investing Early and Addressing Core Risk Factors for Health**		
	Well Child Visits	Improve kindergarten readiness by promotion of parent-child reading at well child visits	Through a grant awarded by the South-Central Oregon Early Learning Hub, 800 books were purchased for distribution to children in the community. Over 500 books were distributed at the *Celebrate Children* event on April 25, including: • First 100 Words Bilingual (Spanish Edition) • Heads, Shoulders, Knees and Toes (Dual-English/Spanish) • Mi Primer Libro del Cuerpo/My First Body Book The remaining books were distributed to provider offices and to parents through the WIC program. In addition to a focus on health literacy, the majority of books focused on behavioral health strategies, for example, *Feet Are Not For Kicking*, *Hands Are Not For Hitting*, *Manners Time*, and *Listening Time*.
	Early Learning Hub	Collaborate with Early Learning Hub to incentivize parents to complete voluntary child assessments and increase the number of at-risk children getting services	CAC champions are working closely with the South Central Oregon Early Learning Hub to identify opportunities to distribute developmental screening tools to parents and to support opportunities for engaging families in the process for developmental promotion.

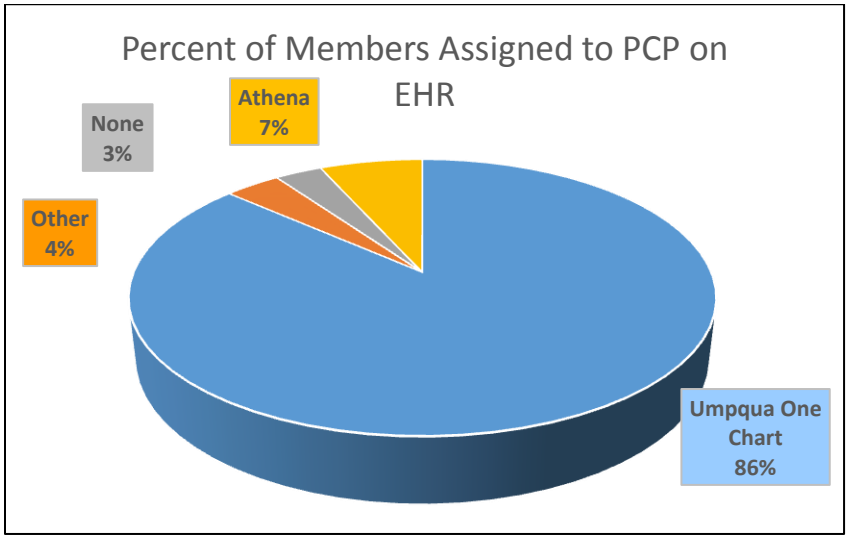
	Adverse Child Experience (ACE)	Identify opportunities for promotion to UHA Members	The CAC received a presentation on the research and health implications of Adverse Childhood Experiences (ACE). UHA is collaborating with our local violence prevention organization, who was awarded a Northwest Health Foundation community-planning grant to develop strategies to integrate ACEs and trauma-informed care across sectors and increase protective factors and resiliency in the community. CAC members participated in and facilitated two ACE presentations and a consumer focus group.

Whole Person Care

Implementation of the CCO model has resulted in a fundamental change in care delivery by generating newfound collaboration to improve care integration, increase communication and coordination, and create a common focus to meet the holistic needs of UHA Members; with attention paid to pockets of Members in rural, high-poverty areas. UHA serves a broad geographic area, which is compounded by distance of more than an hour from any larger city. Douglas County is a rural county located in Southwestern Oregon, and is the fifth largest geographical county in the state and ninth in population. UHA Membership residency is spread across the expanse of Douglas County with a concentration in Roseburg; however, many are also in outlying areas where distance and poverty impede regular access to health care. Creative projects and innovative care models have arisen from the partnerships formed by physical, mental and oral health stakeholders; benefiting Members and the community throughout the UHA service area.

Communication

Architrave Health, LLC and UHA have been pioneers in the creation and promulgation of a community wide electronic health record. Beginning in 2006, our community installed a comprehensive electronic health record, which is capable of extensive interfaces and multiple user defined forms. As the patient registry is community wide, every doctor on the system has access to all the records; which are inclusive of records from Mercy Medical Center, (the only hospital in our service area), the Oregon ALERT Immunization Information System (IIS), and multiple labs. Upon recent formation of the new community mental health authority, mental health providers have been included in the community wide electronic health record; advancing communication among integrated providers with patients in common.



