TRACKING TRANSFORMATION

ASSESSING THE SPREAD OF COORDINATED CARE IN OREGON

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FUNDING:

The project described was supported by Funding Opportunity Number CMS-1G1-12-001 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services and the content provided is solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

EXECUTIVE SUMMARY

PROJECT OVERVIEW

Coordinated Care Organizations (CCOs) are accountable for the Triple Aim of reducing costs, improving patient experience, and improving health at the population level. CCOs are encouraged to follow best practices to meet those aims, but there is no "set" view of what transformation looks like on the ground within any given CCO. Assessing what CCOs are actually doing is critical to understanding which elements of transformation are key drivers of population outcomes.

The Center for Outcomes Research and Education (CORE) in partnership with the Oregon Health Authority (OHA) and researchers at OHSU's Center for Health Systems Effectiveness (CHSE) was charged with assessing the "spread" of key elements of Oregon's CCO model across the health care market. We identified 11 *transformation domains,* loosely organized into four broad categories: governance and collaboration, data & information, care delivery transformation, and payment & finance—that represent elements of transformation integral to Oregon's coordinated care model. Our team of research and policy stakeholders collaboratively designed a tool that could measure an organizations' place along a continuum of possible transformation within each domain. We also designed qualitative interview guides to further explore the domains and go beyond the survey numbers.

WHAT WE DID

SURVEYS: We used a structured survey tool — one aimed at payer organizations, the other at provider organizations — to collect data on the 11 transformational domains. Our sample consisted of 151 organizations that were organized into payer and provider organization types (CCOs and Health Plans) and provider organizations (Hospitals, FQHCs, Physician Groups, and Mental Health Organizations). We received a total of 103 responses, a 68% response rate.

QUALITATIVE INTERVIEWS: Using survey results, we identified a series of supplemental qualitative questions that were used to contextualize and add a deeper understanding of what transformational activities organizations were or were not doing. We determined the sample by analyzing the survey responses and identifying "outliers" - organizations that appeared to be on the high and low end of transformational activities. We conducted 17 interviews with respondents across all the organization types.

WHAT WE FOUND

STARTING NEAR THE TOP

CCO PRIORITIES: COMMUNITY ENGAGEMENT & INTEGRATION

WHAT THE SURVEY TELLS US: At baseline, the domains with the survey scores that represent organizations being the furthest along the transformational spectrum were *better care coordination* and *integrated care*—domains closely associated with the CCO model.

ADDITIONAL CONTEXT: Interviews suggest that soliciting community feedback is common for all organizations, but there is room to grow in terms of providing them with an authentic voice in governance. Interviews also underscored that integration efforts are prioritized and underway, but breaking down the silos of physical, behavioral and dental health present a significant challenge.

OPPORTUNITY TO IMPROVE

UPSTREAM POPULATION HEALTH

WHAT THE SURVEY TELLS US: Lower survey scores for all the organizations were related to shifting toward *upstream population health* management. Integrating and leveraging data for population health management, as well as changing incentives to promote population health, are all areas in which there is room to grow.

ADDITIONAL CONTEXT: Interviews indicate that data systems are a high priority for all organizations. Health plans with the national presence have sophisticated systems, but others are working to have similar capabilities. Incentivizing population health is also paramount; organizations are working to move toward risk-based contracts, with a handful already employing more transformative financial reimbursement models.

NEXT STEPS

This longitudinal study is designed to follow transformation efforts along all of the domains with another round of surveys and interviews, with the addition of a purchaser survey, in mid – 2016. A final report will be delivered in September, 2016.

TRACKING TRANSFORMATION

ASSESSING THE SPREAD OF COORDINATED CARE IN OREGON

INTRODUCTION

This document outlines results from an assessment of Oregon's transformation landscape conducted by the Center for Outcomes Research & Education (CORE). The study's intent is to assess the "spread" of key elements of Oregon's coordinated care model across the health care market over time. Using a tool developed in partnership with key stakeholders, we assess Oregon 's status across 11 key domains of health care transformation, both in total and for distinct types of health care organizations. We supplement the survey data with a series of open-ended interviews designed to contextualize findings and provide a deeper view of transformation efforts across the state. Goals of the study include:

Goal 1. Track transformation using an organizational survey tool developed around key elements of delivery system transformation.

Goal 2. Supplement the survey with qualitative interviews designed to assess the shape and nature of transformation efforts.

Goal 3. Use results from both efforts to improve and refine the tool in order to reassess transformation in 2016.

BASELINE DATA

These data are intended to act as a **baseline:** they represent Oregon's status on key transformation domains as of early 2015. We will re-assess these same qualitative and quantitative measures again in early 2016 in order to track change in key transformation domains, both in total and within distinct types of health care organizations.

BACKGROUND

In 2012, just prior to the ACA Medicaid expansion, the state of Oregon embarked on a radical overhaul of its Medicaid system. Leveraging a localized version of the accountable care model, the Oregon Health Authority (OHA) shifted risk for Medicaid costs to regional public-private collaboratives called Coordinated Care Organizations (CCOs). Inspired by the health reform landscape, Oregon's CCOs are ambitious multi-stakeholder umbrella organizations, including health plans, public health departments, and networks of physical health care, behavioral health care, and dental health care providers. CCOs are regionally defined—they cover Medicaid beneficiaries within a defined geographic boundary — and are accountable for controlling costs while also meeting strict quality standards. Their governance models must include a community advisory council made up of 51% Medicaid consumers, ensuring they retain strong links to the population they serve.

WHY ASSESS TRANSFORMATION?

Oregon's model holds CCOs accountable for the Triple Aim of reducing costs, improving patient experience, and improving health at the population level. However, it also explicitly gives local communities the freedom to identify key priorities and implement local solutions and strategies to meet those aims. As a result, while CCOs are encouraged to follow best practices, there is no "set" view of what transformation looks like on the ground within any given CCO. Assessing what CCOs are actually doing is critical to understanding which elements of transformation are key drivers of population outcomes.

At the same time, Oregon's transformation was never intended to be limited to just Medicaid. CCOs were always intended to catalyze a larger transformation of the state's health care system. Over time, elements of the coordinated care model might spread to other market sectors, reshaping care beyond the boundaries of Medicaid. Spread might come directly from the CCOs — a member organization that redesigns processes for its Medicaid members might deploy them in service to all its members, for instance. But CCOs are not the sole engine of innovation: the spread of transformation elements could also be driven by hospitals and health plans aggressively implementing reforms in an attempt to stay ahead of the curve and respond to the state's changing health care landscape. Understanding the true scope of delivery system reform in Oregon requires assessment not just of what CCOs are doing, but what other health care organizations are doing as well.

TRACKING TRANSFORMATION

Oregon is working to transform its health care system from one defined by fragmentation and rising costs to something that is better integrated, cost-controlled, and produces better outcomes for communities. In this report, we begin to measure what that transformation work looks like on the ground by collecting an initial round of data capturing the state's status in eleven key domains of transformation. These data will act as a benchmark against which future assessments can be compared, allowing us to track the nature and shape of health care transformation in Oregon over time.

"There is no finish line to improvement. It's an on-going project. We need to measure against what we did before and keep plugging ahead."

—Interview Participant at a Hospital System

TRANSFORMATION DOMAINS

WHAT WE MEASURED

Working in partnership with OHA and researchers at OHSU's Center for Health Systems Effectiveness (CHSE), we identified a set of broad *transformation domains* that represent elements of transformation integral to Oregon's coordinated care model, such as payment reform or integrated care. Our initial list of domains was informed by the results of interviews and document analysis conducted by Oregon researchers from earlier studies of Oregon's CCOs, as well as conversations with key state officials.

Once we identified the key domains of transformation, we designed a tool that could measure an organization's place along a continuum of possible transformation within each domain. The tool is designed to "score" organizations in terms of transformation elements, with results ranging from 0 (no major elements of transformation apparent yet) to 10 (indicating that many elements of transformation are present and widely spread throughout the organization). We also used qualitative interviews to further explore and contextualize the scores produced by our survey tool, allowing us to get beyond the numbers in order to understand the specific nature of transformation efforts across the state.

TRANSFORMATION DOMAINS

The eleven domains that our tool is designed to capture are summarized below, and fall into four broad areas: governance and collaboration, data & information sharing, care delivery transformation, and payment and finance. Each domain is a function of multiple individual survey items that combine into a summary score representing an organization's place along the potential transformation continuum. The average of those scores for all organizations in a given sector (eg, all health plans) represents that sector's overall transformation score.

INTERPRETING DOMAIN SCORES: Domain scores are not *performance scores.* Our tool does not make assumptions about what any organization *should* be doing. Rather, scores are best seen as representing how densely transformational elements are present within a given sector at a given point in time. Thus, for example, a score of 5 in the domain of *integrated care* represents a moderate prevalence of such initiatives across the sector in question, not performance against some standard of practice.

LIST OF TRANSFORMATION DOMAINS

We tracked 11 distinct transformation domains, loosely organized into four broad categories: governance and collaboration, data & information, care delivery transformation, and payment & finance. Each domain receives a "score" computed from answers to multiple survey questions (described below).

GOVERNANCE & COLLABORATION	
CROSS-SECTOR PARTNERSHIPS	*Health care works closely with other sectors to improve outcomes.*
COMMUNITY INVOLVEMENT IN GOVERNANCE	*Authentic engagement with consumers and community members.*
DATA & INFORMATION SHARING	
INTEGRATED & SHARED HEALTH CARE DATA	*Data on whole-person care available and used to shape efforts.*
USING DATA FOR POPULATION MANAGEMENT	*Data from other organizations/sectors used to promote broad health.*
CARE DELIVERY TRANSFORMATION	
INTEGRATED CARE MODEL (PHYS, BEH, DENTAL)	*Implementation of whole-person care models.*
BETTER COORDINATION; RIGHT CARE IN RIGHT PLACE	*Efforts to optimize care delivery for efficiency and effectiveness.*
PREVENTION & SDH INTERVENTION EFFORTS	*Strategies addressing social determinants of health[1] through prevention.*
WORKFORCE TRANSFORMATION & DIVERSIFICATION	*Use of non-traditional and diverse workforces to change care.*
PAYMENT & FINANCE	
OWNERSHIP OF RISK (PROXIMITY TO POINT OF CARE)	*Risk moves closer to providers at the point of patient engagement.*
INTEGRATED RISK	*Risk is for all types of health, not separated into silos.*
ALIGNING INCENTIVES & VALUE	*Incentives for providers to focus on smart care that improves health.*

1) Social determinants of health refer to the wider set of societal, system, and contextual forces that might impact a person's health

METHODOLOGY

OVERVIEW OF APPROACH

ORGANIZATIONAL SURVEY: We used a structured survey tool to collect data on transformation activities from key leaders at various health care organizations around Oregon. Data were used to compute scores within each of our 11 transformation domains for each participating organization. Both versions of the tool (one for payers, one for provider organizations) are included in the Appendix.

IN–DEPTH INTERVIEWS: We conducted a series of open-ended, in-depth interviews with a subset of respondents to the organizational survey in order to explore transformational work across the state in greater depth.

SAMPLE

SURVEY: We compiled a list of 288 major health care organizations in Oregon, including both payers and providers, then drew a random sample of 151 such organizations for data collection. We organized participants into six sectors, including payer organizations (CCOs and Health Plans) and provider organizations (hospitals, FQHCs, Physician Groups, and Mental Health Organizations).

PAYERS	TOTAL	SAMPLE	COMPLETED
CCOs	16	16	12
Health Plans	16	16	10
PROVIDERS	**TOTAL**	**SAMPLE**	**COMPLETED**
Hospitals	61	40	31
FQHCs and CHCs	32	32	20
Physician Group/IPA	7	7	5
Mental Health Orgs	148	40	25
All Organizations	288	151	103

Each organization was asked to respond to questions about its entire business. The Oregon healthcare landscape is one of significant overlap: hospitals and carriers participate in CCOs, physician groups contract with multiple payers and serve multiple markets. To account for this, we asked participants to respond from their perspective as a standalone organizational entity (regardless of CCO membership); for example, hospitals that were part of CCOS or larger health systems were asked to speak from the vantage point of their individual entity.

QUALITATIVE: We used initial survey responses to look for "outliers" - organizations that appeared to be doing particularly transformative work along any given domain — to interview. We attempted to spread respondents across organization types to ensure representative perspective. We completed 17 interviews: 5 payers and 12 providers.

RESPONSE RATES: We sampled 151 organizations and received 103 responses, a 68% response rate. Note: See appendix for more details on the interview and measurement plan.

WHAT THIS TELLS US ABOUT TRANSFORMATION

Our primary intent in this project is to assess the *spread* of key transformation elements from CCOs to other health care sectors. By measuring CCOs, we can capture progress in key domains occurring as a direct result of the CCO legislation. By measuring the same domains in other health care organizations, we can compare the presence of transformational elements between CCO and non-CCO sectors. And by tracking scores over time, we can look for spread by identifying cases where other health care organizations begin to implement ideas initiated within CCOs in order to produce comparable domain scores.

SURVEYS

We deployed a pair of online surveys — one aimed at payer organizations, the other at provider organizations — which were delivered to key industry executives, including CEOs, CFOs, and similar officials at key health care organizations around the state.

The surveys were designed to capture baseline high-level data on organizations along a series of dimensions mapped to the transformation domains, producing a score from 0-10 for each domain. Answers to a specific questions contribute "points" to domain scores, and the number of points created within a domain tell us about the total presence of transformational elements within that domain. For instance, a score of 0 in the domain of *integrated care* would represent a complete absence of such initiatives, while a score of 10 would indicate a very strong presence of integrated care initiatives within the responding organization.

INTERVIEWS

For each of our transformation domains, we also identified a series of supplemental qualitative questions that could be added to contextualize and explore the survey results (included as Appendix B). These questions were explicitly designed to add deeper understanding to the domains; qualitative results did not contribute to the scoring.

We analyzed interviews to help characterize the exact nature of each organization's work in a given domain and identify new areas of transformation relevant to the tool. Results will be used to refine the tool for future iterations.

DOMAIN SCORING

Scores for each domain are based on responses to anywhere from 3 to 9 specific survey questions. Every survey item represents one type of potential transformation activity an organization could be doing, and has three possible responses, ranging from not much at all (on the right of the scale) to widespread presence or advanced implementation (on the left of the scale).

Organizations receive points within a domain based on how they answer questions: 0 points for an answer that indicates no activity of that type, 1 point for limited activity or progress, and 2 points for widespread or more developed efforts. Organizations were not scored on questions that they did not feel able to answer. Scores for domains are a function of how many points an organization accumulates across all items that contribute to that domain.

STANDARDIZATION: Domains have a varying number of questions that contribute to their total scoring. For ease of interpretation, all scores were mathematically standardized to a scale of 0-10, with 0 representing no meaningful presence of transformation within that domain and 10 representing widespread transformation.

SCORING EXAMPLE (FROM PROVIDER SURVEY)

4. How easy is it for care providers in your organization to get or share the following kinds of information on your patients?

