Transformation Fund Final Report

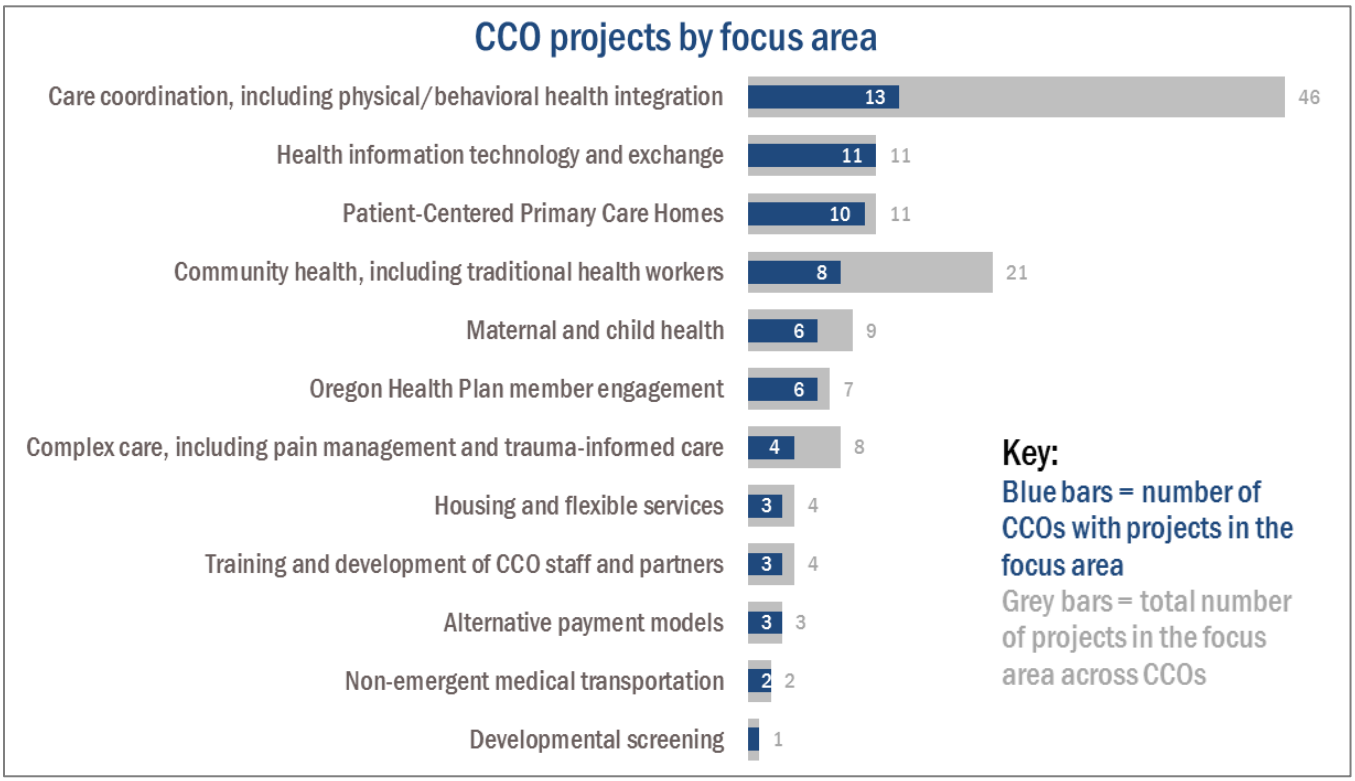
August 5, 2016

The Health System Transformation Fund, approved by Oregon's Legislature in 2013, provided a strategic investment of $30 million in the 16 coordinated care organizations (CCOs). These funds were used by CCOs to develop innovative projects that support better health, better health care and lower costs in their communities. A portion of the fund ($3 million) also leveraged 90 percent federal funding to invest in statewide health information technology to share and aggregate electronic health information. See appendix A for details about how the funds were distributed amongst CCOs.

