Transformation Fund Projects by Coordinated Care Organization

CCO	Focus area	Project	Project summary	Did the CCO intend to continue the project?	Method of sustainability
AllCare Health Plan	Alternative payment models	**PCP Alternative Payment Model**	The CCO designed and implemented six value-based payment methods for primary care, pediatrics, specialty care, mental health and addiction recovery, oral health and facilities. The payment models have fostered lasting change by bringing together physical, behavioral and oral health providers to share data, define roles and coordinate care. The program will become self-sustaining, with a portion of shared savings invested in community health worker training to address social determinants of health.	Yes	Self-sustaining based on billing
Cascade Health Alliance	Care coordination, including integration of physical and behavioral health	**Mobile Crisis Team**	The mobile crisis team responds on-site to mental health crises in Klamath Falls, providing mental health and substance abuse crisis intervention at homes, schools and in the community. The team partners with local first responders, with the goal of diverting individuals from more intensive levels of care. By July 1, 2015, the intervention team received 958 crisis calls and diverted 538 emergency room visits. The program is currently self-sustaining.	Yes	Self-sustaining based on billing
Cascade Health Alliance	Care coordination, including integration of physical and behavioral health	**Youth Crisis Respite and Residential Program**	The youth crisis respite and residential program (Pine View) is an 8-bed, therapeutic living environment for youth with behavioral health disorders. As the first psychiatric respite facility in the county, youth can now stay in their community and maintain important connections with family and community supports. Twenty-nine youth from the community have been served who previously would have had to be sent out of the county for services. Pine View is fully self-sustaining through Medicaid and DHS funding.	Yes	Self-sustaining based on billing
Cascade Health Alliance	Care coordination, including integration of physical and behavioral health	**Care Coordination Program**	The CCO implemented a case management software program for case managers to document activities, develop care plans and report trends. The increased efficiency gives staff more capacity to engage with members, including high risk maternity and special needs patients.	Yes	CCO funding
Cascade Health Alliance	Community health, including traditional health workers	**Community Healthcare Worker and Non-emergent Medical Transportation**	This program established a team of five community health workers who also provide transportation to non-emergency medical services. The community health workers serve high-risk, high-hospital utilizing clients, and they act as advocates and guides and help clients overcome barriers. Emergency department visits decreased among the 320 program clients.	Yes	Partner funding
Cascade Health Alliance	Information technology and exchange	**Implementation of a Health Information Exchange (HIE) System - Jefferson Health Information Exchange (JHIE)**	The CCO connected to the Jefferson Health Information Exchange (JHIE), a secure, electronic exchange of patient health information among Oregon doctors and health care providers. By the end of 2015, 29 clinics and 136 providers in Klamath County were connected to the information exchange. Benefits include secure messaging, immediate notification when members visit the emergency department and discharge summaries, and better ability to coordinate care.	Yes	Self-sustaining based on subscription fees
Columbia Pacific CCO	Care coordination, including integration of physical and behavioral health	**Crisis Respite Capacity**	A crisis respite facility is being developed for Clatsop County and will open by April 1, 2016. Currently there is no psychiatric crisis respite access in the CCO service area, with the only options being the hospital or jail. The new residential treatment facility will offer varying levels of care with about 15 beds.	Yes --> Crisis Respite Facility; No --> Mobile Crisis Unit.	Self-sustaining based on billing
Columbia Pacific CCO	Care coordination, including integration of physical and behavioral health	**SBIRT Training for Primary Care Providers and Support Team**	This project included providing Screening, Brief Intervention and Referral to Treatment (SBIRT) training for providers and staff at two primary care clinics. The clinics have used this evidence-based approach to screening for alcohol and drug use with 2,884 patients (including 100 full screens).	No	Partner funding
Columbia Pacific CCO	Care coordination, including integration of physical and behavioral health	**Detox Bed Capacity**	Bridge to Pathways is a medical and residential 9-bed detox facility. Prior to this project, the CCO service area had no medical-level detox services. Bridge to Pathways has been averaging 4-9 clients per day, and the average stay is 5-10 days. Clients get into detox services within 24-48 hours, and a case manager helps clients set up aftercare, housing and other residential care facilities. The facility is now self-sustaining through billable services.	Yes	Self-sustaining based on billing

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Columbia Pacific CCO	Care coordination, including integration of physical and behavioral health	**Telehealth Interventions - CareMessage**	The CCO is piloting CareMessage with two clinics to use "smart" text and voice messaging to reach Medicaid members with specific medical conditions. The automated program integrates the electronic health record, provides education and encouragement and solicits information. One clinic is offering a diabetes type II education program and the other is piloting a smoking cessation education program for pregnant women. Patients have reported perceived benefits from the educational materials and medication reminders.	Yes - through mid-2016	CCO funding
Columbia Pacific CCO	Community health, including traditional health workers	**Community Health Assessment and Community Health Improvement Plan**	Using a community engagement process, the CCO completed a community health assessment for each of its four counties. Local community advisory councils identified community health priorities and developed a CCO-wide community health improvement plan. Nine community wellness fund grants have been awarded throughout the CCO service area to support the identified priorities, including improving mental health, reducing substance abuse and increasing physical activity.	Yes	CCO funding
Columbia Pacific CCO	Complex care, including pain management and trauma-informed care	**Opiate Performance Improvement Project**	The Opiate Performance Improvement Project established CCO-wide opioid prescribing guidelines and opened three behavioral health and movement based pain clinics in rural settings. Cohorts with persistent, non-cancer/non-terminal illness pain go through a 10-week group program with one 3-hour session per week. As of January 2016, 682 patients had been referred to the program and 66 patients had completed the program. Over 68% of graduates have a pain self-efficacy score of 30 or greater and an average improvement in depression (PHQ-9) scores of 5.3 points.	Yes	Self-sustaining based on billing
Columbia Pacific CCO	Complex care, including pain management and trauma-informed care	**Reducing Inappropriate Emergency Department Use in High-risk Patients**	This project tested two pilots: clinical pharmacists and health resilience specialists. The clinical pharmacist is placed within a hospital system and conducts comprehensive medical reviews and transitions of care for patients at higher pharmaceutical risk. The health resilience specialists follow CareOregon's Health Resilience Program model and empower, educate and walk alongside patients who are at high risk (including chronic opioid use, frequent emergency department use, comorbidities and polypharmacy). The goal of both pilots is to reduce inappropriate emergency department use and ensure patients receive the right care at the right location and time.	Yes	CCO funding and billing
Columbia Pacific CCO	Complex care, including pain management and trauma-informed care	**Resilience Trumps ACEs/Trauma Informed Care Project**	This project will implement the Trauma Informed Care model of the National Council for Behavioral Health. The CCO has not yet finalized its strategic plan for implementing the model, but the CCO will be assessing and training clinics in trauma informed care as part of the 2015-2017 Transformation Plan.	Yes	CCO funding
Columbia Pacific CCO	Housing and flexible services	**Healthy Homes Demonstration Project**	The Healthy Homes Demonstration Project includes home evaluations and modification projects to impact health and safety. Clinics refer patients who are at high risk for respiratory illness or falling to the St. Helens Community Action Team, who then conduct the evaluations and remediation projects like removing carpet and installing ramps. As of December 2015, 22 households have participated in the program, with projects costing an average of $987 each. Healthy Homes was the first time the CCO attempted to address health through the housing lens and found a positive impact on health through relatively low cost, one-time interventions.	Yes	CCO funding
Columbia Pacific CCO	Maternal and child health	**Prenatal Performance Improvement Project (PIP)**	First Steps incentivizes activities associated with a healthy pregnancy and baby. Participants earn incentives by completing activities both within and outside the traditional health care setting such as prenatal appointments, water aerobics and parenting classes. Incentive dollars are then delivered electronically through the Amazon Corporate Gift Card program. As of December 2015, 36 women enrolled and completed almost 200 incentive activities.	Yes	CCO funding