	Easy or routine	Possible, but not routine	A significant challenge
A. Share data with other providers in your organization to coordinate care	O	O	O
SCORE	**2**	**1**	**0**

In this example, a provider organization that answers "possible, but not routine" would gain 1 point toward its transformation score in any domain associated with item 4A. In our proposed crosswalk, item 4A on the provider survey is associated with the "integrated and shared health care data" domain, so the organization would receive 1 point toward that domain score.

USING DOMAIN SCORES: Domain scores can be compared to one another (allowing for a quick comparison of different types of transformation across organizations, for example), or tracked over time (allowing for the spread of transformation to be tracked over time). Organizational scores can grow either by adding new transformation pilots or efforts (moving points from 0 to 1 within a given question), or by furthering the spread of existing pilots or efforts (moving from 1 to 2 within a given question).

DOMAIN MAPPING

The contribution of survey items to each transformation domain is summarized below. Item numbers refer to the surveys, which are available for review in the Appendix.

	PAYER SURVEY QUESTIONS	PROVIDER SURVEY QUESTIONS
GOVERNANCE & COLLABORATION		
CROSS-SECTOR PARTNERSHIPS	8ADE (3 items)	6DE, 11ADE (5 items)
COMMUNITY INVOLVEMENT IN GOVERNANCE	8BC, 9ABC, 10 (6 items)	11BC, 12ABC, 13 (6 items)
DATA & INFORMATION SHARING		
INTEGRATED & SHARED HEALTH CARE DATA	6AEFHI (5 items)	7, 8AEFHIJ (7 items)
USING DATA FOR POPULATION MANAGEMENT	6BCDG (4 items)	8BCDG (4 items)
CARE DELIVERY TRANSFORMATION		
INTEGRATED CARE MODEL (PHYS, BEH, DENTAL)	2ABCD, 7B (5 items)	6ABC, 9AD, 10B (6 items)
BETTER COORDINATION; RIGHT CARE IN RIGHT PLACE	4A, 7ACG (4 items)	9E, 10AEGI (5 items)
PREVENTION & SDH-INFORMED CARE	4BD, 7DEF (5 items)	10CDFH (4 items)
WORKFORCE TRANSFORMATION & DIVERSIFICATION	4AC, 5 (3 items)	9BC (2 items)
PAYMENT & FINANCE		
OWNERSHIP OF RISK (PROXIMITY TO POINT OF CARE)	3ABCD (4 items)	1DEFG, 2 (5 items)
INTEGRATED RISK	1ABCD (4 items)	1ABC (3 items)
ALIGNING INCENTIVES & VALUE	4DE (2 items)	3ABCD, 4ABCD, 5 (9 items)

RESULTS OVERVIEW:

TRANSFORMATION TO DATE

THE STATE OF TRANSFORMATION

We assessed the prevalence of transformational elements within each domain on a scale from 0 (not transformed at all, representing traditional health care systems) to 10 (the highest possible score, representing organizations that have implemented a wide range of initiatives very broadly across their membership). Results from our 2015 baseline survey suggest that Oregon has already seen widespread transformation, with many elements of the coordinated care model permeating CCOs and other health care entities.

Scores (0-10, 10=most transformed)

TRANSFORMATION DOMAINS	Statewide N=103	CCOs N=12	Health Plans N=10	Providers N=81
Community Involvement in Governance	6.1	7.2	6.2	6.0
Cross-Sector Partnerships	6.6	7.9	5.0	6.5
Integrated & Shared Health Care Data	6.3	6.2	6.4	6.3
Data for Population Health Management	3.9	4.0	3.9	3.8
Integrated Care Models	7.1	7.4	8.0	6.9
Better Care Coordination	6.9	6.8	7.5	6.9
Prevention & SDH-Informed Care	6.8	5.2	5.2	7.2
Workforce Transformation	6.4	4.0	3.4	7.1
Ownership of Risk	4.5	5.2	4.1	4.5
Integrated Risk	4.6	4.7	8.5	4.2
Aligning Incentives & Value	4.4	4.6	5.3	4.2

MOST TRANSFORMATION: Overall, Oregon has made the most progress in areas related to *integrated care and better coordination* — two domains explicitly tied to the CCO model. CCOs have led the way in cross-sector partnerships and made significant effort in increasing cross sector partnerships and integrated care—health plans and providers also been working hard to create integrated care and better coordination, and their efforts are apparent in their scores.

LEAST TRANSFORMATION: The lowest transformation scores cluster in areas representing *upstream population health,* especially in the use of data for population health management. Finance reform centered on changing risk models is also still in its infancy in Oregon, though some individual organizations have made extensive progress.

TOP THREE REFORMS: PAYERS	TOP THREE REFORMS: PROVIDERS
Integrated Care Models	Prevention & SDH Informed Care
Better Care Coordination	Workforce Transformation
Community Involvement in Governance	Integrated Care & Care Coordination
SLOWEST PROGRESS: PAYERS	**SLOWEST PROGRESS: PROVIDERS**
Workforce Transformation	Data for Population Health Management
Data for Population Health Management	Integrated Risk

WHO IS LEADING THE WAY?

Both payers (CCOs and Health Plans) and providers have made good progress around care coordination and integrated care, and both have indicated that there have been challenges in supporting population health strategies with the appropriate data. Changing where risk lies in the system has also been a challenge for provider groups and CCOs, but Health Plans have demonstrated good progress in this area, mostly through progress in non-Medicaid markets.

Overall, data suggest that the greatest challenges lie in areas that require the greatest shift in both thinking and operations— coordinating care better is one thing, but shifting from "providing care" to "population health" may require new ways of thinking, new workflows, and new types of data relationships that health care organizations are not always ready to implement quickly. Over time, we will track the changes in these scores in order to measure Oregon's progress along each of these transformation domains.

MORE DETAILED RESULTS

For more information about how Oregon organizations are transforming within each domain, including a more detailed breakout of performance for CCOs, HEALTH PLANs, hospitals, FQHCs, IPAs/physician groups, and mental health organizations, please see pages 8-29 of this report.

WHY ARE ORGANIZATIONS RESPONDING TO THE CALL OF REFORM?

Oregon's CCOs have made important strides in many transformation domains, but they are not alone: other health plans equal or even exceed CCO performance in some cases, as do some provider organizations. Results from our organizational survey clearly suggest that health care transformation is not limited to Oregon's CCOs.

Oregon's CCO reform did more than just implement new legislation—it also changed the conversation about the future of health care in the state. As part of this study, we completed in-depth, open-ended interviews with health care CEOs and other executives designed to explore the key drivers of transformation. Throughout those interviews, we heard a consistent desire, especially among Oregon-based organizations, to undertake transformation because it was the "right thing to do." Respondents believed transformation would keep them competitive, but also expressed a genuine desire to develop a health care system that works better for their communities.

A BELIEF THAT TRANSFORMATION WILL RESULT FROM MARKET FORCES

"The wind is blowing in that [transformational] direction, but when you see what's happening in the market, a lot of folks are betting on the retail play. All of these consulting firms are developing their own exchanges with the focus on the point of enrollment which is what the Affordable Care Act focused on. ACOs are focusing a lot on the point of care, but if you talk to delivery systems outside of Oregon, you see those ACOs focusing on building out their network first and then focusing the point of care— they are saying 'now that we've got five-thousand positions in the hospitals in our network, let's figure out how we are consistently defining quality, what are the common measures, and how we get our disparate systems to speak to each other. That could be a three to five year endeavor before you start focusing on 'what are we actually doing today to reduce the cost of care?' So I think the interventions that focus on doing different treatments and focusing on preventative measures will postpone the substantial performance improvement that we all are hoping to achieve."

A DESIRE TO STAY AHEAD OF TRANSFORMATION

"We do not want the state to dictate the outcomes and metrics that are important to our community. The state prefers to look broader than just Medicaid and to have a stronger voice. We know if the population health model is being used at the state level, it will eventually show up in the commercial market as well. It will show up in how we deal with public employee benefits and the community doesn't want it to be handed down to them from the state. We want to build and fund our local priorities and have a system in place to do that successfully. It's very hard to stay ahead of the state on anything CCO driven and keep up with the changes, so if you don't take the long term approach to look at what you want...you're constantly going to be reacting."

NEXT STEPS FOR THIS DATA

REFINING THE TOOL: The design team will continue meet to refine our assessment tool before the next round of fielding. We are actively working to create a version of the tool aimed at *purchasers*. We are also looking at adding new questions around risk that will help elucidate ways payers and providers are working to put more risk on patients by giving them more "skin in the game." The next iteration of assessment will potentially include these and other changes.

LONGITUDINAL DATA: The data collected here represent an initial descriptive snapshot — a baseline measure, taken in early 2015 — of the state of health care transformation in Oregon. Next, we will repeat our assessment, using the resulting data to track changes in scores within each domain over time and examining those changes in total for the state and separately within each sector.

ALL PAYER, ALL CLAIMS ANALYSIS: We have also provided these data to colleagues at OHSU's Center for Health Systems Effectiveness (CHSE), who are undertaking a companion study employing claims data to examine the spread of transformation across Oregon's health care markets over time.

LIMITATIONS

Although these data represent an important snapshot of transformation in Oregon, they are subject to some key limitations. First, results in this report are intended to reflect baseline measurements, but transformation has been occurring for some time in Oregon. Thus, these are not true baseline measures, but rather a point-in-time of a partially-transformed system against which we can measure future progress.

Second, although we do compare sectors in terms of their scores, it is worth noting that our unit of analysis is *organizations,* and so scores are based on a relatively small number of data points (103 organizational respondents in all). Differences between sectors should be interpreted in the context of these small numbers.

Finally, our data are self-reported, and such data are always subject to potential bias. We surveyed a key informant at each organization — usually the chief executive or a similar senior official — about broad transformation activities, but a given respondent's knowledge of what was actually going on within each transformation domain may not always be perfect.

COMMUNITY INVOLVEMENT IN GOVERNANCE

OVERALL OREGON 2015 SCORE
6.1
(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Community engagement is a key element of linking health care more closely to community needs. A traditional health care system might have some ways to get community input, but voting power is held, and decisions are made, by health care executives. A more transformed system will empower community representatives from outside health care, giving them a meaningful role in decision making around strategies, priorities, and the allocation of health care resources.

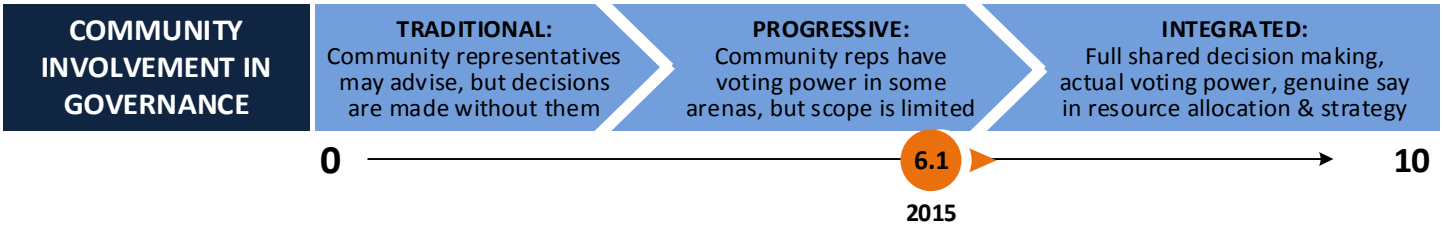
WHAT WE FOUND

Payers averaged a score 6.7 out of 10, with individual results ranging from 1.7 to 10. Providers averaged 6.0 out of 10, with individual results ranging from 0.0 to 10.0.

CCOs and FQHCs exhibited the strongest overall community engagement scores; the Community Advisory Council requirements embedded in the CCO legislation may be a primary driver of this advance. Managed care plans averaged one point behind CCOs in terms of overall community involvement, though many indicated plans to expand in this area. Hospitals and physician groups were also less likely to have made significant progress.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	**6.7**	**7.2**	**6.2**
Uses feedback from members or consumers (0-2)	1.6	1.6	1.6
Uses feedback from at large community residents or laypersons (0-2)	1.0	1.1	1.0
Community members involved in organizational strategy or vision (0-2)	1.2	1.4	0.9
Community members involved in prioritizing community needs (0-2)	1.3	1.5	1.0
Community members help allocate funds for new programs (0-2)	1.2	1.3	1.0
Plans for future expansion of community involvement (0-2)	1.8	1.7	1.9

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	**6.0**	**4.9**	**4.7**	**8.3**	**5.6**
Uses feedback from members or consumers (0-2)	1.3	1.2	1.0	1.7	1.3
Uses feedback from at large community residents or laypersons (0-2)	1.1	1.2	0.8	1.2	1.0
Community members involved in organizational strategy or vision (0-2)	1.1	0.7	0.8	1.9	1.0
Community members involved in prioritizing community needs (0-2)	1.2	0.8	1.0	1.9	1.1
Community members help allocate funds for new programs (0-2)	0.9	0.6	0.6	1.8	0.7
Plans for future expansion of community involvement (0-2)	1.6	1.5	1.4	1.7	1.8



CONTEXT
FROM THE QUALITATIVE INTERVIEWS

COMMUNITY INVOLVEMENT IN GOVERNANCE

KEY FINDING: ROOM TO GROW

We asked what community involvement in governance looked like. Many delivery systems have some form of patient advisory panels or feedback loops that offer the community a voice. These feedback vehicles looked very different depending on the type of organization queried: traditional health plans wanted feedback on satisfaction from members to ensure an ongoing business relationships, while county-owned hospitals include community members on their governance board.

KEY FINDING: WORKING TOWARDS AUTHENTICITY

Many respondents described having a vehicle for soliciting feedback, but there still appears to be a gap between authentic governance participation and the current process. For health plans, the motivation for gathering data on the patient experience from member perspective is about staying competitive in the market. For other providers, the "community" of feedback is considered to be local non-health care leadership, not patients; one hospital told us that patients have a voice in "operational changes that impact care from the patient perspective." Thus, the extent to which the community voice actively enters into actual decisions remains highly varied.

VOICES FROM THE FIELD

PAYER: *We're highly driven by the competitive nature of the business that we're in. It costs a lot of money to bring on a new customer so once you have them, you want to retain them. We're constantly looking to get feedback from our members on our programs and services.*

HOSPITAL: *We're a separate healthcare district so our elected board of seven people provides us with a lot of feedback from the county population. We also have the patient advisory group that meets monthly to talk about concerns, what they heard, and what services they'd be interested in. We hold community meetings and give everybody free hamburgers (laughs) and ask them what they think of the health district and what they want from it. We come to these events prepared to discuss and receive feedback from an involved community.*

HOSPITAL*: For our strategic planning, we involve representatives from all of the different political groups to look into what we should be focused on for the next year, three years, and five years. With the hospital being a big employer we need to take a lead in getting the groups together and having the conversation. We also have an advisory committee made up of community members with various backgrounds that meets six times a year to provide input and feedback.*

SEMINAL CASES:

A HOSPITAL INVITES THE COMMUNITY IN

HOSPITAL: Our structure is a system governance, and the members on our board of directors are all community members except for the CEO of the health system. Those community members are a combination of physicians, business leaders and your average citizen, who drive the strategies for the organization—they are a voice of the community. That would be one example of how we incorporate community feedback into the transformation and direction our health system is headed. At a more grass roots level, at our hospital we've had a patient advisory council for about four years now; these are past patients who, on a monthly basis, we work with to work on structural, operational changes that really impact the care from a patient's perspective.