Integration

It is well recognized that UHA Members have a high rate of multiple chronic medical conditions, and a high rate of co-morbid mental health problems. According to the Robert Wood Johnson Foundation of County Health Rankings and Roadmap[1], in 2015 Douglas County was ranked 32nd of 34 Oregon Counties for health outcomes and length of life. Douglas County Data (OHA/DMAP data for 2010-2011) indicates that of the individuals with chronic medical conditions, 39.4% had more than one condition, and of those, 41.8% had a co-morbid mental health diagnosis. In addition, other research shows that 40% of Members with mental illnesses have some type of substance abuse problem. These undertreated mental or behavioral health issues significantly impact the quality of UHA Member's lives and continue to drive much of the physical health care system costs.

Several integrated care models are available for UHA Members; with approximately 60% of Members served in a clinic with embedded mental health providers and 26% of Members with integrated dental services. To cultivate an integrated health care model to improve coordination of services for Members with severe and persistent mental illness and other co-morbid, complex health conditions that drive health care costs, several Douglas County health practitioners, substance abuse treatment providers, and community members collaborated to develop a framework where physical health, mental and behavioral health, addiction and dental health services would be coordinated in one clinical setting. The Expanded Care Clinic at Umpqua Community Health Center, a local Federally Qualified Health Clinic and community partner, launched in May 2013 with funding subsidy from UHA. To spread mental health and primary care integration, an intensive primary care model was implemented at a UHA network clinic that has physician-led care teams, extended evening and weekend hours, behavioral health services on-site and contiguously located addiction services. Mental and behavioral health providers have also been embedded at two other clinics in the UHA network, to augment integrated care delivery.

Coordination

To better manage and coordinate complex Members with multiple co-morbidities and disease process, UHA has convened the Interdisciplinary Care Team (ICT). The ICT is comprised of staff from dental health, mental health, Department of Human Services, Senior Services, UHA Case Management, Mercy Medical Center and at times primary care providers or other guests when appropriate. The Team reviews patients with complex medical and/or mental health issues (usually when the established processes and interventions have been exhausted), in an effort to identify other ways to engage the patient in needed community services and/or health care. As

[1] Robert Woods Johnson Foundation. County Health Rankings and Roadmaps. (2015). http://www.countyhealthrankings.org/app/#!/oregon/2015/rankings/douglas/county/outcomes/overall/snapshot.

the ICT progressed, it was identified that each entity didn't have a full picture of the resources each agency had to offer and/or any limitations. The team is now able to ascertain what services the patient has utilized or is qualified for, and share information to identify gaps in care and coordinate services.

Flexible Benefits

As an aspect of care coordination and case management, UHA may establish innovative treatment plans, in collaboration with a Member, their primary care provider, and other members of the care team. An aspect of such innovative plan may be a flexible service, which may be recommended if the service provides an equal to or more effective clinical and financial outcome relative to more conventional treatment plan services or approaches. UHA has implemented a process for review of recommended flexible services, which may be for an individual or as a total health and prevention strategy. Flexible services may include training or education for health improvement, support group activities, care coordination, navigation or management activities, home or living environment items, transportation not covered under other benefits, programs to improve community health, housing supports, assistance with food or social supports and other identified needs. Currently, UHA's reviewed flexible spending requests have been related to weight loss and diabetic control education, nutritional counseling, and lodging.

Community Care Transitions

Additional coordination is being accomplished by a community care transitions team. To reduce preventable re-hospitalization, a community care transitions team assists Members discharged from inpatient hospitalization and the emergency department with follow-up appointments, discharge instructions and Member education, to prevent a re-admission to inpatient or emergency department services.

Prevention

DCIPA, Inc. and Architrave Health, LLC have a long history of promoting strong primary care relationships. Beginning in the mid-90's the need for primary care providers to coordinate and manage the care of their primary care patients was recognized, and a primary care case management fee program was implemented. At the turn of millennium, the difficulty of recruiting enough primary care doctors to rural areas was identified and in 2001 DCIPA, Inc. created a clinic whose purpose was to provide a primary care home for those Oregon Health Plan patients who could not find a community physician. UHA's practice has been to assure every Member has a defined primary care provider, and for the past 20 years, 99% of Members have had a primary care provider. Adoption of the Patient Centered Primary Care Home (PCPCH) model and development of a Population Health program have increased care coordination and preventative medicine practices for UHA Members and the community.