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Columbia Pacific CCO	Patient-Centered Primary Care Homes	**Patient & Population Centered Primary Care Learning Collaborative (PC3)**	Patient and Population Centered Primary Care (PC3) is a learning collaborative of seven clinics within the CCO. This collaborative and coaching structure is designed to support practice transformation to meet the requirements of the Patient Centered Primary Care Home program and to meet triple aim outcomes. The content is organized around leadership, data systems, team based care, clinic systems and care management. Eight clinics have participated in the collaborative and were certified as tier 3 patient-centered primary care homes.	Yes	CCO funding
Columbia Pacific CCO	Care coordination, including integration of physical and behavioral health	**Telemedicine Cart Grant Matching Dollars**	Eleven telemedicine carts were placed throughout the CCO service area to increase access to adult and child psychiatric services in rural communities.	Yes	
Columbia Pacific CCO	Patient-Centered Primary Care Homes	**Project ECHO**	Columbia Pacific CCO partnered with Health Share of Oregon on the ECHO hub-and-spoke educational model for upskilling primary care providers. The two cohorts focused on adult psychiatric medication management.	Yes	CCO funding
Columbia Pacific CCO	Care coordination, including integration of physical and behavioral health	**Diabetic Retinopathy Screening**	This project funded a medical assistant to staff a telemedicine cart that performs non-mydriatic diabetic retinopathy screenings. This will increase access to needed diabetic screening services. The project is self-sustaining through billable services.	Yes	Self-sustaining based on billing
Eastern Oregon CCO	Care coordination, including integration of physical and behavioral health	**Lake County Mental Health: Mental Health First Aid Training**	Lake County Mental Health provided "Mental Health First Aid" training to community partners to raise awareness of mental health needs and treatment resources. By June 2015, 80% of local law enforcement, medical providers, DHS staff, emergency medical services providers and crisis center partners received the training. Because of this project, the mental health agency has seen increases in referrals from the medical community, DHS and community corrections.	Yes	CCO funding
Eastern Oregon CCO	Care coordination, including integration of physical and behavioral health	**Gilliam County CAC: Mental health media campaign and services**	This project included a local media campaign to decrease the stigma associated with obtaining mental health services and efforts to increase availability of counseling opportunities for school-age kids and senior citizens. A school counselor was hired and she saw individual students and provided classroom curriculum. Because the school district was otherwise unable to support a counselor position, this project filled a gap for vulnerable students. In addition, the counselor made 33 counseling outreach visits to a senior meal site and held nine support group sessions at an assisted living facility. Because of this outreach, individual counseling appointments with seniors has increased.	Yes	Private funding
Eastern Oregon CCO	Care coordination, including integration of physical and behavioral health	**Lake Health District: Home Health & Hospice Patient Navigation Team**	The Lake Health District created a patient navigation team to help patients access appropriate care in optimal settings. The program enrolled 42 patients who were frequent emergency department users or had been recently hospitalized with chronic conditions. The navigator has built relationships and empowered clients, who have been successful in keeping appointments with health care providers (95%) and community providers (86.8%). The program has shifted culture, strengthened community agency coordination, and given providers a new resource to address psychosocial and environmental barriers to health. Another piece of this project was to provide 8-month physical activity scholarships. Ninety-six applicants started the program and 20% completed it, with 40% of participants exercising regularly. While some individuals had positive outcomes, the community impact was not big enough to justify the cost.	Yes	Self-sustaining based on billing

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Eastern Oregon CCO	Care coordination, including integration of physical and behavioral health	**Lifeways, Inc. Umatilla: Behavioral Health Community Health Workers**	The ConneXions program includes two community health workers and a unified referral and communication system to streamline care coordination for basic, medical, behavioral and mental health needs and health education and prevention. Providers and community partners referred 128 members to the program, which connected members to services using warm hand-offs and provided patient education, system navigation assistance, care coordination and case management. The program has helped reduce loss to follow-up for behavioral health clients in Umatilla County.	Yes	CCO funding
Eastern Oregon CCO	Care coordination, including integration of physical and behavioral health	**(Malheur County) Saint Alphonsus Medical Center Follow-up After Hospitalization for Mental Health and Substance Use**	Saint Alphonsus Medical Center co-located a behavioral health specialist in the hospital and developed a care coordination program to transition patients to outpatient behavioral health and primary care services. Follow-up rates with referral and treatment are at 100%, with all 61 patients enrolled involved in their treatment. About 40 hospital staff have been trained in Mental Health First Aid. Emergency department readmissions have decreased for patients with mental health needs.	Yes	CCO funding
Eastern Oregon CCO	Care coordination, including integration of physical and behavioral health	**Umatilla County: Yakima Valley Farm Workers Clinic**	A behavioral health consultant was hired and co-located at a rural primary care clinic in 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.	Yes	CCO funding
Eastern Oregon CCO	Care coordination, including integration of physical and behavioral health	**Harney District Hospital: Embedded Behaviorist in Primary Care**	Harney District Hospital Family Care Clinic embedded a full-time licensed medical social worker and implemented tele-psychiatry services within the primary care clinic for eight hours per week. In the first three months, the clinic added about 130 hours of local psychiatrist services to this rural county. With this integrated approach, a higher percentage of patients who were referred for mental health services completed the process by making an appointment and receiving services.	Yes	Partner funding
Eastern Oregon CCO	Care coordination, including integration of physical and behavioral health	**(Baker County) St. Alphonsus Medical Center: Nurse Navigators & Care Coordinators**	This complex care coordination project placed a nurse navigator in the hospital and care coordinators in primary care and behavioral health settings. Between November 2014 and April 2015, 39 referrals were made to the behavioral health specialist, of which 13 people engaged in ongoing mental health services. Out of 1165 people who visited the emergency room without a primary care provider listed, 419 (40%) were assigned a patient-centered primary care home. Baker County residents now have increased access to behavioral health services, and emergency department readmissions have decreased for patients with mental health needs.	Yes	CCO funding
Eastern Oregon CCO	Care coordination, including integration of physical and behavioral health	**North Central Public Health District: Public Health Nursing and Care Coordination**	This project implemented home visits from a public health nurse for patients with chronic illness and high utilization of health care services. The program used the evidence-based "Coaching for Activation" model. Provider engagement was difficult because many patients in this frontier county receive care outside the geographic area of the CCO. The most important outcome of the project was heightened awareness of the cross-border service delivery necessary when CCOs serve rural counties without significant health care infrastructure.	No	
Eastern Oregon CCO	Care coordination, including integration of physical and behavioral health	**Blue Mountain Hospital District: EHR Enhancement and Patient Portal**	This project added modules to the hospital district's electronic health record to improve communication among providers, enable patients to access their information and communicate with their health care team, and enable reporting. Modules included ePrescribing for providers to communicate prescriptions to pharmacies electronically and an electronic interface to transfer patient images to radiologists. Greater capacity to track data has allowed providers to better identify patients who require preventive testing.	Yes	

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Eastern Oregon CCO	Community health, including traditional health workers	**South Gilliam County Health District: Wellness Facility**	This project included supplying exercise equipment for a new wellness facility attached to the Mid-Columbia Medical Center, measuring ability to monitor patients' body mass index (BMI), and designing and piloting a wellness program. The facility is free to the public, allows patients to be enrolled by their clinicians, and includes space for physical therapy, which was previously unavailable in the region. About 5% of the community is using the facility daily, with 30% enrolled. The five patients enrolled in the pilot program had an average 4% decrease in fasting glucose, 4% decrease in BMI and 9.5% decrease in systolic pressure.	Yes	
Eastern Oregon CCO	Community health, including traditional health workers	**Malheur County Health Dept.: Community Health Worker Training and Support**	The Malheur County Health Department coordinated a county-wide community health worker training provided by the Northeast Oregon Network (NEON). A culturally and linguistically diverse cohort of 19 participants completed the 90-hour curriculum. This training created a network of trusted community health workers who understand the community's health issues and health care system so they can work to identify, address and resolve underlying causes of persistent health inequities in the community.	Yes	Self-sustaining based on billing
Eastern Oregon CCO	Community health, including traditional health workers	**Good Shepherd Health Care System: Community Health Worker Workforce Development**	ConneXions is a community health worker program that helps clients navigate and engage with the health care system, provides health screenings and education, and connects clients to social service programs. In the first eight months, the program developed a strong support and referral process, with over 900 referrals for community health worker services. The program has implemented bedside assessments within the emergency department and will expand to a hospital and primary care clinic. Clients engaged with community health worker services had an 8% decrease in emergency department readmissions, 7.86% improvement in primary care engagement, 8.65% improvement in health risks, and 97% appointment retention rate.	Yes	CCO funding
Eastern Oregon CCO	Community health, including traditional health workers	**Malheur County Lifeways, Inc.: School-based Adolescent Health**	The Adolescent Health Access (AHA!) project is a school-based intervention to increase access to health and social services for pregnant and parenting youth. A certified community health worker conducted individual interventions, arranged nine small-group health promotion presentations, and helped organize a school-wide health promotion event. The community health worker made 38 referrals for the nine clients from the target population, who had a 87% referral completion (or anticipated completion) rate. Seven other individuals, including two parents of students, were also enrolled. The project had a high proportion of Hispanic clients. The AHA! project showed that having a community health worker in a high school can bridge cultural gaps between teens and community providers and it serves as a replicable model for other rural frontier communities.	Yes	CCO funding
Eastern Oregon CCO	Community health, including traditional health workers	**Wallowa County: Youth Fitness and Nutrition Programming (Fit Fridays)**	Fit Fridays provided physical education programming and nutrition education for children not currently engaged in activities outside the home on Fridays due to the four-day school week. The program held 30 classes in three areas: Wallowa Resources Exploration of Nature, SwimFit and WinterFit. Sixteen community partners contributed time or materials. Fit Fridays reached 90 children and family members, which represents 25% of the K-8 student body with a majority being from high-risk families. Ninety-five percent of youth reported that participating in Fit Friday increased their level of fitness.	Yes	Partner funding and private funding
Eastern Oregon CCO	Community health, including traditional health workers	**Wheeler County CAC: Health Education and Outreach Campaign**	The Wheeler County health education and outreach campaign involved four quarterly community-wide mailings and two 6-month body mass index (BMI) reduction groups. The program included tracking daily exercise and diet on tablets and monthly counseling session. Sixty-eight people (78%) completed the program with an average weight loss of 5.6 pounds per person. About 20% lost 10 pounds or more. Seven scholarships were given to local exercise classes. Mailings were shown to be ineffective, with mixed results in improving physical activity. Going forward, the county will instead try to replicate Wallowa County's success with the Complete Health Improvement Program.	Yes	CCO funding