CROSS-SECTOR PARTNERSHIPS

OVERALL OREGON 2015 SCORE
6.6
(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Effective inter-organizational collaboration is a key element of accountable care. Under health care transformation, we expect that partnerships between delivery-system partners (hospitals and primary care, for example) will be cultivated to improve outcomes. A more progressive system will look beyond the system to include organizations that serve the population from other sectors (like housing) to incorporate social determinants of health; a transformative system will be driving that collaboration upstream.

WHAT WE FOUND

Overall payers averaged a score 6.6 out of 10, with individual results ranging from 1.7 to 10. Providers averaged 6.6, with individual results ranging from 1.0 to 10.

CCOS and FQHCs were the most transformative when it comes to building cross-sector partnerships. CCOs and FQHCs have a large Medicaid base, with entities serving a broader patient mix—health plans, hospitals, and physician groups — scoring the lowest. However, there appears to be a certain amount of spread within some aspects of cross-sector partnership building: scores around incorporating feedback from social service organizations and public health were relatively similar across all organizations, suggesting that the notion of creating partnerships with social service-type organizations that can work on population and social determinants of health is beginning to seep into the health care sector. CCOs are making the greatest strides when it comes to thinking of nontraditional partnerships, with payers and physician groups scoring the lowest.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	**6.6**	**7.9**	**5.0**
Uses feedback from providers in decision making (0-2)	1.7	1.9	1.5
Uses feedback from public health and social services in decision making (0-2)	1.3	1.6	1.0
Uses feedback from partners outside of health services in decision making (0-2)	0.9	1.2	0.5

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	**6.6**	**5.7**	**6.8**	**7.3**	**7.0**
Collaborates with public health to deliver whole-person care (0-2)	1.5	1.3	1.6	1.7	1.7
Collaborates with community groups to deliver whole-person care (0-2)	1.5	1.2	1.4	1.7	1.7
Uses feedback from providers in decision making (0-2)	1.5	1.6	2.0	1.7	1.2
Uses feedback from public health decision making (0-2)	1.1	1.0	1.4	1.4	1.1
Uses feedback from partners outside health care in decision making (0-2)	0.9	0.6	0.4	1.0	1.3

CONTEXT
FROM THE QUALITATIVE INTERVIEWS

CROSS-SECTOR PARTNERSHIPS

KEY FINDING: MAKING PROGRESS

Work that respondents described around cross sector partnerships was related to other transformation domains, like improving data-sharing capabilities across delivery systems, integrating care, and thinking more broadly about the social determinants of health. Despite low scores for organizations on this measure, there were some examples of various organizations of partnering outside of healthcare sectors, particularly with schools. One organization described working with a school district as part of an initiative to set up a dental sealant program at a local schools. CCOs are doing more work connecting outside of the healthcare system, while other organizations indicated that "cross-sector partnership building" resembled strategic partnerships with other healthcare entities.

KEY FINDING: SPREAD, BUT WITHIN THE SYSTEM

Interviews revealed that most respondents' organizations are realizing that partnering with other organizations is necessary to achieve cost and quality goals. However, the conversations suggested that their definition of a cross-sector partnership differs from the definition in the transformation domain. Healthcare entities are focusing on building alliances within the system; these alliances are more like contracting with IT companies and working with insurance clients that were already in their client base to implement interventions designed to reduce cost and increase quality (as described below). Entities associated with CCOs note that cross sector partnerships beyond the healthcare domain are beginning to form as a result of stakeholder efforts, but not necessarily because the organizations themselves are working to build them.

SEMINAL CASES:

A HOSPITAL WORKS WITH A SCHOOL DISTRICT ON DENTAL HEALTH

HOSPITAL: We wrote a grant and received funding to do planning for how we can put preventative dental care in the schools, working with three to five year olds to start. So at our organization, there's a lot of work going on around dental health. We are beginning to see how you can at least start planning and thinking in terms of [these partnerships].

VOICES FROM THE FIELD

HOSPITAL: *We see that in order for us to remain independent years down the road, we probably will need to make more 'strategic alliances.' That means not billing ourselves out, but rather reaching agreements with larger systems to improve the referral process. An example: we reached an agreement with a group that has an implemented infrastructure of IT staff and servers that could provide the ongoing support needed for our system. The new system would provide a shared database so that when we refer patients we would have accurate information on what happened to them once they arrived at our facility. It's not only just a financial arrangement, it also greatly improves patient care while allowing us to remain independent.*

PAYER: *We look at building strategic partnerships, but it's more at the national level versus the community level. Building strategic partnerships is happening more robustly at broader levels. An example of that is we found a lot of our innovation comes out of our management of national account relationships. Typically, those large employers are more sophisticated and demanding so they have tendency to innovate more. One of the innovations that we implemented was focused on cardiovascular surgery patients that we found had multiple bouts of depression after they had a major cardiac event. We started an intervention that immediately after discharge, all of the follow-up visits are tele-video done in the convenience of the person's home to avoid the stigma associated with going into a behavioral health provider's office. The compliance rate or adoption rate of this program is very high. That's an example of the type of innovations that we look at as a company that are scalable nationally.*

PROVIDER: *We don't have a lot of community organizations involved; however, our stakeholders do, so in a sense there is strategic partnership building by extension—we work with our stakeholders who are working with community organizations.*

INTEGRATED & SHARED HEALTH CARE DATA

OVERALL OREGON 2015 SCORE
6.3
(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Effectively sharing data is a key challenge of transformation – across settings of care, across provider groups and organizations, and across the traditional silos of physical, behavioral, and dental health. In a transformed system, we expect that providers can see data on each aspect of a person's care, and that it will become easier for providers to see data about what happened when their patients got care in a different setting or from a different organization elsewhere in the community.

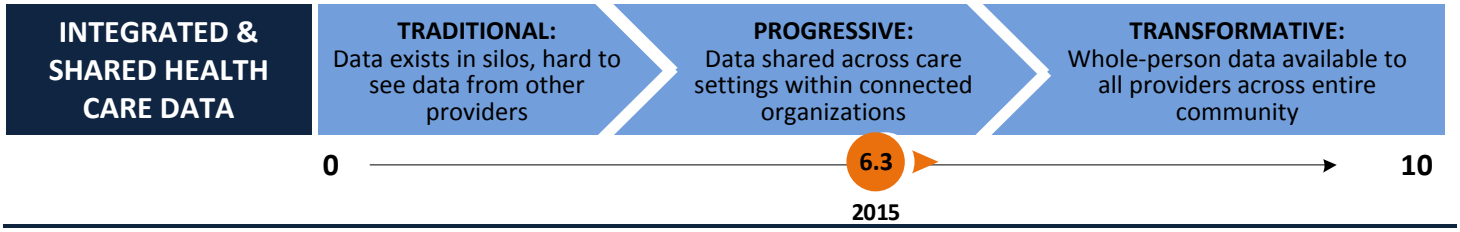
WHAT WE FOUND

Overall payers averaged a score 6.3 out of 10, with individual results ranging from 3.0 to 9.0. Providers overall averaged 6.3 with individual results ranging from 0.7 to 10.

Overall scores for all organizations were relatively similar, with widespread use of electronic records and integrating information within their organizations. Health plans and physician groups have the greatest capabilities for tracking chronic conditions; FQHCS were the most advanced when it comes to integrating demographic data and HER connectedness. Reverse integration (of chronic illness data into mental health organizations) was very limited and represents a slow-moving area.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	**6.3**	**6.2**	**6.4**
Integrates inpatient & outpatient data from providers within your organization (0-2)	1.7	1.9	1.4
Accesses systems for predictive risk stratification for patient populations (0-2)	1.3	1.3	1.3
Accesses registries to track chronic illness and preventative measures (0-2)	1.1	0.8	1.5
Accesses data on addiction services (0-2)	1.0	0.9	1.2
Accesses information on patients' race, ethnicity & primary language (0-2)	1.1	1.2	1.0

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	**6.3**	**6.4**	**6.6**	**6.9**	**5.5**
Amount of providers in organization that are connected via an EHR (0-2)	1.8	1.8	1.8	1.9	1.8
Integrates inpatient & outpatient data within organization (0-2)	1.5	1.7	1.4	1.5	1.3
Accesses systems for predictive risk assessment for patients (0-2)	0.5	0.6	0.8	0.6	0.2
Registries to track chronic illness and preventative measures (0-2)	0.9	1.1	1.6	1.3	0.3
Accesses data on addiction services (0-2)	1.0	0.7	1.0	0.9	1.4
Transmits prescriptions to pharmacies, confirms fill (0-2)	1.4	1.4	1.8	1.6	1.1
Accesses information on patients' race, ethnicity & primary language (0-2)	1.6	1.5	1.0	1.8	1.6



CONTEXT
FROM THE QUALITATIVE INTERVIEWS

INTEGRATED & SHARED HEALTH CARE DATA

KEY FINDING: ROOM TO GROW

Though one physician group mentioned a handful of practices under their purview still working with paper records, most respondents described utilizing electronic health records to help with various metric reporting and to try and help providers make data-driven decisions around care management. Some delivery systems were having success sharing data internally, however sharing data across systems was described as a persistent challenge. Likewise, mental health organizations had the lowest score on the survey (5.5) and described lagging behind in this area because of the inability to link data from external systems.

KEY FINDING: THE CAPACITY ISSUE

Though the concept of data-driven decision making is spreading, several respondents indicated that the main barrier to leveraging this data was provider capacity to actually review and use it.

SEMINAL CASES:

HOSPITALS CONNECT TO OUTPATIENT DATA SYSTEMS

HOSPITAL: We have a single computer network between the two facilities in our community and we also have our own internal systems exchanging data. In other words, lab results from the hospital are populated in the clinic's patient record. The emergency doctors can bring up the clinic patient chart as well as the hospital patient chart in the ER so they have access to everything.

VOICES FROM THE FIELD

HOSPITAL: *We are working on sharing data, but the problem was we didn't have enough providers. We started to ramp up staffing in January 2014 when the Medicaid sign up started. We had three family practice doctors, two nurse practitioners, and two physician's assistants (PA). The nurse practitioners and PAs are all part time. We talked about outreach and managing segments of the population such as people with diabetes. We asked ourselves: how do you manage that population? Well, you have to have enough providers. We just signed another family practice doctor who's going to start with us, so we'll go from three providers to four. We are adding more staff so we can do more data work.*

PAYER: *We have an issue with providers having the capacity to review anything. There's a lot more information coming in than providers have time to review. We perform really well when it comes to getting the data if someone wants its, but a lot of providers don't know what to ask for or simply don't have time to read what they get, which is a constant struggle. There's not (particularly for smaller practices) anyone with five hours of freedom every week to understand information in order to do the best you can with things like certified risk scores and population health management tools. Time constraints are a constant issue.*

PROVIDER*: We have claims data and data from EMRs which helps us understand the cost measures for the quality of the care delivery and provides us information about diagnoses. In a majority of the cases the primary care provider does not have all the diagnoses of their patient. So if the patient was seen at a hospital and a new diagnosis was made, or they were seen at a specialist's office and a new diagnosis was made, not all of the necessary information reaches the primary care provider. However, all the information comes together once the claim is generated with that diagnosis. In order to help care coordination, we add that information to our claims and we do a monthly analysis of these claims, which creates a hybrid of data streams coming from the EMRs and claims.*

DATA FOR POPULATION HEALTH MANAGEMENT

OVERALL OREGON 2015 SCORE
3.9
(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Improving population health is a pillar of both the Triple Aim and the Accountable Care model. To accomplish this, data-driven decision making on how to provide care is necessary. More traditional systems might only have access to clinical health data, while a more progressive systems might additionally have access to data from housing agencies, social welfare systems and other public health organizations. Ultimately, a transformed system will be using data to understand the needs of their patient population and the community, and investing in upstream initiatives.

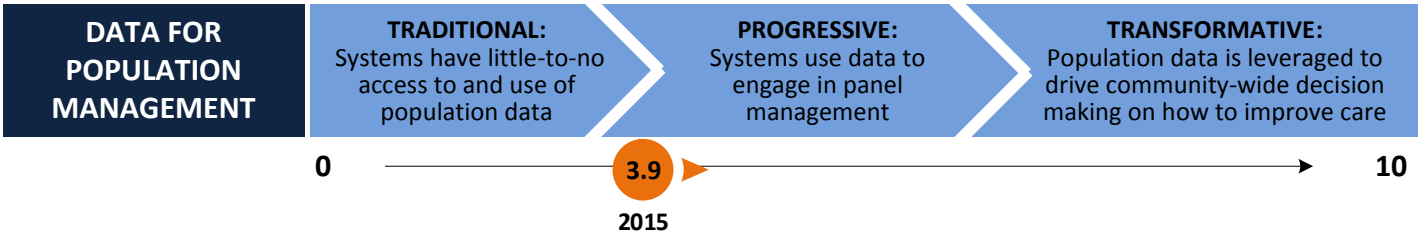
WHAT WE FOUND

Overall payers averaged a score 3.9 out of 10, with individual results ranging from 0.0 to 7.5. Providers overall averaged 3.8 with individual results ranging from 0.0 to 8.8.

This was the lowest scoring domain in our survey, suggesting that many organizations continue to struggle with key aspects of population health management. Data integration across silos—physical, mental, and dental, appears to be a challenge, with most organizations indicating that it is possible, but not routine, for them to do so. Likewise, accessing and using data related to social determinants of health and the larger community (beyond patient panels) presents a challenge for all health care organizations.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	**3.9**	**4.0**	**3.9**
Integrates inpatient & outpatient data from providers outside your organization (0-2)	1.3	1.3	1.2
Accesses data on patients' physical, mental and dental health (0-2)	1.0	1.1	1.0
Accesses data on patients' food, transportation housing and other basic needs (0-2)	0.2	0.2	0.2
Accesses data on health needs of the larger community you serve, not just your patients (0-2)	0.6	0.6	0.7

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	**3.8**	**4.0**	**2.0**	**4.8**	**3.3**
Integrates inpatient & outpatient data from outside providers (0-2)	0.8	0.8	0.4	1.2	0.7
Accesses data on patients' physical, mental and dental health (0-2)	0.9	0.9	0.8	1.1	0.7
Accesses data on patients' basic needs (food, housing, etc) (0-2)	0.7	0.6	0.2	0.7	0.8
Accesses data on larger community you serve, not just your patients (0-2)	0.7	0.9	0.2	0.9	0.5



CONTEXT
FROM THE QUALITATIVE INTERVIEWS

DATA FOR POPULATION HEALTH MANAGEMENT

KEY FINDING: VARIABLE SUCCESS IN DATA USE

All qualitative respondents agreed that leveraging data is the key to population health management but there was variability in the level of sophistication. The current challenges in doing so revolve around connecting disparate data systems, which explains the low scores on the survey for this measure. In general, the larger organizations described more sophisticated systems and efforts—moving away from a reliance on claims and developing EHR systems that track patients in real time—while smaller organizations lacked the resources and capital to move as quickly in building these systems. Interviews suggest that national payers have far greater capabilities than local delivery systems or CCOs, but these capabilities are leveraged around population management as it relates to chronic disease panels instead of the larger community. Like with integrating data, provider capacity is a barrier to leveraging available data.