The remaining funding led to 127 projects that positively impacted health care utilization, care integration, provider capacity, patient outcomes or a combination of these factors. Final progress reports indicate that projects are leading to outcomes such as decreased emergency department visits and greater access to primary care or prenatal care.

Summary of CCO Transformation Fund projects

Each project was designed to be innovative, scalable, transferable and related to CCO transformation plans. The wide range of projects across the 16 CCOs reflects the individual strengths and needs of each CCO community. CCO projects fit into the 12 focus areas shown below. See appendix B for a description of each focus area.



Project results and impact

In their final Transformation Fund progress reports, CCOs indicated that launching many of these innovative projects would not have been possible without the Transformation Fund grants. Final reports also provided valuable information about the reach, sustainability and targets met for each project, as well as the creation of ongoing community grant programs within CCOs. Specifically:

- **Project reach –** The 127 projects had statewide reach, with all 36 Oregon counties being served by at least one Transformation Fund project.
- **Projects sustained** – One hundred (79%) of the projects will be sustained. Over half have received CCO funding, over one-third have secured funding through a community partner, and about 20 projects will be funded through billable services. Some projects will be sustained through more than one funding source.
- **Measures met –** CCOs developed their own set of unique metrics for each Transformation Fund project. In total, 441 metrics were developed, and 357 (81%) measures were reported as being met. Some areas of success included developmental screening, training and development of CCO staff and partners, alternative payment models, community health and traditional health workers, and patient-centered primary care homes. The widest variation in CCOs' ability to meet their targets were for care coordination and community health projects, which were also the two categories with the largest number of projects. Challenges included implementing projects within the funding period, especially information technology projects, and staffing new positions. Metrics also varied greatly in how difficult they were to meet during the funding period.
- **Continuing community grant programs –** The Transformation Fund projects helped establish a process for future funding of innovative projects within the CCOs. As a result of their Transformation Fund experience, all CCOs have either set up or are in the process of finalizing a formal, internal grant-making process to fund community innovation projects and programs.

Project highlights

Transformation Fund projects implemented by CCOs are helping to transform the system to achieve better health, better care and lower cost through:

- Decreased emergency department visits;
- Expanded provider capacity;
- Advanced care integration;
- Enhanced primary care;
- Improved health outcomes of patients with complex needs;
- Decreased costs through changing payment models;
- Improved community health; and
- Reduced opiate use.

For more details, see Figure 1 below, which highlights one innovative project per CCO. The summary of all 127 projects, including CCO, focus area, description and sustainability plan, is available at: http://www.oregon.gov/oha/HPA/CSI-TC/Documents/Transformation-Fund-Projects.pdf.

Figure 1: CCO Transformation Fund Project Highlights

Each CCO was asked to choose one Transformation Fund project to highlight. Projects were then grouped based on eight common project goals.