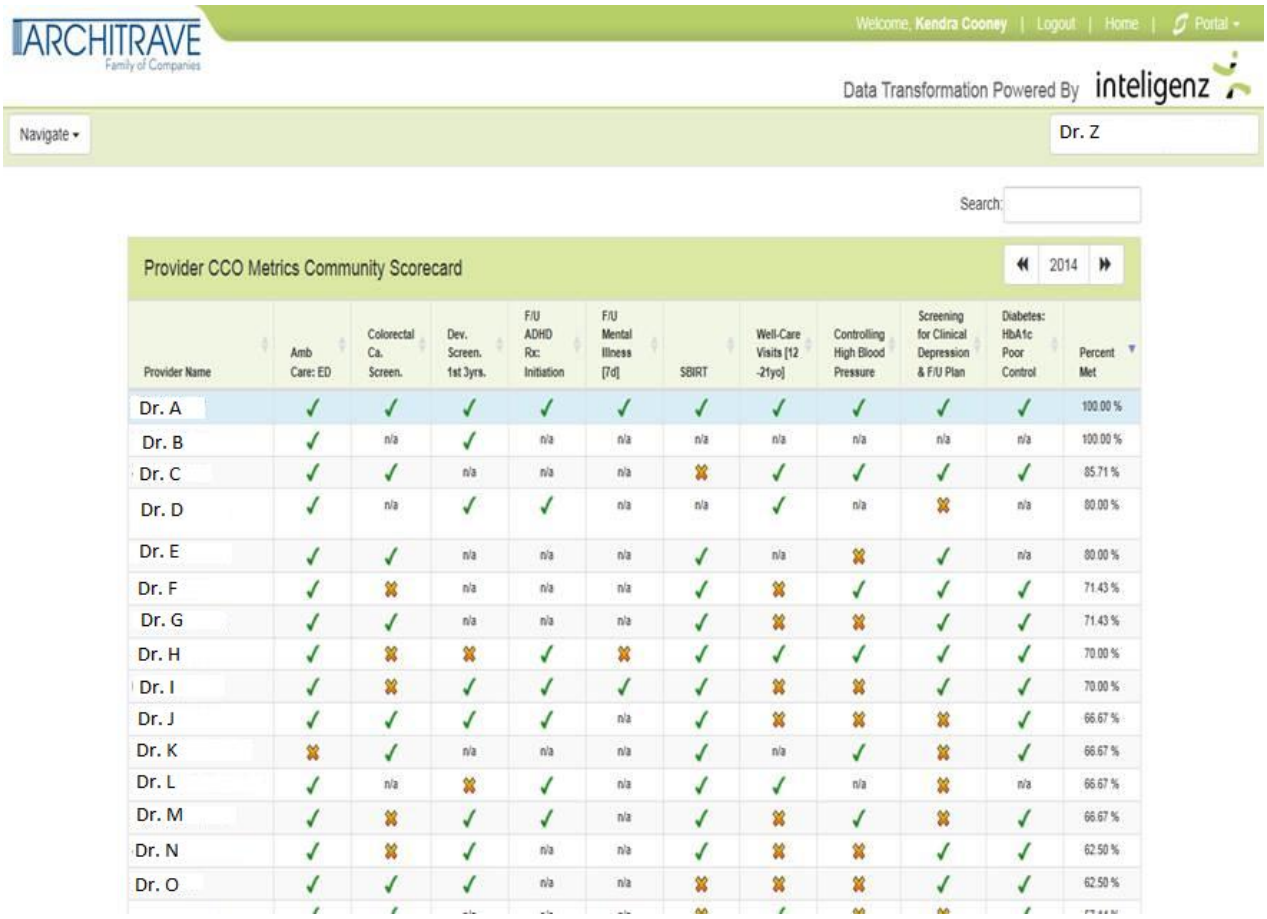
The PCPCH program standards foster improved care coordination, increased accessibility, strong patient-provider relationships, and patient engagement. To support local provider PCPCH recognition, UHA employs a PCPCH Project Coordinator to provide support and clarification of PCPCH measurements, assist with workflow development and share barrier solutions; which assuaged provider anxiety and increased program participation. The PCPCH Coordinator has developed tools to aid recognized provider's preparedness for a potential PCPCH site visit for recognition verification, and is a resource for program updates and assistance for initial and increased tier level PCPCH attestation. Approximately 89% of UHA Members are assigned to PCPCHs recognized by the State of Oregon. To strengthen the PCPCH model in the UHA network, coordination of palliative care is offered to network providers. Offering a palliative care program to support engagement of patients in end-of-life planning and assistance with advance directive/POLST completion and registry submission supports PCPCH, as palliative care is a Standard requirement and additional option for PCPCH recognition (Standard 5.F.1[2]).