KEY FINDING: WORKING TOWARD IMPROVEMENT

Data for managing population health is a priority for all organizations; respondents made it clear that there is a lot of mobilization and effort around improving capabilities here. Traditional commercial payers described population health data as something that gives them a competitive edge when contracting with providers.

SEMINAL CASES:

LARGE, NATIONAL PAYER MAKES SIGNIFICANT DATA INVESTMENTS

PAYER: We offer a care management platform. It incorporates claims data and clinic data like lab results and gets their algorithms to create care alerts that go out to members and physicians saying 'hey this is a forty year old female, she hasn't had a mammogram in three years' and the alert will go to the member and the provider. There's a whole host of other capabilities that the software has. Those are some of the assets that we can bring a relationship that are not traditional payer-provider.

VOICES FROM THE FIELD

HOSPITAL: *I think data capabilities are probably one of our biggest gaps at this point. We're attempting to close the gap by putting systems in place that will allow us to have better data analytics, but right now we're limited to information we can pull out of our financial cycle as well as our clinical database. They're not necessarily connected, so you can see where your gaps are from a financial perspective, but you can't link that well with the outcomes from a quality perspective; this is an area where we need to continue to invest. We are doing some partnerships at a state level with an alliance and trying to put in a database that will allow for these reports and analytics to be provided to our hospitals and to have a comparative group in order to drive potential changes. I think everyone who is trying to transform recognizes that data and good, clean actionable data is a gap right now and we're all trying to figure out the best way to close that gap.*

PAYER: *We not only have the reporting ability to look at patient populations who may need more intervention than others, we have a lot of predictive modeling regarding who is likely to have a high cost or who is likely to be hospitalized this year. I think we are getting better at this, and we've learned a lot through our ACO relationship, but I don't believe any payer should be doing population health management. We have really good health coaches and we get really good rates of people quitting smoking and losing weight, but we do it on a smaller number than a medical group could do. In a perfect world, the payers wouldn't have to have case managers, health coaches and management programs because it would be done through the physicians' offices. In some of our relationships, we are the most successful when our team that uses those analytics shares information with our provider partners. Together, they make decisions and they meet. Ideally, we would support them in a way that it could all happen in the provider office. Now, the gap I think we have yet to solve is it requires a lot of data transfer, which is hard for an office to manage. We can set up piles of reports, but I'm not sure they're always going to be gleaned for the pieces of information that need to be addressed for individual answers.*

INTEGRATED CARE MODELS

OVERALL OREGON 2015 SCORE
7.1
(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

The coordinated care model in Oregon is intended to remove traditional silos and move health care systems toward "whole person care," with physical, mental, and dental health managed in a comprehensive and integrated way across the population. A more transformed system will have increasingly sophisticated ways to provide contextually-informed care that takes into account all health needs, as well as the cultural, social, and economic factors that might impact outcomes.

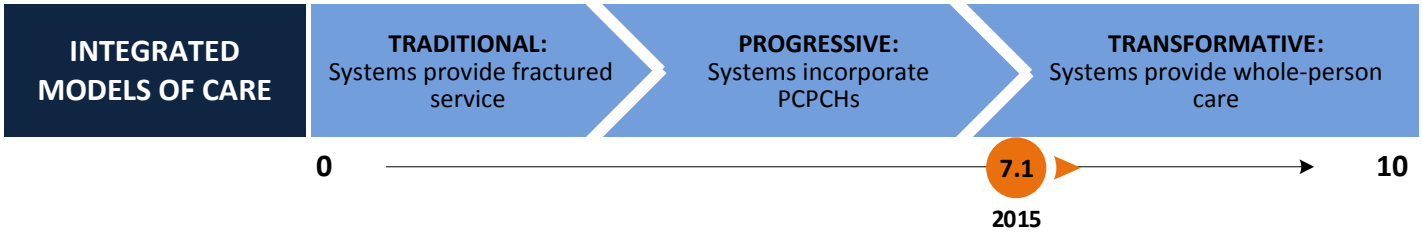
WHAT WE FOUND

Overall payers averaged a score 7.7 out of 10, with individual results ranging from 1.0 to 10. Providers overall averaged 6.9 with individual results ranging from 0.0 to 10.

Though sharing data across physical, mental, and behavioral health was a challenge, organizations scored high (overall state score 7.1) on integrating care, with health plans and FQHCs leading payers and providers with scores of 8.0 and 8.7. This suggests that the push to move toward more integrated care—a major transformation priority in Oregon — is happening collectively across organizations and markets.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	**7.7**	**7.4**	**8.0**
Contracts directly with physical health care (0-2)	1.8	1.8	1.8
Contracts directly with mental health care (0-2)	1.6	1.4	1.8
Contracts directly with substance use care (0-2)	1.6	1.4	1.8
Contracts directly with dental health care (0-2)	1.1	1.1	1.2
Launched initiatives for better integration of physical, mental, behavioral & dental health (0-2)	1.6	1.7	1.4

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	**6.9**	**6.1**	**6.4**	**8.7**	**6.5**
Collaborates directly with mental health providers (0-2)	1.6	1.3	1.6	1.9	1.8
Collaborates directly with substance use providers (0-2)	1.4	1.0	1.5	1.6	1.8
Collaborates directly with dental health providers (0-2)	1.1	1.0	1.0	1.7	0.8
Adoption of PCPCH recognition by clinics within organization (0-2)	1.4	1.6	1.8	1.9	0.7
Adoption of culturally sensitive programs within organization (0-2)	1.4	1.3	0.8	1.7	1.4
Efforts toward co-location of physical, mental, behavioral dental (0-2)	1.4	1.3	1.2	1.8	1.4



CONTEXT
FROM THE QUALITATIVE INTERVIEWS

INTEGRATED CARE MODELS

KEY FINDING: EVIDENCE OF INVESTMENT

All organizations are working toward better integration of physical, behavioral, and dental health. Many described investing in programs that either co-locate physical or mental health, or offer care coordinators or healthcare navigators that are based in primary care but plugged into patients' mental health needs. Organizations recognize that there is cost savings associated with integration; they identified behavioral health issues as being associated with the high-utilizing populations, thus better integrated care would lead to savings. Mental health organizations we talked to indicated that the state-level integration push has been a big driver of change and effort on the part of the physical health world to better integrate the two fields.

KEY FINDING: THE CHALLENGES OF INTEGRATION

There is agreement that integration is a necessary step forward, albeit for different reasons: providers acknowledge that doing so would improve quality of care, and traditional health plans see selling clients a single integrated insurance package as a boon to their business model. However, respondents noted that the system level barriers—from regulations around privacy to things like irreconcilable billing codes, often seem like an insurmountable challenge. Interviews also imply that there is a diffusion of responsibility as to where the burden of integration effort should fall: payers feel that the delivery system needs to integrate before it can change fragmented reimbursement models, while providers feel that they cannot integrate care without being able to change how they bill.

VOICES FROM THE FIELD

HOSPITAL: *We feel we have changed as a health district much quicker than our mental health provider locally and our dental provider locally. They're both capitated for Medicaid services and they were not staffed to take care of the hugely expanding population in the county. We brought this to attention, which may have been unwelcomed, but because of it we feel they are now being more responsive. We expect them to play at our level so which has not made us particularly popular, but we're getting responses, which is the whole point.*

PAYER: *From the business point of view, selling clients medical, behavioral, dental, and disability is an all in one platform that would be easy for a provider to deal with. We would love to offer that kind of product, however, we find out it's not that easy because there's firewalls between behavioral and medical. Somebody gets admitted to the hospital because they're acutely ill from alcohol, but then they can't get them out of the hospital into treatment, so now they're under behavioral instead of medical. The rules that we write for what benefits end up in what buckets make it really complicated for people to manage. It would be far simpler if all of the dollars went to the provider and they decided what to spend it in.*

SEMINAL CASES:

A HOSPITAL HELPS FUND A MENTAL HEALTH CRISIS CENTER

Hospital: Mental health comes up in every [redacted] needs assessment. We are funding a Crisis Center. The idea is it's going to be funded through mental health and county dollars. It has not been uncommon the last year to have someone living in our ER for a week or three or four days for mental health related issues. The two hospitals in our region have agreed to make it so that if the police are called, the police don't have to bring the person to the healthcare facility first and they can just take them directly to the Crisis Center. We'd have those horror stories where the police are holding someone in a cell and they need mental health care, not physical health care, but we have only had a hospital to take them to. This is an exciting step in mental health care.

BETTER COORDINATION OF CARE

OVERALL OREGON 2015 SCORE
6.9 (0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Coordinating care is a crucial response to integrating the fragmented healthcare system and achieving a workable model of accountable care. A traditional system might not coordinate with other providers at all, while a more progressive system will be focused on transitions of care, such as avoidable readmission and connection with primary care post-emergency department visits. A transformed system will be less reactive and more deliberate in regard to organizing patient care activities.

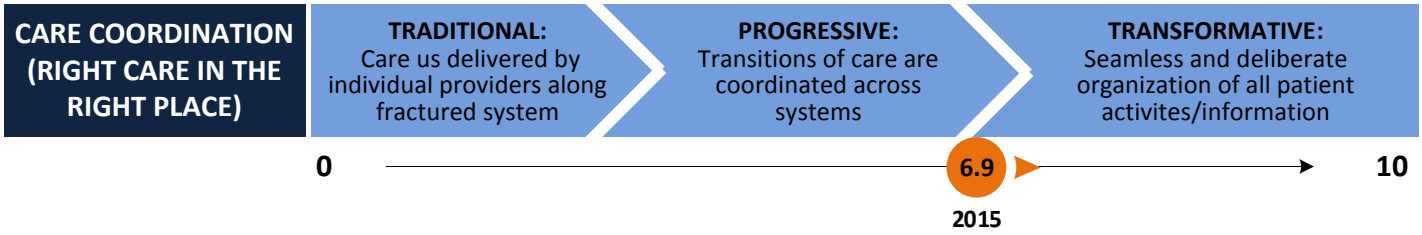
WHAT WE FOUND

Payers averaged a score 7.1 out of 10, with individual results ranging from 0.0 to 10. Providers averaged 6.9 with individual results ranging from 0.0 to 10.

Health plans and FQHCs have the highest scores for care coordination (7.5 and 7.6), with mental health organizations scoring the lowest (6.5). There appears to be emphasis on efforts to spread the medical home model, improve care transitions, and focus on the high-utilizing patient population. However, there is less traction around contracting with nontraditional health care force— social workers or community health workers, for instance– to improve care coordination.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	**7.1**	**6.8**	**7.5**
Contracts with incentives for social workers or care navigators to provide better care (0-2)	0.7	0.7	0.8
Initiatives designed to encourage the spread of PCPCH's (0-2)	1.7	1.9	1.5
Initiatives designed for better care coordination for high utilizers (0-2)	1.9	1.8	1.9
Initiatives designed to improve access to care for your members (0-2)	1.6	1.5	1.8

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	**6.9**	**6.7**	**7.0**	**7.6**	**6.5**
Clinics within org. adopted programs that target specific patients (0-2)	1.5	1.5	1.2	1.8	1.3
Initiatives designed to create referral pathways between physical, mental, behavioral and dental health resources (0-2)	1.4	1.2	1.4	1.8	1.4
Initiatives designed to create better care transitions (0-2)	1.3	1.5	1.6	1.2	1.2
Initiatives designed to encourage appropriate utilization (0-2)	1.4	1.3	1.4	1.4	1.4
Initiatives designed to create other population health programs (0-2)	1.3	1.3	1.4	1.5	1.2



CONTEXT
FROM THE QUALITATIVE INTERVIEWS

BETTER COORDINATION OF CARE

KEY FINDING: MAKING AN EFFORT

Care coordination is common jargon in the healthcare transformation discourse, but interviews reveal that there are a variety of interpretations. Many conversations around the domain overlapped heavily with care integration and population health management, as well as discussions about how to leverage contracting relationships. Overall, care coordination programs are specifically aimed at target populations like high-utilizers. All respondents indicated that coordinating care is a strategic priority, but there is little uniformity in how they are attempting to reduce fragmentation.

KEY FINDING: CARE COORDINATION IS DEPENDENT ON DATA

Respondents understand care coordination as a pathway to improving quality and reducing cost, but doing so effectively requires the appropriate data pathways to identify patients and track them through the delivery system. One more transformed system (quoted on the right) with sophisticated contracting strategies for traditional services underscored that the lack of formal processes around agreements for information sharing with agencies that are not traditional health care is a challenge. Others (below) describe focusing on high utilizers, both across their national client base and at an Oregon location.

VOICES FROM THE FIELD

PAYER: *In their national model they set up what they call an "extensivist clinic ." They have doctors that are internists (who are generally formal hospitalists) and they have been able to show in a few markets they can reduce the cost of care for the 20% of the population that uses 50% of the resources by providing a concierge level of service to those members. They have methods using the EMR systems in data to identify them as high-cost patients based on diagnoses or diagnoses codes. They work really hard at coordinating the care for the 20% of the patients that bought 80% of the premiums. They're about to get started in the fourth market in 2016,and they're in discussions with us and some of the other health systems in the area to formalize those contracts in increments.*

PROVIDER: *What we're trying to do is coordinate care for high utilizers and high-cost patients by coordinating the care being delivered at the provider level and clinic level with the information that is gathered at the health plan. We are trying to get information shared between the entities that are delivering care to these high utilizing and high-cost patients through the exchange of information any of these entities receives in regards to the change in the clinical settings of the patients. For example, any information upon being admitted in the hospitals needs to be shared with the primary care physicians so they can take action when the patient is discharged. Information on treatment received at the hospital and an attempt to get them back into the PCP office for a follow-up visit after that hospitalization can be used in order to find out why they were hospitalized for and then to manage them accordingly.*

SEMINAL CASES:

A PAYER USES CONTRACTING STRATEGY TO DRIVE CARE COORDINATION

PROVIDER: Most of our care is provided internally: we've got primary care, specialty care, hospital, dental, et cetera. Additionally, we contract for select services, so there's some specialties that we'll contract with for behavioral health. For those services that we do contract with, we set up arrangements with those contractor partners and build into those contracts ways to coordinate care together. When we start working with the outside agents then we have more diligence required around HIPAA. So as we're beginning to, in all parts of our organization, reach out more and bring in new types of partnerships that's one of the issues that we need to resolve. It's more straightforward if you create a contract, for example, with a community health worker agency because there's certain rules requiring business associate agreement to exchange information because they're a paid provider. Some of the discussions and exchange of information between the more informal agencies is a bit more slippery.

