Eastern Oregon CCO House Health Care Committee Presentation

1. CCO Structure

Quick Facts about EOCCO:

EOCCO provides coverage to nearly 50,000 Medicaid patients in 12 rural and frontier counties in eastern Oregon. The land mass of our service area is approximately 50,000 square miles, representing over 52% of the land area in the State of Oregon. Our enrollment has increased by 65% since 12/31/13 as a result of the ACA expansion. One third of EOCCO's current membership is expansion patients and we provide coverage to nearly 25% of the entire population within our 12 counties.

Governance structure:

EOCCO's governing board includes each of our owners along with individuals from the community at large, including three county commissioners, public health, physical and behavioral health provider representatives as well as a member of our regional community advisory council (RCAC).

EOCCO is administered by Greater Oregon Behavioral Health, Inc. (GOBHI) and Moda Health.

Key Partners:

EOCCO has a diverse ownership structure that includes providers, hospital systems and community partners who provide care for OHP members within the 12-county EOCCO service area.

EOCCO Owners:

- Greater Oregon Behavioral Health, Inc. (GOBHI)
- Moda Health
- Good Shepherd Health Care System

- Grand Ronde Hospital, Inc.
- Saint Alphonsus Health System, Inc.
- St Anthony Hospital
- Pendleton IPA, Inc.
- Yakima Valley Farm Workers

Each of these entities works in partnership with local hospitals, providers, public health, school-based health centers (SBHCs), county governments and other community partners with the goal of advancing the Triple Aim for EOCCO members. For example, EOCCO works closely with our SBHCs through partnerships with county public health departments on a variety of projects focused on meeting and improving quality incentive measures. Measures we are working on with SBHCs include adolescent well care visits, SBIRT, and effective contraception.

We currently have seven SBHCs: Baker, Umatilla (two), Union (two), Wheeler, and Grant and will have eight when Morrow County opens in October 2015.

Grant County's LCAC dedicated EOCCO-provided funds to open the county's only SBHC in April 2015, featuring co-located dental, mental and physical services.

Beyond the ownership group, we consider all the delivery system partners within our 12 counties as well as such tertiary hospitals such as St. Alphonsus in Boise and St. Charles in Bend.

EOCCO has a nine-member Clinical Advisory Panel (CAP) that includes physicians, a PA, a dentist and a licensed behavioral health clinician. The role of the EOCCO CAP is to serve as a clinical issues focus group for the EOCCO Medical Director and to help evaluate new clinical strategies that will achieve the Triple Aim.

Who Bears the Risk?

EOCCO owners bear the ultimate risk for operating within the global budget based on their level of ownership within the organization.

In addition to the ownership risk, EOCCO implemented a shared savings/Alternate Payment Methodology (APM) model in 2014 that has been expanded in 2015. Under our current shared savings/APM model, participating hospitals, specialists and GOBHI are at risk for up to 5% of the payments they receive from EOCCO.

The DCOs bear the risk for 100% of the services they provide on behalf of EOCCO.

The Nature of the Delivery System:

The EOCCO service area extends beyond its 12 counties because not all services are available locally. We have also had to establish relationships with PCP Specialists and hospitals in Idaho, Washington State, and in larger, urban communities throughout Oregon. This was especially important for providing tertiary hospital care as there are no tertiary hospitals within our 12-county geography.

Hospitals

Within the 12 counties of EOCCO there are 10 hospitals. Seven of the 10 are Type A/Critical Access hospitals and five of the 10 are part of health districts. There are no tertiary hospitals within our 12 counties so agreements with hospitals in border states, and within larger Oregon metro areas including Bend, Portland and The Dalles have been developed to ensure access to services based on long-established community referral patterns.

Primary care and PCPCHs

There are 57 widely dispersed clinics and individual providers that serve the majority of EOCCO members within and bordering the 12-county geography:

- 24 are Rural Health Clinics (RHCs)
- 6 are Federally Qualified Health Centers (FQHCs)
- 24 of EOCCO's contracted clinics within the 12 counties of EOCCO are PCPCHs. An additional Twenty-two (22) clinics that boarder the EOCCO geography are also certified as PCPCHs.