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Eastern Oregon CCO	Community health, including traditional health workers	**Grant County Community Counseling Solutions: Health Promotion on Obesity, Oral Health and Children's Health**	The "Healthy Together" project hosted monthly educational and participatory group meetings for patients and their families led by health professionals. These meetings focused on mental wellness, aging gracefully (elder health and caregiver health) and medical screenings. Participants were invited to sign up for free wellness activities like cooking classes, walking groups, Living Well with Chronic Illness, blood draws and gym memberships. Participants improved their scores in pre-/post-intervention knowledge assessments, and the events increased awareness of community resources available.	No	
Eastern Oregon CCO	Community health, including traditional health workers	**Wallowa Memorial Hospital: Complete Health Improvement Program**	The Complete Health Improvement Program is an evidence-based 8-week intensive lifestyle intervention program to support adults with chronic disease to develop healthier lifestyle habits. This 18-session program includes live and video lectures, reading assignments, cooking demonstrations, biometric testing and discussion. Wallowa Memorial Hospital held three cohorts, with 134 participants completing the program. Participants saw measurable improvements in every biometric assessment. Overweight and obese participants lost an average of 4.6% of their body weight, and participants with elevated fasting blood glucose reduced levels by an average of 8.5%. Participants with high LDL cholesterol dropped by an average of 12.5%, with many able to decrease or eliminate their need for statin drugs. Participants with dangerous triglyceride levels dropped their levels by nearly 52%, on average. The program is becoming well known in this community of 7,000 people, and stores and restaurants have added healthier products because of customer requests.	Yes	Partner funding
Eastern Oregon CCO	Information technology and exchange	**Blue Mountain Home Health & Hospice: Improved Communication for Hospice and Home Health**	Nine encrypted tablets were purchased for hospice and home health workers so they can do charting in the field instead of traveling back to the office. Once policies were developed and Wi-Fi challenges overcome, the tablets increased productivity and efficiency. Families have a shorter wait time to their first visit and providers can spend more time with each patient.	Yes	CCO funding
Eastern Oregon CCO	Maternal and child health	**Morrow County CAC: Interdisciplinary Community Care Team**	The Community Access for Resources Effectiveness (CARE) team aims to keep students in school by providing wraparound care for students and their families. The team has received 90 referrals from students, teachers, administrators and school counselors. The team connects students and their families to wellness, health, safety, attendance and behavioral supports and helps remove barriers that impact student success. Mental health referrals for youth are a priority, and the team also assisted Advantage Dental with dental screenings in all eight Morrow County schools. Follow-up surveys showed that 97% of respondents had increased their knowledge of community resources and 99% received recommended services.	Yes	
Eastern Oregon CCO	Maternal and child health	**Center for Human Development, Inc. Union County: Low Birth Weight Social Marketing Campaign**	The Union County Preconception Health Project provided incentives to health care providers and women to increase engagement in prenatal care, contraceptive counseling and health services. The ultimate goal of the project was to decrease the number of low birth weight babies. Participants included 211 women who received a $25 gift card for completing an eligible service. The rate of babies with low birth weight in Union County decreased in 2015, though the role of this project has not been established. While the gift card did not seem to be a significant motivator for behavior change, the project did foster greater community collaboration and increased awareness of low birth weight and contributing factors.	No	
Eastern Oregon CCO	Non-emergent medical transportation	**Community Connection of Northeast Oregon Union County: Non-Emergent Medical Transportation**	The Rides to Wellness program expands an existing transportation call center to facilitate same-day health care appointments and pharmacy deliveries to outlying communities in rural Union County. At the end of the first year, the program delivered 847 same-day medical trips (347% of baseline). This program reduced the burden on medical staff to broker trips and provided meaningful medical access to rural communities. While more analysis is needed to determine causation, the program is filling a critical role in allowing clients to age in place and decreasing missed appointments and unnecessary trips to the emergency room. Rides to Wellness has secured temporary preservation funding from the Oregon Department of Transportation and gained national attention.	Yes	Public funding

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Eastern Oregon CCO	Patient-Centered Primary Care Homes	**Warner Mountain Medical Clinic Lake County: Patient Centered Primary Care Development**	Warner Mountain Medical Clinic took several steps toward becoming the first patient-centered primary care home (PCPCH) clinic in the county. The clinic implemented an electronic medical record – the first clinic to do so within a 100-mile radius – and completed the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The clinic has implemented daily provider team huddles and has focused on shared decision-making with patients. The clinic will continue to make improvements to obtain PCPCH recognition.	Yes	
FamilyCare, Inc.	Care coordination, including integration of physical and behavioral health	**Improving Health Information Technology Infrastructure**	To improve health information technology infrastructure, the CCO conducted provider surveys, held information sessions for providers about statewide strategies for health care information technology (Direct messaging and CareAccord) and implemented EDIE PreManage (emergency department information exchange). Several provider groups in the CCO network are also implementing PreManage, which provides real-time notification of emergency department and inpatient encounters. The rate of providers in the CCO using electronic health records increased from 69.8% to 72.9%.	Yes	CCO funding
FamilyCare, Inc.	Community health, including traditional health workers	**Community Health Education (Homeless Youth Care Team, Family Resource Coordination)**	The Community Health Education Project focused on multiple community-based education programs. The CCO partnered with the Gladstone Family Resource Coordination Project, a comprehensive education and human service center. The CCO offered the 6-week Cooking Matters program, an evidence-based curriculum of hands-on cooking and nutrition classes with education about food stamps, WIC and emergency food sources. The CCO helped establish the Outside In Homeless Youth Care Team Project, which incorporates educational aspects into the health services provided to transition-age homeless youth. The CCO also completed three onboarding member benefit seminars in Vietnamese, Chinese, Korean and Spanish.	Yes	CCO funding
FamilyCare, Inc.	Community health, including traditional health workers	**Promoting Nutritional Emphasis**	The Nutritional Emphasis Project focused on establishing nutritionist services by working with providers to share best practices through counseling and trainings. Eighteen dietetic interns were placed in six clinics. The CCO's registered dietician nutritionist (RDN) provided materials and coaching during the internships. The goal of the project was to generate interest and support from providers to incorporate nutritionist services into their medical homes. An RDN visited provider clinics to assess current nutrition-related practice needs and provide trainings.	Yes	CCO funding
FamilyCare, Inc.	Oregon Health Plan member engagement	**Re-Engineering Integrated Care**	Patient/Provider Oriented Resource Teams (P^2ORTs) consist of care management professionals who provide integrated care services to achieve effective, timely and positive connections between providers and members. As of June 2015, nine teams were established and served 100% of practices and 100% of members with complex health care needs. 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. Emergency department use decreased to 36.7%, and readmission rate was reduced to 12.8%.	Yes	CCO funding
FamilyCare, Inc.	Patient-Centered Primary Care Homes	**Patient Centered Primary Care Home (PCPCH) Technical Assistance**	This project focused on providing technical assistance to increase the number of practices within the CCO's provider network that are certified as a patient centered primary care home (PCPCH), as well as increase the level of PCPCH recognition for providers currently in Tier 1 or Tier 2. As of June 2015, 81% of members were assigned to a Tier 2 or Tier 3 PCPCH clinic, and the number of recognized clinics increased from 32% to 76%.	Yes	CCO funding
Health Share of Oregon	Care coordination, including integration of physical and behavioral health	**Addictions Provider Education**	This project supported the new regional opiate prescribing standard by creating a strategy for training providers on addressing addiction, pain and trauma. Key activities included convening a steering committee, delivering six addiction education sessions at grand rounds and trainings, developing six curriculum sessions and holding a day-long CME conference for primary care and behavioral health providers. Over 160 participants attended the conference.	Yes	CCO funding