PREVENTION & SDH-INFORMED CARE MODELS

OVERALL OREGON 2015 SCORE
6.8 (0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

The coordinated care model is designed to move resources and efforts upstream to improve population health through increased focus on prevention and the social determinants of health, like the impacts of the built environment and other structural realities like poverty. A traditional system might allocate most of their resources towards acute treatment, but a transforming system would progress towards allocating the majority of the resources for prevention and upstream interventions. The social determinants of health become increasingly more important as a focal point of community care and health strategies around prevention.

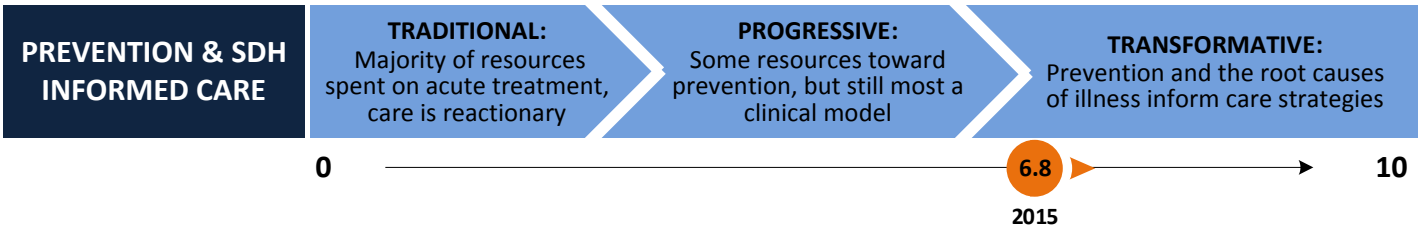
WHAT WE FOUND

Payers averaged a score 5.2 out of 10, with individual results ranging from 2.0 to 10. Providers averaged 7.2 with individual results ranging from 0.0 to 10.

Payers had consistent scores on prevention and SDH-informed care (5.2), with providers scoring higher (7.2) and Physician groups doing the most transformative work in this domain; they had the highest scores related to transformation associated with primary care, such as improved access to clinicians, medication management, and preventative care promotion, a positive outgrowth of the state's patient-centered primary care home initiative.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	**5.2**	**5.2**	**5.2**
Contracts with incentives for non-clinical patient needs such as food or housing (0-2)	0.5	0.6	0.4
Contracts with incentives for providers to reduce ED or hospital visits (0-2)	1.0	1.0	1.0
Initiatives designed for better integration with systems outside health care (0-2)	1.1	1.3	1.0
Initiatives designed for flex funds to support health engagement and lifestyle changes (0-2)	1.2	1.1	1.4
Initiatives designed to focus on health & prevention on the larger community (0-2)	1.3	1.3	1.4

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	**7.2**	**6.5**	**8.3**	**7.8**	**7.4**
Initiatives designed for referrals for basic patient needs (0-2)	1.2	0.9	1.0	1.4	1.4
Initiatives designed for medication management for at risk-patients (0-2)	1.5	1.3	1.8	1.5	1.8
Initiatives designed to improve access to clinicians (0-2)	1.6	1.5	2.0	1.8	1.5
Initiatives designed for preventative care promotion (0-2)	1.4	1.5	1.8	1.6	1.2



CONTEXT
FROM THE QUALITATIVE INTERVIEWS

PREVENTION & SDH-INFORMED CARE MODELS

KEY FINDING: A STRATEGIC PRIORITY FOR ALL

Delivery systems have mobilized around prevention; one self-insured entity described promoting wellness among employees, a hospital CEO indicated that his organization was doing extensive partnership with community-based wellness organizations, and national payers are working closely with employer clientele on specific preventative interventions like reducing depression after surgery. CCOs and delivery systems are sensitive to the role that social determinants of health play for their patient population. Community health worker initiatives, as well as the below-described effort to improve the health of a single patient with a lot of psychosocial barriers, was common.

KEY FINDING: PREVENTION MATTERS

Prevention is a focus across markets; we observed focus on social determinants is more limited to the Medicaid market, although one national payer noted that they have care coordination programs in their Medicare ACOs. Oregon CCOs have made tackling psychosocial issues a priority; for example, one hospital recounted an instance in which they used an empty room at their facility to care for a patient who required surgery and follow-up care but was having difficulty getting to appointments. The need for upfront investment to fund prevention initiatives, coupled with shortages in primary care are the key barriers standing in the way to making these initiatives successful and scalable.

VOICES FROM THE FIELD

HOSPITAL: *As an employer, we manage our own health insurance. In terms of physical health improvements and preventative care we want to improve the overall physical health of our employees. We've implemented a number of strategies around involving individuals in their health improvement through physical exercise, diet, and nutrition. We're trying to partner with other employers in the community to begin providing those types of incentives and programs for their employees as well. One of the initiatives that was sent out by the state of Oregon, and led by the former governor, was to move Oregon to becoming the healthiest state in the nation. We've embraced that initiative and we're hopeful that will continue and with the new governor's platform. We're taking on that initiative at a local level and we're partnering with the chamber, other businesses, school district, and the university to incorporate the concept, which will get at the improvement of the overall health of the community in terms of physical, spiritual, and mental health.*

SEMINAL CASES:

A HOSPITAL HOUSES A HIGH UTILIZER WHO CAN'T GET TO APPOINTMENTS

HOSPITAL: This scenario may sound amazing, but it's really not when you think about it: we had a morbidly obese person that couldn't even walk who needed some other types of surgery but couldn't get up because they were so overweight so we put them in the hospital in a vacant room for about two or three months. They had daily counseling, daily coaching from physical therapy, and from dietary. They lost a lot of weight, they got their surgery, and so on. When you think about it even though we're so called 'losing' two or three thousand dollars a day on that patient, the fact is we have to make room. Having them stay at the hospital probably cost us $50 a day. We're able to do those kind of things that larger hospital systems just cannot. I think our ethics and our mission have to be in the right place. We also need to have a really good understanding of the finances because I hear so many people talk about how we can't do 'x' because we spend $3000 a day on that patient, but that's not true. You have slack capacity, which is very inexpensive, and so we have a huge advantage in taking care of the high-utilizer patients.

WORKFORCE TRANSFORMATION

OVERALL OREGON 2015 SCORE
6.4 (0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Oregon has championed the role of non-traditional health workers—such as social workers, community health workers, and care coordinators - in the advent of reform. A traditional system might still be relying on traditional care providers. As systems progress towards transformation, we expect that there will be expanded multidisciplinary focus that incorporates non-traditional, and non-clinical, roles such as community health workers or peer support networks to help address social determinants of health.

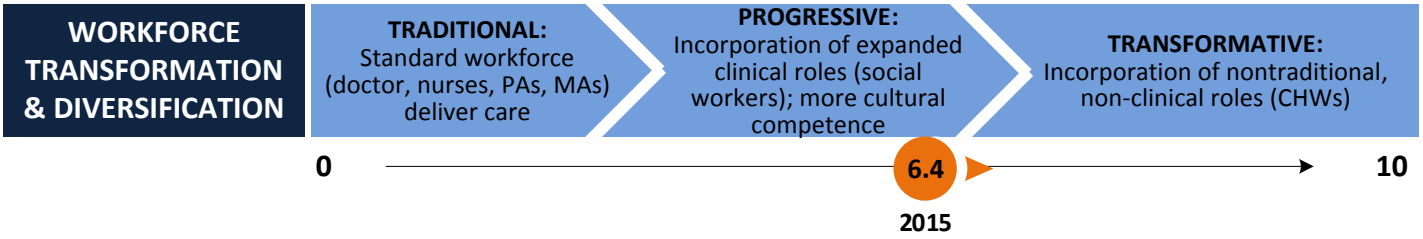
WHAT WE FOUND

Payers averaged a score 3.8 out of 10, with individual results ranging from 0.0 to 10. Providers averaged 7.1, with individual results ranging from 0.0 to 10.

Overall providers overall scored much higher (7.1) compared to payers (3.8) in regard to workforce transformation. Among providers, FQHCs were doing the most transformative work around adoption of multi-disciplinary care teams and employing a non-traditional workforce. Providers appear to favor using a multidisciplinary and team-based care approach, however, employment of non-traditional workforces is still in rudimentary stages for providers other than FQHCs and mental health organizations.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	**3.8**	**4.0**	**3.4**
Contracts with incentives for having social workers to provide better coordinated care (0-2)	0.7	0.7	0.8
Contracts with incentives for having a non-traditional workforce (0-2)	0.6	0.8	0.5
Contracts with relaxed billing rules to allow providers flexibility to provide non-traditional healthcare services (0-2)	0.9	1.0	0.8

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	**7.1**	**6.2**	**5.0**	**9.1**	**7.0**
Adoption of multidisciplinary, team-based care (0-2)	1.6	1.6	1.4	1.9	1.4
Employing non-traditional workforce (0-2)	1.3	0.9	0.6	1.8	1.4



CONTEXT
FROM THE QUALITATIVE INTERVIEWS

WORKFORCE TRANSFORMATION

KEY FINDING:

We observed workforce transformation taking place in two ways: the first involved promoting a model of team-based care that included non-clinical roles like social workers, and the other was introducing roles like community health workers to support providers. Non clinical roles were recognized as being able to improve care delivery for patients and reduce the burden on primary care providers, particularly when these roles were used specifically for the complex patient population.

KEY FINDING: THE CHALLENGES OF "SPREAD"

Medicaid's reimbursement for nontraditional health workers appears to facilitate workforce diversification for that market. One physician group secured a grant for a Community Health Care pilot program to better manage complex patients (regardless of payer). This program was well-received by physicians and patients alike, however, there was uncertainty about the sustainability of the role when grant funding ran out. There were examples of team-based care in other markets; for example, one payer described using team based care for their older patient population. Outside of Medicaid, reimbursement for nontraditional healthcare workers might be thwarted by regulations around licensure: one payer noted that to formalize a community health worker role could threaten NCQA status because that worker would be considered "under-licensed."

SEMINAL CASES:

A DELIVERY SYSTEM PROMOTES TEAM-BASED CARE

HOSPITAL: Complex Care Medical Home was the last rung in the ladder for our medical home model, so we've been on this journey for the last five years. It's pretty much implanted in the buildings. We're certified in all our medical office buildings and we're really using that platform to transform. We are now taking it one step further to transform how we deliver care by using a team-based approach by incorporating a pharmacist, social worker, navigator (which is non-clinical) RN, physician and behaviorist.

VOICES FROM THE FIELD

PAYER: *Using a model in population health, we've segmented into populations of ones, twos, threes, and fours. The fours are the people that might have a chance of dying within the next two years from an actuarial standpoint. In 2014 this group has mainly been a geriatric population. One of the first things we did was to use team-based care model and the medical home model to provide the best possible care tailored to this population.*

HOSPITAL: *One thing that we have done outside of the CCO is hire certified social workers to work in our clinics. So much of what people are dealing with are addictions and they are not willing to go to any kind of center because of the stigma associated with it, but they are willing to work with our social workers at our clinics, which is working out very well.*

PAYER: *We are definitely finding a way to align care coordinators and care managers in the clinic as the health plan and as a hospital. We have touch points at each of those locations whether it be a discharge nurse at the hospital with a report, a care manager that's looking at chronic conditions of patients or the primary care provider offices. We are starting to feel alignment in conversations between the three groups of people. I think that's one of those partnerships and engagement areas sections where we are to see those conversations happen and we are starting to see people leverage those different areas of outreach. We have community health workers, Promotorres and outreach teams, and then within the clinics we've got the population management nurses that are making all those reminder calls and doing all of the follow up work.*

OWNERSHIP OF RISK

OVERALL OREGON 2015 SCORE
4.5
(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Risk shifting - or moving away from a transactional financial reimbursement model—represents a radical shift in the way providers are incentivized and is hypothesized to be an important lever in reducing costs. In a traditional system, insurers own the risk and providers operate as fee for service. As the system shifts, there might be a blended model with risk bearing entities. In a transformed system providers might own more risk, and by doing so will work to provide effective care more efficiently.

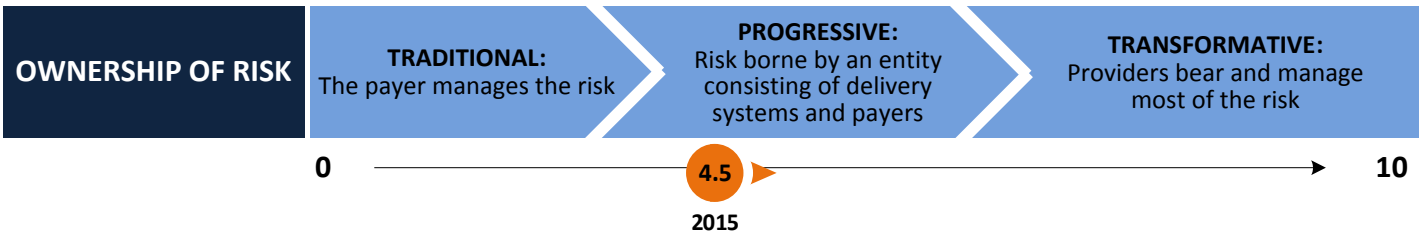
WHAT WE FOUND

Payers averaged a score 4.7 out of 10, with individual results ranging from 1.3 to 10. Providers averaged 4.5, with individual results ranging from 0.0 to 10. Physician groups and mental health organizations have the highest scores for ownership of risk (7.0 and 5.6), with FQHCs scoring the lowest (3.4). CCOs were more likely to share risk with providers, but health plans were not far behind.

Provider side risk takes several forms: we see an emphasis on contracts with withholds designed to incentivize quality, and a comparative de-emphasis on contracts with bundled payments around care episodes or other risk arrangements. Physician groups were generally more likely to see these quality withholds than FQHCs, hospitals, or mental health organizations.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	**4.7**	**5.2**	**4.1**
Contracts with risk shared by the care providers (0-2)	1.2	1.4	1.1
Contracts with bundled payments around care episodes (0-2)	0.6	0.6	0.6
Contracts with case rates for care providers (0-2)	0.9	0.8	0.9
Contracts with provider withholds to incentivize quality (0-2)	0.9	1.1	0.6

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	**4.5**	**3.8**	**7.0**	**3.4**	**5.6**
Contracts with risk for bundled payments around care episodes (0-2)	0.5	0.5	0.5	0.5	0.7
Contracts with withholds designed to incentivize quality (0-2)	0.9	1.0	1.6	0.7	0.9
Contracts with other kinds of risk arrangements not mentioned (0-2)	0.4	0.2	1.4	0.3	0.5
Proportion of patients covered by risk-based contracts (0-2)	1.3	1.1	1.6	1.0	1.6



CONTEXT
FROM THE QUALITATIVE INTERVIEWS

OWNERSHIP OF RISK

KEY FINDING: ROOM TO GROW

Respondents acknowledged that their organizations were, on some level, discussing and enacting strategies to move away for fee for service payment models, with the exception of mental health and FQHCs (as one FCHQ put it, they were too overwhelmed to do anything other than *react* to payment reform). Most of the transformational traction was associated with upside risk and incentives—discussed in further detail on the alignment of incentive and values page. A few respondents described having their providers at downside risk; in one case this model pre-dated CCO legislation; another delivery system mentioned experimenting with bundled payments for certain services.