EOCCO has seen a significant increase in the number of members receiving primary care from a State certified PCPCH. In 2012, only 3.7% of EOCCO members were being served by a single PCPCH in our geography. Today EOCCO works with 46 state certified PCPCHs who provide primary care for over 65% of EOCCO's members.

Specialty care

EOCCO works with all available specialty providers within its 12 counties including and with specialists outside of the 12-county service area. Many of our specialists are employed by local hospitals or are visiting specialists from larger hospital systems.

Behavioral Health (mental health and chemical dependency) and NEMT

EOCCO capitates behavioral health services to GOBHI, which works with providers within each of the 12 counties to provide services. This includes the use of licensed behavioral health providers employed within PCPCHs.

Dental

EOCCO capitates Dental services to Advantage, Capital and ODS Dental.

The role of the Community Advisory Council:

EOCCO has taken a unique approach to involving the community in our CCO. OHA required that each CCO have a Community Advisory Council. Due to the vast geographic land area and the unique needs of each county, it was not practical for EOCCO to have one Community Advisory Council. Instead, EOCCO created 12 Local Community Advisory Councils (LCACs) -- one for each county. LCACs are governed by a Charter. Their primary purpose is to advocate for preventive care practices, to oversee and collaborate with community partners on a community health assessment and to develop, implement and report on a Community Health Improvement Plan. Members of the LCACs are appointed by each individual county commission and the EOCCO board. Please see the attached list of LCAC members by County:

EOCCO LCAC
Membes as of 6.17.1

From each LCAC, the chair, along with a county commissioner (or designee), serves on a Regional Community Advisory Council (RCAC). The primary charge of the RCAC is to bring the ideas/suggestions/work from each of the LCACs, consolidate the information and oversee activities to ensure that each LCAC is responsive to member and community needs. The RCAC also approves a single Regional Community Health Improvement Plan that represents the needs of all 12 counties. The RCAC chair, Grant County Commissioner Chris Labhart, also serves on the EOCCO governing board.

In addition to the oversight duties required of the LCACs, EOCCO provides a small amount of funding to each LCAC that will be used to support EOCCO's efforts to improve quality measures. $422,000 in total funding is being provided across our 12 LCACs based on a formula that provides equal base funding for each of the 12 counties with an additional amount based on membership in the county.

The Eastern Oregon Healthy Living Alliance (EOHLA) is a non-profit organization that was established to help gain resources (beyond those provided by EOCCO) for the implementation of the Regional Community Health Improvement Plan.

Profitability:

Reinvestments on the community:

EOCCO has made a number of reinvestments within the communities we serve. Examples of our reinvestments in 2013 and 2014 include:

- Enhanced PCPCH payments: $2.8 Million
- EOCCO shared savings/APM returns: $5.2 Million
- EOCCO Transformation Grants: $1.6 Million
- EOCCO Quality Measure returns: $7.2 Million

- **Total reinvestments to date: $16.8 Million**

Savings/APM model: Our investments in state-certified PCPCHs and our quality measure reinvestments are outlined throughout this document.

2. Health Care delivery and financing in the community

Many of the activities and initiatives in which EOCCO has participated since its formation are collectively changing the way health care is being provided and paid for in the community. Our shared savings/APM model, increased funding to PCPCHs and funding to our LCACs are examples of EOCCO working to fundamentally change the way healthcare is being financed and delivered throughout Eastern Oregon.

The funding provided through our shared savings/APM and PCPCH payment mechanisms allow our providers to invest dollars in tools and ways to produce better outcomes, as well as helping to increase access to preventive care and provider access in general. These investments are evident through our improved quality measure results when comparing 2013 to 2014. The funding for LCAC's allows the communities to focus on initiatives to change and improve health care delivery based on their specific needs.

Integration of Physical behavioral, Dental and NEMT has given us opportunities to better integrate care. For example, EOCCO is now beginning to pay for behavioral health services provided by licensed mental health professionals employed within PCPCHs. We are working with our DCO partners on reducing emergency department utilization related to dental issues and we are now working with a single NEMT brokerage where before the integration we had three within our geography.