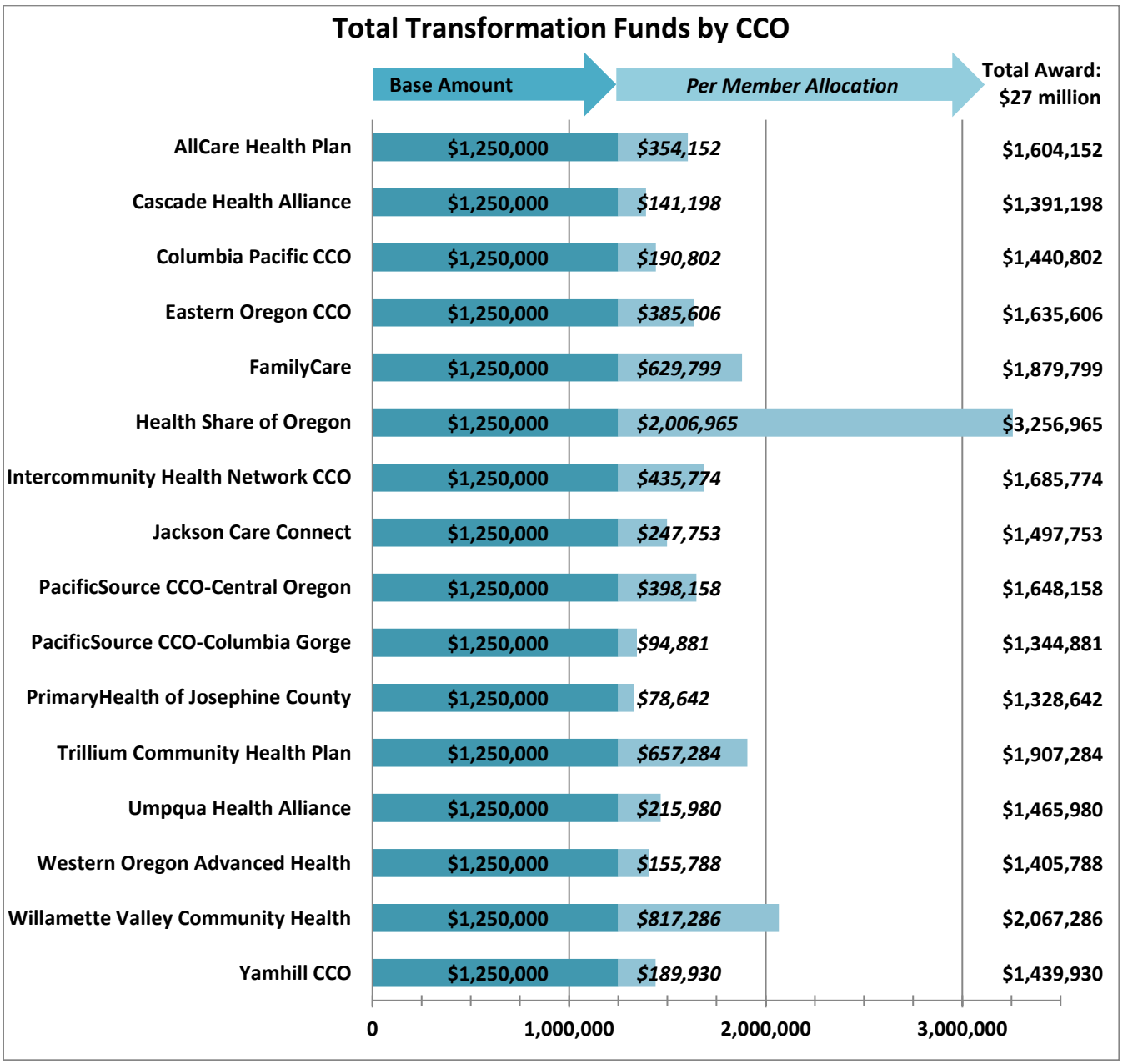
Project goal	Description	CCO Project Examples
Decrease emergency department visits	Many projects diverted emergency department visits and facilitated access to primary care by meeting Oregon Health Plan (OHP) members where they are, such as in schools and service sites for the homeless. CCOs strengthened multi-sector partnerships with housing, education, corrections and social services.	**Cascade Health Alliance** developed the first-ever local short-term youth crisis respite program to improve services to youth with behavioral health disorders and keep families and other community supports more closely engaged with fewer transfers outside of the community. Pine View, a 12-bed respite residential program for boys and girls ages 12-18 experiencing a severe behavioral health episode, has served 29 youth from the community. It is fully self-sustaining through Medicaid and Department of Human Services funding.
		Western Oregon Advanced Health improved care coordination by developing patient risk stratification data to identify patients at greatest risk for avoidable emergency department and hospital visits.
		Yamhill CCO prevented unnecessary emergency department use through a community paramedicine program delivering routine and follow-up care. Members enrolled in this program have had a 5.7% reduction in ambulance transport costs, 6.2% reduction in inpatient service costs and 16.8% increase in primary care costs.
Expand provider capacity	Some projects improved patient outcomes through increased coordination of care and expanding the capacity to provide care through the use of tele-mentoring and traditional health workers.	**PacificSource – Central Oregon** increased access to specialty care by implementing telemedicine cardiology services in a rural primary care clinic.
		Health Share of Oregon increased primary care capacity by implementing Project ECHO, an evidence-based tele-mentoring program that includes lectures and case studies with specialists through videoconferencing. As of January 2015, the program had held 55 sessions focused on psychiatric medication management, with approximately 21 primary care providers attending each session in the second cohort. In the second year, Health Share shared costs with Columbia Pacific CCO, expanding access outside the metro area. Based on the success of the pilot, Health Share will fund a second ECHO clinic focused on developmental health.
Advance care integration	Projects advanced integration of care, including behavioral and oral health into primary care.	**Eastern Oregon CCO** improved access to behavioral health services by co-locating a bilingual behavioral health clinician in the Yakima Valley Farm Workers Clinic in rural Umatilla County. In six months, 930 patients (14.4%) met with the behavioral health consultant. More than 50% of patients with positive screens significantly improved their depression (PHQ-9) scores and about 68% significantly improved their anxiety (GAD-7) scores.
		InterCommunity Health Network improved integration of care by establishing a regional electronic health information exchange. This shared resource brings together information from physical, behavioral, oral and pharmacy providers, as well as safety net organizations. With patient data from public, private and nonprofit partners shared in one system, partners are empowered to collaborate on patient-centered, whole-person care.