KEY FINDING: THE CHALLENGES OF "SPREAD"

The spread of payment reform is hindered in some areas by penetration and whether or not there is a large enough population to move away from a fee for service model to something more transformative, like capitation.

VOICES FROM THE FIELD

HOSPITAL: *The CFO for the Oregon region said 'don't you dare do a capitated model on anything with Medicaid' because we don't have a big enough population.*

PAYER: *We don't have any ACOs operating in commercial marketplace in Oregon and we do not have much managed care penetration in this marketplace, so Medicaid is really our test for commercial managed care.*

HOSPITAL: *Everything is kind of up in the air, so while theoretically everyone says we need to move to capitated models and we need to help out the population, getting from point A to point B is really painful. What I have found is that people are good at A and they're good at doing things in B, but most people aren't really the change agent to move you from point A to point B. I think that's where we're all kind of feeling our way into by being creative.*

SEMINAL CASES:

A CCO/PAYER PUTS PROVIDERS AT DOWNSIDE RISK

PAYER: Most of our primary care providers take risks, our behavioral health providers have excessive risk, our hospital system is at risk, but our specialty providers are not. By referring to 'at risk' I mean both upside and downside risk. It means there's an opportunity to make money and an opportunity to lose money. The same upside and downside risk is true for the CCO, prior to events contracted to the state. We have the opportunity to gain money and lose money, so being at risk is a concept the community has embraced fully and is working on. At risk also means everyone's contracts are a little bit different because we're testing different methods of alternative payment.

INTEGRATED RISK MODELS

OVERALL OREGON 2015 SCORE
4.6
(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Risk shifting represents a radical shift in the way providers are incentivized and is hypothesized to be an important lever in reducing costs. In a traditional system, insurers might own risk, but often for only one portion of a persons' total care – dental or mental health my be carved out or otherwise excepted, for instance. As the system shifts, there might be a blended model, with organizations at risk for the entire range of a person's care. More transformed models might also create risk around population health markers, rather than just outcomes for attributed patient populations.

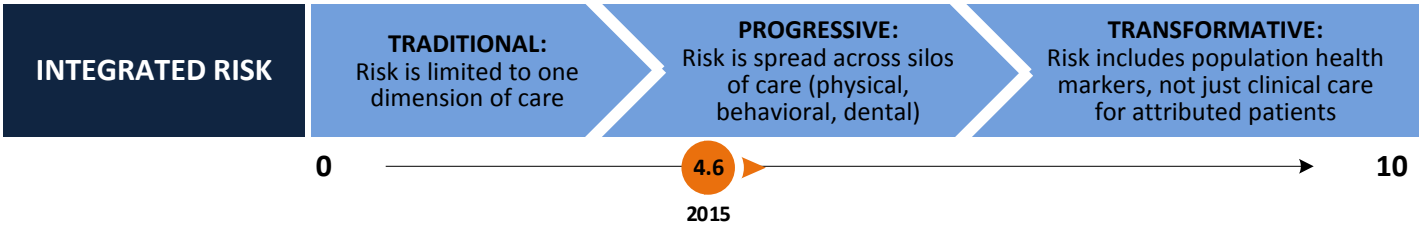
WHAT WE FOUND

Payers averaged a score 6.5 out of 10, with individual results ranging from 0.0 to 10. Providers averaged 4.2, with individual results ranging from 0.0 to 10.

Health plans scored higher (8.5) on integrated risk compared to the other organizations, especially compared to CCOs, whose results were much lower (4.7). Payers scores for each of the domains are relatively similar, with direct risk for dental health being the lowest.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	**6.5**	**4.7**	**8.5**
Direct risk for physical health care (0-2)	1.5	1.1	1.9
Direct risk for mental health care (0-2)	1.4	0.9	1.8
Direct risk for substance use care (0-2)	1.4	0.9	1.8
Direct risk for dental health care (0-2)	1.1	0.8	1.3

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	**4.2**	**3.9**	**5.3**	**2.5**	**5.6**
Contracts with risk for physical health care (0-2)	0.8	1.0	1.6	0.7	0.5
Contracts with risk for mental health care (0-2)	0.9	0.6	0.4	0.4	1.7
Contracts with risk for care your patients get in a different setting (0-2)	0.7	0.6	1.2	0.4	1.1



CONTEXT
FROM THE QUALITATIVE INTERVIEWS

INTEGRATED RISK MODELS

KEY FINDING: ROOM TO GROW

Overall, respondents indicated that integration from the financial perspective was a challenge; mental health organizations felt that they had very little capacity to be forward thinking about better integration with physical health. One payer indicated that from their perspective, better integration of physical and behavioral health is outside of their desired scope and would have to happen at the delivery system level.

KEY FINDING: THE CHALLENGES OF REIMBURSEMENT

The most transformational example of risk integration was happening at the CCO level, with other payers prioritizing these types of efforts less. As with integrating data, challenges were systemic: issues reimbursing across silos were described as an obstacle to spread.

VOICES FROM THE FIELD

MENTAL HEALTH : *The whole system has changed so much, especially in the drug and alcohol world. It used to be that the state would award your agency some state-funded beds. Thereby, your job was to make sure that you had met the utilization and that those state-funded beds were full with individuals covered by Medicaid. You didn't necessarily have to worry about payment because you turned in your utilization report to prove that they were full or not full and how they were used. Now with CCOs and funding in the local communities, we have found there's a lot more of an authorization process that has to happen with each one of those contracts and there is no uniformity between the CCOs.*

PAYER: *We offer the full suite and behavioral health is embedded in all of our products as a medical benefit. I can't think of an example of where behavioral health is carved out. It used to be that there were national behavioral health vendors that had pretty decent penetration with employers, like larger employers. It was a standalone benefit through a standalone vendor or separate vendor. Today, it's almost always integrated into medical benefits, and so the downstream integration of behavioral health would happen with the delivery systems because from a benefit design, it's all integration.*

HOSPITAL: *As you probably heard numerous times, there are challenges in accessing mental health and dental health and there are difficulties around the reimbursement side of these two areas, which creates issues on the overall health of the population perspective, particularly your low income citizens. On the mental health side, our corporation is the only provider of inpatient mental health services and the work is expanding, particularly with the customer to be seen as a regional resource for those services. While we're not reimbursing at the level we need to sustain that, we also know that it is a benefit to our communities and the broader healthcare system so we're continuing to figure out how can we sustain those services and do that not only for now but for the long term.*

SEMINAL CASES:
A CCO INCENTIVIZES INTEGRATION

PAYER: We incentivize collaboration across physical, mental, and dental health. Sometimes it goes as well as you want, sometimes it goes better than you want, but we incentivize collaboration. We have a community governing part and that's why we developed contracting metrics that partners collaborate on and share. It would be a problem if we sat in a room and talked about every cost pack together, but ...our funding goes back into the community, and that gets more people interested in participating.

ALIGNING INCENTIVES & VALUE

OVERALL OREGON 2015 SCORE
4.4
(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

One of the hopes for accountable care organizations is that they will address the widely accepted notion that health care inflation is based on fee-for-service (FFS) payment methods. FFS is the status quo, and changes in financing that incentivize value over volume are an important element of transformation. A system moving to value will reward quality, while a transformed system might replace FFS with pay for performance or full capitation.

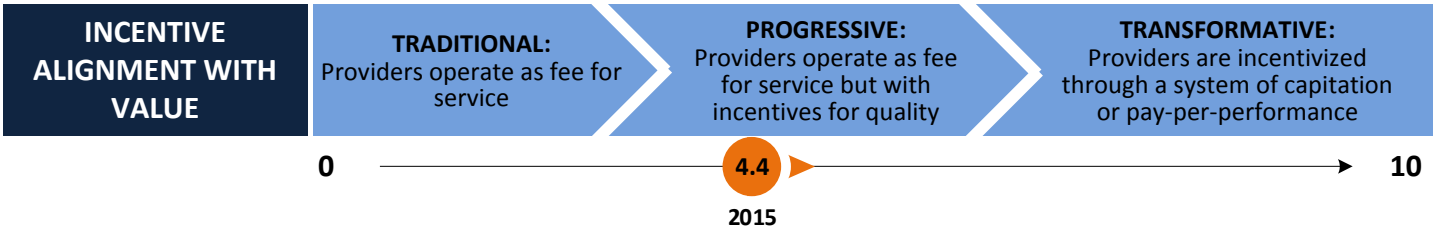
WHAT WE FOUND

Payers averaged a score 4.9 out of 10, with individual results ranging from 0.0 to 10. Providers averaged 4.2, with individual results ranging from 0.0 to 9.0.

Almost all organizations have made some effort to align financial incentives with good outcomes (like quality, prevention, and reduction in emergency department use). CCOs and other payers appear to be making strides to build in cost reductive and population health management incentives into their provider contracts. Physician groups in particular scored highly on measures associated with aligning financial incentives with prevention and reducing costly utilization.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	**4.9**	**4.6**	**5.3**
Contracts with incentives for providers to reduce ED or hospital visits (0-2)	1.0	1.0	1.0
Contracts with incentives tied to population health metrics rather than clinical care (0-2)	1.0	0.8	1.1

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	**4.2**	**4.1**	**6.2**	**4.5**	**3.7**
Risk-based contracts with Medicaid (0-2)	1.5	1.3	2.0	1.2	1.8
Risk-based contracts with Medicare (0-2)	0.6	0.8	1.8	0.4	0.5
Risk-based contracts with Commercial/Private(0-2)	0.5	0.8	1.3	0.2	0.4
Contracts with incentives for clinical quality performance (0-2)	1.0	1.0	1.4	1.3	0.7
Contracts with incentives for integration of care (0-2)	0.6	0.7	0.2	0.6	0.6
Contracts with incentives for reducing ED or hospital visits (0-2)	0.8	0.7	1.4	1.1	0.6
Contracts with incentives for screenings or other preventive care (0-2)	1.0	0.9	1.4	1.2	0.7
Confidence in the quality of the outcomes used for incentives (0-2)	1.1	1.0	1.2	1.3	1.1



CONTEXT
FROM THE QUALITATIVE INTERVIEWS

ALIGNING INCENTIVES & VALUE

KEY FINDING: MAKING STRIDES

When asked about the types of incentive alignment efforts organizations were taking on, qualitative respondents identified value based care is as a common strategy. Payers and Physician groups described building pay-for-performance into their contracts. Providers were also taking on more contracts that incentivized value-based care, although we observed that from their perspective, the amount of reporting required was often frustrating and overwhelming.

KEY FINDING: THE CHALLENGES OF "SPREAD"

Interviews suggest that the barrier to spread in this domain is largely associated with the providers working on the ground, who are disincentivized by pay for performance contracts, even if they are willing to do the work around improving quality. One care delivery system argued that vertical integration is the best solution, because salaried doctors are more receptive to working under the population health improvement model. Another payer noted that contracting for value was more about building transparent relationships with providers.

VOICES FROM THE FIELD

HOSPITAL: *We wanted to make sure that we were all going in the right direction and all the "kumbaya" stuff was more important to all of us than the financial stuff, which is also how the contracts were read for the doctors. Unlike most, the employment contracts with the physicians are almost exclusively salary based and very little performance based. This was at the providers request because they felt like if it was a heavy performance based contract, something like 'you must see 'x' number of patients every week.' We had this conversation last week in the middle of health reform and discussed that if you have a performance based contract with the doctors, they don't want to do outreach and they don't want to do patient education, they don't want to go to meetings about population health and the like because it's cutting into their income. If they're salary-based, they're willing to do that and they say that's why they went into medicine in the first place, to make people well. Basically, performance based contracts with doctors can be a disincentive to do health reform.*

SEMINAL CASES:

A CCO/PAYER INCENTIVES INTEGRATION

HOSPITAL: Yes. We're working with our payers and in our negotiations as we're moving forward with renewals or even new payment contracts, we are incorporating different models than we would have likely incorporated a number of years ago. Areas where we've got more risk, so we would for instance put a portion of our payments at risk for up-coming measures like quality service, cost efficiency but this is a new area from where we would traditionally function in contract negotiations with the payers. A lot of the work that we're seeing now as being effective in models are around the CCOs because the CCOs seem to be more open and versed in those types of relationships. However, we're starting to see that when we're engaging with local employers and their insurance providers and providing health services for the local employers, we're starting to put outcome measures into those payment structures.

PAYER: *I think when people start looking at volume to value, it starts to sound like the capitation of the early 90's, which it's really not. I think where we are in the journey is half of the battle is not what should the contract pay and what are we going to pay you. From my point of view, half the battle is if can we build a collaborative relationship and work together to the same goals so that at the end of the year when we're doing a reconciliation of what the spend was, it's completely clear to you why you're getting a certain portion of the savings, and there are no surprises why you don't.*

APPENDIX

This document outlines a proposed measurement system for the SIM grant's assessment of the "spread" of transformation elements within and beyond CCOs in Oregon.

DOMAINS: WHAT ARE WE TRYING TO MEASURE?

Previously, the SIM workgroup identified a set of "domains" of transformation along which we would measure progress over the course of the study. Here, we propose a slightly simplified set of domains, along with a proposed system for measuring progress along those domains over time.

Our domain scores are best seen not as *performance scores* — our intent is to avoid making assumptions about what any organization *should* be doing. Rather, the scores are best seen as representing the *density* of given transformational elements within the health care system — how much of certain things are present across the system at a given point in time. Thus, for example, a score in the domain of *integrated care models* represents the density of such initiatives across the system, not the performance of any given organization against some standard of practice.

OVERVIEW OF PROPOSAL

We propose a mixed methods assessment framework that can be applied either with or without an intensive qualitative layer:

SURVEYS: Our proposed framework is built primarily off of a pair of surveys — one aimed at payers, the other at provider organizations — which will be delivered via mail or online to key industry executives and representatives. These surveys are designed to capture high-level data on organizational progress along a series of dimensions mapped to the transformation domains. Organizations contribute "points" to transformation domain scores by answering questions certain ways, and the number of points created within a domain tell us about the density of those elements across the system. We will track how this density changes over time.

QUALITATIVE SUPPLEMENTS: For each of our transformation domains, we have also identified a series of supplemental qualitative questions that could be added to contextualize each domain of inquiry. These questions are explicitly designed to add context and understanding to the domain scores, but to be *optional* in terms of the objective scoring. Thus, they are best used to characterize the exact nature of each organization's work in a given domain. They can also be used to help identify new areas of transformation that should be added as items to future iterations of the survey or other potential improvements to the tool.

FIELDING: We propose fielding the surveys with a large number of organizational representatives, but selecting a subset of those organizations (from both within and outside of CCOs) to add the qualitative supplement.