Overall we believe all our initiatives are moving us forward towards meeting the Triple AIM objectives. With a predictable and sustainable global budget, we believe that EOCCO can continue to change healthcare delivery and financing within the EOCCO geography.

Transformation Grants

EOCCO's focus on communities and counties was taken into consideration in developing its strategy for the use of its $1.6 million in transformation funds. With our diverse geography and the varied and unique needs of each community, we knew that a one-size-fits-all approach would not work. As a result, and with agreement by the EOCCO board, we implemented our own grant process. We issued widespread requests for applications within our 12 counties including hospitals, providers, public health and our LCACs. Our goals and strategies for this approach were to:

1. Fund the most innovative projects from our providers and communities that are related to overall transformation goals. Our goal was to implement the most transformative and effective projects across our CCO which would be sustainable after the transformation funds were exhausted.
2. Fund at least one project in each of the 12 counties of our service area and for similar projects in the same county we required collaboration between the applicants as a condition of funding.
3. In order to have a fair and impartial review process, Moda, using its own funds on behalf of EOCCO, hired the OHSU Center for Evidenced-based policy to administer the grant making process.

Overall we received 36 proposals totaling $2.8 million dollars in requested funds. We ended up funding 23 of the projects and met our goal of funding at least one grant in each county. It's also important to note that 100% of the $1.6 million in transformation funds was distributed throughout the communities. None of the funds were used to cover administrative expenses.

Examples of our transformation grants include:

South Gilliam County Health District (Gilliam County) - EOCCO funded the building of a wellness center in Condon that will be attached to the health district office. Goals of the wellness center are to decrease obesity rates and disease burden, provide access and equipment for physical therapy, which is a service not available in the community today. The wellness center will benefit the entire community, not just the Medicaid population.

Good Shepherd Health Care Systems (Umatilla County)- The purpose of this grant was to create a workforce of community health workers (in collaboration with the Community Action Program East Central Oregon, Umatilla Public Health and the Hispanic Advisory Committee) to conduct community outreach, assist with health promotion, health coaching, case management, referrals for follow-up services and health screenings. The goal was to reduce health disparities by lowering ED rates among low income families and minorities.

Morrow County Community Advisory Council (Morrow County) - The county hired two nurse care managers to address unmet health needs for women and children. Their focus is on prenatal care, well child checkups including behavioral health services and screenings. The county developed a care team that includes multiple state and public agencies within the county such as head start and school districts. Funding of this grant also supports one of the CHIP activities identified by the county.

Once these initial projects are completed we will begin implementing the most transformative, effective and sustainable programs.

3. Integration of Physical, Mental and Behavioral health

EOCCO is unique in that GOBHI, which was a Mental Health Organization (MHO) for the Oregon Health Plan since 1994, was one of its founding partners. This equity position has dramatically changed the dynamics of behavioral health in the region.

The Substance Use Disorder (SUD) Treatment benefit, previously managed as part of the physical health benefit, and now managed as part of an integrated behavioral health benefit *throughout* the region.

As a not-for-profit MHO, GOBHI historically sub-capitated its risk to the Community Mental Health Programs that served as the backbone of the delivery system. Unfortunately, funding was almost entirely focused on the populations with the greatest needs and funds were often not adequate to provide preventive services or earlier integration. Under the CCO model, contracts now are being awarded to Tier 3 PCPCHs to employ licensed mental health professionals who deliver integrated services. In a further effort to de-stigmatize access to behavioral health services, GOBHI, in collaboration with the Intermountain Early learning Hub, is funding CARE Coordinators and de-identified mental health professionals to work in the schools of Umatilla, Union, and Morrow counties. The efforts of these individuals are population-based prevention to assist teachers and other school employees in the early identification of children with emerging behavioral health needs. Services then are provided in trauma-informed individual and group settings at the schools, up to and including therapeutic classrooms. Through collaborations such as these children are now being served in their community rather than being transported across the state for specialty care.