To support preventative care and improved health of UHA Member populations, UHA utilizes an analytic program that embeds population health metrics into medical management and care coordination information systems. The embedded program provides users the ability to assess several population health metrics for our Membership and filter results for selected populations. UHA Population Health staff oversees the population health data collection and analysis, and provide outreach and workflow solutions to UHA providers, to decrease identified gaps in population health. Providers also have direct access into the analytic program, to identify real-time progress toward the population health metrics and the ability to identify applicable assigned Members included in specific measurement gaps that require an appointment (example below).

	Diabetes: HbA1c Poor Control Gap List							
	Members who are in the denominator but do not meet the measure: Percentage of diabetic patients age 18-75 whose most recent HbA1c level, during the measurement period, is greater than 9.0%. (a lower number suggests better control of diabetes							
Member #	Currently Active	Member Name	DOB	Currently Attributed PCP	Last PCP in Year 2015	Qual. Office Visit Date	Most Recent HbA1c Test Date	HbA1c Level
1	Yes	Patient 1	1950-01-01	Doctor 1	Doctor 1	2015-05-12	2015-01-29	8.4
2	Yes	Patient 2	1950-01-02	Doctor 2	Doctor 2	2015-05-13	2015-01-30	7.5
3	Yes	Patient 3	1950-01-03	Doctor 3	Doctor 3	2015-05-14	2015-01-31	6.1
4	Yes	Patient 4	1950-01-04	Doctor 4	Doctor 4	2015-05-15	2015-02-01	5.8
5	Yes	Patient 5	1950-01-05	Doctor 5	Doctor 5	2015-05-16	2015-02-02	5.9
6	Yes	Patient 6	1950-01-06	Doctor 6	Doctor 6	2015-05-17	2015-02-03	9.0
7	Yes	Patient 7	1950-01-07	Doctor 7	Doctor 7	2015-05-18	2015-02-04	5.8
8	Yes	Patient 8	1950-01-08	Doctor 8	Doctor 8	2015-05-19	2015-02-05	7.6

To further encourage provider commitment to proactively manage chronic diseases and preventative screenings, a community wide scorecard will be shared with all providers.

[2] http://www.oregon.gov/oha/pcpch/Documents/2014%20PCPCH%20Criteria%20Quick%20Reference.pdf.



Health and Wellness

To create opportunities that were guided by the Community Health Assessment and Community Health Improvement Plan to provide healthy lifestyle choices and wellness focused activities for Members and the community, the CAC and UHA collaborated with other area organizations to sponsor and promote over 340 healthy lifestyle events for the summer of 2014 by establishing Kick Start Douglas County. Kick Start 2015 is underway, and has already captured over 300 events and activities focused on health and wellness that are available for Member and community participation. A calendar of these events are available on the UHA website, were published in the local newspaper and included in a Facebook events page, to provide multiple methods for Members to find healthy activities. UHA also contracted with the local YMCA to offer two 12-week pilot programs, Healthy Living Challenge. The Healthy Living Challenge is a physician referred program that includes fitness assessments, weekly group fitness classes and semi-monthly nutritional motivation workshops, to offer a solution-based program to promote healthy lifestyles for Members.