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Health Share of Oregon	Care coordination, including integration of physical and behavioral health	**Improving Community Care Coordination through Information Sharing**	This project included convening partners to align efforts for multi-system care coordination through the Emergency Department Information Exchange (EDIE) platform. All hospitals in the tri-county area have adopted EDIE, and the CCO purchased PreManage so designated external providers (specialty, primary care, etc.) can view their members' emergency department use. In 2016, the CCO will pilot PreManage with three mental health organizations.	Yes	CCO funding
Health Share of Oregon	Care coordination, including integration of physical and behavioral health	**Leveraging Health Information Technology**	This project included working with Providence Center for Outcomes Research and Education to expand the CCO's reporting capacity to include member engagement, geo mapping, etc. and improve data integrity.	No	
Health Share of Oregon	Care coordination, including integration of physical and behavioral health	**Behavioral Health Promotion/ Prevention**	This project involved a regional approach for community-level behavioral health promotion and prevention activities. Key elements included developing a centralized registry of certified trainers, developing a web-based registration platform for all behavioral health promotion and prevention activities, doing outreach to target populations about training opportunities and launching a regional anti-stigma media campaign.	Yes	Partner funding
Health Share of Oregon	Community health, including traditional health workers	**Enhancing Community Health Integration: Community Health Improvement Plan**	To support areas of need identified in the CCO's community health improvement plan, the CCO supported six community-based organizations in hiring community health workers and peer support specialists to work with members with chronic disease and behavioral health issues. All five organizations with data available exceeded the target number of patients served.	Yes for all projects.	CCO funding, private funding and fees
Health Share of Oregon	Housing and flexible services	**Enhancing Community Health Integration: Chronic Disease Management Programs in Supported Housing**	This project focused on integrating chronic disease self-management programs in supportive housing environments. A public health nurse made 677 visits with residents, with an average of 10 visits per resident. Activities included 52 organized walks, 12 food distribution events, 34 client visits with a nutritionist, and a weight loss support group with 26 participants. Due to difficulty engaging residents in Living Well services, Clackamas County and the CCO are partnering on the OHA Sustainable Relationships for Community Health project to close the referral loop between providers and Living Well with Chronic Conditions and diabetes education classes.	Yes for all	Partner funding
Health Share of Oregon	Housing and flexible services	**Enhancing Community Health Integration: Expand Healthy Homes Asthma Program**	This project expanded Multnomah County's Healthy Homes Asthma Program to Washington and Clackamas counties. The program includes a community health nurse and community health worker who provide home visits to identify and remove asthma triggers in the home. The program provides education and supplies (pillows, bed covers, vacuums) for families and works with housing partners. Emergency department use and hospitalization have decreased for asthmatic children whose families completed interventions. In Washington County, the percent of program clients with uncontrolled asthma decreased from 83.3% to 8.3% after the intervention.	Yes for all	
Health Share of Oregon	Maternal and child health	**Enhancing Community Health Integration: Future Generations Collaborative**	The Future Generations Collaborative began in 2011 as a partnership of the Native community and local health/human services government agencies. The collaborative is committed to improving the health of urban Native communities by identifying and addressing the causes of substance-exposed pregnancies among 15-24 year olds. During this grant, the collaborative recruited 12 new elders/natural helpers, graduated the first cohort of 31 Native-identified community health workers trained and working in an urban setting, delivered four fetal alcohol spectrum disorder trainings for health care providers and community health workers, and held four powwows and community events. The collaborative plans to expand their collective impact model to work closely with the Healthy Birth Initiative, which addresses disproportionate poor birth outcomes among Black families.	No	

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Health Share of Oregon	Maternal and child health	**(New) Project Nurture: Improve care for pregnant women with substance abuse**	Project Nurture is a collaboration of five community partners to integrate prenatal, postnatal and pediatric services in an addiction treatment setting, and to integrate addictions treatment services in a midwifery clinic. At both locations 100% of participants were engaged in substance use services during prenatal care. In the addiction treatment setting, 76% of women were engaged in substance use services postpartum. In the final reporting period, there were six births and no DHS removals (including one adoption and one unknown status). Patient stories highlight the positive impact of the program on their lives.	Yes	CCO funding
Health Share of Oregon	Oregon Health Plan member engagement	**Engaging Members**	This project changed workflows to incorporate progressive visits for new patients. A member navigator (registered nurse) does the front-end work including health and medication history, medication reconciliation, chronic disease education, etc. The patient then sees a provider for their exam, then has additional time with the nurse to get connected to resources (behavioral health provider, clinical pharmacist or community health worker). These visits take approximately 100 minutes. Through this process, 2,537 patients were assessed and established into primary care. Patient satisfaction increased as a result of this project, and patients felt their medical needs were met above and beyond their initial expectations.	Neighborhood Health - Milwaukie Clinic --> No Virginia Garcia - Beaverton Clinic --> Yes	
Health Share of Oregon	Patient-Centered Primary Care Homes and information technology and exchange	**Strengthening Primary Care Capacity: Telementoring (Project ECHO) and development of an Advanced Primary Care Model**	Project ECHO is an evidence-based tele-mentoring program that uses videoconferencing to increase the capacity of primary care providers by connecting them with a specialist team. Project ECHO sessions include lectures and case reviews. The first two cohorts focused on psychiatric medication management, with evaluations indicating improved knowledge and comfort in managing patients with complex psychiatric diagnosis and medications. Fifty-five sessions have been held, with an average of 21.5 providers participating per session in cohort two. A second ECHO clinic will launch in March 2016 and focus on developmental pediatrics. The CCO also developed two Advanced Primary Care Collaboratives. The first collaborative focused on developing new models of care for the adult high utilizer population, especially to support behavioral and psychosocial needs. Based on the success of this collaborative, the CCO launched a second collaborative focused on developing medical homes to support children who enter the foster care system.	Yes	CCO funding
Health Share of Oregon		**Warriors of Wellness (WOW)**	Warriors of Wellness is building a model through which CCOs and health systems can partner with community health worker programs. Through this project, community health workers have been co-located at two clinics. Community health workers have provided one-on-one culturally appropriate health education to 93 members, reached 56 members through support and education groups, advocated for members 350 times in the health care system, conducted 15 depression screenings, scheduled 44 primary care appointments and provided over 65 counseling and social support sessions. Other highlights were a Photo Voice project and collaboration with the Immigrant and Refugee Community Organization (IRCO).	Yes	
Health Share of Oregon	Care coordination, including integration of physical and behavioral health	**Head Start Fluoride Varnish Program**	Dental 3 (D3) contracted hygienists provided oral health education risk assessments and fluoride varnish application for 1685 children in Multnomah and Washington counties. D3 has partnered with Head Start to develop plans for all children in the Portland Tri-County Head Start and Early Head Start programs to have the opportunity to receive an oral health risk assessment and fluoride varnish application three times per year. These services will be provided by community partners and contracted hygienists. Common forms, materials and processes were developed for all Head Start sites.	Yes	Partner funding
Health Share of Oregon	Care coordination, including integration of physical and behavioral health	**Saving Smiles**	The Saving Smiles project held one dental fair and eight Saturday dental clinics. At the clinics, 122 people received services. Out of 120 appointments scheduled, 81 patients were seen. No-show rates were a challenge, but patients were very appreciative of having dental care access on Saturdays. The program received a grant to continue offering Saturday clinics.	Yes	Private funding