The opportunity to be involved in the life of the entire person and family rather than just being a provider of specialty care has dramatically changed the role of GOBHI and all of its providers. As the risk-bearing entity for Non-emergent Medical transportation (NEMT) we see the needs of people with multiple chronic conditions as much more than simply transportation. Working with the transportation brokerage, we are having the same drivers consistently assigned to these individuals and are working to get these drivers certified as community health workers. Our goal is to build on these relationships to provide numerous services and supports to these individuals, such as shopping, exercise, engagement in educational opportunities to assist with management and recovery from these conditions. As a risk-bearing owner of the CCO, GOBHI is actively engaged in the development of pain clinics in conjunction with local partners to provide evidence-based care to those suffering from chronic pain and to offer prescribers alternatives to medications for the relief of pain. In the system from which we are migrating, twice as much was spent on opiate prescriptions as on outpatient SUD treatment. EOCCO and all of its owners are working diligently to change this as we move toward achieving the Triple Aim.

4. Quality Measures

EOCCO believes that the CCO quality measures are resulting in more preventative care, improved outcomes and are an important element to achieving the Triple Aim. As a result EOCCO has developed a number of initiatives and made some significant investments with the EOCCO quality measure funds received to date. A summary of this work has been provided for your reference.

In 2013 EOCCO met 12 of 17 quality measures and received 80% ($1.9 Million) of our eligible quality measure withhold. The EOCCO board used these funds to make investments in two key areas.

1. Future technology assistance for our providers so that clinics can report accurate clinical data.
2. A distribution of funds to PCP's, Hospitals, GOBHI and our Local Community Advisory Council (LCAC) partners to recognize collective efforts in helping EOCCO meet quality measure targets.

Although the 2014 quality measure results have not been finalized EOCCO is expecting to meet at least 13 of 17 quality measures and is expecting to receive 100% or $6 Million in eligible quality measure withhold payments.

The EOCCO board has finalized its proposed distribution of the 2014 quality measure funds:

1. Additional funding for technical assistance to improve accurate clinical data reporting.
2. Increased funding to State certified tier 3 Patient Centered Primary Care Homes (PCPCHs) from $8.00 PMPM to $15.00 PMPM. Incentives for tier 2 PCPCH's to become tier 3's by increasing PCPCH payments by an additional $2.00 PMPM with a pledge to achieve Tier 3 status within six months. EOCCO believes that highly functioning advanced tier PCPCHs represent EOCCO's best opportunity to achieve quality measure targets.
3. EOCCO will develop a formula that will allow distribution of future quality measure funds to primary care providers who meet selected quality measures targets beginning in 2015.
4. EOCCO is establishing a fund to provide future transformation grants.
5. EOCCO will begin paying for community health worker services when provided by a State-certified community health worker.
6. EOCCO recognizes that there is an inadequate provider workforce in rural eastern Oregon and this represents a major obstacle to health care transformation in EOCCO's service area. EOCCO has allocated funds to pursue options to expand residency programs in the EOCCO service area.
7. EOCCO will provide additional funding to each of our LCACs. The funds will be used for grass roots community initiatives that will help EOCCO achieve the Triple Aim and meeting quality measure targets.

Quality Measure Improvements:

The following chart illustrates that our focused efforts have resulted in a number of improvements in our 2014 quality measure results compared with 2013 (for the 2014 results currently available). For example, in 2013 we did not meet the SBIRT or Follow-Up after hospitalization for mental illness measures but we are meeting these in 2014.

Measure	2014 Rate (preliminary)	2013 Rate	2014 Target
Alcohol and Drug Misuse Screening (SBIRT)	5.5%	0.8%	3.8%
ED Visits (per 1,000 member months) *(lower is better)*	53.5	59.2	57.7
Developmental screening (0-36 months)	35.9%	30%	32%
Electronic Health Record Adoption	60%	44.8%	47.8%
Follow-Up after hospitalization for Mental Illness	60%	55.3%	58.3%
Mental and Physical Health Assessment for Children in DHS Custody	66.7%	55.3%	58.8%

Quality Measures that Need Improvement:

The following chart illustrates some quality measures that EOCCO has not met or that need further improvement.

For example, EOCCO has not met the Adolescent Well Care Visit measure for the past two years. Our 2014 rate on the AWC measure is particularly disappointing as we created an incentive in the form of a gift card for those individuals who received the screening. Despite our efforts to improve our results over 2013, we did not meet this measure.