SCORING: Every survey item contributes information to one or more of our domain scores, and each domain score is a function of responses to multiple survey items. We compute a "score" in each domain based on the answers we get; our average score across all respondents can be seen as an indication of overall density of transformational elements within a given domain across the system as whole. In our proposed tool, scores in a given domain change when organizations do one of two things: launch new initiatives or elements identified as transformative, or spread existing transformation elements more broadly across their organization. Thus, the scoring gives "credit" for trying more things, but also for picking fewer things and implementing them more widely. Our ultimate goal is to score progress along each of our transformation domains, then track changes in scores over time.

GOALS: Our goals by the end of the grant period include the following:

- To track the "density" of transformation over time across our domains by administering the quantitative tool multiple times across the study period;
- To understand the shape and nature of transformation efforts using the results of the qualitative supplements; and
- To use results from both efforts to improve and refine the tool, leaving OHA with a tool that can be deployed after the grant with minimal additional qualitative effort.

TRANSFORMATION DOMAINS

The SIM workgroup originally identified 16 *transformation domains* that would define an organizations' potential movement toward a more transformed system. This proposed measurement system would create a tool for assessing and scoring organizations along those respective domains.

Here, we propose a simplification of the original domains, combining some into broader domains and splitting others to better distinguish between distinct elements of transformation. We propose capturing data within a total of 11 domains. The following table summarizes the relationship between the original and newer proposed domains; our domains are described in greater detail starting on page 14.

ORIGINAL DOMAIN(s)	NEW DOMAIN NAME	DESCRIPTION
GOVERNANCE & COLLABORATION		
Community Involvement in Governance	Community Involvement in Governance	Measures degree to which community members are actively engaged in the organization's governance and decision making.
Partnerships & Joint Initiatives	Cross-Sector Partnerships	Measures degree to which health care organizations partner across sectors (with public health, social services, or other interconnected systems that fall outside traditional health care).
DATA & INFORMATION SHARING		
EHR Adoption and Use	Integration & Sharing of Health Care Data	Measures how organizations access and share health care data, including physical, behavioral, and dental. Covers both the ease of sharing and the scope of data they are able to share.
Data for Population Management	Using Data for Population Management	Measures how data is actually *used,* in particular, whether data is accessed and/or used that moves beyond traditional clinical care and speaks to upstream or population health approaches.
CARE DELIVERY TRANSFORMATION		
Integration	Integrated, whole-person care models	Covers integration of physical, behavioral, and dental care.
Pharmacy & Medication Management; Site of Care; Care Coordination; Access; Cultural Competency	Better Coordination: Right care in the right place	Covers efforts to better manage care, including improving access, coordinating care to reduce unnecessary visits, or other efforts designed to optimize the efficiency of care delivery
Prevention; Models of Care	Prevention and SDH-informed care	Covers efforts to build upstream activities and thinking into health care, including prevention or population health efforts or care models informed by the social determinants of health.
Workforce	Workforce transformation and diversification	Covers attempts to diversify or broaden the health care workforce to meet a broader array of patient needs, either through non-traditional or multidisciplinary care or improved competency meeting the needs of diverse patient populations.
RISK & REIMBURSEMENT		
Ownership of risk	Ownership of risk	Refers to the proximity of risk to the point of care — whether providers are at "downside" risk for outcomes.
n/a	Integration of risk	Refers to the *types* of risk organizations bear, and the degree to which that risk cuts across the various dimensions of "whole person care."
Incentive Alignment with Value; Redistribution of incentives	Aligning incentives and value	Refers to attempts to incentivize population health or other value-based care or services via "upside risk" for providers (bonuses or other incentives tied to transformation).

MAPPING & SCORING

A. MAPPING OF SURVEY QUESTIONS INTO DOMAINS

We have identified 11 domains of transformation we would like to measure. We propose mapping each question on the survey into one or more domains. Each domain will then receive a score based on the combination of responses to the items contributing to those domains, and we can track that score over time to observe the progress of transformation.

There is certainly room for interpretation about how items contribute to domains, and we do not necessarily picture a mutually exclusive approach — domain scores should be the result of distinct combinations of items, but individual items could contribute to more than one domain score. The following table summarizes our preliminary proposal for mapping items to domains. Our surveys can be found on pages 39-47, and our domains are further detailed starting on page 31.

	PAYER SURVEY QUESTIONS	PROVIDER SURVEY QUESTIONS
GOVERNANCE & COLLABORATION		
CROSS-SECTOR PARTNERSHIPS	8ADE (3)	6DE, 11ADE (5)
COMMUNITY INVOLVEMENT IN GOVERNANCE	8BC, 9ABC, 10 (6)	11BC, 12ABC, 13 (6)
DATA & INFORMATION SHARING		
INTEGRATED & SHARED HEALTH CARE DATA	6AEFHI (5)	7, 8AEFHIJ (7)
USING DATA FOR POPULATION MANAGEMENT	6BCDG (4)	8BCDG (4)
CARE DELIVERY TRANSFORMATION		
INTEGRATED CARE MODEL (PHYS, BEH, DENTAL)	2ABCD, 7B (5)	6ABC, 9AD, 10B (6)
BETTER COORDINATION; RIGHT CARE IN RIGHT PLACE	4A, 7ACG (4)	9E, 10AEGI (5)
PREVENTION & SDH-INFORMED CARE	4BD, 7DEF (5)	10CDFH (4)
WORKFORCE TRANSFORMATION & DIVERSIFICATION	4AC, 5 (3)	9BC (2)
PAYMENT & FINANCE		
OWNERSHIP OF RISK (PROXIMITY TO POINT OF CARE)	3ABCD (4)	1DEFG, 2 (8)
INTEGRATED RISK	1ABCD (4)	1ABC (3)
ALIGNING INCENTIVES & VALUE	4DE (2)	3ABCD, 4ABCD, 5 (9)

B. SCORING OF ITEMS

Every survey item has three responses representing the spread or breadth of that element across an organization, ranging from not much at all (on the right of the scale) to widely present or integrated across the organization (on the left of the scale).

We propose that each answer contribute a number of points toward an organization's transformation score in the domains to which that question contributes, with the least transformed answer providing 0 points (no progress toward transformation) and the most transformed answer providing 2 points.

SCORING EXAMPLE (FROM PROVIDER SURVEY)

4. How easy is it for care providers in your organization to get or share the following kinds of information on your patients?

	Easy or routine	Possible, but not routine	A significant challenge
A. Share data with other providers in your organization to coordinate care	O	O	O
SCORE	**2**	**1**	**0**

In this example, a provider organization that answers "possible, but not routine" would gain 1 point toward its transformation score in any domain associated with item 4A. In our proposed crosswalk, item 4A on the provider survey is associated with the "integrated and shared health care data" domain, so the organization would receive 1 point toward that domain score.

C. SCORING OF DOMAINS

We propose that each organization receive a total "transformation score" for each domain, composed of the sum of the points accumulated across all the items that contribute to that domain.

WHAT SCORES MEAN: By design, scores of a 0 are intended to mean that relatively little of that transformational element is present in the organization. A score of 1 indicates presence, but with limitations (with something in place only via pilots or in a limited number of sites), while a 2 represents widespread adoption throughout the organization.

Organizations that have not accomplished any meaningful milestones in a given dimension would have a net score of 0, representing a more traditional health care organization. It is important to note that transformation scores are not intended to imply value judgments about an organization's optimal choices in the face of transformation, nor do they necessarily represent how good a job they are doing or otherwise reflect "performance." Rather, they are a simple way to assess spread and depth of specific transformative elements the SIM workgroup identified as markers of transformation.

SCORING EXAMPLE (FROM PROVIDER SURVEY)

4. How easy is it for care providers in your organization to get or share the following kinds of information on your patients?

	Easy or routine	Possible, but not routine	A significant challenge
SCORING	**2**	**1**	**0**
D. Access data on patients' food, transportation, housing, or other basic needs	O	O	**X**
E. Access data to track your performance on key quality improvement outcomes	**X**	O	O
G. Data about health needs in the larger community you serve, not just your patients	O	**X**	O

TOTAL DOMAIN POINTS: 3

In this example, a provider organization receives 3 points (out of a possible 6 *points*) in the transformation domain of using data for population management (items 4D, E, and G on the provider survey tool).

The final score for any domain across the entire sample of organizations (or a specified subsample of organizations) will be the average domain scores of all participating organizations.

To move its score, this organization could either introduce new pilots around access to basic needs data (moving item D from 0 to 1) or work to spread its use of data on health needs in the community (moving item G from 1 to 2). Thus, scores can be improved either by trying new initiatives or working to spread/improve existing pilots and models.

HOW SCORES MOVE: Scores are a function both of how many *different* elements an organization is pursuing within a given domain (represented by the number of different items within a domain where the organization scored at least one point), and also the degree to which elements have *spread* through the organization (represented by the numerical score on any given item). Thus, organizations can earn "points" toward transformation either by launching or piloting new ideas and elements, or by working to increase the spread of an existing idea or element across the organization.

POTENTIAL WEIGHTING: Because we are trying to avoid making judgments about which approaches "should" be seen in any given organization or community, we propose weighting each transformation element equally and conceptualizing scores as a construct representing the density of transformational elements rather than an assessment of performance or progress. However, it would also be possible to weight elements within domain scores differentially. For instance, If some elements are seen as particularly crucial to transformation in a given domain, they could be up weighted in the computation of the domain score. For now, we propose not weighting domain scores, at least until a round of data is available and the SIM team can assess the tool's performance in capturing key elements of transformation and discriminating between more and less transformed entities.

POTENTIAL STANDARDIZATION OF DOMAIN SCORES: Our eleven domains consist of between three and seven items, each with a range of responses that can contribute 0-2 "points" toward a domain score. Value ranges for our domains will thus range from 0-6 (for a three item domain) to 0-14 (for a seven item domain).

D. TRACKING TRANSFORMATION & SPREAD

To track transformation and spread across Oregon, we will compute at each assessment point the average domain score (representing the average of all organizational scores in a particular domain of transformation), as well as the average domain score for distinct subsets of organizations including CCOs, non-CCO payer organizations, non-CCO provider organizations, and other groupings as requested. We will then track transformation scores over time.

Because domain scores will be computed as the average scores from a set of surveys within any given subset of organizational respondents, we can compute standard errors for each score and test changes in domain scores over time for statistical significance.

The data will have the greatest value not as assessments of any individual organization, but as a summary snapshot of the "density" of transformation elements present within any given domain across a given sector of the health care landscape.

TRACKING EXAMPLE: DOMAIN SCORES OVER TIME

DOMAIN: USING DATA FOR POPULATION MANAGEMENT

	First Assessment	Second Assessment	Third Assessment
All Organizations (N=XXX)	2.4	2.8	3.4
CCOs (N=XXXX)	2.6	2.8	3.5
Non-CCO Payers (N=XXX)	2.2	2.7	3.2
Non-CCO Providers n=XXX)	2.4	2.8	3.4
Regional Subgroup (N=XXX)	2.4	2.7	3.4
Other Subgroup (N=XXX)	2.4	2.8	3.0

SCORES RANGE FROM 0-6.

In this hypothetical example, scores for a variety of different organizational groupings are compared over time for the domain "using data for population management." Scores represent the average domain score for all organizations in that particular category.

Because scores are computed based on averages from a sample of respondents, standard deviations can be computed and scores can be tested for significant change over time.

Organizations can be grouped into bundles of interest (by type, by geography), and scores can be recomputed for any given bundle to allow for tracking of overall transformation and transformation within any given subset of the data.

E. QUALITATIVE DATA

We have created optional qualitative supplements for each domain on each of our instruments. These open ended questions are intended to solicit more detailed information on the type, nature, and utility of transformation efforts (as opposed to the presence or spread of them within an organization), as well as the particular challenges or successes of an organization's efforts.

We do not anticipate that the qualitative supplement will be administered to every respondent. Instead, we propose selecting a purposive subsample of respondents about whom the SIM team hopes to collect deeper or more nuanced information, then administering the qualitative questions as a supplemental, semi-structured interview with key leaders from that organization. We would then transcribe, code, and analyze that data for key themes and common elements that can inform our quantitative assessment.

This data would serve two key purposes. First, it would be used to contextualize transformation efforts within key industry partners or organizations, as well as providing lessons learned that could help other organizations who are working on similar transformation goals. Second, it can help improve the quantitative assessment tool by identifying areas of transformation activity the tool is either not asking about or capturing with insufficient nuance. This would allow for future iterations of the tool to be improved to capture these elements, creating a more responsive assessment system that can react to changes in the shape of transformation as it unfolds in Oregon.

SIM QUALITATIVE GUIDE

PAYER VERSION

GENERAL

- Please describe your organization. How many lives do you cover? What types of products do you offer?
- How familiar is your organization with the coordinated care model?

RISK

- Is your organization at risk for all elements of a person's health — physical, mental, behavioral, and dental?
- If not, how does your risk profile impact the ability of your organization to respond to a person's overall care needs?

CONTRACTS

- How do your contracting relationships impact your ability to improve coordination of care across the silos — physical, mental, behavioral, dental?
- If you don't contract directly with a given type of provider, but you want to coordinate better with them because what they do impacts your members, what are your strategies?
- What are your view on networks?

PAYMENT STRUCTURES

- Tell us more about the specific payment reforms you are working on?
- What other kinds of payment reform that aren't listed here might help improve care? Is your organization working on developing or piloting these?
- What kinds of payment reform ideas might help improve population health across a community, rather than just improving clinical care?

NON TRADITIONAL REIMBURSEMENT

- Are there other agreements or services you are purchasing that fall outside of traditional health care reimbursement models?
- If your organization isn't working toward reimbursement of non-traditional workforces , what are the key barriers you are facing in doing so?
- If you could (or do) incentive providers around population health metrics, what sort of measures do you use? Have you faced resistance from those providers?

DATA AND INFORMATION SYSTEMS

- When you want to develop an improvement system or program, how hard is it to put together all the data you need to do it right? What are the main barriers?
- Is the data you have really actionable? How easy is it to share with providers and other partners, and how often do they actually use it?
- In addition to sharing data across silos of health care, what are the barriers to sharing data beyond health care — for instance, with social service, corrections, public health, or other connected systems?
- Do you have any way to see data on the basic needs of your members — food, transportation, housing, and so on? If you could, how would you use that data to help transform care for your members?

SIM QUALITATIVE GUIDE

PAYER VERSION, CONTINUED

TRANSFORMATION SYSTEMS

- Tell us more about the specific transformation initiatives or programs you are working on as an organization? Which are you highest priorities?
- Are there other important transformation initiatives we haven't captured?
- What are the key barriers you've faced in launching and/or spreading transformation initiatives?
- Are providers usually on the same page with these initiatives, or do they sometimes create friction? What are the main sticking points?
- Are you working on any initiatives that try to connect health care to connected systems outside of health care (such as corrections, social services, and so on)? What do those look like, and what are the challenges you've faced in launching them?