CCO	Focus area	Project	Project summary	Did the CCO intend to continue the project?	Method of sustainability
Health Share of Oregon		**Corrections Health Assessment Team**	This project included embedding a community health nurse in the Assessment and Referral Center to provide physical health assessments and support clients recently released from jail stabilize while they are awaiting primary care appointments and other health services. Clients are supported by a cross-departmental Health Assessment Team including a community health nurse, community health worker, corrections counselor, psychiatric nurse practitioner lead and parole or probation officer. The team enrolled 203 clients in the Oregon Health Plan, conducted 515 alcohol and drug evaluations and completed 44 referrals to primary care.	No	Public funding
Intercommunity Health Network	Information technology and exchange	**Regional Health Information Collaborative (RHIC)**	The Regional Health Information Collaborative is establishing an electronic health information exchange called Care Team Link to facilitate better provider-to-provider communication and better access to comprehensive medical histories. Care Team Link combines patient data from public, private and nonprofit partners and empowers partners to collaborate. This shared resource brings together information from mental, physical, behavioral, oral and pharmacy providers, as well as safety net organizations. A contract is in place, data share agreements with partner organizations are being executed and implementation is in process. Several partner organizations completed electronic health record upgrades to allow interoperability. The collaborative also established a privacy work group with partner organizations.	Yes	
Jackson Care Connect	Complex care, including pain management and trauma-informed care	**Care Coordination: Pain Management and Opiate Prescribing Guidelines; Traditional Health Workers; and Case Management Program**	This project included many initiatives to coordinate and improve care for members with complex health needs. A few activities are highlighted here: • Created a trauma-informed primary care home (Birch Grove Clinic) for members with mental health or addiction disorders • Created bike sharing program to reduce transportation barriers • Purchased naloxone nasal adapters for clinic partners • Implemented a morphine equivalent dose ceiling • Opened a behavioral health clinic for alternative pain treatment • Developed a Transitions Program (decreasing hospital visits by 50% for 60 members) and a Health Resilience Program (all 21 enrollees show reduced hospitalization) • Purchased a shower trailer and clothing trailer to support members in transitional housing; the trailers are providing 300 meals, 126 showers and 90 loads of laundry per week	Yes	CCO and partner funding
Jackson Care Connect	Information technology and exchange	**Data Sharing and Health Information Technology: Jefferson Regional Health Information Exchange (JHIE)**	This project has involved deepening connectivity to the Jefferson Health Information Exchange (JHIE). As of June 2015, five core clinical partners have clinics enrolled in Referrals and Direct Messaging through JHIE, and 75 clinics in the county are enrolled. The project included creating a community health record, which the CCO's population health team uses daily to coordinate and manage care. Partners are also using the community health record, including Federally Qualified Health Centers, addiction service providers, specialty providers and immediate care facilities. A Community Connect Network (C2) is also in development, which will connect the social service, health care and education sectors to reduce duplication and provide a client-centered approach.	Yes	Self-sustaining based on subscription fees
Jackson Care Connect	Patient-Centered Primary Care Homes	**PCPCH Capacity Building and Learning**	This project included several activities to build capacity of patient-centered primary care homes. The CCO launched a primary care behavioral health learning collaborative with 36 attendees. Forty clinical partners attended health coaching training. Key staff from four clinic systems participated in Primary Care Transformation Training, and participants decided to continue to meet monthly for case studies. Five out of six clinic systems are now participating in pay for performance incentives.	Yes	CCO funding

CCO	Focus area	Project	Project summary	Did the CCO intend to continue the project?	Method of sustainability
Jackson Care Connect	Training and development of CCO staff and partners	**Systems Management**	This project area included several initiatives: • Starting Strong, a perinatal incentive program that awards material incentives for appropriate pre- and postnatal care and education, engaged 128 members, who have redeemed 1350 vouchers; • Hepatitis C treatment pilot to upskill a primary care physician through consultations with a specialist; • Local health literacy training; • Two implicit bias trainings; • Planning for an 18-month community-wide trauma informed care training • Purchasing a bus to transport children from rural child care settings to Kid Time, which will offer stimulating activities for children and mentoring for providers	Yes	CCO funding
PacificSource Community Solutions – Central Oregon	Alternative payment models	**Global payments for practices that integrate behavioral health into primary care**	This project assessed the capacity of primary care clinics that provide behavioral health services to implement a global payment model. Four primary care practices received site visits and completed a variety of checklists and tools to assess infrastructure, processes, strengths, gaps, reporting capacity and cost.	Yes	CCO funding and billing
PacificSource Community Solutions – Central Oregon	Care coordination, including integration of physical and behavioral health	**Community Paramedicine Project & Medical Transportation System Optimization**	Commute Options initiated and developed relationships with health practitioners and transportation professionals to identify gaps in services and opportunities to improve cost, access and quality of medical transportation options. This project will inform future non-emergent medical transportation initiatives. The Community Paramedicine pilot project involved hiring two community paramedics to make home visits. The paramedics made 403 visits to 55 patients with chronic obstructive pulmonary disease, congestive heart failure or diabetes. The most common referral to the program was for medication reconciliation. Intervention patients had fewer emergency department visits and a statistically significant decrease in ambulance rides. It is estimated that 5.71 patients per day would make this program self-sustaining.	Yes	CCO and partner funding
PacificSource Community Solutions – Central Oregon	Care coordination, including integration of physical and behavioral health	**Pediatric Health Engagement Team**	The Pediatric Health Engagement Team developed focused care plans for children and young adults with type I diabetes and piloted Evolution Blue, a software-based intervention tool. Quantitative measures are not believed to be significant due to low sample size (12 enrollees) and varying participation time, but at the end of the intervention, participants did have lower average A1C levels, more daily blood sugar tests and fewer emergency department visits.	Yes	Partner funding
PacificSource Community Solutions – Central Oregon	Care coordination, including integration of physical and behavioral health	**Central Oregon Clinical Pharmacy Services (CPS)**	The Central Oregon Clinical Pharmacy Services pilot project integrated an ambulatory clinical pharmacist into a primary care practice to identify and resolve medication-related problems. The pharmacist visited with 372 patients and identified 896 medication-related problems. Of the problems needing provider approval for change, about 85% of recommendations were accepted. The top three medication-related problems identified were related to low medication adherence or sub-optimal treatment regimen. Physician support of the program was high.	Yes	Partner funding
PacificSource Community Solutions – Central Oregon	Community health, including traditional health workers	**Everybody Brush! Bending the OHP Dentistry Cost Curve in Central Oregon by Reducing the Burden of Oral Disease**	Everybody Brush! was a community-wide toothbrush distribution campaign. The project mailed oral health kits to the homes of all children and adolescents on the Oregon Health Plan in Central Oregon. The mailing was repeated every three months, and half the population also received telephone support and postcards. Advantage Dental is working with the University of Washington to evaluate the effectiveness of the project.	Yes	