While we met our SBIRT target for 2014, we are still well below the statewide benchmark. We will be further challenged in meeting SBIRT in 2015 as the screening now includes children/teens 12 and older. Prior to 2015 the SBIRT screening was limited to adults over 18.

The CAHPS access to care measure is a state administered member survey that asks members questions such as "Did you receive care for illness/injury/condition as soon as you thought you or your child needed it?"

We believe that EOCCO is in jeopardy of missing this measure again for calendar year 2014 as a result of the ACA expansion and the lack of any new significant provider access points in Eastern Oregon.

Measure	2014 Rate (preliminary)	2013 Rate	2014 Target	2014 Benchmark
Adolescent Well Care Visits	23.7%	22.3%	25.8%	57.6%
SBIRT	5.5%	0.8%	3.8%	13%
CAHPS-Access to care	TBD	83.7%	85.6%	88%

Actions to Improve Performance:

There are a number of on-going activities in place to improve our quality measure results. This work is also taking into account the increased targets and new quality measures that were implemented for 2015. Examples of this work include but are not limited to:

- EOCCO quality measure sub-committee: The purpose of the subcommittee is to identify the incentive measures we want to target for improvement and to develop specific programs/tools to support the identified improvement activities. As a result of the sub-committees work, EOCCO implemented a number of training activities and developed tools to assist our providers with incentive measure improvements in 2013 and 2014.

- Annual Clinician Summits: EOCCO hosted Clinician summits in 2013 and 2014. Part of the summit is used to educate providers about the 17 CCO incentive measures. During the 2013 summits EOCCO provided training on two measures (SBIRT/Child Developmental screenings). SBIRT trainings continued throughout 2013 and 2014 for specific practices.

  The 2014 summit included educating providers about the incentive measures as well as sharing examples of best practices along with providing an overview of the 2013 results and the status of the 2014 results.

- PCP Progress Reports: EOCCO began sending progress reports to all primary care practices in 2013. The progress reports target 7 of the 17 incentive measures that we believe primary care providers can have the most impact on. The progress reports include information about the incentive measures, the clinics specific rate compared to EOCCO's target and which of the clinics patients are in need of specific screenings i.e. SBIRT, Adolescent Well Care visits, etc.

- Adolescent Well care visits: In 2014, EOCCO created an incentive that rewarded teens with a gift card if they completed a visit during the calendar year. In addition to the gift cards some of our LCACs used a portion of their 2013 quality measure funds received from EOCCO to focus on improved Adolescent well care visit rates. LCACs used a variety of different strategies. For example, Community Health Education programs, Health Fairs and Community Screenings were used to improve

EOCCO's rate. Other LCACs chose to pay clinic staff to call and schedule visits with members while others produced flyers and purchased media. While we had success improving our Adolescent Well Care visit rates in certain counties EOCCO's overall rate didn't change much over our 2013 rate. Our focus for 2015 is to work with school-based health centers and primary care practices that perform sports physicals to turn those screenings into full AWC visits.

- SBIRT: We will focus on outreaching to providers that see a large proportion of adolescents to improve our SBIRT rate in 2015. This will be in addition to recruiting new practices to implement the screenings for adults. EOCCO works with staff at OHSU who are able to train practices to implement SBIRT screenings.

- CAHPS Access to Care: While access to care continues to be an issue for rural eastern Oregon, we continue to make investments in improving access. For example, our increase in PCPCH PMPM payments will allow some practices to extend their days/hours of operation to improve access and further reduce unnecessary emergency department visits. EOCCO is also starting some PCPCH learning collaborative to help additional clinics obtain PCPCH certification and offer open access scheduling.

  Moda, in partnership with the Pendleton IPA, also made an investment in a new Medicaid clinic in Pendleton to expand access to care. The clinic offers a safety net within the community and was a strategic investment that was made in advance of the ACA expansion. EOCCO also supported the opening of a new clinic in Lakeview to address access needs in that community. Additionally, as mentioned above, the EOCCO board chose to invest $1 Million from our 2014 quality measure funds to address the inadequate provider workforce in rural eastern Oregon. The funds will be used to pursue options to expand residency opportunities in the EOCCO service area.