Quality and Utilization

UHA has projects, processes and a Clinical Advisory Panel that support objectives for improving patient experience of care, improving our populations' health and reducing the cost of healthcare. The UHA quality strategy is to sustain sharp focus on improving access and quality through ongoing measurement, analysis and intervention. The UHA quality program has an internal program evaluation process, quality improvement committee, utilization review oversight committee, and a process to assess quality and appropriateness of care furnished to all Members and Members with special health care needs. There is also a strategy to improve care coordination for Members with serious and persistent mental illness, measure and report grievances, ongoing efforts to ensure consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System are maintained, assess fraud, waste and abuse, and avid participation in the OHA Quality and Health Outcomes Committee (QHOC).

Performance improvement projects, Transformation focus areas, grievance program and utilization trends are aspects of the UHA quality program. UHA's Clinical Advisory Panel (CAP) contributes feedback to quality improvement activities, by monitoring UHA performance improvement project (PIP) performance, utilization review and making recommendations regarding grievance and appeals, utilization trends compared to guidelines and policies, care coordination, peer review, procedure and referral development, formulary additions and medication guidelines.

To address any identified disparity of care related to race, ethnicity or residential location that impede appropriate care being delivered in the appropriate setting, a quality strategy that focuses on improving preventative screening rates of Members living in *High Poverty Hot Spots*[3] has been created. Compiled information regarding these groups' population health metric performance indicates lower achievement in colorectal cancer screening and alcohol and drug misuse screening with the SBIRT tool, compared to the UHA Membership performance. A high percentage of Members living in Glide and Yoncalla are assigned to two of the larger primary care clinics in the UHA network. The strategy includes a mail-out of colorectal cancer screening kits to Members assigned to the two UHA clinics with the largest Membership living in the hotspots and provision of SBIRT (*Screening-Brief Intervention-Referral to Treatment*) education materials and tool kits to these clinics to support alcohol and drug misuse screening.

Member Engagement

To increase Member health literacy and engagement via multiple mediums, UHA partnered with community collaborators to create a program which includes weekly health-related articles by

[3] Oregon DHS Office of Forecasting. Research & Analysis, *High Poverty Hot Spots 2013*, April 2013.

local health practitioners featured in the local newspaper, an opportunity to submit health questions to providers and their responses, and a radio program for interviewing health leaders to gain information about current health programs and services available in the community. These articles offer insight and tips, in layman's terms, to address common health concerns and answer questions from the public. Links to the published articles and answers are posted on the UHA website, for non-subscribers of the local paper.

Quality Metric Performance

Of the seventeen CCO Performance Metrics, UHA's performance was lowest on Adolescent Well Care Visits, Follow-Up after Hospitalization for Mental Illness and Mental and Physical Health Assessments within 60 Days for Children in DHS Custody.

Adolescent Well Care Visits

The foremost challenge to improving performance of the Adolescent Well Care measure, is discerning a strategy to engage the intended population segment, 12-21 years of age. UHA is exploring opportunities that offer easy access and applicable incentive. Possible innovations include offering a comprehensive service clinic, which provides a sports physical, well child visit and any other preventative screenings. UHA has approached the School Based Clinics, to foster performance of adolescent well care visits at their sites. Other strategies to incentivize adolescents to complete a well care visit are under discussion.

Follow-Up after Hospitalization for Mental Illness

Ensuring a 7 day follow up appointment after hospitalization for mental illness has also been a challenge for UHA. The most significant barriers have been receiving prompt notification of a Members discharge from the mental health hospitals and same-day follow up appointments not being included for the measure. To improve follow up post discharge from hospitalization for mental illness, the UHA inpatient mental health provider is providing case management via their crisis team to the hospitalized Members. Upon discharge, the crisis team initiates notification for the follow up visit. UHA is exploring utilization of Non-Emergent Medical Transportation (NEMT) as a mode for notification and follow-up after hospitalization for mental illness; via subcontracting mental health providers as NEMT service providers.

Mental and Physical Health Assessments within 60 Days for Children in DHS Custody

UHA struggles meeting the CCO metric for ensuring children in DHS custody receive mental health and physical health assessments within 60 days of custody placement. The major barrier identified has been the incorrect data communication between DHS and the Oregon Health Authority systems. As this is a known issue, the UHA Population Health Team works closely with local DHS staff to ensure the list of children in custody is promptly received. The Population Health Team then facilitates appointments for primary care, dental and mental health for the applicable children.