Enhance primary care	Projects improved primary care delivery systems by increasing the availability of patient-centered primary care homes.	**PrimaryHealth of Josephine County** improved birth outcomes and increased access to comprehensive care by partnering with Women's Health Center of Southern Oregon to develop a maternal medical home. Efforts included care management, warm hand-offs to behavioral health services, dental referrals and medical assistant certifications. Every prenatal patient at the clinic was screened for clinical depression and substance abuse for five straight quarters, and 98% of pregnant women received timely prenatal care, which is care within the first trimester or within 42 days of Medicaid enrollment. The CCO considers this project to be one of its most "upstream" efforts toward system transformation and it will continue to be funded.
		Trillium Community Health Plan improved care coordination by hiring nine clinical performance assistants to improve workflow and performance at 14 clinics. Between February and June 2015, this team scrubbed 25,000 charts and closed over 7,000 care gaps. The clinical performance assistants contacted members and encouraged them to receive preventive services and establish relationships with their patient-centered primary care homes.
Improve health outcomes of members with complex needs	Many projects improved the coordination of care for CCO members with complex health needs.	**Willamette Valley Community Health** developed a centralized care coordination system to bring together the medical, mental health, school and support services that provide care to children with complex medical needs and their families. Family support coordinators trained in wraparound care models have become a permanent component of the CCO's delivery model.
		FamilyCare, Inc. established nine Patient/Provider Oriented Resource Teams (P2ORTs), which consist of care management professionals who provide integrated care services to achieve effective, timely and positive connections between providers and members. The teams respond to enrollment and eligibility questions; coordinate services and transitions; manage primary care provider assignments; schedule appointments; assist with interpreter services, transportation and other logistics; and answer billing, claims and benefits inquiries. One team is culturally specific in collaboration with the Asian Health and Services Center, and one team serves the Medicare Dual population. As of June 2015, the teams served 100% of practices and 100% of members with complex health care needs. During this time, emergency department use decreased to 36.7%, and readmission rate was reduced to 12.8%.
		PacificSource – Columbia Gorge improved care coordination for members with complex health needs by enhancing stakeholder communication through the Jefferson Health Information Exchange. A community health record connects the CCO to social services and nonprofit organizations, including the regional jail. The exchange receives direct data feeds from clinics, and area hospitals are also being connected. As of December 2015, 39 organizations were enrolled in the exchange and providers had made more than 600 unique searches for client information in the community health record.