PARTNERSHIPS AND ENGAGEMENT SYSTEMS

- Has your organization developed any new strategic partnerships over the last 3 years?
- What does engagement and feedback with these groups look like in your organization? How is that feedback collected, and who "presents" it in your meetings?
- Who decides whether feedback is incorporated or not into a decision? Who communicates that decision back to the stakeholders, if they aren't already present?
- What kinds of decisions are most important for you to engage with stakeholders? Are there decisions where your organization would prefer to act without that engagement?

COMMUNITY INVOLVEMENT

- How did (or do) you find the community members who serve in your organization? Are they connected to partners you work with?
- If community members vote or otherwise actively participate in decisions, how much of the total "vote" do they represent? Are they just one or two votes out of many, or a significant proportion of the total votes?
- Are there specific times or issues where community members don't attend meetings or vote, even if they are typically part of your board or governing structure? What characterizes those times?

CONCLUSION

- We discussed how your organization has been changing. All told, what would you define as the motivation behind making these changes?

SIM QUALITATIVE GUIDE

PROVIDER VERSION

GENERAL

- Please describe your organization. What types of clinics are within your umbrella? What is your patient mix?
- How familiar is your organization with the (or coordinated care) model?

RISK

- How are you working toward incorporating payment reform into your practices? How are risk, incentives, and payments changing?
- How much risk does your organization and the practices within it take on? How meaningful is the financial impact?
- How does your risk profile impact the ability of your organization to respond to a person's overall care needs?
- What about patients taking on more risk/consumer engagement in care?
- Tell us more about how your organization feels about/is responding to the call for payment reform?

COLLABORATION

- How do your contracting relationships impact your ability to improve coordination of care across physical, mental, behavioral, and dental health?
- If you don't contract directly with a given type of provider, but you want to coordinate better with them because what they do impacts your patients, what are your strategies?

DATA AND INFORMATION SYSTEMS

- How actionable is your data? How easy is it to share with providers and other partners, and how often do they actually use it?
- In addition to sharing data across silos of health care, what are the barriers to sharing data beyond health care — for instance, with social service, corrections, public health, or other connected systems?
- How does your organization use data to tackle any or all of the following: population health, preventative care, or social determinants of health?

MODELS OF CARE

- How are you using team-based care/the medical home model to improve population health?
- What is your strategy around the medical home model among clinics under your organizational umbrella?
- What kinds of efforts are clinics undertaking to improve cultural competency?
- How are you working towards improved care integration or better "whole person" care, and what role is payment reform playing in that?

TRANSFORMATION SYSTEMS

- Tell us more about the specific transformation initiatives or programs you are working on as an organization? Which are you highest priorities?
- What are the key barriers you've faced in launching and/or spreading transformation initiatives?
- Are providers usually on the same page with these initiatives, or do they sometimes create friction? What are the main sticking points?
- Are you working on any initiatives that try to connect health care to connected systems outside of health care (such as corrections, social services, and so on)? What do those look like, and what are the challenges you've faced in launching them?
- Do you have concerns about provider shortages at your organization? How are you ensuring that patients have access to providers when they need the?
- Are you working on any initiatives to try and reduce high-cost utilization (like ED visits) in favor of primary care? What do those look like, and what are the challenges you've faced in launching them?

SIM QUALITATIVE GUIDE

PROVIDER VERSION, CONTINUED

PARTNERSHIPS AND ENGAGEMENT SYSTEMS

- Has your organization developed any new strategic partnerships over the last 3 years?
- What does engagement and feedback with these groups look like in your organization? How is that feedback collected, and who "presents" it in your meetings?
- Who decides whether feedback is incorporated or not into a decision? Who communicates that decision back to the stakeholders, if they aren't already present?
- What kinds of decisions are most important for you to engage with stakeholders? Are there decisions where your organization would prefer to act without that engagement?

COMMUNITY INVOLVEMENT

- How did (or do) you find the community members who serve in your organization? Are they connected to partners you work with?
- If community members vote or otherwise actively participate in decisions, how much of the total "vote" do they represent? Are they just one or two votes out of many, or a significant proportion of the total votes?
- Are there specific times or issues where community members don't attend meetings or vote, even if they are typically part of your board or governing structure? What characterizes those times?

CONCLUSION

- We discussed how your organization has been changing. All told, what would you define as the motivation behind making these changes?

HEALTH CARE TRANSFORMATION

TRACKING SURVEY

—PROVIDER VERSION—

This survey is designed to collect information about your organization's journey through health care transformation. Please give your best estimate in response to each question, and skip any questions you aren't sure how to answer.

We're collecting this data in order to catalogue the different ways health care organizations are responding to transformation. We aren't rating organizations against each other in terms of performance; instead, the intent is to understand and monitor the overall transformation landscape in Oregon.

YOUR RISK ARRANGEMENTS

1. In how many of your contracts with payers does your organization bear the following types of financial risk?

	Most or all of our contracts (>50%)	Some of our contracts (1%-49%)	None of our contracts (0%)
A. Risk for physical health care	O	O	O
B. Risk for mental or behavioral health	O	O	O
C. Risk for care your patients get in a different setting (such as the ED)	O	O	O
D. Bundled payments around care episodes	O	O	O
E. Withholds designed to incentivize quality	O	O	O
F. Other kinds of risk arrangements not mentioned here	O	O	O
G. What proportion of your patients are covered by a risked-based contract?	O	O	O

2. What proportion of your patients are covered by a risked-based contract?

- O All or nearly all (>50%)
- O Some, but not all (1%-49%)
- O None (0%)

3. What type of payers comprise your risked-based contracts? Select all that apply.

	Most or all of our risk based contracts (>50%)	Some of our risk-based contracts (1%-49%)	None of our risk based contacts con-tracts (0%)
A. Medicaid	O	O	O
B. Medicare	O	O	O
C. Commercial/Private	O	O	O
D. NA/No Risk based contracts	O	O	O

INCENTIVE STRUCTURES

4. In how many of your contracts with payers does your organization have a chance to qualify for the following kinds of incentive or bonus payments?

	Most or all of our contracts (>50%)	Some of our contracts (1%-49%)	None of our contracts (0%)
A. Incentives for clinical quality performance	O	O	O
B. Incentives for integration of physical, mental, and behavioral health	O	O	O
C. Incentives for reducing ED or hospital visits by your patients	O	O	O
D. Incentives for screenings or other types of preventive care	O	O	O

5. How confident are you that the quality and clinical outcomes used to determine the incentives are accu-rate?

- O Very confident
- O Somewhat confident
- O Not at all confident

COLLABORATIONS

6. Do you or your organization collaborate or partner directly with the following types of service providers in order to provide better whole-person care?

	Yes, Extensively	Yes, in small or Limited Ways	No
A. Mental health care providers	O	O	O
B. Substance use care providers	O	O	O
C. Dental health care providers	O	O	O
D. Public health or social service agencies	O	O	O
E. Community groups or advocacy organizations	O	O	O

DATA & INFORMATION SYSTEMS

7. How many of the care providers in your organization are connected via an electronic health record?

- O All or nearly all (>50%)
- O Some, but not all (1%-49%)
- O None (0%)

8. How easy or routine is it for care providers in your organization to get or share the following kinds of information on your patients?

	Easy or routine	Possible, but not routine	A significant challenge
A. Integrate outpatient and inpatient data from providers within your organization?	O	O	O
B. Integrate outpatient and inpatient data from providers outside your organization	O	O	O
C. Access data on all aspects of a patients' health—physical, mental, & dental	O	O	O
D. Access data on patients' food, transportation, housing, or other basic needs	O	O	O
E. Access sophisticated systems for predictive risk assessment and risk stratification for patient populations?	O	O	O
F. Access registries to track chronic illness and preventative measures?	O	O	O
G. Access data about health needs in the larger community you serve, not just your patients	O	O	O
H. Access data on addiction services	O	O	O
I. Transmit prescriptions to pharmacies and confirm whether they have been filled electronically?	O	O	O
J. Access to information on patients' race, ethnicity, and primary language	O	O	O

MODELS OF CARE

9. Have clinics within your organization adopted any of the following models of care?

	Yes, all or nearly all	Yes, some	No
A. Patient Centered Primary Care Home (PCPCH) recognition	O	O	O
B. Multidisciplinary, team-based care	O	O	O
C. Employing non-traditional workforce (community health workers, peer support, etc.)	O	O	O
D. Culturally sensitive care programs or initiatives	O	O	O
E. Programs focused on targeting a specific group of patients (high utilizers, etc.)	O	O	O

OTHER TRANSFORMATION INITIATIVES

10. Has your organization launched any provider-level initiatives or efforts designed to do any of the following?

	Yes, large scale or major efforts	Yes, some pilots or small efforts	No
A. Referral pathways between physical, mental, behavioral, and dental health resources	O	O	O
B. Co-location of physical, mental, behavioral, and/or dental providers	O	O	O
C. Mechanism for referrals for basic patient needs (e.g. food, housing, transportation)	O	O	O
D. Medication management for at risk patients	O	O	O
E. Programs to better manage care transitions	O	O	O
F. Efforts to improve access to clinicians	O	O	O
G. Programs to encourage appropriate utilization among your patients	O	O	O
H. Preventative care promotion initiatives	O	O	O
I. Other population health focused initiatives or programs	O	O	O

PARTNERSHIPS & ENGAGEMENT

11. How often does your organization's governing body partner with or meaningfully incorporate feedback from the following communities into its decision making?

	Most decisions include this feedback	Some decisions include this feedback	Few or no decisions include this feedback
A. Physicians and/or other direct care providers	O	O	O
B. Patients who get care in your organization	O	O	O
C. At large community residents or laypersons	O	O	O
D. Public health or social services agencies/groups	O	O	O
E. Partners outside health services, like education or criminal justice	O	O	O

COMMUNITY INVOLVEMENT

12. How extensively are patients or at-large community members involved in your organization's actual decision making?

	They have meaningful voting power	They discuss & participate, but don't vote	Their feedback may be solicited, but no direct role
A. Decisions about organizational strategy or vision	O	O	O
B. Decisions about which programs or efforts should be prioritized	O	O	O
C. Decisions about how funds are allocated for new programs/initiatives	O	O	O

13. How would you describe your organization's future plans in terms of community involvement in governance and decision making?

- O We want to expand community involvement
- O We're happy with the way things are now
- O We want to reduce or minimize community involvement

HEALTH CARE TRANSFORMATION

TRACKING SURVEY

—PAYER VERSION—

This survey is designed to collect information about your organization's journey through health care transformation. Please give your best estimate in response to each question, and skip any questions you aren't sure how to answer.

We're collecting this data in order to catalogue the different ways health care organizations are responding to transformation. We aren't rating organizations against each other in terms of performance; instead, the intent is to understand and monitor the overall transformation landscape in Oregon.

YOUR RISK PORTFOLIO

1. Thinking about your products, how often does your organization bear **direct risk** for the following types of care?

	Most or all of our products (>50%)	Some of our products (1%-49%)	None of our products (0%)
A. Physical health care	O	O	O
B. Mental health care	O	O	O
C. Substance use care	O	O	O
D. Dental health care	O	O	O

YOUR PROVIDER CONTRACTS

2. Does your organization contract directly with any of the following types of service providers?

	Yes, Extensively	Yes, in small or limited Ways	No
A. Physical health care	O	O	O
B. Mental health care	O	O	O
C. Substance use care	O	O	O
D. Dental health care	O	O	O

YOUR PAYMENT STRUCTURES

3. How often do your provider contracts include the following types of payment elements?

	Most or all of our contracts (>50%)	Some of our contracts (1%-49%)	None of our contracts (0%)
A. Meaningful risk shared by the care providers	O	O	O
B. Bundled payments around care episodes	O	O	O
C. Case rates for care providers	O	O	O
D. Provider withholds to incentivize quality	O	O	O

NON-TRADITIONAL REIMBURSEMENT

4. How many of your provider contracts include incentives or direct payments for providing any of the following types of services?

	Most or all of our contracts (>50%)	Some of our contracts (1%-49%)	None of our contracts (0%)
A. Social workers or care navigators to provide better coordinated care	O	O	O
B. Enabling services for non-clinical patient needs such as food or housing	O	O	O
C. Non-traditional workforces, like community health workers or peer support networks	O	O	O
D. Incentives for providers to reduce ED or hospital visits for patients	O	O	O
E. Incentives tied to population health metrics rather than clinical care	O	O	O

5. For your contracts that don't formally allow payment for non-traditional healthcare services, how often are billing rules relaxed to allow providers flexibility to provide these services?

O Frequently O Occasionally O Never

DATA & INFORMATION SYSTEMS

6. How easy or routine is it for you to get or share the following kinds of information on your members or beneficiaries?

	Easy or routine	Possible, but not routine	A significant challenge
A. Integrate outpatient and inpatient data from providers within your organization?	O	O	O
B. Integrate outpatient and inpatient data from providers outside your organization	O	O	O
C. Access data on all aspects of a patients' health—physical, mental, & dental	O	O	O
D. Access data on patients' food, transportation, housing, or other basic needs	O	O	O
E. Access sophisticated systems for predictive risk assessment and risk stratification for patient populations?	O	O	O
F. Access registries to track chronic illness and preventative measures?	O	O	O
G. Access data about health needs in the larger community you serve, not just your patients	O	O	O
H. Access data on addiction services	O	O	O
I. Access to information on patients' race, ethnicity, and primary language	O	O	O

TRANSFORMATION INITIATIVES

7. Has your organization launched any initiatives or efforts designed to do any of the following?

	Yes, large scale or major efforts	Yes, some pilots or small efforts	No
A. Encourage the spread of patient-centered primary care homes	O	O	O
B. Better integration of physical, mental, behavioral, and dental health	O	O	O
C. Better care coordination for high priority or high utilizer members	O	O	O
D. Better integration with connected systems outside health care (social services, housing, etc.)	O	O	O
E. Flex funds or other programs to support health engagement & lifestyle change	O	O	O
F. Health & prevention initiatives focused on the larger community, not just your own members	O	O	O
G. Improve access to care for your members	O	O	O
H. Health initiatives to reduce disparities for populations such as race, ethnicity, location (rural vs urban), etc.	O	O	O

PARTNERSHIPS & ENGAGEMENT

8. How often does your organization partner with or meaningfully incorporate feedback from the following communities into your decision making?

	Most decisions include this feedback	Some decisions include this feedback	Few or no decisions include this feedback
A. Physicians and other care providers	O	O	O
B. Members or consumers of your products	O	O	O
C. At large community residents or laypersons	O	O	O
D. Public health or social services agencies/groups	O	O	O
E. Partners outside health services, like education or criminal justice	O	O	O

COMMUNITY INVOLVEMENT

9. How extensively are consumers or at-large community members involved in your organization's decision making?

	They have meaningful voting power	They discuss & participate, but don't vote	Their feedback may be solicited, but no direct role
A. Decisions about organizational strategy or vision	O	O	O
B. Decisions about which community needs should be prioritized	O	O	O
C. Decisions about how funds are allocated for new programs/initiatives	O	O	O

10. How would you describe your organization's future plans in terms of community involvement in governance and decision making?

O We want to expand community involvement

O We're happy with the way things are now

O We want to reduce or minimize community involvement