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PacificSource Community Solutions – Central Oregon	Housing and flexible services	**Flexible Services Fund**	The Patient Support Fund established a process for primary care providers to request reimbursement for "non-covered" items or services for Oregon Health Plan clients. The program received 520 requests for 411 people from 24 organizations. Of these, about 67% were approved for funding. The most frequent request categories were fitness passes, alternative treatments, and dentures or dental services. Requests in several categories addressed increasing accessibility to improve activities of daily living, independence and overall health. While the project was too burdensome and resource heavy to be sustained, it provided abundant learning to inform future flexible services programs.	No	
PacificSource Community Solutions – Central Oregon	Information technology and exchange	**Telemedicine: Bridging Specialty Care Barriers for Mosaic Medical Patients**	This project provided telemedicine cardiology services to eight patients in a primary care clinic. Patients were extremely satisfied with the telemedicine care. The project was limited due to provider turnover, and it was not expanded into the second clinic as originally planned because a different specialty group had a local presence for cardiology referrals. The CCO does plan to continue the project at the pilot clinic and will look into expanding to other specialties.	Yes	Partner funding
PacificSource Community Solutions – Central Oregon	Maternal and child health	**Public Health/Primary Care Partnership: Maternal, Infant, and Child Health (through 12/2014)**	This project involved embedding a public health educator in an obstetrics clinic. The health educator provided 172 clients with nearly 600 client services and referrals not traditionally available in the clinic setting. Based on the success of this pilot, the model was implemented and expanded to an additional clinic.	Yes	CCO and partner funding
PacificSource Community Solutions – Central Oregon	Maternal and child health	**Pediatric Hospitalist Program**	The Pediatric Hospitalist Program was developed to provide dedicated inpatient services for pediatric patients. The team includes a medical director and 2-4 doctors, and pediatricians from the community are working together to establish best practices and standard policies.	Yes	Partner funding
PacificSource Community Solutions – Central Oregon	Oregon Health Plan member engagement	**Member Engagement**	The Proactive Health Screening and Orientation project included activities to engage and orient Oregon Health Plan members. A multimedia education campaign, including short videos, a fotonovela and Medicaid brochure, focused on member education and orientation to benefits. The videos were mostly shown to members on tablets by providers and community partners, and a majority of respondents felt the videos were helpful. This project also included Eliza, a health information management platform that delivered interactive voice response reminders to members nearing their redetermination deadlines. This strategy may have reduced gaps in care, but it was discontinued when the state suspended the redetermination process.	Yes	CCO funding
PacificSource Community Solutions – Columbia Gorge	Care coordination, including integration of physical and behavioral health	**Network Coordination "Hub"**	The Bridges to Health Pathways will be a region-wide infrastructure of community health workers embedded across multiple agencies. These community health workers will help connect families to services. The project is in early implementation stages and community partners have signed a declaration of cooperation. An initial success of increased collaboration among social services, early childhood, home visiting and health care services was the adoption of a standardized approach to home visiting. The program has secured a grant from Meyer Memorial Trust to initiate this model with the housing challenged population.	Yes	Private funding
PacificSource Community Solutions – Columbia Gorge	Care coordination, including integration of physical and behavioral health	**Clinical Pharmacy Services Project, Phase I**	The Clinical Pharmacist Services Pilot integrated clinical pharmacists into medical care teams. The pharmacists saw 108 patients and identified 442 medication-related problems with an average of four per patient. Providers accepted 94% of the recommendations that needed their approval and felt the pharmacists helped patients improve their health. MTMCare, a network of pharmacists that provides clinical pharmacy services, will continue to serve the CCO's members and plans to engage other health plans.	Yes	Self-sustaining based on billing

CCO	Focus area	Project	Project summary	Did the CCO intend to continue the project?	Method of sustainability
PacificSource Community Solutions – Columbia Gorge	Care coordination, including integration of physical and behavioral health	**Clinical Pharmacy Services Phase II**	Phase II of the Clinical Pharmacy Services project involved engaging high utilizers in clinical pharmacy services including medication therapy management. Between September and December 2015, 30 patients received services, including three CCO members. The project experienced many barriers, including the clinic with the majority of Medicaid patients backing out of the project due to lack of resources. Clinicians have requested ongoing ambulatory pharmacy services, which will be supported by the pharmacy department. The CCO and hospital will continue to discuss how to maintain this important program.	Yes	Partner funding
PacificSource Community Solutions – Columbia Gorge	Care coordination, including integration of physical and behavioral health	**InteGREAT**	The InteGREAT project engaged four primary care practices and the local mental health authority to establish a framework for integrated behavioral health in the region. The project worked with practices to create the foundation for successful integration (clinically, operationally and financially) and provided technical assistance as practices began to develop or refine their integrated models. The project used a mix of national expertise, local practice facilitation and targeted clinic engagement to build capacity for providing integrated care.	No	
PacificSource Community Solutions – Columbia Gorge	Community health, including traditional health workers	**Meals on Wheels for post-surgical patients**	This project funded the region's existing Meals on Wheels program to provide post-surgical patients with nutritious meals during recovery. The overall goal was to reduce re-hospitalization rates by providing high risk patients with balanced meals to help them heal and reduce stress. Patients also benefited by volunteer drivers checking on them. Many of the 29 patients referred to the program were also food insecure, and the program was able to guide them to food boxes and other services.	No	
PacificSource Community Solutions – Columbia Gorge	Community health, including traditional health workers	**Community health worker training center**	This project provided a capacity-building, evidence-based training program for community health workers. Through this project, 52 community health workers across 20 agencies and clinics completed the rigorous 90-hour course. Twelve participants have received state certification, and another 12 attended community health worker supervisor training. Participants are now meeting monthly as a community of practice, and organizations that support community health workers are collaborating to address systemic barriers.	Yes	Private funding
PacificSource Community Solutions – Columbia Gorge	Community health, including traditional health workers	**Community Action Plan for Reducing Childhood Obesity**	This project began with collecting children's height and weight data and individual interventions, but focus shifted to engagement and coalition building of community leaders. Funds were used to facilitate an Oregon Solutions project (Childhood Obesity Reduction Coalition of Wasco County) to convene local civic, business, health, education and philanthropic leaders to address childhood obesity. Twenty-one entities signed a declaration of cooperation. The coalition has created work groups to promote access to nutritious foods, increase physical activity, develop a sugar sweetened beverage policy and create a Safe Routes to Schools action plan.	Yes	
PacificSource Community Solutions – Columbia Gorge	Community health, including traditional health workers	**Intentional Peer Support (IPS) Training**	Intentional Peer Support Training is a globally recognized, trauma-informed curriculum for people to have experienced mental or emotional challenges or trauma to help others dealing with similar problems. Attendees included 21 participants across six agencies. Two participants are candidates for advanced certification to allow them to host future classes.	Yes	Partner funding
PacificSource Community Solutions – Columbia Gorge	Complex care, including pain management and trauma-informed care	**Community Health Team Phase II**	The Community Health Team included a registered nurse, a social worker and two community health workers who made home and office visits to identify and bridge gaps in resources that could improve patient outcomes. The team received 103 referrals and enrolled 79 patients. The team also created a manual outlining the program structure, roles, protocols, resources and lessons learned.	Yes	
PacificSource Community Solutions – Columbia Gorge	Complex care, including pain management and trauma-informed care	**Chronic Pain Strategic Education for Providers**	The CCO's clinical advisory panel developed opiate prescribing policies for chronic pain and provided education to over 190 allied health care providers in 11 practices. Total per member per month health care costs for chronic opiate users decreased by 34%, and the percent of patients on high dose morphine decreased from 10% to 6.6%. Of the 120 cohort members, the percent of patients who filled opiate prescriptions for at least six months decreased from 80% to 63%.	Unsure yet	