Decrease cost of care by changing payment models	Some CCOs focused on implementing alternative payment models, including paying for value instead of volume and incentivizing changes in primary care practice patterns.	**AllCare CCO** is paying providers differently to improve the quality of care, population health and patient experience at a lower cost. Alternative payment models were developed for primary care, pediatrics, specialty care, behavioral health, dental care and facilities (hospitals, skilled nursing facilities and surgery centers). Each value-based payment method has a shared savings component that rewards providers who ensure access to care, manage utilization and perform well on quality metrics. The payment models have fostered lasting change by bringing together physical, behavioral and oral health providers to share data, define roles and coordinate care.
Improve community health	Projects engaged members in wellness activities and education to help manage chronic diseases and encourage preventive health, including classes, gym memberships and preconception health incentives. Community advisory councils guided many of these projects as part of implementing their community health improvement plans.	**Jackson Care Connect** implemented several community wellness initiatives to improve care for members including YMCA passes (1100 members generating 9000 visits monthly at one location), a bike-share program (132 members participating), Starting Strong perinatal incentive program (138 members participating), and a shower and laundry trailer to support members in transitional housing. As of December 2015, 3,000 members benefited from these programs. **Umpqua Health Alliance** partnered with local businesses and agencies as part of its community health improvement plan to provide free or low-cost access to exercise activities, healthy eating and living events, and educational classes in the community. One highlight was the Healthy Living Challenge, a physician-referred, 12-week, outcome-based health and wellness program.
Reduce opiate use	Projects implemented strategies to reduce opiate use for chronic non-cancer pain including community-wide opiate prescribing guidelines and alternative pain management programs.	**Columbia Pacific CCO** developed three persistent pain clinics in rural settings – one in each county the CCO serves. Patients with chronic, non-cancer/non-terminal illness pain are enrolled in a 10-week behavioral health and movement-based group program. As of January 2016, 682 patients had been referred to the program and 66 patients had completed the program. Over 68% of graduates had a pain self-efficacy score of 30 or greater and an average improvement in depression (PHQ-9) scores of 5.3 points.

Appendix A: Transformation Fund Distribution

Health System Transformation Fund Total:	**$30,000,000**
Amount allocated for shared statewide HIT investments:	**$3,000,000**
Amount distributed for Transformation Projects:	**$27,000,000**
Total number of Transformation Fund Projects:	**127**



Appendix B: Transformation Fund Project Focus Areas

Care coordination, including physical/behavioral health integration
Organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care

Information technology and exchange
Technology and information exchange that allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically – improving the speed, quality, safety and cost of patient care

Patient-Centered Primary Care Homes
A health care clinic that has been recognized for their commitment to patient-centered care; care is organized around patient needs

Community health, including traditional health workers
Health initiatives focused on population groups and communities; this also includes projects involving traditional health workers, such as peer support specialist, health navigators, community health workers and doulas

Maternal and child health
Programs organized to provide medical and social services for mothers and children, including prenatal and postnatal services, family planning care and infant pediatric care

Oregon Health Plan member engagement
Activities to engage Oregon Health Plan members in their care

Complex care, including pain management and trauma-informed care
Activities addressing needs of patients with chronic illness, chronic pain, histories of trauma and social and behavioral barriers

Housing and flexible services
Health-related services provided to members outside of the typical medical services

Training and development of CCO staff and partners
Training to promote the capacity of CCO staff and partners to transform health

Alternative payment models
Provider payment models that pay for quality and outcomes

Non-emergent medical transportation
Developing or expanding availability of transportation to assist members in getting to health care appointments and receiving pharmacy deliveries

Developmental screening
A test to tell if a child is learning basic skills when he or she should, or if there are delays