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PacificSource Community Solutions – Columbia Gorge	Complex care, including pain management and trauma-informed care	**Persistent Pain Education Program for Patients**	The Persistent Pain Education Program is an eight-week comprehensive pain management program. Each talk is led by a different health care professional and is designed to help people with chronic pain learn self-management skills to decrease pain and improve quality of life. As of June 2015, 27% of class participants had a clinically significant improvement in their Brief Pain Inventory score and the average improvement on the Chronic Pain Acceptance Questionnaire was 4.18 points.	Yes	Partner funding
PacificSource Community Solutions – Columbia Gorge	Information technology and exchange	**Community-wide Health Information Exchange (HIE)**	This project introduced a community health record for the CCO area using the Jefferson Health Information Exchange (JHIE). Social services and nonprofit organizations were connected, including the regional jail. The exchange is receiving direct data feeds from clinics, and area hospitals are 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.	Yes	Partner funding
PacificSource Community Solutions – Columbia Gorge	Maternal and child health	**Emotional Literacy Training**	The Transforming Health through Emotional Literacy project involved emotional literacy trainings (Pocket Full of Feelings Boot Camp) for parents interested in better meeting the social and emotional needs of their children. Parents took the ASQ and ASQ-SE developmental screening assessments prior to the class and eight months after the class. Eighty parents were trained (representing 150 youth ages 6 months to five years), as well as 52 agency staff including school special education staff. Due to popularity, a second series was begun for parents with children ages 6-15. Key partnerships have been established, and schools have requested classroom-specific curriculum.	Yes	
PacificSource Community Solutions – Columbia Gorge	Oregon Health Plan member engagement	**Proactive Health Screening & Orientation**	The Proactive Health Screening and Orientation project included activities to engage and orient Oregon Health Plan members. A multimedia education campaign, including short videos, a fotonovela and Medicaid brochure, focused on member education and orientation to benefits. The videos were mostly shown to members on tablets by providers and community partners, and a majority of respondents felt the videos were helpful. This project also included Eliza, a health information management platform that delivered interactive voice response reminders to members nearing their redetermination deadlines. This strategy may have reduced gaps in care, but it was discontinued when the state suspended the redetermination process.	Yes	Partner funding
PacificSource Community Solutions – Columbia Gorge	Oregon Health Plan member engagement	**Enrollment Continuity**	The enrollment continuity project included strategic outreach to potential and existing Oregon Health Plan members, and collaboration with other enrollment assisters and community agencies, to increase the rate of continuous reenrollment for those who qualify. As of July 2015, 2500 people were assisted and 735 people were enrolled or renewed. While this was a needed service for members, this work will not be self-sustaining at the current state-level reimbursement rate for applications.	No	
PacificSource Community Solutions – Columbia Gorge	Patient-Centered Primary Care Homes	**Care Management Training**	This project strengthened the skills of registered nurse care managers. Six nurses completed a Care Management Plus training, and 14 primary care clinic registered nurses participated in the American Academy of Ambulatory Care Nursing Care Coordination and Transition Management course. Nurses oversaw the workflow of developmental screenings, and rates for 1-3 year olds increased from 33% to 83%. During this project, emergency department visits also decreased from 35.2 to 27.3 visits per 1000 patient months.	Yes & No	CCO funding
PrimaryHealth of Josephine County	Care coordination, including integration of physical and behavioral health	**Information Technology**	This information technology project included implementing Inteligenz analytic software to help identify utilization patterns, gap lists and measurement results. The CCO also upgraded the CCO's network and servers to host public websites, provider websites, intranet and secure email.	Yes	CCO funding
PrimaryHealth of Josephine County	Care coordination, including integration of physical and behavioral health	**Enhanced Care Delivery System Pilot**	The Enhanced Care Delivery System Pilot included sponsoring an extended care team at a multi-specialty clinic to increase access to comprehensive, coordinated care. Co-located behavioral health services were successfully integrated, with 73.6% of individuals receiving an assessment or screening. Medical home assistants, a care management nurse and community health workers were also essential team members. During this project, the clinic earned certification as a Tier 3 Star Patient Centered Primary Care Home.	Yes	CCO and partner funding

CCO	Focus area	Project	Project summary	Did the CCO intend to continue the project?	Method of sustainability
PrimaryHealth of Josephine County	Information technology and exchange	**Network Health Information**	This project involved increasing connectivity to the Jefferson Health Information Exchange. Functionality includes alerts to the CCO when a member visits the emergency department, hospital or urgent care center, as well as discharge summaries and notifications of transfers. By the end of 2015, 96% of the CCO's members were served by a primary care provider capable of securely sharing a portion of health information in real time (compared to a baseline of 69.7%).	Yes	Self-sustaining based on subscription fees
PrimaryHealth of Josephine County	Maternal and child health	**Maternal Medical Home**	The CCO and Women's Health Center of Southern Oregon collaborated to develop a maternal medical home. Efforts included care management, warm hand-offs to behavioral health services including alcohol and drug counselors, dental referrals and medical assistant certifications. Prenatal screenings for clinical depression and substance abuse were at 100% for the prior five quarters, and timeliness to prenatal care for 2014 was 98%. The CCO considered this project to be one of its most "upstream" efforts toward system transformation in and will continue to be funded.	Yes	CCO funding
PrimaryHealth of Josephine County	Patient-Centered Primary Care Homes	**Patient Centered Primary Care Home Development Support**	This project included a learning collaborative for medical home implementation, hosted a medical home leadership group, provided medical home practice coach training and provided bonuses to clinics for being patient centered primary care homes (PCPCHs). This project also included embedding primary care into a mental health clinic and embedding an alcohol and drug counselor into a federally qualified health center. As of December 2015, 100% of the CCO's members were assigned to a Tier 3 PCPCH.	Yes	CCO funding
PrimaryHealth of Josephine County	Training and development of CCO staff and partners	**Transformation Training Programs**	This project funded 310 staff, providers and community partners to attend 27 training programs. The CCO focused on trainings that impact transformation, including opiate prescribing, health literacy, screening practices, leading quality improvement, motivational interviewing, adverse childhood experiences and primary care home transformation coaching. Staff from every primary care clinic in the CCO region have participated in at least one of the educational opportunities offered.	Yes	CCO funding
PrimaryHealth of Josephine County	Training and development of CCO staff and partners	**CCO Staff Transformation Development**	This project included hiring staff in key transformational roles including a portfolio manager, transformation guide/quality improvement nurse and community health workers. For super utilizer members engaged with a community health worker for at least three months, median costs decreased by 42%. Cost reductions are being sustained over time.	Yes	CCO and partner funding
Trillium Community Health Plan	Care coordination, including integration of physical and behavioral health	**Shared Care Plan: Integration of Physical and Mental Health and Development of PCPCH**	The CCO contracted with TransforMED, which helped 14 provider clinics identify and change workflows and behaviors to realize the benefits of the integrated patient-centered primary care home (PCPCH). Eight clinics continued to participate in phase II, a rapid cycle transformation program. A performance metrics coordinator launched a metrics learning collaborative for PCPCH providers and provided direct support to clinics. The CCO also hired nine clinic performance assistants to assist with workflow.	Yes	CCO funding
Trillium Community Health Plan	Care coordination, including integration of physical and behavioral health	**Shared Care Plan: Improve Care Coordination and Disease Management**	This project included hiring a team of community health workers to improve care coordination and disease management, with a savings-to-cost ratio of 2.71. The CCO also hired nine clinic performance assistants who worked with clinics to improve workflow. Over 25,000 charts were scrubbed and 7,000 gaps closed. Care Timeline software was used for care coordination, and Health Integrated was hired to perform health risk assessments, manage disease management programs and create individualized care plans.	Yes	CCO funding
Trillium Community Health Plan	Information technology and exchange	**Shared Care Plan: Enhance and facilitate Health Information Exchange**	The CCO researched and worked through barriers to enhance and facilitate a health information exchange. Care Timeline was developed as a care coordination tool, and the CCO is moving forward with the state-sanctioned Share Care Plan software. Information is being exchanged with Lane County perinatal staff and providers (including dental providers, for the first time).	No	
Trillium Community Health Plan	Oregon Health Plan member engagement	**Shared Care Plan: Engage Members in Their Care and Well-Being**	Clinic performance assistants contacted members and encouraged them to receive preventive services and establish relationships with their patient-centered primary care home. An incentive program provided members with a $15 gift card for receiving certain services. Health Integrated was contracted to perform member health risk assessments and engage members in active disease management programs.	Yes	CCO funding

CCO	Focus area	Project	Project summary	Did the CCO intend to continue the project?	Method of sustainability
Umpqua Health Alliance	Care coordination, including integration of physical and behavioral health	**Expanded Care Clinic (ECC)**	The Expanded Care Clinic provided coordinated care to members with severe and persistent mental illness by integrating mental, physical and dental health, addiction services and nurse case management in one location. The initial project was discontinued, but in July 2015, the model was spread to a CCO network clinic. This included expanded access to wraparound, holistic care through an on-site psychiatrist, extended evening and weekend hours and patient navigator services. The psychiatrist played a key role in increasing access to mental health in the community, especially during the days just after the Umpqua Community College shooting.	Yes	Partner funding
Umpqua Health Alliance	Care coordination, including integration of physical and behavioral health	**Co-location of Addiction and Primary Care Services**	The CCO collaborated with a local addictions services provider and domestic violence advocacy agency to co-locate services on the campus of a primary care clinic. A warm hand-off process was developed, and patients with a referral to addiction services had a 92% follow-through for initial contact.	Yes	CCO and partner funding
Umpqua Health Alliance	Care coordination, including integration of physical and behavioral health	**IT Population Metrics Solutions**	This project involved embedding population health metrics into the CCO's clinical engagement and care coordination information systems. A provider portal gives primary care providers access to their individual performance on CCO and state performance measures. A population health and metrics manager and population health navigators were hired to oversee population health data collection and analysis.	Yes	CCO funding
Umpqua Health Alliance	Community health, including traditional health workers	**Implementation of Community Wellness Services**	Based on the CCO's community health improvement plan priorities and with input from the community advisory council, the CCO sponsored over 350 wellness events. The CCO collaborated with 12 local businesses and community partners to provide free or low-cost access to exercise activities, healthy eating and living events and classes. This included a pilot project for a physician-referred 12-week health and wellness program.	Yes	CCO funding
Umpqua Health Alliance	Non-emergent medical transportation	**Non-Emergent Medical Transportation (NEMT) Services**	The CCO convened a community stakeholder work group and hired a consultant to develop a plan for providing non-emergent medical transportation (NEMT) to CCO members. The CCO developed a brokerage system with a transportation company, and NEMT service delivery began October 1, 2015.	Yes	CCO funding
Umpqua Health Alliance	Patient-Centered Primary Care Homes	**Expansion of Patient Centered Primary Care Homes**	This project aimed to expand the patient-centered primary care home (PCPCH) model to smaller and more rural practices. A PCPCH project coordinator was hired to provide education, clerical support, expertise and outreach to providers. Between December 2013 and December 2015, the percent of CCO members assigned to a PCPCH increased from 76% to 91%.	Yes	CCO funding
Western Oregon Advanced Health	Care coordination, including integration of physical and behavioral health	**Advanced analytics to identify needs of patients requiring complex care**	This advanced analytics project included implementing Milliman's risk stratification tool at all significant provider practices in Coos County. This tool helps identify patients at high risk for adverse health events and avoidable emergency department and hospital visits. This project has improved the CCO's emergency department visits per 1,000 member months. The CCO also tested a possible community-level health information exchange, and is now exploring other platforms.	Yes	CCO funding
Western Oregon Advanced Health	Care coordination, including integration of physical and behavioral health	**Medication Therapy Management**	This project aimed to increase access to pharmacist-delivered medication therapy management services in Coos and Curry counties. Eight local pharmacists completed a certification course, and a federally qualified health center opened a full-scale, in-house pharmacy. This pharmacy is now providing medication reconciliation for patients discharged from the hospital. By December 2015, at least 80% of all CCO members diagnosed with both diabetes and certain persistent mental health conditions received medication therapy management services.	Yes	Self-sustaining based on billing
Western Oregon Advanced Health	Information technology and exchange	**Planning and Implementation for Analytics and Shared Community Health Information**	A community-based planning team established a free-standing legal entity, along with a governance structure, to serve as the backbone organization for a community-held health information exchange.	Yes	

CCO	Focus area	Project	Project summary	Did the CCO intend to continue the project?	Method of sustainability
Western Oregon Advanced Health	Training and development of CCO staff and partners	**Strategic Transformation Planning and Portfolio Management**	The CCO hired a strategic portfolio manager and convened a steering committee to guide the CCO's strategic and transformation planning process. Multiple portfolio projects were completed including metric attainment, Spanish language health interpreter training, onboarding the child and adolescent needs and strengths tool, and further integration for addiction and primary care services through a health psychologist.	Yes	CCO funding
Willamette Valley Community Health	Care coordination, including integration of physical and behavioral health	**Care Coordination for Children with Complex Medical Needs**	This project aimed to develop 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 were hired and trained in wraparound care models and provided informational and emotional support, helped families schedule appointments, arranged transportation and identified community and CCO resources. The CCO has made this a permanent component of the delivery system.	Yes	CCO funding
Willamette Valley Community Health	Developmental screening	**Early Learning Developmental Screening**	The Developmental Screening Initiative was a collaboration between the early learning and primary care systems to increase the rate of developmental screening. The CCO funded incentives for early learning providers completing developmental screenings, and processes were implemented for early learning providers to share screening results with the medical community. In 2015, over 1,000 developmental screenings were documented in the CCO region. This project increased communication between early learning and pediatric medical providers and is a step in ensuring continuity of care.	Yes	Partner funding
Willamette Valley Community Health	Information technology and exchange	**Community Health Information Sharing**	Silverton Health piloted Arcadia health information exchange software for data aggregation, analytics and population health management. A CCO metric scorecard was developed to analyze metrics performance by system, clinic and provider. The dashboard allows users to identify patients who haven't had screenings and view a hybrid of both clinical and claims data.	Unsure yet	
Willamette Valley Community Health	Patient-Centered Primary Care Homes	**Patient Centered Primary Care Home Development**	The Patient Centered Primary Care Home Proliferation Initiative involved organizing learning collaboratives to develop high-functioning medical homes and discuss areas for cross-system collaboration. In response to needs identified in these collaboratives, the CCO will implement a physical-behavioral health information exchange, PreManage and community-wide care coordination.	Yes	CCO funding and billing
Yamhill Community Care Organization	Alternative payment models	**Alternative Payment Model (APM) Development Support**	This project involved developing a value-based payment model for behavioral and physical health services in patient-centered primary care homes. All primary care clinics in the CCO region received some level of alternative payment, and four clinics received a per member per month add-on. Another payment model is being developed for a maternal medical home.	Yes	CCO funding
Yamhill Community Care Organization	Care coordination, including integration of physical and behavioral health	**Embedded Behaviorist Program Expansion**	The Embedded Behaviorist Program Expansion included expanding delivery of behavioral health services in physical health settings. Behaviorists were hired and embedded in four prenatal clinics. As of December 2015, 63 expectant moms saw a behavioral health provider, 90% of expectant moms entered care in their first trimester, and all expectant moms were screened for depression and asked about alcohol and drug use.	Yes	CCO funding and billing
Yamhill Community Care Organization	Care coordination, including integration of physical and behavioral health	**Primary Care Provider Team Expansion and Bilateral Integration Support**	The goal of this project was to increase access to primary care by developing primary care teams and providing physical health services during behavioral health visits. A nurse practitioner was hired and 2,611 CCO members were added to clinic panels.	Willamette Heart: Yes Villa Medical: No Virginia Garcia: Yes Physician's Medical Clinic: Yes	Self-sustaining based on billing
Yamhill Community Care Organization	Care coordination, including integration of physical and behavioral health	**Data Coordination & Health Strategy Support**	As part of the Data Coordination and Health Strategy Support project, the CCO hired a quality program coordinator and business intelligence coordinator. The CCO engaged 15 agencies in a Quality Program work group and established a Quality Management Committee to oversee quality assurance and improvement in physical, behavioral and oral health programs.	Yes	CCO funding

CCO	Focus area	Project	Project summary	Did the CCO intend to continue the project?	Method of sustainability
Yamhill Community Care Organization	Complex care, including pain management and trauma-informed care	**Chronic Pain Management Solution**	The Persistent Pain Program was implemented to address members' chronic pain issues and help decrease opioid use. The program included behavioral health services, physical therapy and social services. The program was launched in February 2015. Of 249 patients referred to the program, 84 patients started it and 43 patients completed it. In addition, 62 providers attended an annual pain summit.	Yes	CCO funding
Yamhill Community Care Organization	Information technology and exchange	**Local Health Information Exchange Tool Implementation/ Support**	After evaluating health information exchange tools, the CCO withdrew from Crimson and Care Connect and will implement PreManage to provide access to the CCO's providers, community health workers and Persistent Pain Program.	Yes	
Yamhill Community Care Organization	Oregon Health Plan member engagement	**Population Health Management Clinical Initiatives**	The CCO funded five population health initiatives: • **Community Paramedicine Program** delivered routine and follow-up care to prevent unnecessary emergency department visits. This program has redistributed spending, and 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 (including home visits). • **Emergency Room Observation Unit** provided care for chest pain, chronic obstructive pulmonary disease, renal colic and back pain as an alternative to expensive inpatient stays. • **Student, Nutrition & Activity Clinic for Kids (SNACK) Program** provided nutrition education and physical activity services. • **Newborn Toolkits ("Best Kits")** were given to parents of infants and included health information and supplies. • **Provoking Hope Program** engaged pregnant women in primary care and addressed substance abuse issues by using certified recovery mentors.	• Provoking Hope - Responsible Mom's Program: Yes • West Valley Fire Department - Community-based EMS Model Program: Yes • SNACK Program: Yes • Newborn Toolkit: No • Emergency Room Observation Unit: Yes	CCO funding
Yamhill Community Care Organization	Patient-Centered Primary Care Homes	**Medical Home Model Development**	The Medical Home Model Development project involved helping all providers in the CCO service area advance to Tier 3 patient-centered primary care homes. Nine clinics participated in a primary care learning collaborative, and a member engagement specialist was hired. The CCO is also developing a maternal medical home model.	Yes	CCO funding